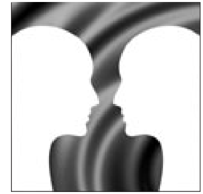

Mental illness: diagnostic title or derogatory term? (Attitudes towards mental illness) Developing a learning resource for use within a clinical call centre. A systematic literature review on attitudes towards mental illness

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Mental Illness: diagnostic title or derogatory term? (Attitudes towards mental illness) Developing a learning resource for use within a clinical call centre. A systematic literature review on attitudes towards mental illness

With one in three people likely to experience mental health problems during their lifetime, it is paradoxical that stigma and negative attitudes towards mental illness are so prevalent in the UK today. This systematic literature review was completed to investigate what the most common negative attitudes towards mental illness are, and the most common recommendations made to address them. The findings were used to inform teaching resources used in an National Health Service Direct call centre. Guidelines for undertaking a systematic review, produced by the Centre for Reviews and Dissemination, were used. Terms were set and a search of electronic databases and peer-reviewed academic journals was completed, from which 16 primary research papers (from the UK) were obtained and used. These were assessed, using evidence-based critical appraisal tools, to obtain data pertinent to the original question. This paper describes the process, including a detailed account of the methodologies employed to gather and analyse relevant data. Put into context, alongside key drivers (e.g. government papers), the findings are presented and discussed, along with underlying theories, where appropriate. Recommendations for professional practice are then presented.

Keywords: clinical call centre, mental health, mental health education, NHSD, negative attitudes, systematic literature review

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Introduction

'Wog', 'yid', 'chinky', 'paki', 'kraut' and 'coon' are not words one would expect to hear in a clinical healthcare setting – and if they were, the person using them would undoubtedly be challenged. Why, then, is it apparently acceptable to hear the terms 'nutter', 'loony', 'schizo' or 'weirdo' – used in relation to some people who have mental health problems (most often those who have a severe and enduring mental illness)? And why does use of these terms rarely go unchallenged (Putman 2002)?

Mental illness and negative attitudes towards it are extremely common; government figures show, at any time, one in six people in the UK will be experiencing mental distress, and the lifetime risk of having a mental health problem is as high as one in three [Department of Health

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(DoH) 2006]. For such a common condition, the prevalence of negative attitudes is a paradox which needs to be addressed.

Lack of knowledge and understanding of mental illness has been given as a reason for the use of terms mentioned in the opening paragraph, but in reality, the words are a stark demonstration of negative attitudes and as they can have such a distressing impact on the people who experience them, use of these terms should be challenged at every opportunity.

Negative attitudes towards people with mental illness are recognized as a major public health problem. In an effort to address this, the government has joined a 5-year international campaign to fight stigma and discrimination by supporting 'Shift' (Shifting Attitudes and Behaviour to Mental Health) through the work of the National Institute of Mental Health in England (NIMHE 2005). In addition, mental health promotion is the first standard in the National Service Framework for Mental Health (NSFMH) (DoH 1999). Raising awareness and educating people about mental illness should help reduce negative attitudes.

National Health Service Direct (NHSD) has been introduced in England and Wales as part of the government modernization programme (DoH 1997). The main aim of NHSD is to provide confidential healthcare information and advice enabling people to make informed decisions for themselves. Registered nurses screen callers' symptoms, using a computer decision support software system, and provide advice on treatment options. NHSD also aims to reduce inappropriate use of ambulance and accident and emergency services by providing advice on self-management. Being available 24 h a day 365 days a year makes NHSD easily accessible and reduces pressure on other primary care services.

Healthcare provision via telephone helplines has originated in the United States where they have been introduced to reduce healthcare costs (Turner *et al.* 2002). The need to reduce pressure on primary care health providers has led to increased use of helplines throughout the world (Donaldson 2000).

In the UK, a large number of registered nurses work for NHSD (and other healthcare telephone helpline services), but unqualified healthcare advisors initially prioritize calls and manage 'health information' enquiries using the computer decision support system. NHSD receives about 500 000 calls a month and in 2006 employed 3746 whole-time equivalent nurses (Mulholland 2006).

In 2000, as a result of an evaluation of NHSD by Sheffield University (Munro *et al.* 1998), the government funded a year-long mental health project to improve the service delivered to people experiencing mental health problems, and each individual NHSD site (22 at the time) appointed a mental health site lead (MHSL). At the end of the project, it was agreed that the MHSL role should become a permanent feature within NHSD, and objectives were set to continue to assist NHSD with the implementation of the NSFMH (DoH 1999).

Part of the MHSL role is the responsibility for the development, delivery and evaluation of all mental health teaching sessions for staff, from induction to ongoing knowledge reviews, individual coaching and personal development sessions. It is also to be a catalyst, inspiring and educating others – particularly those who have little or no positive experience of working with people who have a mental illness. The MHSL is therefore in a strong position to identify and address any negative attitudes within NHSD.

Although many important and significant areas are covered in the education programme for NHSD staff, one area remains poorly addressed: that of reducing negative attitudes associated with mental illness. Not all staff are able to develop an essential rapport with people experiencing mental health problems (particularly when that rapport has to be established via the telephone), and this has the potential for a negative effect on the subsequent outcome for the patient (Hawton *et al.* 1995, Friedman *et al.* 2005).

Analysis of the computer-based clinical screening algorithms used and internal audit of 'frequent callers' (examining details of the patient's presenting symptoms and subsequent management) shows that many of the frequent and challenging callers to NHSD have a diagnosed mental illness. A list of these symptoms is shown below:

- anxiety;
- attempted suicide;
- behaviour change;
- delusions;
- hallucinations;
- low mood;
- manic behaviour;
- mental confusion;
- mood swings;
- obsessive or compulsive behaviour;
- paranoia;
- self-harm;
- sleep disturbance;
- suicide ideation.

This client group forms a significant number of the total 'mental health' calls received each day. This often generates anxiety amongst the operational staff, which subsequently manifests itself in negative attitudes to all patients with a mental illness, thus perpetuating the phenomena.

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Methods

Aim

The purpose of this paper is to present a summary of a literature review which systematically examined published research about attitudes to mental illness which had been completed within the last 10 years, comparing and contrasting the papers to establish what the common themes and recommendations are, so this knowledge can be used to inform the development of learning resources for use within NHSD.

Design

The NHS Centre for Research Dissemination Guidelines for completing a systematic review (Khan *et al.* 2001), were adopted in order to consider the proposal stated above.

Search methods

The search was completed between 1 March and 31 May 2006. Inclusion criteria were as follows:

Requirement	Rationale
• Primary research, completed in the UK between 1 January 1996 and 31 March 2006	Attempt to capture the most recent literature To have confidence in the validity and to reduce potential bias Findings of research completed outside of UK may not be transferable. Avoids overload in the searches
• Published in a reputable publication (only academic, peer-reviewed journals were used)	Reduces the risk of obtaining unreliable work
• Published in English	For ease of review and confidence in understanding
• Obtained free of charge	No funding to support review

Literature was searched for using recognized electronic databases via an Athens account. Databases used are shown in Table 1. Search engines used are shown in Table 2.

The following keywords were used:

- attitudes to mental illness;
- attitudes;
- mental illness;
- stigma;
- stigma to mental illness;
- public attitudes to mental illness.

Table 1
Databases used and rationale for use

Database	Rationale for use
Ovid (full-text journals)	Access to electronic journals and electronic book collections
Science Direct	Access to over 1500 scientific, technical and medical peer-reviewed journals, links to papers from over 80 publishers
ProQuest	Electronic access to over 850 medical, nursing, psychology and other clinical journals for National Health Service (NHS) staff
NHS National Library for Health	Access to all NHS library and information services
BioMed Central (*BMC Psychiatry*)	Scientific publisher providing free access to peer-reviewed biological and medical research
Directory of Open Access Journals, web based	Categorized, searchable links to free, full-text, quality-controlled scientific and scholarly journals
MyLibrary	Offers facility for users to compile their own individual library resources on line

Source: MyAthens, 14 June 2006 ('MyAthens' is a computer access management system that simplifies access to internet resources).

Table 2
Search engines/web sites used and rationale for use

Place	Rationale for use
Google (Google Scholar)	Search engine, offering UK-specific pages as well as world results; provides a search of scholarly literature across many disciplines and sources
http://www.rcpsyc.ac.uk/	The professional and educational body for psychiatrists in the UK and the Republic of Ireland, access to research papers
British Journal of Psychiatry	Published monthly by the Royal College of Psychiatrists, full-text online version
Personal Social Services Research Unit (PSSRU)	The PSSRU has branches in three UK universities, carrying out independent research aimed at improving the equity and efficiency of social and health care
Lancet	A general medical journal – coverage is international and extends to all aspects of human health

Source: MyAthens, 14 June 2006.

Other information was obtained from an internet search of UK national newspapers and web sites of charities and organizations working for people with mental health problems (see Table 3).

Where material from these sources was used, the reputation of the commissioning and publishing organizations were investigated to ensure reliability and assess compliance to ethical rigour. This was achieved by scrutinizing each organization's research governance processes. All met equivalent standards to those required for research studies in the NHS, in line with the Research Governance guidance (DoH 2005).

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Attitudinal theory was considered in order to gain an understanding of how attitudes arise and are sustained, and also to critique methods suggested to reduce them [Allen 1990, Goffman 1990, Biddiss 1997, Byrne 1997, Porter 1998, Haralambos & Holborn 2004, Mental Health Aftercare Association (MACA) 2004, Watts *et al.* 2004, Southwark 2005, Appleby 2006, Trueman 2006].

Search outcome

Seventeen million one hundred thirty-eight thousand one hundred fifteen papers were initially identified through the search process. This was significantly reduced to 31, by refining the keywords and selecting only those meeting the exact requirements. These were then reviewed in more detail for inclusion suitability. Using the funnel technique (Grbich 1998), these papers were reduced to the final 16 (listed in Table 4), which were then subjected to further analysis using a recognized appraisal tool (see Fig. 1).

The review included studies from a variety of subject groups – people living with a mental illness; healthcare

Table 3
National newspapers and mental health charities (listed in alphabetical order)

National newspapers	Charities/organizations
The Guardian	Mental Health Alliance
The Daily Express	Mental Health Foundation
Daily Mail	Mentality
The Independent	Mind
The Mirror	National Institute for Health and Clinical Excellence
The Sun	National Institute of Mental Health in England
Telegraph	Rethink
Times	Sainsbury Centre for Mental Health
	The Health Care Standards Unit
	Together (formerly Mental Health Aftercare Association)

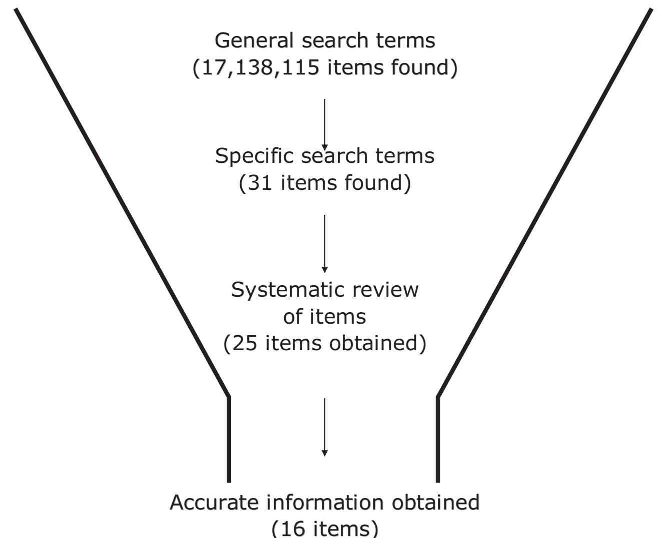

Figure 1
The funnelling technique as applied to literature searching. Source: Grbich (1998)

Table 4
Final papers included in review (listed in alphabetical order)

Addison S. & Thorpe S. (2004) Factors involved in the formation of attitudes towards those who are mentally ill. *Social Psychiatry and Psychiatric Epidemiology* **39**, 228–234.
Brinn F. (2000) Patients with mental illness: general nurses' attitudes and expectations. *Nursing Standard* **14**, 32–36.
Crisp A. Gelder M., Rix S., Meltzer H. & Rowlands O. (2000) *Stigmatisation of People with Mental Illness*. Office of National Statistics survey for the Royal College of Psychiatrists, HMSO, London.
DePonte P., Bird L. & Wright S. (2000) *Pull Yourself Together A Survey of the Stigma and Discrimination Faced by People Who Experience Mental Distress*. ISBN 0 90194487 4. Mental Health Foundation.
Dinos S., Stevens S., Serfaty M., Weich S. & King M. (2004) Stigma: the feelings and experiences of 46 people with mental illness. *British Journal of Psychiatry* **184**, 176–181.
DoH (2003) *Attitudes to Mental Illness*. HMSO, London.
Hannigan B. (1999) Mental healthcare in the community: an analysis of contemporary public attitudes towards, and public representations of, mental illness. *Journal of Mental Health* **8**, 431–440.
Kingdon D., Sharma T. & Hart D. (2004) What attitudes do psychiatrists hold towards people with mental illness? *Psychiatric Bulletin* **28**, 401–406.
MACA (2004) *Reporting Mental Illness. A Survey of Journalists' Attitudes to Covering Mental Health Stories*.
Mukherjee R., Fialho A., Wijetunge A., Checinski K. & Surgenor T. (2002) The stigmatisation of psychiatric illness: the attitudes of medical students and doctors in a London teaching hospital. *Psychiatric Bulletin* **26**, 178–181.
National Institute of Mental Health in England (2005) *Shift Media Survey*. Final Report to NIMHE. Sainsbury Centre for Mental Health/Mental Health Media/Rethink.
Pinfold V., Toulmin H., Thornicroft G., Huxley P., Farmer P. & Graham T. (2003) Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry* **182**, 342–346.
Read J. & Baker S. (1996) *Not Just Sticks and Stones.* Mind, London.
Secker J., Armstrong C. & Hill M. (1999) Young people's understanding of mental illness. *Health Education Research* **14**, 729–739.
Warner L. (2002) *Out at Work. A Survey of the Experiences of People with Mental Health Problems within the Workplace*. ISBN 1 903645 28X. Mental Health Foundation.
Wolff G., Pathare S., Craig T. & Leff J. (1996) Community attitudes to mental illness. *British Journal of Psychiatry* **168**, 183–190.

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professionals; young people and members of the general public. Although it focused on the UK, no studies from Northern Ireland were found.

A combined total of 9985 people were involved as subjects over a 10-year period. The age range was from 12 to 80 years; all social groups and occupations [as categorized by the Office for National Statistics (2003)] were represented, ensuring this work reflects the views of a wide range of the British public.

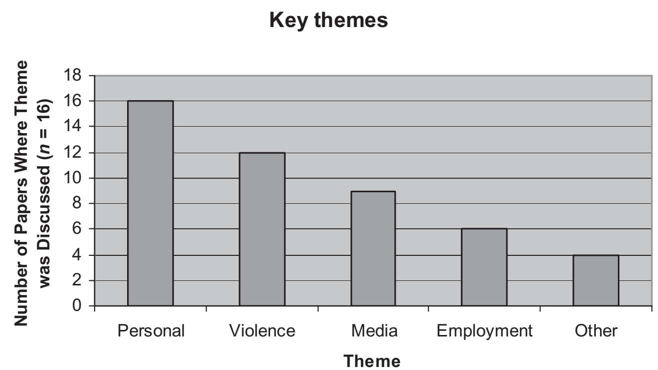

Figure 2
Summary of key themes

Table 5
Individual components of themes

Personal	Violence
Selves to blame	From people with mental illness:
Never recover	Afraid of attack
Hard to talk to	Fear of violence
Should pull self together	About people with mental illness:
Burden on society	Unpredictable behaviour
Don't deserve sympathy	Expect aggression
Are weak	Danger to others
Lack self-control	Likely to be violent
Problems with family and friends	
Lack of confidence	
Feel different	

Media	Employment
Link with violence	Lack of employment opportunities
Negative representation	Patronizing attitude from colleagues
Frequent words used to describe person with mental illness:	Feeling more monitored (at work)
Mad	Not given responsibility
Madman	Mistakes attributed to mental distress
Nutter	Snide/sarcastic comments from colleagues
Psycho	
Maniac	
Crazed/crazy	
Nut	

Other
Lack of understanding
Discrimination

Source: Individual statements from papers reviewed.

Quality appraisal

The Research Appraisal Checklist (RAC) by Duffy (1985) was the appraisal tool used, with minor alterations to make it relevant for this study (additional columns were added to record the negative attitudes and recommendations mentioned in the papers). The RAC contains 51 criteria which have been ordered under eight major research categories. It has been designed to assist careful and systematic assessment of the worth of written research reports. All papers included used a qualitative approach.

Data abstraction

Data were extracted from the completed RAC forms using tables to identify key themes. 'Key' themes were those recurrent themes which appeared in several papers. An Excel spreadsheet was designed to facilitate this process.

Synthesis

The tables previously described were analysed to establish any similarities between the findings – for both negative attitudes and also for the recommendations made to address them. These were then recorded in an Excel spreadsheet and the themes grouped under headings to facilitate clear reporting of the findings.

Results

Findings: most common negative attitudes

Negative attitudes towards people with mental illness is a very broad subject; the presence of which is likely to depend on a number of factors. Analysis of the selected evidence identified five main themes, as shown in Fig. 2.

A breakdown of the components of the themes is shown in Table 5 and is discussed below.

For people with mental illness, the breakdown in family and social life is common. This may be partly due to the effects of the illness itself (e.g. less motivation, low self-esteem with depression; thought disorder, with psychosis), but many respondents attributed it to lack of understanding, based on ignorance of mental illness, from family, friends and work colleagues – where relevant (Read & Baker 1996, DePonte *et al.* 2000, Dinos *et al.* 2004).

Less negative responses were reported to a diagnosis of depression than to schizophrenia or bipolar affective disorder.

Conflicting evidence was found where respondents agreed having people with a mental illness as neighbours

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would be acceptable, yet still perceived this group as being more likely to be violent and therefore undesirable to have in the neighbourhood (Wolff *et al.* 1996, DoH 2003).

The one common element was fear of violence, with all groups expressing fear of physical attack. It seems ironic that both people with a mental illness and those without should share the same fear. Research demonstrates more people with mental illness are likely to be the victim of physical abuse or attack than vice versa (DoH 2001a).

This fear was found in all groups of respondents: young people (Secker *et al.* 1999, Pinfold *et al.* 2003), general public (Wolff *et al.* 1996), healthcare professionals (Brinn 2000, Mukherjee *et al.* 2002) and people with mental illness (Warner 2002, Dinos *et al.* 2004). People with mental illness were fearful of attack from the general public, not from others with mental illness.

It appears there is little difference between social class, gender or ethnicity – the fear is present in all groups although Wolff *et al.* (1996) comment that it may be the ‘lack of knowledge’ about mental illness, rather than social situation and upbringing, influencing the presence of negative attitudes.

Schizophrenia appears to have the worst prospects in terms of negative attitudes. It is associated most commonly with a perceived propensity for violence (Wolff *et al.* 1996, Brinn 2000, DePonte *et al.* 2000, Mukherjee *et al.* 2002). Only doctors recognized that the assessment of an individual’s mental state is more useful in determining the level of risk of violence (Mukherjee *et al.* 2002) and applies to any type of mental health problem, not just schizophrenia.

Even within the ‘patient’ group, there appears to be a hierarchy of diagnostic terms, which indicate the prevalence of associated negative attitudes, whereby to have ‘depression’ is less stigmatizing than to have ‘schizophrenia’ (Warner 2002, Dinos *et al.* 2004).

The impact of negative attitudes towards mental illness for the general public appears to be based on ignorance, and peoples’ views are influenced by what they see and read in the media (NIMHE 2005).

Almost every study mentioned the influence of the media in establishing and perpetuating negative attitudes towards mental illness. All media forms were considered, written and broadcast (Hannigan 1999, Dinos *et al.* 2004, MACA 2004, NIMHE 2005).

The MACA (2004) and NIMHE (2005) studies confirmed what was already known about the media representation of mental illness, in that there is less coverage about mental illness than physical illness, and the coverage is four times as likely to be negative than positive (Lawrie 2000 as cited in NIMHE 2005). These two studies represent a thorough investigation using newspapers, television, radio and popular magazines to explore the phenomenon.

Where people with mental illness were employed, the personal impact was fear of losing their job. Many people reported difficulty telling their employers about their diagnosis; some believed they had been dismissed or were denied access to employment because of their illness. Others found colleagues were unsupportive and made snide remarks, or felt they had to perform at a higher level to ‘make up’ for the fact that they had an illness (Warner 2002).

Read & Baker (1996) reported the most ‘intolerant’ group of employers were within health and social care. The worst cases of overt displays of negative attitudes reportedly came from the nursing and social work professions. This was also mentioned by Warner (2002) who highlighted how people from these professional groups who had a mental illness felt harassed, intimidated and were teased by colleagues.

Warner (2002) found this response was not universal as some people did receive positive support from their employers (most often, these were people working for a mental health organization).

The remaining negative attitudes were reported under the title of ‘other’ and included lack of understanding and discrimination. These are rather vague, subjective terms and, as such, the impact and interpretation of them varied. Both elements were most commonly associated with effects on employment and engagement with family/friends (Dinos *et al.* 2004).

The overwhelming evidence is in support of distress being caused by negative attitudes from the general public towards people with mental illness. This finding is significant when put into context of the sample size.

Findings: recommendations

With regard to recommendations made to address these issues, education – of the public and professionals – was the most common (see Fig. 3).

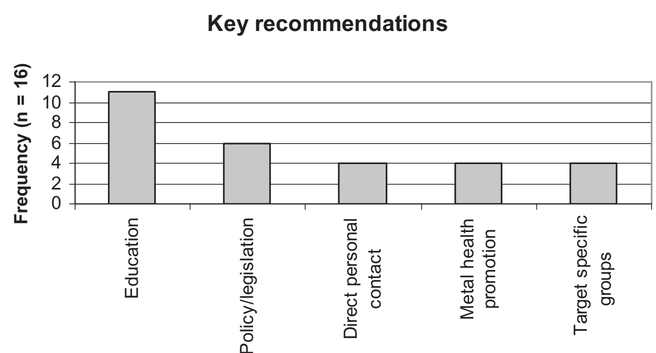

Figure 3
Summary of key recommendations

Training programmes for medical (Kingdon *et al.* 2004) and general nursing staff do not appear to include sufficient exposure to mental illness. Nurse training has undergone significant changes since the introduction of Project 2000 when universities initiated student nurse education. Although this brought about many advantages, one disadvantage was the physical separation between the university and placement areas, thus reducing the availability of suitable clinical placements (Rivett 2006).

Mental illness has ceased to be a mandatory part of the 'general adult' course so not all students have the opportunity to experience working with the mentally ill.

Better education of the public is also essential. Secker *et al.* (1999) and Pinfold *et al.* (2003) both raised this in their studies, which involved young people. Attitudes are formed during childhood and, once established, can be hard to change. It must be better to support the development of positive attitudes from an early age than to try and change them once adulthood is reached. Developing systems for people with mental illness to visit schools and talk to the students about their condition should be encouraged. Users and carer groups are well established throughout the country and could be utilized to support this.

Direct personal contact with people who live with mental illness may also improve the education of nursing, medical and social work professionals.

Employment legislation and polices have been mentioned as another way of raising awareness, with the ultimate aim of reducing negative attitudes (Hannigan 1999). If mental illness were to be seen as equal to physical conditions and dealt with in a similar manner within the work place, then negative attitudes may reduce (Warner 2002), e.g. strengthening the recognition of mental illness within the Disability Discrimination Act (2005).

Mental health promotion is closely linked to education and is supported in 25% of the studies. This area presents plenty of opportunity for innovative work from statutory and non-statutory organizations. The NSFMH (DoH 1999) has devoted an entire standard to it and includes guidance on what might be done. The findings from this review appear to suggest the impact has been rather limited. The MACA study (2004) found that mental health promotion amongst newspaper journalists did have a positive affect on their report of mental health stories.

National Institute of Mental Health in England (2005) found that most journalists contact doctors for information when researching a mental health story, and recommended they contact people who have the relevant mental illness for information to inform their reports, as well as medical staff.

Mental health promotion is known to have a role in preventing some problems (e.g. depression, anxiety and substance misuse); it also enhances recovery for people with mental illness and acts as a conduit for raising awareness amongst the public (Mentality 2003). This should help to increase understanding, reduce fear and therefore limit negative attitudes towards mental illness.

Wolff *et al.* (1996) and Secker *et al.* (1999) made significant comments about ensuring any intervention to reduce negative attitudes should be designed for groups which needed them. This would require preparatory work to establish what the needs are and how they might best be addressed, rather than attempting to deliver a 'one-size-fits-all' campaign to a group of indiscriminate people. Two aspects need to be considered. One is the target population and the other is recognizing different learning styles within that population.

Education theory supports this as it is known that people learn in different ways (Kolb 1985) so, not only does a campaign to reduce negative attitudes to mental illness have to reach the target populations, but the message has to be delivered in an appropriate manner.

It appears the recommendation with the potential for most impact is development of national policies and legislation (Wolff *et al.* 1996, Crisp *et al.* 2000, DoH 2003, Addison & Thorpe 2004). Changing the law to improve the situation for people with mental illness may sound like a radical step to take, but if one compares this to the struggle for rights for physically disabled people or to racial equality, it is no different. Getting the law changed to reflect this may have far-reaching consequences elsewhere in society which, when supported by better education, would have positive impact on the development and continuity of negative attitudes to mental illness, including health and social care staff.

Discussion

A literature review can only provide a snapshot of evidence (LoBiondo-Wood & Haber 2001). Negative attitudes to mental illness was the common theme, but all studies were completed differently so the review is not comparing like with like.

It has to be recognized that not every piece of published work relating to the topic was accessed. The recommendations of this study were based on only 16 pieces of work. The review was limited because of time and funding constraints; therefore, the extent to which all relevant material could be included was reduced. Using a systematic approach ensured studies were prioritized so the best available were included.

Time constraints were critical. All comments were subjective and there was no opportunity for any of the review tools to be peer reviewed, nor to be tested by inter-rater reliability (Polit *et al.* 2001).

There are gaps in the literature relating to how effective previous campaigns have been at meeting the identified

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needs. This reduces the amount of information available which might have been relevant and useful for this work.

The narrow focus for this review means the recommendations may not be transferable outside of the UK, so the usefulness is somewhat restricted, although extremely relevant for the UK where clinical call centres are becoming more common.

Conclusions

Key elements identified are the confirmation that professional staff (e.g. general nurses, doctors and social workers) have been recognized as having identified learning needs; schizophrenia appears to have the worst 'reputation' and campaigns need to be targeted. All of these have relevance to NHSD.

Reducing negative attitudes to mental illness is a big change, affecting a whole cultural system. Lewin (cited in Greathouse 1997) stated that for change to take place, it is necessary to include the whole situation, not to introduce change in isolation. Nationally, the recent government initiatives seem to be addressing negative attitudes towards mental illness in a more encompassing approach than has previously been done, and this may prove to be beneficial in the future. NHSD should encompass mental health issues across the whole organization to reduce the level of negative attitudes.

Various campaigns have been introduced to address the matter [e.g. 'Changing Minds' (Royal College of Psychiatrists 1998)], but there has been little follow-up to establish how effective they have been. The findings from this review appear to suggest the impact has been rather limited. One reason for this may be such work is best completed as a longitudinal study which is expensive and difficult to achieve (Parahoo 2006). Another may be because the policies already introduced are too 'new' for any significant changes to have been observed, yet.

Change management theories indicate effective change needs to be carefully managed, and the principles might explain why the campaigns appear to have had little impact. Recommendations for NHSD should therefore be incorporated into a formal strategy, continuing over a significant period of time and including regular reviews and evaluation of progress and effectiveness.

Common themes throughout the papers are awareness of the facts about mental illness should be greater; campaigns should be repeated frequently to maintain awareness, and people need to be actively involved. The essence of this is summarized in a quote attributed to Confucius:

Tell me, and I will forget. Show me, and I may remember. Involve me, and I will understand (Confucius ca 450 BC as cited in Lewis 2005, p. 33).

Recommendations

An audit of all publicity materials used (internal and external) within NHSD should be completed, to ensure that it is not inadvertently using imagery or text which is derogatory or stigmatizing towards people with a mental illness. This should be included in the annual NHSD audit programme. This activity would be transferable to the wider NHS and beyond.

A greater emphasis on the scope and impact of the effects of negative attitudes (on an individual with mental illness) should be included within educational programmes at every opportunity. For NHSD staff, this must include appropriate teaching on de-stigmatization and exploration of their own attitudes, values and beliefs.

The role of the MHSL should be strengthened at site level to ensure there is a local educational resource and a positive role model for operational staff to learn from. Clinical placements in a mental health setting should be made available for all operational staff. This would readily transfer to the wider NHS and other areas where clinical call centres are used.

A process to regularly involve mental health service users in teaching sessions wherever possible should be established and supported throughout the organization. The evidence suggests that this is a positive way of reducing negative attitudes and of improving understanding of mental illness. However, people with a mental illness should not be expected to attend teaching sessions for nothing so there is a cost implication – albeit for nominal expenses – which may prevent some NHSD call centres from pursuing this.

Accessing volunteers from the Expert Patient programme (DoH 2001b) may be one route to facilitate this process within NHSD and elsewhere within the NHS.

The NHSD MHSL should also raise awareness of national UK mental health promotion campaigns, ensuring local involvement and compliance, and be actively involved in developing local strategies to facilitate the requirements of governmental mental health strategies (e.g. the National Suicide Prevention Strategy, DoH 2002).

National Health Service Direct should develop partnership work between various mental health agencies to add strength to the message and to benefit from pooled resources.

The numbers of staff working in clinical call centres are likely to increase, as more GP out-of-hours services are using telephone triage and assessment protocols to manage patient demand, so the significance of the findings is likely to be transferable to other areas.

Addressing this issue across the whole nation is beyond the scope of this work, but starting in one area – with a

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strong, ongoing commitment – is likely to achieve a better outcome than a programme delivered in isolation.

Many nurses leaving NHSD return to other areas of practice. Educating and positively influencing their attitudes towards mental illness while at NHSD will be something they take with them when they leave, with potential to widen the impact both in professional practice and also within their personal life.

National Health Service Direct should develop a formal 3- to 5-year strategy to cover all the aspects of these recommendations. The strategy should, of course, be subject to regular review throughout that time.

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Mark Vincent; Ken and Mollie Plackett; Ken and Jackie Buttenshaw; Martin, Sarah and David Putman.

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Glossary

National Health Service Direct (NHSD) Clinical Call Centre	Established in England by the NHS in 1998. The clinical call centre offers telephone advice and information on a wide range of healthcare topics – from finding out more about diagnosed conditions and treatments to giving details of local health services. For assessment of symptoms, registered nurses use their skills and experience, together with a comprehensive computer system, to advise callers/patients on the most appropriate course of action to take.
Frequent caller	An individual who calls NHSD eight times or more during the course of 1 month.
Operational staff	Staff (clinical and non-clinical) who work online within the clinical call centre, taking and dealing with telephone calls.

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