

Article

## Lessons from Community Mental Health to Drive Implementation in Health Care Systems for People with Long-Term Conditions

Michele Tansella <sup>1,\*</sup>, Graham Thornicroft <sup>2</sup> and Heidi Lempp <sup>3</sup>

<sup>1</sup> Department of Public Health and Community Medicine and WHO Collaborating Centre for Research and Training in Mental Health and Service Evaluation, University of Verona, Verona 37134, Italy

<sup>2</sup> Health Service and Population Research Department, Centre for Global Mental Health, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, UK;  
E-Mail: graham.thornicroft@kcl.ac.uk

<sup>3</sup> Clinical Trails Group/Academic Rheumatology, School of Medicine, King's College London, Weston Education Centre, 10, Cutcombe Rd., London SE5 9RJ, UK;  
E-Mail: heidi.lempp@kcl.ac.uk

\* Author to whom correspondence should be addressed; E-Mail: michele.tansella@univr.it.

*Received: 19 March 2014; in revised form: 8 April 2014 / Accepted: 11 April 2014 /*

*Published: 30 April 2014*

---

**Abstract:** This paper aims to identify which lessons learned from the evidence and the experiences accruing from the transformation in mental health services in recent decades may have relevance for the future development of healthcare for people with long-term physical conditions. First, nine principles are discussed which we first identified to guide mental health service organisation, and all of which can be potentially applied to long term care as well (autonomy, continuity, effectiveness, accessibility, comprehensiveness, equity, accountability, co-ordination, and efficiency). Second, we have outlined innovative operational aspects of service user participation, many of which were first initiated and consolidated in the mental health field, and some of which are now also being implemented in long term care (including case management, and crisis plans). We conclude that long term conditions, whether mental or physical, deserve a long-term commitment from the relevant health services, and indeed where continuity and co-ordination are properly funded implemented, this can ensure that the symptomatic course is more stable, quality of life is enhanced, and the clinical outcomes are more favourable. Innovations such as

self-management for long-term conditions (intended to promote autonomy and empowerment) need to be subjected to the same level of rigorous scientific scrutiny as any other treatment or service interventions.

**Keywords:** long term conditions; chronic disorders; mental health care and services; community mental health; integrated care

---

## **1. Introduction**

In most high income countries there has been a profound transformation in mental health care over the last 30 years. A system that was based in large and often remote psychiatric hospitals has been reconfigured into a far more complex pattern. This new system includes different types of community mental health teams, a range of treatment, rehabilitation, employment and residential care facilities in the community, and liaison with primary care, alongside the continuing provision of a relatively small number of acute hospital beds. Further, there is an increasingly central role for service users in planning and/or in providing services, with close working with patient and carer advocacy groups [1].

In this paper we offer a personal reflection upon these historic changes, in particular those affecting people with long-term disorders. We aim to identify which lessons learned from the evidence and the experiences accruing from this transformation in mental health services may have relevance for the future development of healthcare for people with long-term physical conditions (which we prefer to the term ‘chronic disorders’ which tends accentuate therapeutic pessimism). We use a public health approach, by which we mean largely state funded healthcare systems, for both mental and physical healthcare services. We appreciate therefore that these lessons may not fully apply to systems which are largely or substantially privately funded or provided.

Long term conditions are increasingly common. In England, for example, more than 15 million people (30% of the population) have one or more long-term conditions, a figure expected to increase to 18 million by 2025 [2]. These figures include people with a range of conditions that can be managed, rather than cured, by medication and/or other treatments and therapies, such as diabetes, arthritis, asthma and hypertension. To this we can add conditions such as HIV/AIDs and certain cancers, which have not traditionally been considered long-term conditions, but which are increasingly regarded as such as therapeutic outcomes improve over time.

Many mental health problems can also be considered long-term conditions, nevertheless for the sake of clarity we use the term ‘long-term conditions’ here to refer to physical health conditions alone. It is also important to recognise that long term mental and physical disorders often co-occur. In England, for example, 30% of people with a long-term condition also have a mental health problem, and 46% of people with a mental health problem have a long-term condition [2]. Nevertheless, comorbidity is not the main focus of this paper. Rather we shall discuss the usual configuration of healthcare in most countries worldwide, namely the separation between services for people with physical and mental conditions.

A word of caution is needed. We are aware that transferring lessons learned in one historical and geographical context to another may be a complex process. Many factors influence which innovations

or interventions may be congruent with the healthcare system, the socio-cultural and economic context, and determine whether a health service component may have a degree of fit to a new context, if it is locally adapted. But there will also be cases in which no such adaptation is practicable. We therefore offer these ‘lessons’ in the spirit of ideas which may be of use to the reader, depending upon local circumstances.

## **2. Establishing Fundamental Principles, Followed by Planning and Implementing Service Changes for People with Long-Term Conditions**

The context for the provision of treatment and care for people with long-term mental disorders in many high income countries has been that, until the last generation, many were kept as long-term in-patients over many decades. Throughout Western Europe, for example, most of these beds, and many of these hospitals, have been closed and now subsequent generations of people with severely disabling mental conditions are mostly treated outside hospital [3]. In designing community-based mental health services, we have proposed a series of 9 principles to guide planning decisions [4]. These principles were initially considered as orthogonal, or mutually independent, but experience has demonstrated to us that in fact some of these principles may be either positively or negatively correlated with each other.

These nine fundamental principles can also be used to guide decisions related to long-term conditions. However a number of caveats need to be kept in mind. First, there has not been the need to de-institutionalise care for people with most long term conditions (with the exception of tuberculosis). Second, historical and current levels of funding mean that the level or coverage (meaning the proportion of people with a particular diagnosis who actually receive treatment) shows an ‘inverse care law’ in that in many high income countries about 75% of people with long term conditions are treated, whereas only 25% of people with mental disorders receive care [5,6]. Third, demand for mental health care may be substantially impeded by stigma-related factors, including lack of knowledge of locally available services, as well as expectations of low quality treatment, and of stigmatising reactions to a person who has received psychiatric treatment [7,8].

### *2.1. Autonomy*

This is a patient-level characteristic consisting of the ability to make independent decisions and choices, alongside the presence of continuing symptoms or disabilities. This principle has been put into practice in mental health services, for example, using such innovations as decision support tools, crisis plans, advanced statements and forms of self-management [9,10]. This is highly relevant for long-term conditions such as rheumatoid arthritis where self-management is now well developed, for example in cognitive-behaviour therapy self-management groups for chronic fatigue or for flare-ups (sudden periods of clinical deterioration) of rheumatoid arthritis [11,12]. There is accumulating evidence that self-efficacy, and psychological well-being can be enhanced by self-management for people with arthritis [13]. A review of self-management approaches for 28 long term disorders shows that: such programmes can have a beneficial effect on the wellbeing of participants in the short term and achieve increased knowledge, self-efficacy and use of self-management behaviours, and this was particularly

the case for people with diabetes mellitus and hypertension [14], although the quality of the relevant research studies is not consistently strong.

## 2.2. Continuity

This refers to ability of health services to offer interventions which provide coherence between different members of staff, and across different clinical teams, in the short-term (*cross-sectional continuity*), and which offers a stability of relationships and therapeutic knowledge, in the context of a regular series of contacts, in the long term (*longitudinal continuity*). The importance of continuity of care for people with long term mental disorders has been understood for over a decade [15,16], with a range of methods implemented to enhance continuity by the use of case managers [17]. Case management is now also increasingly recognised in relation to long-term conditions [18]. To measure the impact of continuity of care, Cowie *et al.* have applied a multi-dimensional model to people with seven long-term conditions (arthritis, coronary heart disease, stroke, hyper-cholesterolaemia hypertension, diabetes mellitus or COPD) [19]. They found that patients' experiences of health care can be understood in terms of both relational and management continuity' [19].

## 2.3. Effectiveness

We have defined effectiveness as 'the proven, intended benefits of services provided in real life situations' [4]. This is now the central tenet of evidence-based medicine and a large series of systematic review referring to long term conditions are available at evidence repositories such as the Cochrane Library. A recent systematic review suggests that the range of treatments available for mental and physical conditions, including those which may have long-term consequences, have essentially similar effect sizes [20]. Nevertheless there is now a robust debate on *who* should decide which outcomes are most important, and who should design scales to measure these criteria, as we discuss below in the section on patient participation.

## 2.4. Accessibility

This is a service characteristic, experienced by service users and their carers, which enables them to receive appropriate care where and when it is needed. The actual location of care will vary according to where healthcare (at the appropriate level of expertise) is available, and according to the complexity of individual cases. For example, where primary care staff are sufficiently trained and have access to relevant investigations and equipment, then there may be little need to refer cases to secondary (specialist) care. At the same time a person with highly unstable diabetes mellitus may need to have less accessible but more specialised care. This is an example of a trade-off (or offset) between principles, which may in some cases be competitive rather than complementary[21].

### 2.5. Comprehensiveness

This is a service characteristic with two dimensions: by *horizontal comprehensiveness* we mean how far a service extends across the whole range of severity of mental illnesses; by *vertical comprehensiveness* we mean the availability of the basic components of care (out-patient and community care; day care; acute in-patient and longer-term residential care; interfaces with other services), and their use by prioritised groups of patients. For people with long term conditions, there is evidence of very considerable variations in people's experiences and in the quality of the care they receive. For rheumatoid arthritis (RA), for example, many people report that: they wait too long for referral to a specialist, the care they receive over-emphasises pharmacological treatment at the expense of psycho-social interventions [22].

### 2.6. Equity

This refers to the fair distribution of resources and the basis upon which competing needs can be prioritised. For example, it is clear across the world that extremely low proportions of national healthcare budgets are spent on mental health services, regardless of the levels of need or the global burden of disease [23]. In relation to long-term care, a number of factors need to be kept in mind, including whether patients of different sub-groups of the population have reasonable and equal access to new forms of treatment or self-management [24], for example by ethnicity [25], or by age [26]. There may also be elements of competition, not only *between* these principles, but also *within* aspects of the same principle. For example, issues of equity of choice of treatments may conflict with equity of outcomes across the whole patient population [27].

### 2.7. Accountability

This principle is a function which consists of complex, dynamic relationships between health services and patients, their families and the wider public, who all have legitimate expectations of how the service should act responsibly. In fact this principle applies in the same way to both mental [28,29] and physical healthcare [30] in that both need to be managed in a way that shows the relevant funders that resources are being spent responsibly, fairly and effectively.

### 2.8. Co-Ordination

A service characteristic which is manifested by coherent treatment plans for individual patients. Each plan should have clear goals and should include interventions which are needed and effective: no more and no less. By *cross-sectional* co-ordination we mean the co-ordination of information and services within an episode of care (both within and between services). By *longitudinal* co-ordination we mean the inter-linkages between staff and between agencies over a longer period of treatment, often spanning several episodes [31]. This concept has for over two decades been applied within mental health services [32,33], and is now also being applied to long-term conditions [34].

### *2.9. Efficiency*

A service characteristic, which minimises the inputs needed to achieve a given level of outcomes, or which maximises the outcomes for a given level of inputs. This principle can be applied directly and with equal relevance to both physical and mental long-term conditions [35].

## **3. Innovative Forms of Patient Participation in Care**

One of the major developments in mental health care in recent decades has been the direct participation of both service users and carers in planning, delivering and evaluating services [1,36,37]. Indeed in several high income countries it has become common that mental health service users' legitimate demands for involvement in these aspects of care systems, and in exercising choice concerning specific treatments, have become progressively realised. Illustrations of these processes include decision aid tools for specific therapies [38], disclosure decisions regarding diagnoses [9], or a focus upon user-defined recovery goals [39,40]. There is also growing evidence that such forms of participation may bring measurable benefits, for example in relation to inter-personal skill training for staff [41], stigma reduction interventions [42], in developing treatment guidelines [43,44], in assessment both unmet needs [45,46], or in employing service user researchers [47,48].

Similar developments including the participation of patients/service users are a more recent phenomenon in most areas of long-term care [49]. The National Institute of Health Report in England has categorised service user participation into four categories as: (i) none; (ii) consultation; (iii) collaboration; or (iv) service user control. As yet there are fewer published examples in the long-term care field of the more fully developed forms of service user participation.

Nevertheless, a range of innovative service user centred modalities related to long-term conditions have emerged in recent years. For example shared care arrangements in rheumatoid arthritis encompasses treatment, ongoing education and specialist management within a shared care arrangement between patients, primary and secondary care [50,51]. Peer support programmes are more recent novel approaches, for example as applied to diabetes care [52]. In breast cancer care the development of a risk assessment and decision support aid has been shown to enhance informed and patient-centred prevention decisions [53].

There is also growing evidence that the treatment priorities and preferences of patients may differ substantially from those of health professionals. This was brought to the foreground in a series of recent publications on the outcomes of patients with chronic obstructive airway disease. Clinicians offered treatment based upon their own judgements of clinical needs, whereas patients were willing to accept such treatment recommendations provided that they were also enabled to increase their level of independence and maintain their own self-sufficiency disease [54].

A further aspect of service user or patient participation refers to patient-rated outcome measures (PROMs) and patient-generated, patient-rated outcome measures (PG-PROMs). The former have been developed in a few areas of long term conditions, such as haemophilia or scleroderma, over the last five years [55–57], whereas the latter have so more often been explored in relation to people with longer term mental disorders [58–63].

Forms of service user participation in treatment and care have also been elaborated as collaborative care packages. The collaborative management of chronic illness model proposed by von Korff, for example, consists of four inter-linked elements: (i) collaborative definition of the problems; (ii) joint goal setting and planning; (iii) training and support in self-management; and (iv) active and sustained follow-up. This model emphasises that patients' contribution to their self-care and their medical care are complementary [64]. An integrative overall framework of this chronic care model has undergone a transformation to the adoption of the Innovative Care of Chronic Conditions framework (ICCC) that encompasses long term conditions management with community involvement, and policy implementation to improve long-term care [65,66].

#### **4. Conclusions**

The lessons identified in this paper belong to two categories. First, principles which we first identified to guide mental health service organisation, all nine of which can be potentially applied to long term care as well. Second, we have outlined innovative operational aspects of service user participation, many of which were first initiated and consolidated in the mental health field, and some of which are now also being implemented in long term care.

The implementation of both these principles and these operational innovations needs to be fine-tuned when guided by an appreciation of both the similarities and differences between long-term mental and long-term physical disorders. Examples of the similarities include: many of these conditions have relapsing and remitting clinical courses; in severe relapses individuals may need urgent care or admission; there may be fewer or less severe relapses where there is continuity of care with regular monitoring of clinical and social status; the people affected, including family members, will often benefit from psycho-social education and self-management; rates of medication adherence may be similarly low [67]; routine outcome assessment can be an important basis for ongoing care planning.

On the other hand, perhaps the most important set of differences between long-term mental and physical disorders refer to the consequences of stigma, which can act as a powerful barrier to help seeking. Help-seeking can be conceptualised as a complex process in which health care staff practices are an important and potentially modifiable element in modeling access to healthcare [68]. The reasons why people with mental ill health sometimes avoid or delay seeking help from health services include lack of perceived need, not knowing where to go for help, perceived lack of effectiveness of treatments offered, thinking the problem will resolve itself, preferring to solve the problem on one's own, and fear of being hospitalised against one's will [69].

Recent reviews have examined the impact of stigma on access to mental health care and each concluded that it had a significant detrimental effect [70–76]. Evidence is lacking from low and middle income countries. In a recent systematic review most studies (69%, 99/143) were conducted in the United States or Canada; 20 were undertaken in Europe; 10 in Australia and New Zealand; 8 in Asia; and 1 in South America. A negative association was found between treatment stigma and help-seeking, effect size  $-0.41$ ,  $-2.73$  to  $0.36$ , from 33 studies.

Perhaps paradoxically, health professionals tend to hold negative attitudes towards people with long-term mental illness [72,77–82]. Practitioners, including family physicians, report more negative

ratings of people with mental illness than the general public [83–90]. The term ‘diagnostic overshadowing’ has been defined as the process by which people with mental illness receive poorer physical health care because staff mis-attribute physical symptoms to mental illness, and so under-investigate and less often treat physical disorders well [91,92]. One consequence of this, although the evidence is from high income countries, is that life expectancy is reduced by 15–20 years among people with mental disorders [93–96]. Although there are aspects of stigmatisation that apply towards some types of long-term disorder, for example against people with epilepsy or HIV/AIDS, there is evidence that this is less intensive than against people with mental illness.

This analysis leads us to the following conclusions: long term conditions, whether mental or physical, deserve a long-term commitment from the relevant health services, and indeed where continuity and co-ordination are properly funded implemented, this can ensure that the symptomatic course is more stable, quality of life is enhanced, and the clinical outcomes are more favourable. When asked, people with long-term conditions of whatever types often say that they wish to have their clinical and social needs assessed in a holistic and integrated way, rather than to have care fragmented [54,97]. Finally, we would emphasise the need to continue to strengthen the evidence-based approach to investment decisions relating to both long- term mental and physical conditions, so that cost-effective interventions can be generalised and made available to all patients able to benefit, and so that ineffective interventions and services are decommissioned. From this it follows that innovations such as self-management for long-term conditions (intended to promote autonomy) need to be subjected to the same level of rigorous scientific scrutiny as any other treatment or service intervention [11,98–103].

### Author Contributions

Michele Tansella, Graham Thornicroft, and Heidi Lempp all directly contributed to the design, writing, editing and final approval of this paper.

### Conflicts of Interest

The authors declare no conflicts of interest.

### References

1. Rose, D.; Lucas, J. The User and Survivor Movement in Europe. In *Mental Health Policy and Practice Across Europe. The Future Direction of Mental Health Care*; Knapp, M., McDaid, D., Mossialos, E., Thornicroft, G., Eds.; Open University Press: Milton Keynes, UK, 2006.
2. Naylor, C.D.; Parsonage, M.; McDaid, D.; Knapp, M.; Fossey, M.; Galea, A. *Long-Term Conditions and Mental Health : The Cost of Co-Morbidities*; King’s Fund and Centre for Mental Health: London, UK, 2012.
3. Thornicroft, G.; Gooch, C.; Dayson, D. The TAPS project. 17: Readmission to hospital for long term psychiatric patients after discharge to the community. *BMJ* **1992**, *305*, 996–998.
4. Thornicroft, G.; Tansella, M. *Better Mental Health Care*; Cambridge University Press: Cambridge, UK, 2009.

5. Ormel, J.; Petukhova, M.; Chatterji, S.; Guilar-Gaxiola, S.; Alonso, J.; Angermeyer, M.C.; Bromet, E.J.; Burger, H.; Demyttenaere, K.; de Girolamo, G.; *et al.* Estability and treatment of specific mental and physical disorders across the world. *Br. J. Psychiatry* **2008**, *192*, 368–375.
6. Thornicroft, G. Most people with mental illness are not treated. *Lancet* **2007**, *370*, 807–808.
7. Clement, S.; Brohan, E.; Jeffery, D.; Henderson, C.; Hatch, S.L.; Thornicroft, G. Development and psychometric properties the Barriers to Access to Care Evaluation scale (BACE) related to people with mental ill health. *BMC Psychiatry* **2012**, *12*, doi:10.1186/1471-244X-12-36.
8. Clement, S.; Schauman, O.; Graham, T.; Maggioni, F.; Evans-Lacko, S.; Bezborodovs, N.; Morgan, C.; Rusch, N.; Brown, J.S.; Thornicroft, G. What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychol. Med.* **2014**, *26*, 1–17.
9. Brohan, E.; Henderson, C.; Slade, M.; Thornicroft, G. Development and preliminary evaluation of a decision aid for disclosure of mental illness to employers. *Patient Educ. Couns.* **2014**, *94*, 238–242.
10. Mead, N.; MacDonald, W.; Bower, P.; Lovell, K.; Richards, D.; Roberts, C.; Bucknall, A. The clinical effectiveness of guided self-help *versus* waiting-list control in the management of anxiety and depression: A randomized controlled trial. *Psychol. Med.* **2005**, *35*, 1633–1643.
11. Hewlett, S.; Ambler, N.; Almeida, C.; Cliss, A.; Hammond, A.; Kitchen, K.; Knops, B.; Pope, D.; Spears, M.; Swinkels, A.; *et al.* Self-management of fatigue in rheumatoid arthritis: A randomised controlled trial of group cognitive-behavioural therapy. *Ann. Rheum. Dis.* **2011**, *70*, 1060–1067.
12. Barlow, J.; Turner, A.; Swaby, L.; Gilchrist, M.; Wright, C.; Doherty, M. An 8-yr follow-up of arthritis self-management programme participants. *Rheumatology* **2009**, *48*, 128–133.
13. Barlow, J.; Wright, C.; Sheasby, J.; Turner, A.; Hainsworth, J. Self-management approaches for people with chronic conditions: A review. *Patient Educ. Couns.* **2002**, *48*, 177–187.
14. Chodosh, J.; Morton, S.C.; Mojica, W.; Maglione, M.; Suttrop, M.J.; Hilton, L.; Rhodes, S.; Shekelle, P. Meta-analysis: Chronic disease self-management programs for older adults. *Ann. Int. Med.* **2005**, *143*, 427–438.
15. Johnson, S.; Prosser, D.; Bindman, J.; Szmukler, G. Continuity of care for the severely mentally ill: Concepts and measures. *Soc. Psychiatry Psychiatr. Epidemiol.* **1997**, *32*, 137–142.
16. Bindman, J.; Johnson, S.; Szmukler, G.; Wright, S.; Kuipers, E.; Thornicroft, G.; Bebbington, P.; Leese, M. Continuity of care and clinical outcome: A prospective cohort study. *Soc. Psychiatry Psychiatr. Epidemiol.* **2000**, *35*, 242–247.
17. Marshall, M.; Lockwood, A. Assertive community treatment for people with severe mental disorders. *Cochrane Database. Syst. Rev.* **2000**, *34*, 577–601.
18. Warren, J.; Bamba, C.; Kasim, A.; Garthwaite, K.; Mason, J.; Booth, M. Prospective pilot evaluation of the effectiveness and cost-utility of a “health first” case management service for long-term Incapacity Benefit recipients. *J. Public Health* **2014**, *36*, 117–125.
19. Cowie, L.; Morgan, M.; White, P.; Gulliford, M. Experience of continuity of care of patients with multiple long-term conditions in England. *J. Health Serv. Res. Policy* **2009**, *14*, 82–87.

20. Leucht, S.; Hierl, S.; Kissling, W.; Dold, M.; Davis, J.M. Putting the efficacy of psychiatric and general medicine medication into perspective: Review of meta-analyses. *Br. J. Psychiatry* **2012**, *200*, 97–106.
21. Hamer, L. Improving Patient Access to Health Services: A National Review and Case Studies of Current Approaches; Health Development Agency: London, UK, 2004.
22. Pollard, L.C.; Graves, H.; Scott, D.L.; Kingsley, G.H.; Lempp, H. Perceived barriers to integrated care in rheumatoid arthritis: Views of recipients and providers of care in an inner-city setting. *BMC Musculoskelet Disord.* **2011**, *12*, doi:10.1186/1471-2474-12-19.
23. Saxena, S.; Thornicroft, G.; Knapp, M.; Whiteford, H. Resources for mental health: Scarcity, inequity, and inefficiency. *Lancet* **2007**, *370*, 878–889.
24. Furler, J.; Harris, M.; Rogers, A. Equity and long-term condition self-management. *Chronic Illn.* **2011**, *7*, 3–5.
25. Smith, D.B.; Feng, Z.; Fennell, M.L.; Zinn, J.; Mor, V. Racial disparities in access to long-term care: The illusive pursuit of equity. *J. Health Polit. Policy Law* **2008**, *33*, 861–881.
26. Mathur, R.; Badrick, E.; Boomla, K.; Bremner, S.; Hull, S.; Robson, J. Prescribing in general practice for people with coronary heart disease; Equity by age, sex, ethnic group and deprivation. *Ethnic Health* **2011**, *16*, 107–123.
27. Deeming, C.; Keen, J. Choice and equity: Lessons from long term care. *BMJ* **2004**, *328*, 1389–1390.
28. Ganju, V. Mental health quality and accountability: The role of evidence-based practices and performance measurement. *Adm. Policy Ment. Health* **2006**, *33*, 659–665.
29. Kilbourne, A.M.; Fullerton, C.; Dausey, D.; Pincus, H.A.; Hermann, R.C. A framework for measuring quality and promoting accountability across silos: The case of mental disorders and co-occurring conditions. *Qual. Saf. Health Care* **2010**, *19*, 113–116.
30. Redman, B.K. Accountability for patient self-management of chronic conditions; Ethical analysis and a proposal. *Chronic Illn.* **2007**, *3*, 88–95.
31. Kmietowicz, Z. GPs are key to effective coordination of care for people with chronic conditions, study concludes. *BMJ* **2013**, *347*, doi:10.1136/bmj.f6349.
32. Thornicroft, G.; Ward, P.; James, S. Care management and mental health. *BMJ* **1993**, *306*, 768–771.
33. Simpson, A.; Miller, C.; Bowers, L. Case management models and the care programme approach: How to make the CPA effective and credible. *J. Psychiatr. Ment. Health Nurs.* **2003**, *10*, 472–483.
34. Burgess, T.; Young, M.; Crawford, G.B.; Brooksbank, M.A.; Brown, M. Best-practice care for people with advanced chronic obstructive pulmonary disease: The potential role of a chronic obstructive pulmonary disease care co-ordinator. *Aust. Health Rev.* **2013**, *37*, 474–481.
35. Wagner, E.H.; Austin, B.T.; Davis, C.; Hindmarsh, M.; Schaefer, J.; Bonomi, A. Improving chronic illness care: Translating evidence into action. *Health Aff.* **2001**, *20*, 64–67.
36. Rose, D. *Users' Voices, the Perspectives of Mental Health Service Users on Community and hospital care*; The Sainsbury Centre: London, UK, 2001.
37. Thornicroft, G.; Tansella, M. Growing recognition of the importance of service user involvement in mental health service planning and evaluation. *Epidemiol. Psychiatr. Soc.* **2005**, *14*, 1–3.

38. Stein, B.D.; Kogan, J.N.; Mihalyo, M.J.; Schuster, J.; Deegan, P.E.; Sorbero, M.J.; Drake, R.E. Use of a computerized medication shared decision making tool in community mental health settings: Impact on psychotropic medication adherence. *Community Ment. Health J.* **2013**, *49*, 185–192.
39. Whitley, R.; Strickler, D.; Drake, R.E. Recovery centers for people with severe mental illness: A survey of programs. *Community Ment. Health J.* **2012**, *48*, 547–556.
40. Slade, M. *Personal Recovery and Mental Illness. A Guide for Mental Health Professionals*; Cambridge University Press: Cambridge, UK, 2009.
41. Perry, J.; Watkins, M.; Gilbert, A.; Rawlinson, J. A systematic review of the evidence on service user involvement in interpersonal skills training of mental health students. *J. Psychiatr. Mental Health Nursing* **2013**, *20*, 525–540.
42. Pinfold, V.; Thornicroft, G.; Huxley, P.; Farmer, P. Active ingredients in anti-stigma programmes in mental health. *Int. Rev. Psychiatry* **2005**, *17*, 123–131.
43. Harding, E.; Pettinari, C.J.; Brown, D.; Hayward, M.; Taylor, C. Service user involvement in clinical guideline development and implementation: Learning from mental health service users in the UK. *Int. Rev. Psychiatry* **2011**, *23*, 352–357.
44. Kendall, T.; Glover, N.; Taylor, C.; Pilling, S. Quality, bias and service user experience in healthcare: 10 years of mental health guidelines at the UK National Collaborating Centre for Mental Health. *Int. Rev. Psychiatry* **2011**, *23*, 342–351.
45. Lasalvia, A.; Bonetto, C.; Tansella, M.; Stefani, B.; Ruggeri, M. Does staff-patient agreement on needs for care predict a better mental health outcome? A 4-year follow-up in a community service. *Psychol. Med.* **2008**, *38*, 123–133.
46. Slade, M.; Leese, M.; Cahill, S.; Thornicroft, G.; Kuipers, E. Patient-rated mental health needs and quality of life improvement. *Br. J. Psychiatry* **2005**, *187*, 256–261.
47. Gillard, S.; Borschmann, R.; Turner, K.; Goodrich-Purnell, N.; Lovell, K.; Chambers, M. “What difference does it make?” Finding evidence of the impact of mental health service user researchers on research into the experiences of detained psychiatric patients. *Health Expect* **2010**, *13*, 185–194.
48. Rose, D.S.; Wykes, T.H.; Bindman, J.P.; Fleischmann, P.S. Information, consent and perceived coercion: Patients’ perspectives on electroconvulsive therapy. *Br. J. Psychiatry* **2005**, *186*, 54–59.
49. Bradshaw, P.L. Service user involvement in the NHS in England: Genuine user participation or a dogma-driven folly? *J. Nurs. Manag.* **2008**, *16*, 673–681.
50. Luqmani, R.; Hennell, S.; Estrach, C.; Basher, D.; Birrell, F.; Bosworth, A.; Burke, F.; Callaghan, C.; Candal-Couto, J.; Fokke, C.; *et al.* British society for rheumatology and British health professionals in rheumatology guideline for the management of rheumatoid arthritis (after the first 2 years). *Rheumatology* **2009**, *48*, 436–439.
51. Hewlett, S.; de Witt, M.; Richards, P.; Quest, E.; Hughes, R.; Heiberg, T.; Kirwan, J.R. Patients and professionals as research partners: Benefits, challenges and practicalities. *Arthritis Care Res.* **2006**, *55*, 676–680.
52. Heisler, M. Different models to mobilize peer support to improve diabetes self-management and clinical outcomes: Evidence, logistics, evaluation considerations and needs for future research. *Fam. Pract.* **2010**, *27*, i23–i32.

53. Ozanne, E.M.; Howe, R.; Omer, Z.; Esserman, L.J. Development of a personalized decision aid for breast cancer risk reduction and management. *BMC Med. Inform. Decis. Mak.* **2014**, *14*, doi:10.1186/1472-6947-14-4.
54. Cooke, M.; Campbell, M. Comparing patient and professional views of expected treatment outcomes for chronic obstructive pulmonary disease: A Delphi study identifies possibilities for change in service delivery in England, UK. *J. Clin. Nurs.* **2014**, *1*, doi:10.1111/jocn.12459.
55. Riva, S.; Bullinger, M.; Amann, E.; von Mackensen, S. Content comparison of haemophilia specific patient-rated outcome measures with the international classification of functioning, disability and health (ICF, ICF-CY). *Health Qual. Life Outcomes* **2010**, *8*, doi:10.1186/1477-7525-8-139.
56. Pope, J. Measures of systemic sclerosis (scleroderma): Health Assessment Questionnaire (HAQ) and Scleroderma HAQ (SHAQ), physician- and patient-rated global assessments, Symptom Burden Index (SBI), University of California, Los Angeles, Scleroderma Clinical Trials Consortium Gastrointestinal Scale (UCLA SCTC GIT) 2.0, Baseline Dyspnea Index (BDI) and Transition Dyspnea Index (TDI) (Mahler's Index), Cambridge Pulmonary Hypertension Outcome Review (CAMPHOR), and Raynaud's Condition Score (RCS). *Arthritis Care Res.* **2011**, *63*, S98–S111.
57. Chang, S.; Newton, P.J.; Inglis, S.; Luckett, T.; Krum, H.; Macdonald, P.; Davidson, P.M. Are all outcomes in chronic heart failure rated equally? An argument for a patient-centred approach to outcome assessment. *Heart Fail. Rev.* **2014**, *19*, 153–162.
58. Patel, K.K.; Veenstra, D.L.; Patrick, D.L. A review of selected patient-generated outcome measures and their application in clinical trials. *Value Health* **2003**, *6*, 595–603.
59. Priebe, S.; Golden, E.; McCabe, R.; Reininghaus, U. Patient-reported outcome data generated in a clinical intervention in community mental health care-psychometric properties. *BMC Psychiatry* **2012**, *12*, doi:10.1186/1471-244X-12-113.
60. Milne, J.L.; Robert, M.; Tang, S.; Drummond, N.; Ross, S. Goal achievement as a patient-generated outcome measure for stress urinary incontinence. *Health Expect* **2009**, *12*, 288–300.
61. Trujols, J.; Portella, M.J.; Iraurgi, I.; Campins, M.J.; Sinol, N.; de Los Cobos, J.P. Patient-reported outcome measures: Are they patient-generated, patient-centred or patient-valued? *J. Ment. Health* **2013**, *22*, 555–562.
62. Nicklin, J.; Cramp, F.; Kirwan, J.; Urban, M.; Hewlett, S. Collaboration with patients in the design of patient-reported outcome measures: Capturing the experience of fatigue in rheumatoid arthritis. *Arthritis Care Res.* **2010**, *62*, 1552–1558.
63. Hofmann, D.; Ibrahim, F.; Rose, D.; Scott, D.L.; Cope, A.; Wykes, T.; Lempp, H. Expectations of new treatment in rheumatoid arthritis: Developing a patient-generated questionnaire. *Health Expect* **2013**, *4*, doi:10.1111/hex.12073.
64. Von Korff, M.; Gruman, J.; Schaefer, J.; Curry, S.J.; Wagner, E.H. Collaborative management of chronic illness. *Ann. Int. Med.* **1997**, *127*, 1097–1102.
65. Epping-Jordan, J.E.; Pruitt, S.D.; Bengoa, R.; Wagner, E.H. Improving the quality of health care for chronic conditions. *Qual. Saf. Health Care* **2004**, *13*, 299–305.

66. Overland, J.; Mira, M.; Yue, D.K. Differential shared care for diabetes: Does it provide the optimal partition between primary and specialist care? *Diabet. Med.* **2001**, *18*, 554–557.
67. Haynes, R.B.; Ackloo, E.; Sahota, N.; McDonald, H.P.; Yao, X. Interventions for enhancing medication adherence. *Cochrane Database Syst. Rev.* **2008**, *16*, doi:10.1002/14651858.CD000011.pub3.
68. Andersen, R.M. National health surveys and the behavioral model of health services use. *Med. Care* **2008**, *46*, 647–653.
69. Kessler, R.C.; Berglund, P.A.; Bruce, M.L.; Koch, J.R.; Laska, E.M.; Leaf, P.J.; Manderscheid, R.W.; Rosenheck, R.A.; Walters, E.E.; Wang, P.S. The prevalence and correlates of untreated serious mental illness. *Health Serv. Res.* **2001**, *36*, 987–1007.
70. Schomerus, G.; Angermeyer, M.C. Stigma and its impact on help-seeking for mental disorders: What do we know? *Epidemiol. Psychiatr. Soc.* **2008**, *17*, 31–37.
71. Thornicroft, G. Stigma and discrimination limit access to mental health care. *Epidemiol. Psychiatr. Soc.* **2008**, *17*, 14–19.
72. Corrigan, P. How stigma interferes with mental health care. *Am. Psychol.* **2004**, *59*, 614–625.
73. Gulliver, A.; Griffiths, K.; Christensen, H. Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry* **2010**, *10*, doi:10.1186/1471-244X-10-113.
74. Sirey, J.A.; Bruce, M.L.; Alexopoulos, G.S.; Perlick, D.A.; Raue, P.; Friedman, S.J.; Meyers, B.S. Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *Am. J. Psychiatry* **2001**, *158*, 479–481.
75. Corrigan, P.W.; Larson, J.E.; Rusch, N. Self-stigma and the “why try” effect: Impact on life goals and evidence-based practices. *World Psychiatry* **2009**, *8*, 75–81.
76. Rusch, N.; Corrigan, P.W.; Wassel, A.; Michaels, P.; Larson, J.E.; Olschewski, M.; Wilkniss, S.; Batia, K. Self-stigma, group identification, perceived legitimacy of discrimination and mental health service use. *Br. J. Psychiatry* **2009**, *195*, 551–552.
77. Lundberg, B.; Hansson, L.; Wentz, E.; Bjorkman, T. Stigma, discrimination, empowerment and social networks: A preliminary investigation of their influence on subjective quality of life in a Swedish sample. *Int. J. Soc. Psychiatry* **2008**, *54*, 47–55.
78. Chaplin, R. Psychiatrists can cause stigma too. *Br. J. Psychiatry* **2000**, *177*, doi:10.1192/bjp.177.5.467.
79. Horsfall, J.; Cleary, M.; Hunt, G.E. Stigma in mental health: Clients and professionals. *Issues Ment. Health Nurs.* **2010**, *31*, 450–455.
80. Hugo, M. Mental health professionals’ attitudes towards people who have experienced a mental health disorder. *J. Psychiatr. Ment. Health Nurs.* **2001**, *8*, 419–425.
81. Cooper, A.E.; Corrigan, P.W.; Watson, A.C. Mental illness stigma and care seeking. *J. Nerv. Ment. Dis.* **2003**, *191*, 339–341.
82. Corrigan, P.W.; Williams, O.B.; McCracken, S.G.; Kommana, S.; Edwards, M.; Brunner, J. Staff attitudes that impede the implementation of behavioral treatment programs. *Behav. Modif.* **1998**, *22*, 548–562.

83. Jorm, A.F.; Korten, A.E.; Jacomb, P.A.; Christensen, H.; Henderson, S. Attitudes towards people with a mental disorder: A survey of the Australian public and health professionals. *Aust. N. Z. J. Psychiatry* **1999**, *33*, 77–83.
84. Nordt, C.; Rossler, W.; Lauber, C. Attitudes of mental health professionals toward people with schizophrenia and major depression. *Schizophr. Bull.* **2006**, *32*, 709–714.
85. Feret, H.; Conway, L.; Austin, J.C. Genetic counselors' attitudes towards individuals with schizophrenia: Desire for social distance and endorsement of stereotypes. *Patient Educ. Couns.* **2011**, *82*, 69–73.
86. Reynolds, A.; Pitts-Brown, S.; Thornicroft, G. Mental health. Everybody needs good neighbours. *Health Serv. J.* **1996**, *106*, 32–33.
87. Hori, H.; Richards, M.; Kawamoto, Y.; Kunugi, H. Attitudes toward schizophrenia in the general population, psychiatric staff, physicians, and psychiatrists: A web-based survey in Japan. *Psychiatry Res.* **2011**, *186*, 183–189.
88. Arvaniti, A.; Samakouri, M.; Kalamara, E.; Bochtsou, V.; Bikos, C.; Livaditis, M. Health service staff's attitudes towards patients with mental illness. *Soc. Psychiatry Psychiatr. Epidemiol.* **2009**, *44*, 658–665.
89. Nguyen, E.; Chen, T.; O'Reilly, C. Evaluating the impact of direct and indirect contact on the mental health stigma of pharmacy students. *Soc. Psychiatry Psychiatr. Epidemiol.* **2012**, *47*, 1087–1098.
90. O'Reilly, C.L.; Bell, J.S.; Kelly, P.J.; Chen, T.F. Exploring the relationship between mental health stigma, knowledge and provision of pharmacy services for consumers with schizophrenia. *Res. Social. Adm. Pharm.* **2013**, *4*, doi:10.1016/j.sapharm.2013.04.006.
91. Jones, S.; Howard, L.; Thornicroft, G. "Diagnostic overshadowing": Worse physical health care for people with mental illness. *Acta Psychiatr. Scand.* **2008**, *118*, 169–171.
92. Thornicroft, G. *Shunned: Discrimination against People with Mental Illness*; Oxford University Press: Oxford, UK, 2006.
93. Wahlbeck, K.; Westman, J.; Nordentoft, M.; Gissler, M.; Laursen, T.M. Outcomes of Nordic mental health systems: Life expectancy of patients with mental disorders. *Br. J. Psychiatry* **2011**, *199*, 453–458.
94. Thornicroft, G. Physical health disparities and mental illness: The scandal of premature mortality. *Br. J. Psychiatry* **2011**, *199*, 441–442.
95. Lawrence, D.; Hancock, K.J.; Kisely, S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population based registers. *BMJ* **2013**, *346*, doi:10.1136/bmj.f2539.
96. Thornicroft, G. Premature death among people with mental illness. *BMJ* **2013**, *346*, doi:10.1136/bmj.f2969.
97. Singh, D.; Ham, C. *Improving Care for People with Long-Term Conditions. A Review of UK and International Frameworks*; NHS Institute for Innovation and Improvement: London, UK, 2006.
98. Schrank, B.; Bird, V.; Rudnick, A.; Slade, M. Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review. *Soc. Sci. Med.* **2012**, *74*, 554–564.

99. Cook, J.A.; Copeland, M.E.; Jonikas, J.A.; Hamilton, M.M.; Razzano, L.A.; Grey, D.D.; Floyd, C.B.; Hudson, W.B.; Macfarlane, R.T.; Carter, T.M.; *et al.* Results of a randomized controlled trial of mental illness self-management using Wellness Recovery Action Planning. *Schizophr. Bull.* **2012**, *38*, 881–891.
100. Druss, B.G.; Zhao, L.; von Esenwein, S.A.; Bona, J.R.; Fricks, L.; Jenkins-Tucker, S.; Sterling, E.; Diclemente, R.; Lorig, K. The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. *Schizophr. Res.* **2010**, *118*, 264–270.
101. Lloyd-Evans, B.; Mayo-Wilson, E.; Harrison, B.; Istead, H.; Brown, E.; Pilling, S.; Johnson, S.; Kendall, T. A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry* **2014**, *14*, doi:10.1186/1471-244X-14-39.
102. Gayer-Anderson, C.; Morgan, C. Social networks, support and early psychosis: A systematic review. *Epidemiol. Psychiatr. Sci.* **2013**, *22*, 131–146.
103. Kleinberg, A.; Aluoja, A.; Vasar, V. Social support in depression: Structural and functional factors, perceived control, and help-seeking. *Epidemiol. Psychiatr. Sci.* **2013**, *22*, 345–353.

© 2014 by the authors; licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution license (<http://creativecommons.org/licenses/by/3.0/>)