

Title: Mental Health Consumer and Caregiver Perceptions of Stigma in Australian
Community Pharmacies

Kathy Knox¹

Jasmina Fejzic^{1,2}

Amary Mey²

Jane L. Fowler¹

Fiona Kelly¹

Denise McConnell²

Laetitia Hattingh^{2,3}

Amanda Wheeler^{1,4}

¹Griffith Health Institute, Griffith University, Brisbane, Australia

²School of Pharmacy, Griffith University, Gold Coast, Australia

³School of Pharmacy, Curtin University, Perth, Australia

⁴Faculty of Medical and Health Sciences, University of Auckland, Auckland, New Zealand

Running head: Consumer Perceptions of Stigma in Pharmacies

Mental Health Consumer and Caregiver Perceptions of Stigma in Australian Community Pharmacies

Stigma associated with mental illness has been widely documented since the early 1950s (Rabkin, 1974) and presents a barrier to recovery by negatively affecting social status, self-esteem, and social networks (Mental Health Council of Australia, 2011). Stigma occurs in the form of public stigma or an internalized response to stigma (self-stigma). Public stigma refers to the negative ways in which the general population react to people who have been identified as having a mental illness. Internalized or self-stigma refers to negative self-beliefs that persons with mental illness hold and the associated impact on behaviour (Corrigan & Watson, 2002; Drapalski et al., 2013). Recent Australian surveys indicate that stigma is commonly experienced (Reavley & Jorm, 2011). For example, the National Mental Health Charity, SANE Australia, reported that 75% of 427 people with mental illness surveyed had experienced public stigma or discrimination in the previous 12 months (Thompson & Little, 2011). This finding is of concern given that this rate is no different to the 74% found in 2006 (SANE Media Centre, 2011) and in light of the increased attention to addressing stigma world-wide.

Stigmatising and discriminatory attitudes regarding mental illness exist in the general population, health professionals and health students in training. Members of the public have been reported to view people with mental illness with fear, dislike, and express a desire to remain socially distant (Angermeyer & Matschinger, 2003; Martin, Pescosolido, & Tuch, 2000). Stigmatising views include the belief that mental illness is self-inflicted, that people with a mental illness are hard to communicate with, or likely to display violent behaviour (Crisp & Gelder, 2000; Jorm, Korten, Jacomb, Christensen, & Henderson, 1999; Kai &

Crosland, 2001; Kobau, Dilorio, Chapman, Delvecchio, & Members, 2010; Scheerder et al., 2011). Similar attitudes held by health professionals affect the provision of care to mental health consumers and caregivers (Jorm et al., 1999; Mental Health Council of Australia, 2011; Phokeo, Sproule, & Raman-Wilms, 2004; Scheerder, De Coster, & Van Audenhove, 2009). Inclusion of information identifying a person as having mental illness can result in health professionals making a biased interpretation of behaviour (Farina & Felner, 1973). For example, a study which compared mental health professionals with the general public found health professionals rated descriptors such as 'abnormal' and 'stupid' as more characterising of people with mental illness than did the public (Lauber et al. 2006). Research shows that consumers commonly perceive and experience stigma from health professionals including psychiatrists, general practitioners (GPs), mental health nurses and psychologists (Thompson & Little, 2011; Wahl, 1999). Negative beliefs and stigmatising attitudes also exist among students of pharmacy (Bell et al., 2010; Bell, Johns, & Chen, 2006; Volmer, Maesalu, & Bell, 2008), nursing (Keane, 1991), and medicine (for example, El magd & Al Zamil, 2013; Mas & Hatim, 2002; Mukherjee, Fialho, Wijetunge, Checinski, & Surgenor, 2002).

Studies of mental health consumers show that they perceive themselves as stigmatised, encounter rejection and discrimination, and experience reduced life satisfaction (for a review, see Wahl, 1999). Depending on the situation, consumers' emotional reactions to stigma experiences might include anger, hurt, sadness, and discouragement (Corrigan & Watson, 2002; Wahl, 1999, 2011). Long-term consequences include lowered self-esteem and self-confidence, avoidance of social contact or disclosure, and experiences that further contribute to anxiety and depression (Boyd Ritsher, 2003). Coping strategies include advocacy and use of selective disclosure about mental illness (Wahl, 1999).

A widespread lack of accurate knowledge and negative attitudes contribute to the difficulties faced by this vulnerable population (Angermeyer & Dietrich, 2006; Corrigan & Watson, 2002; Wahl, 1999; World Health Organization, 2001). Given the prevalence and negative impact of stigma, efforts to reduce the experience of stigma are warranted. Consumers have recommended public education about mental illness as an anti-stigma strategy, and in one survey, two out of three participants believed that mental health caregivers needed to be better informed (Wahl, 1999). However, some findings suggest mixed results: informing people about mental illness might not necessarily affect attitudes or lead to reduced stigma (Angermeyer & Dietrich, 2006; Griffiths, Christensen, Jorm, Evans, & Groves, 2004; Schomerus et al., 2012).

Almost half of all Australians (45.5%) are affected by mental illness in their lifetime (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). In Australia (as is the case internationally), mental health care is largely managed within the community (Wilson, 2000; World Health Organization and World Organization of Family Doctors, 2008). Australian community pharmacy staff have regular contact with mental health consumers (defined here as persons with mental illness who obtain medicines and health care support from a community pharmacy) and caregivers through the ongoing supply of medicines and provision of primary health care services. Therefore, community pharmacies are well placed to provide support and services to mental health consumers and caregivers. In the Australian context, mental health reform is a national priority area (Commonwealth of Australia, 2009; Council of Australian Governments, 2012), and professional capability statements describe the high standards that are expected of community pharmacists in the provision of mental health care (Pharmaceutical Society of Australia, 2003, 2013).

A recent USA survey found that a sense of connectedness with pharmacy staff was the single strongest individual predictor of prescription medication adherence among Americans with chronic medical conditions, including mental illness (Langer Research Associates, 2013). However, the stigma associated with mental illness can act as a barrier to seeking or accessing the support available in community pharmacies (Mental Health Council of Australia, 2011). For example, a survey of 79 consumers in Canada found that one in four persons (25%) with mental illness had experienced stigma within a community pharmacy (Black, Murphy, & Gardner, 2009).

There appears to be greater research focus on public stigma towards people with mental illness (and the consequences for consumers), neglecting self-stigma. The value of exploring consumer perspectives and how consumers engage with community pharmacy staff in shaping the delivery of mental health care is increasingly apparent (Salzburg Global Seminar, 2011). However, consumers' perspectives regarding the stigma of mental illness in community pharmacy has not yet been sufficiently documented (Black et al., 2009). In addition, there is a lack of evidence regarding the extent of stigma from community pharmacy staff providing medicines and services to mental health consumers and caregivers in Australia. Exploring the stigma of mental illness can inform future community pharmacy initiatives on provision of patient centred health care.

This article examined the perceptions and experiences of stigma within the Australian community pharmacy setting through the lens of persons with mental illness (consumers) and their caregivers. The social-cognitive model (Corrigan, 2000; Corrigan & Watson, 2002) was used to understand how consumers' and caregivers' experiences in community pharmacy

translate into perception of self- and public stigma. This model has previously been applied to understanding situational reactions to stigma (Corrigan & Watson, 2002). In this model, markers or cues (such as atypical behaviour or a prescription for psychotropic medication) signal others about the presence of mental illness. Such signals can lead to the perpetuation of stereotypes, for example “mentally ill people are dangerous”. In turn, stereotypical thoughts may lead to negative behavioural reactions and discrimination (Corrigan, 2000). Individual and group interviews were undertaken in order to address the following research questions:

- What are the perceptions or experiences of stigma, discrimination, and support in the community pharmacy setting from mental health consumers/caregivers’ perspectives?
- What strategic improvements could be made to community pharmacy services to reduce the consumer/caregiver’s perceptions or experiences of stigma?

Data and methods

Participants

The research was conducted in Australia (Queensland, New South Wales and Western Australia). Participants were a convenience purposive sample of 74 consumers and caregivers. Eight participants self-identified as Aboriginal or Torres Strait Islanders¹. Nine consumer/caregiver focus groups were conducted ($n = 66$ participants) with assistance from community mental health facilities. The number of participants and the community facility for each focus group is summarised in Table 1. According to personal preference or remote location, eight consumers/caregivers were interviewed individually rather than attend a focus group.

¹ Indigenous Australians who made up 2.5% of the Australian population in 2006 (Australian Bureau of Statistics, 2009)

INSERT TABLE 1 ABOUT HERE

Materials

A semistructured interview guide was developed for collecting data. The content of the guide was informed by a similar instrument (University of South Australia, 2005) and a literature review investigating mental health consumers' medication management needs (Mey et al., 2013). Following pilot interviews with two mental health consumers, the interview guide was amended to simplify language. The topics explored in the interviews included experiences of community pharmacy, motivational issues, and cultural needs (Table 2). The interview guide did not directly address stigma or discrimination.

INSERT TABLE 2 ABOUT HERE

Procedures

Ethics approval was obtained from a University Human Research Ethics Committee. Participants provided their written consent. Data were collected using semistructured individual and focus group interviews. All interviews and focus group discussions were audio recorded. Participants each received a \$20 gift voucher as a token of appreciation.

Individual interviews were conducted by a trained interviewer at a time and place that was convenient for the participants. Five interviews were conducted by telephone, and three interviews took place face-to-face. Each individual interview was approximately 30 minutes in duration (range 11 to 45 minutes). Depending on the natural flow of dialogue, the number of trigger questions varied across interviews. Prompts were used when necessary. The

interviewer probed to explore additional ideas that arose during the interview, and exercised discretion in conducting each interview to ensure topics were covered sufficiently and that data saturation point was reached.

Focus group interviews were held at community mental health facilities. Two trained facilitators were present for each focus group. One facilitator took field notes. The other facilitator read and explained the consent material, and conducted the group interview. An interpreter was available when required. Focus group participants ($n = 66$) were given an optional one-page survey on their demographic characteristics, health conditions, and frequency of access to health care services. Sixty-one completed survey forms were returned.

Group interviews began with an introduction, explanation of purpose, and ground rules (“Please be respectful of other’s opinions”). Participants were asked warm-up questions (“How often would you visit a community pharmacy?”). The facilitator asked questions and used prompts as per the interview guide. Two concluding questions elicited participants’ opinions on the most important focus group interview topic and additional thoughts or comments. Group interviews took on average 1 hour to complete (range 40 minutes to 1 hour and 40 minutes). Light refreshments were provided. Facilitators met afterwards to debrief, compare notes and summarise topics.

Analysis

Interviews were transcribed verbatim and identifiable information was removed from the transcripts. Analysis of the interview data followed the general inductive approach (Thomas, 2006) and focused on themes emerging from participants’ responses describing perceptions

or experiences of stigma and discrimination in the community pharmacy context, elicited indirectly throughout the course of the interviews.

NVivo[®] software was used to manage the data. Transcripts were read and re-read by two coders to gain an understanding of the broad issues and create 'open codes'. By discussion, the coders agreed on 'axial codes': a set of specific themes which captured core messages reported by the participants. All transcripts were coded in this manner. To ensure the process was reliable, two additional coders reviewed the codes and corresponding text units. This ensured that the framework of axial codes were sufficient to accurately capture the core messages and breadth and depth of participants' experiences. Finally, 'selective codes' were created that represented domains that emerged from the coded text, and key quotations that most strongly identified the selective codes were chosen. The researchers maintained open dialogue throughout the analytical process. This article focuses on the reporting of content relating to stigma that emerged through the data analysis process. Other thematic elements to emerge will be reported elsewhere.

Results

The majority of the 74 participants were female (62%). Other demographic characteristics are summarised in Table 3. One participant reported an intellectual disability, one had cancer, and one had an acquired brain injury in conjunction with a mental health condition. Diagnostic information was not verified and is presented merely to help describe the sample.

INSERT TABLE 3 ABOUT HERE

Three themes relating to stigma were identified: 1) perceived and experienced stigma can present a barrier to effective management of mental health, 2) self-stigma can impede consumers' engagement with community pharmacy, and 3) positive relationships with community pharmacy staff reduce the experience of stigma. Participants also provided potential solutions to reduce stigma in community pharmacy practice. Themes are described using examples from the transcripts to illustrate. As recommended by others (Sandelowski & Leeman, 2012), findings were translated into thematic statements by presenting quotes from transcripts along with statements representing thematic syntheses of the data. Quotes have been identified with codes to indicate whether the participant was a consumer (C), caregiver (CR) or both (C/CR) and FG and SSI to indicate that the information was gathered in a focus group setting or semistructured interview, respectively.

Stigma can Present a Barrier to Managing Mental Health

Stigma was mentioned by most participants, and emerged as a major barrier to effective health management:

The perception of stigma and discrimination . . . is personal. It varies from person to person what that may be, but nevertheless . . . there is a tremendous underlying stigma and discrimination against mental ill health and people with mental ill health feel this (C/FG).

Stigma was experienced in terms of self-stigma, and public stigma associated with interactions with pharmacy staff or the general public. Participants referred to stigma directly through stories depicting their negative pharmacy experiences. These experiences are reflected in the following statements:

There were a number of pharmacies I would go to where you tell that perhaps people went “Oh she’s on mental health drugs” because of the reaction . . . you could watch them putting stuff [medicines] together, and . . . The pharmacist looks. You could see it across their face because it’s visible (C/CR/FG).

I don’t like everyone knowing about my medication because I take lots of it and get accused that you’re on too much medicine all the time and I don’t like people knowing . . . my friends and that know, but not any other people. I don’t like going into the chemist and they look at you because I go to pick up my *Webster-pak*[®] [dose administration aid] and then I get extra medication that the doctor hasn’t put in and I do look like a big druggie walking out there, and I hate that, that thing that you see from other people (C/FG).

Consumers and caregivers appeared to have a heightened awareness of judgemental or stigmatising attitudes and behaviours, were fearful of such experiences, and reported being subjected to such experiences by community pharmacy staff and other people in the pharmacy:

Participant 1: . . . and the privacy and confidentiality because you’re not likely to open up about questions about antipsychotics or your drugs for schizophrenia or your bipolar medicine because there is a fear of being judged while you’re there . . .(C/FG).

Participant 2: Also it’s quite likely that your neighbour or your workmate is in the chemist with you. This is a small town (C/FG).

This young girl humiliated me in front of the whole chemist. She said very loudly “Have you taken this before?” like she had a really dirty look on her face. I said “Well I have been on it for a year now,” and then she turned around . . . behind the counter and she said “Oh she hasn’t had it in a year.” She had obviously misheard me. With that an older lady has come up and sort of tried to calm me down. And I just said “I have been prescribed this drug by a psychiatrist. I have taken it for a year. Here is my identification. Can I please have my script? I want to get the hell out of here now!” I had never felt so bad in my life for being medicated! (C/FG).

Linked to the need for non-stigmatising treatment was the need for consumers/caregivers to receive information in a way that respects their privacy and confidentiality, within an appropriate space and time:

Why do I have to keep explaining myself to inexperienced staff? I want to be treated with respect. That’s all I ask for. I mean it’s bad enough to have the illness. It’s bad enough to have to go to the Doctor constantly to get scripts you know, I’ve got enough problems to deal with, than having to face that (C/FG).

Perceptions such as these appeared to characterise the background against which some consumers might interpret their interactions with pharmacy staff. Consumers called for increased awareness of privacy and confidentiality. A private consultation room was perceived as desirable:

The pharmacy that I go to, there's no real privacy area, you're kind of still looking over the bench but everyone's around with ears that go flap, flap, flap . . . particularly if you're talking about mental health, there is stigma around it (C/FG).

. . . they could just say, "Could you come with me please and we'll discuss this" and go and address it in that little room with the door closed and no one else hears it and then you just walk back up the counter and pay . . . But that doesn't happen. What they do is they either come and they sit next to you where everyone can still hear you because it's open, or they tell you at the front counter and it's so embarrassing (C/FG).

However, participants acknowledged the need for balance between pharmacies as a place of commerce versus pharmacy as a health care environment, and recognized that a private consultation space within the pharmacy is difficult to achieve.

Self-Stigma can Impede Consumers' Engagement with Community Pharmacy Services

Although some participants reported that community pharmacy staff stereotyped and discriminated against them, they also acknowledged the potential influence of their own self-perceptions. The negative impact of self-stigma was seen as a barrier to medication adherence, accessing community pharmacy services, and other assistance-seeking behaviours:

. . . [in the past] you never spoke about diagnosis but people had breakdowns and all the rest of it. But that was [perceived as], "well that person obviously was a weak person because that happened to him." I was dealing with that when I was about 45

[years of age] and, as well as having a diagnosis, you actually go through that process [of thinking] “This is because I'm a weak person.” . . . We [consumers] feel because we've got this thing going wrong, that it's our fault, or we feel embarrassed about it. Some people feel that because they've been treated badly by some people, so you want to try sneak in [to the community pharmacy] and not make a fuss about it (C/SSI).

There was also a theme of consumer acceptance of their health condition which tended to be associated with reduced self-stigma, for example:

I'm just saying it's not the pharmacy's problem. If we've [consumers] got problems with stereotypes and discriminations that's our problem, not theirs (C/FG).

I have come to the point where I am ok with my mental illness but there was a lot of shame around it for years but I am ok with it now (C/FG).

The potential for interaction between self-stigma and public stigma to contribute to the perceptions of stigmatising attitudes from pharmacy staff also emerged, for example:

. . . because of the stigma, if you're working and have a good place in the community, you may not want people to know. Even if you're not working you may not want people to know (C/FG).

Pharmacy processes such as long prescription waiting times, saying medication names, or avoidant behaviour by the pharmacist (who serves as a role-model for other staff) were seen

to perpetuate the consumers' experience of stigma. For example, one consumer reported that having to wait for her prescription to be filled within the pharmacy can make her agitated and could trigger a panic attack. Her perception was that the pharmacy staff would not understand this, mistake her behaviour for intoxication, and respond negatively:

. . . because I get shakes really bad too, so I get real worried about going out in public. So pretty much I hope that they don't think that I'm drunk or that I'm - the way they look down on you, or something, like there's something wrong with you. . . Because I have anxiety, I just want to get in there and get out as fast as possible. But sometimes the wait just like really gets to [me] and [I'm] just sitting there for ages. Sometimes they just take forever, and that's probably the worst thing, that's what happens to me [when] waiting for so long (C/SSI).

Interviews also revealed that types of medications prescribed, and the packaging that medications come in can act as illness markers, which consumers perceive as triggers for negative attitudes from others.

Good Relationships with Staff Reduce the Experience of Stigma

Participants described how positive relationships with knowledgeable and understanding pharmacy staff members reduced their perception of the stigma of mental illness. Improved general knowledge about mental disorders was seen as a fundamental way to promote such effective consumer-staff relationships:

A more general knowledge, a wider knowledge of the specific drugs, what they do, how they can help people, and that they don't all suit each personality (because we're

all different), but not to add stigma to the people because there's enough stigma on people with mental health issues. And when you're depressed and then you get added pressure from people who are serving you, it makes you feel worse (C/CR/FG).

When consumers saw pharmacists as approachable and easy to talk to, this was associated with absence of stigma or feeling labelled. Consumers described how they felt at ease to speak openly with approachable pharmacists:

He's a very approachable [pharmacist]. He is genuine. He doesn't project any feeling of fear to the client or distrust. I would say that in old medical terminology, he's got good bedside manner (C/CR/FG).

Solutions to Reduce Stigma in the Community Pharmacy Setting

Several solutions to reduce stigma were offered by participants. These include education to increase staff awareness of stigma, improve communication with mental health consumers and caregivers, and increase knowledge of pharmacotherapy, mental health management and strategies to promote recovery:

There needs to be more education about that and how to explain that in the manner to the client that is not demeaning, that is enabling and giving people their respect back regardless of how they're feeling. Because when you're depressed, and already feeling like a worm, you don't need to feel like "Oh, I need this tablet or these tablets for my, these antidepressants," and to go and be made to feel you're going through the mill because you need those tablets (C/CR/FG).

Participants commented on the need to address stigma with all staff members whom interact with customers, and that stigma awareness should be included in support staff training. This could be achieved by nurturing a culture of valuing the customer, and developing more effective communications between pharmacy staff and customer:

I don't know whether they [community pharmacy staff] currently get training in dealing with people who may be confused just because any illness can make you confused, but people with dementia, people who maybe psychotic or even just understanding that if you're feeling really depressed what an effort it is to get to there. So I don't know whether they get training in that, but that would be really helpful; just understanding a little bit of what it's like to experience mental illness (C/FG).

Practical suggestions that could be implemented to reduce stigma in pharmacy practice were given:

From my experience of turning up at pharmacies, there is a variety of reactions from staff, stigmatised reactions . . . The [pharmacy] experience can be good just from explanations about things quietly, off to the side rather than across the counter in front of people, or calling out people's names in front of people, where the medication is visible. Because these sorts of things . . . feed into the stigma if people recognise what the box is, or recognise the person's name, or overhear the conversations about the particular issues around the drugs, that [community pharmacy staff] need to be aware of. Just minor things that can be done differently that would make the experience easier for the consumer (CR/SSI).

From a caregiver's viewpoint, the above passage summarised the typical consumers' perceptions, experiences, and strategies.

Discussion

In this exploratory study, three themes relating to stigma emerged, and simple practical strategies were suggested. Findings are discussed in relation to each theme, then potential recommendations are given, and limitations are discussed.

Perceived and experienced stigma can present a barrier to effective management of mental health. As previously documented in the context of the public, health professionals, and students (Bell et al., 2010; Jorm et al., 1999; Mental Health Council of Australia, 2011; Volmer et al., 2008), stigma from staff was perceived in the Australian community pharmacy setting despite the mental health education pharmacists receive during their training. Consistent with the social-cognitive model (Corrigan, 2000; Corrigan & Watson, 2002), public stigma in the community pharmacy setting was perceived in subtle cues including 'a look', a facial expression, or a 'sense' from other people. Similar consequences of perceived stigma have been reported in the context of help seeking from a GP, psychiatrist, mental health service (Mental Health Council of Australia, 2011). This qualitative research adds knowledge of mental health consumers' personal experiences and perceptions of stigma in the context of community pharmacy.

Self-stigma can impede consumers' engagement with community pharmacy. The experience of self-stigma related to negative self-beliefs (Corrigan & Watson, 2002), and in this study, existed on a spectrum ranging from embarrassment to shame. Current findings build on previous work (Black et al., 2009) for example, it is known that people who perceive self-

stigma might postpone help-seeking (Wrigley, Jackson, Judd, & Komiti, 2005) or avoid hospitalisation (Link & Cullen, 1986; Link, Cullen, Frank, & Wozniak, 1987; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Transcripts exemplified that the consumers' perception of stigma can negatively impact their willingness to visit a community pharmacy, obtain prescription medications, or to engage with pharmacy staff; all of which can affect treatment outcomes (Sirey et al., 2001). To the extent that staff are not aware of the consequences and the impact on consumers' behaviour, or lack skills to manage it, they might unintentionally contribute to the consumers' experience or perception of stigma.

Current results further characterise the phenomenon of self-stigma. For example, persons with mental illness previously reported being aware of negative stereotypes about them (Corrigan & Watson, 2002), but did not necessarily subscribe to such beliefs (Hayward & Bright, 1997). Consumers' response to stigma depends on the situation (Corrigan & Watson, 2002) and other factors including recovery expectations (Muñoz, Sanz, Pérez-Santos, & Quiroga, 2011) or sense of meaning in life (Ehrlich-Ben Or et al., 2013). When others' negative responses are viewed as unjust or irrelevant by the consumer, there might be little reduction in self-esteem due to stigma (Corrigan & Watson, 2002). Accordingly, some participants in this study responded to stigma with indifference.

As described in the social-cognitive model (Corrigan & Watson, 2002), consumers perceived that signals such as their behaviours or symptoms might trigger stereotypes among community pharmacy staff, which might mediate stigmatising staff behaviour. Consistent with previous findings (Boyd Ritsher, 2003), participants in this study avoided contact with community pharmacy staff or other mental health service providers, and described using selective disclosure (Wahl, 1999) of personal information within the pharmacy setting as a

strategy to avoid negative reactions or experiences. This consumer behaviour can severely restrict their interactions with pharmacy staff, limit opportunities for provision of care, and have an impact on consumer health outcomes.

Positive relationships with community pharmacy staff reduce the experience of stigma. As previously demonstrated (Black et al., 2009; Mental Health Council of Australia, 2011), stigma was identified as a barrier to effective management of mental health because consumers associated stigma with fear and distrust. As per previous findings (Wahl, 1999), consumers reported coping with stigma through exercising choice: in selective disclosure to others, and in their selection of pharmacy. The overall impact of stigma was to prevent formation of trusting therapeutic relationships in community pharmacy, which are known to be crucial in the provision of health care and particularly for medication adherence (for example, Jon & Wiederholt, 1995; Penn, Watermeyer, & Evans, 2011).

Traditionally, pharmacy students' education on mental health emphasised pharmacology and medicines over communication skills (Pharmaceutical Society of Australia, 2013). Emerging research shows that current curricula regarding mental health for pharmacists in Australian accredited courses is predominantly biomedically oriented, and psychosocial aspects including the consumer's experience of stigma appear to be lacking (A. Mey, personal communication, January 16, 2013). In addition, about three-quarters of community pharmacy patrons will interact with a support staff member rather than a trained pharmacist during their pharmacy visit (University of South Australia, 2005). Given that there appears to be a positive association between familiarity with mental illness and acceptance of people with mental health issues (Angermeyer & Dietrich, 2006), current findings suggest that knowledge of consumer's experience of mental illness, education content delivered by

consumers themselves, along with training in communication skills for pharmacy staff, seem warranted. Consumers in this study offered simple, practical suggestions such as increased general knowledge of mental illness and cultural sensitivity as central to the process of being welcoming and building a therapeutic relationship.

Lack of privacy appeared to impede the formation of relationships, which can augment perceived stigma within community pharmacy. Mental health care consumers and caregivers recognized community pharmacy's dual role as a place of commerce and a health care environment, and acknowledged that a private space is difficult to achieve. These findings highlight the importance of creating the conditions for open communication between community pharmacy staff and consumers to promote positive mental health experiences. This might necessitate a broader conceptualisation of pharmacy space to include personalised follow-up by phone, email or other means, once the consumer is away from the physical pharmacy environment (Rapport, Doel, & Jerzembek, 2009; Wheeler, Barrows, & Burgess, 2012).

Recommendations. Pharmacy staff might benefit from understanding how customer groups' needs differ (not only mental health consumers), and adopt a holistic, patient-centred care approach. Consumers and caregivers suggested strategies which indicated an opportunity to introduce mental health training for community pharmacy staff to increase their awareness of stigma, improve communication skills, and reduce the negative experience of stigma with the Australian community pharmacy context. Ideally, such training would acknowledge the nuanced ways in which public stigma and self-stigma are manifest, reducing the opprobrium of mental illness and fostering positive relationships. Attention should be given to the consumers' personal response to stigma in Australian pharmacy curricula at undergraduate

and postgraduate levels, and in continuing professional development for pharmacists. These interventions are likely to benefit other pharmacy customers, not only those with a mental illness.

Strategies that foster open communication at the appropriate time and space within the community pharmacy environment should be adopted. Notably, a culture of welcoming and valuing customers would ideally extend to any community pharmacy staff whom come into contact with customers, including students and support staff. Practical suggestions also included creating suitable consultation areas within the pharmacy, and reduced consumer waiting times through development of more streamlined practices, and might involve enabling consumers/caregivers to phone ahead or arrange a designated time to collect prescription medicines. These interventions would require careful reconsideration of pharmacy layout and workflow, but could result in more effective care, higher customer/consumer retention, and increased consumer satisfaction. Further research would be required to evaluate such practical applications.

Limitations. Purposive sampling potentially introduced recruitment bias towards motivated participants. However, purposive sampling was the most appropriate method of ensuring that the perspectives of consumers and caregivers were included (Buetow, 2007). Participants in this study represented a wide range of mental illness groups. In this study, mental illness was defined broadly. As such, recommendations might not apply to specific diagnoses, and are intended as general suggestions only. Further work on consumer perspectives should endeavour to include other underrepresented groups including Aboriginal and Torres Strait Islander people, the homeless, less educated persons, and culturally or linguistically diverse

populations. Future studies should compare results over time to evaluate the efficacy of training and education for all community pharmacy staff.

Conclusion

The stigma of mental illness is a commonly encountered phenomenon in many health care settings worldwide. In-depth qualitative consultation revealed that mental health consumers and caregivers perceived stigma and discrimination in the Australian community pharmacy setting. Attempts to better manage mental illness and reduce stigma seem justified, and suggestions for how this can be achieved were apparent. Along with strategic practical suggestions, three main themes emerged: 1) stigma is a barrier to effective management of mental health, 2) self-stigma can impede consumer engagement with community pharmacy services, and 3) positive relationships with knowledgeable staff are important in reducing stigma. The current findings improve our understanding of the management of mental health in the Australian setting, and promote the importance of pharmacy as a safe health care space. As part of a larger project, findings from this study will inform training and professional development interventions for pharmacy staff. Interventions might include education to increase awareness of the consumers' and caregivers' personal responses to mental illness stigma, introduction of strategic and targeted practice improvements, and enabling community pharmacy staff to better support consumers' mental health. In pharmacy practice, stigma perceived by consumers and caregivers is likely to adversely affect the provision of care to consumers (Healthcare Management Advisors, 2010; Jorm et al., 1999; Nordt et al., 2006; Scheerder et al., 2011). As shown in this study, stigma can also adversely affect consumer's choice of pharmacy, adherence and ultimately their health management.

Acknowledgement

We thank Rhonda Knights and Brad McConnachie for administrative support of the study.

Funding acknowledgement

This project is funded by the Australian Government Department of health and Ageing as part of the Fifth Community Pharmacy Agreement Research and Development Program managed by The Pharmacy Guild of Australia. This report was produced with the financial assistance of the Australian Government Department of Health and Ageing. The financial assistance provided must not be taken as endorsement of the contents of this report.

Table 1. *Number of participants, community mental health facility and length of focus groups*

Number of participants		Community mental health facility	Length
Consumers	Caregivers		
9	0	Not for profit support organisation for those living in shared or supported social housing	0:56:00
11	0	Community-based not for profit support organisation	0:40:30
2	1	Regional community mental health service	1:14:00
10		Not for profit organisation run by mental health consumers	1:16:00
5	1	Remote regional community mental health service	1:30:00
10	0	Non-government multicultural mental health centre (non-English speaking participants)	0:53:30
3	0	Peak body consumer support organisation	0:47:00
8	1	Consumer-run community support organisation	0:33:45
0	5	Caregiver support network	0:47:00

Table 2. *Interview framework*

Current level of knowledge of community pharmacy
Expertise and Role of the pharmacist
Role of the support staff
Services provided / available
Current needs from community pharmacy
Health care, treatment, product needs
Information, advice, reassurance
Deficiencies in service currently provided
Who is responsible for changes
Past and present experiences of community pharmacy
Current use of community pharmacy in management of mental illness
Strengths of current experience
Who is responsible for changes
Current expectations of community pharmacy
How well are expectations currently being met
How can shortfalls be addressed
Engagement in changes
Perceptions of medicine taking
Role of community pharmacy / consumer
Barriers to adherence /motivation
Efficacy of treatment management Potential future role for pharmacy
Cultural needs/beliefs/issues

Table 3. *Participant Demographic Characteristics*

Age in years	<i>n</i> (%)	Frequency of pharmacy visit	<i>n</i> (%)	Frequency of health professional visit	<i>n</i> (%)	Self-reported mental health conditions	<i>n</i> (%)
18-25	3 (4.0)	Monthly	20 (27.3)	Monthly	26 (35.1)	Depression	23 (31.1)
26-40	13 (17.6)	Fortnightly	16 (21.6)	Fortnightly	16 (21.6)	Anxiety disorder	18 (24.3)
41-55	23 (31.1)	Weekly	15 (20.3)	Weekly	0 (0.0)	Bipolar affective disorder	11 (14.9)
> 55	22 (29.7)	Other	9 (12.1)	Other	17 (22.9)	Schizophrenia or psychotic disorder	13 (17.6)
Missing	13 (17.6)	Missing	14 (18.9)	Missing	15 (20.3)	Missing	9 (12.1)
Total	74		74		74		74

Note: Semi-structured interview participants were not asked demographic questions, and some focus group participants chose not to provide information.

References

- Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*, 163-179.
- Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: Effect of labelling on public attitudes towards people with mental disorders. *Acta Psychiatrica Scandinavica*, *108*, 304-309.
- Australian Bureau of Statistics. (2009). Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021 Retrieved 10 January 2013, from <http://www.abs.gov.au/ausstats/abs@nsf/Products/744FB2E9312BC13CCA25762A001CBA54?opendocument>
- Bell, J. S., Aaltonen, S. E., Airaksinen, M. S., Volmer, D., Gharat, M. S., Muceniece, R., . . . Chen, T. F. (2010). Determinants of mental health stigma among pharmacy students in Australia, Belgium, Estonia, Finland, India and Latvia. *International Journal of Social Psychiatry*, *56*, 3-14.
- Bell, J. S., Johns, R., & Chen, T. F. (2006). Pharmacy students' and graduates' attitudes towards people with schizophrenia and severe depression. *American Journal of Pharmaceutical Education* *70*, 77.
- Black, E., Murphy, A. L., & Gardner, D. M. (2009). Community pharmacist services for people with mental illnesses: preferences, satisfaction, and stigma. *Psychiatric Services*, *60*, 1123-1127.
- Boyd Ritsher, J. E. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry in Research*, *121*, 31-49.
- Buetow, S. (2007). *Health research methods: A tabular presentation*. South Carolina, U.S.A: Nova Biomedical Books.
- Commonwealth of Australia. (2009). *Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014*. Canberra: Commonwealth of Australia.
- Corrigan, P. W. (2000). Mental Health Stigma as Social Attribution: Implications for Research Methods and Attitude Change. *Clinical Psychology: Science and Practice*, *7*, 48-67.
- Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1*, 16-20.
- Council of Australian Governments. (2012). *Roadmap for National Mental Health Reform 2012-2022*. Retrieved from <http://www.coag.gov.au/node/482>.
- Crisp, A. H., & Gelder, M. G. (2000). Stigmatisation of people with mental illness. *The British Journal of Psychiatry*, *177*, 4-7.
- Drapalski, A. L., Lucksted, A., Perrin, P. B., Aakre, J. M., Brown, C. H., DeForge, B. R., & Boyd, J. E. (2013). A model of internalized stigma and its effects on people with mental illness. *Psychiatric Services*, *64*, 264-270.
- Ehrlich-Ben Or, S., Hasson-Ohayon, I., Feingold, D., Vahab, K., Amiaz, R., Weiser, M., & Lysaker, P. H. (2013). Meaning in life, insight and self-stigma among people with severe mental illness. *Comprehensive Psychiatry*, *54*, 195-200.
- El magd, M. H. A., & Al Zamil, L. (2013). Medical and non-medical female students' attitudes toward mental illness and psychiatric patients at Umm Al Qura University. *Life Science Journal*, *10*, 882-888.

- Farina, A., & Felner, R. D. (1973). Employment interviewer reactions to former mental patients. *Journal of Abnormal Psychology, 82*, 268-272.
- Griffiths, K., Christensen, H., Jorm, A., Evans, K., & Groves, C. (2004). Effect of web-based depression literacy and cognitive-behavioural therapy interventions on stigmatising attitudes to depression. *The British Journal of Psychiatry, 185*, 342-349.
- Hayward, J. A., & Bright, P. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health, 6*, 345-354.
- Healthcare Management Advisors. (2010). Managing mental illness and promoting and sustaining recovery: The role of community pharmacy Retrieved April 06, 2011, from http://www.guild.org.au/iwov-resources/documents/The_Guild/PDFs/CPA%20and%20Programs/4CPA%20General/2007%2008-07/RFT0807%20MMI%20Full%20Final%20Report%20FINAL.pdf
- Jon, C. S., & Wiederholt, J. B. (1995). A field investigation of participant and environment effects on pharmacist-patient communication in community pharmacies. *Medical Care, 33*, 567-584.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry, 33*, 77-83.
- Kai, J., & Crosland, A. (2001). Perspectives of people with enduring mental ill health from a community-based qualitative study. *The British Journal of General Practice, 51*, 730-736.
- Keane, M. (1991). Acceptance vs. Rejection: Nursing Students' Attitudes About Mental Illness. *Perspectives in Psychiatric Care, 27*, 13-18.
- Kobau, R., Dilorio, C., Chapman, D., Delvecchio, P., & Members, S. C. M. I. S. P. (2010). Attitudes about mental illness and its treatment: Validation of a generic scale for public health surveillance of mental illness associated stigma. *Community Mental Health Journal, 46*, 164-176.
- Langer Research Associates. (2013). Medication adherence in America: A national report card. Retrieved from http://www.ncpanet.org/pdf/reportcard/AdherenceReportCard_Full.pdf
- Link, B. G., & Cullen, F. T. (1986). Contact with the mentally ill and perceptions of how dangerous they are. *Journal of Health and Social Behavior, 27*, 289-302.
- Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The social rejection of former mental-patients: Understanding why labels matter. *American Journal of Sociology, 92*, 1461-1500.
- Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public Health, 89*, 1328-1333.
- Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: The role of 'disturbing behavior,' labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of Health and Social Behavior, 41*, 208-223.
- Mas, A., & Hatim, A. (2002). Stigma in mental illness: attitudes of medical students towards mental illness. *The Medical Journal of Malaysia, 57*, 433-444.
- Mental Health Council of Australia. (2011). Consumer and carer experiences of stigma from mental health and other health professionals. Canberra: MHCA.
- Mey, A., Fowler, J. L., Knox, K., Shum, D. H., Fejzic, J., Hattingh, L., . . . Wheeler, A. (2013). Review of community pharmacy staff educational needs for supporting mental health consumers and carers. *Community Mental Health Journal, 10*, 10.

- 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.
- Muñoz, M., Sanz, M., Pérez-Santos, E., & Quiroga, M. d. l. Á. (2011). Proposal of a socio-cognitive-behavioral structural equation model of internalized stigma in people with severe and persistent mental illness. *Psychiatry Research*, 186, 402-408.
- Nordt, C., Rossler, W., & Lauber, C. (2006). Attitudes of mental health professionals towards people with schizophrenia and major depression. *Schizophrenia Bulletin*, 32, 709-714.
- Penn, C., Watermeyer, J., & Evans, M. (2011). Why don't patients take their drugs? The role of communication, context and culture in patient adherence and the work of the pharmacist in HIV/AIDS. *Patient Education and Counseling*, 83, 310-318.
- Pharmaceutical Society of Australia. (2003). *Competency standards for pharmacists in Australia* Deakin, ACT: Pharmaceutical Society of Australia.
- Pharmaceutical Society of Australia. (2013). Mental health care framework Retrieved March 04, 2013, from <http://www.psa.org.au/archives/21010>
- Phokeo, V., Sproule, B., & Raman-Wilms, L. (2004). Community pharmacists' attitudes toward and professional interactions with users of psychiatric medication. *Psychiatric Services*, 55, 1434-1436.
- Rabkin, J. (1974). Public attitudes towards mental illness: a review of the literature. *Schizophrenia Bulletin*, 10, 9-33.
- Rapport, F., Doel, M. A., & Jerzembek, G. S. (2009). "Convenient space" or "a tight squeeze": Insider views on the community pharmacy. *Health and Place*, 15, 315-322.
- Reavley, N. J., & Jorm, A. F. (2011). National Survey of Mental Health Literacy and Stigma. Canberra: Department of Health and Ageing.
- Salzburg Global Seminar. (2011). The Salzburg Statement on Shared Decision Making. Session 477. Retrieved from <http://press.psprings.co.uk/bmj/march/Salzburg.pdf>
- Sandelowski, M., & Leeman, J. (2012). Writing usable qualitative health research findings. *Qualitative Health Research*, 22, 1404-1413.
- SANE Media Centre. (2011). Stigma hurtful and common for people with mental illness Retrieved 30 January, 2012, from <http://www.sane.org/releases-2011/1056-stigma-hurtful-and-common-for-people-with-mental-illness>
- Scheerder, G., De Coster, I., & Van Audenhove, C. (2009). Community pharmacists' attitude toward depression: a pilot study. *Research in Social and Administrative Pharmacy*, 5, 242-252.
- Scheerder, G., Van Audenhove, C., Arensman, E., Bernik, B., Giupponi, G., Horel, A.-C., . . . Hegert, U. (2011). Community and health professionals' attitude towards depression: a pilot study in nine EAAD countries. *International Journal of Social Psychiatry*, 57, 337-401.
- Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, 125, 440-452.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., & Meyers, B. S. (2001). Stigma as a barrier to recovery: Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services*, 52, 1615-1620.
- Slade, T., Johnston, A., Oakley Browne, M. A., Andrews, G., & Whiteford, H. (2009). 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *Australian and New Zealand Journal of Psychiatry*, 43, 594-605.
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27, 237-246.

- Thompson, R., & Little, J. (2011). Stigma hurtful and common for people with mental illness Retrieved 30.01.12, from <http://www.sane.org/releases-2011/1056-stigma-hurtful-and-common-for-people-with-mental-illness>
- University of South Australia. (2005). Consumer experiences, needs and expectations of community pharmacy Retrieved 06 April, 2011, from http://www.guild.org.au/iwov-resources/documents/The_Guild/PDFs/CPA%20and%20Programs/3CPA%20General/2005-501/Final%20Rept_8Mar06.pdf
- Volmer, D., Maesalu, M., & Bell, J. (2008). Pharmacy students' attitudes toward and professional interactions with people with mental disorders. *International Journal of Social Psychiatry*, 54, 402-413.
- Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, 25, 467-478.
- Wahl, O. F. (2011). Stigma as a barrier to recovery from mental illness. *Trends in Cognitive Sciences*, 16, 9-10.
- Wheeler, A. J., Barrows, H., & Burgess, S. (2012). A role for pharmacists in mental health promotion. *Australian Pharmacist*, November, 882-886.
- Wilson, J. (2000). Mental health services in New Zealand. *International Journal of Law & Psychiatry*, 23, 215-228.
- World Health Organization. (2001). The world health report 2001: Mental health: New understanding, new hope Retrieved 06 April, 2011, from http://www.who.int/whr/2001/en/whr01_en.pdf
- World Health Organization and World Organization of Family Doctors. (2008). Integrating Mental Health into Primary Care: A Global Perspective, from http://whqlibdoc.who.int/publications/2008/9789241563680_eng.pdf
- Wrigley, S., Jackson, H., Judd, F., & Komiti, A. (2005). Role of stigma and attitudes toward help-seeking from a general practitioner for mental health problems in a rural town. *Australian and New Zealand Journal of Psychiatry*, 39, 514-521.