

GENERAL PRACTITIONERS' BELIEFS ABOUT PEOPLE WITH SCHIZOPHRENIA AND WHETHER THEY SHOULD BE SUBJECT TO DISCRIMINATORY TREATMENT WHEN IN MEDICAL HOSPITAL: THE MEDIATING ROLE OF DANGEROUSNESS PERCEPTION.

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Abstract

This study explored the relationships between General Practitioners' (GPs) beliefs about People With Schizophrenia (PWS) and GPs' recommendations regarding restrictions for such people when in medical (non-psychiatric) hospital, and whether these relationships were mediated by dangerousness perception. Three-hundred twenty-two randomly selected GPs completed a questionnaire measuring beliefs about PWS. Structural Equation Model (SEM) was used to explore the effects of these beliefs on the GPs' views about the need for restrictive rules in hospital. Thirty-one percent of GPs firmly believed that, in medical wards, PWS should be supervised and 18% that they should be separated from other patients. SEM revealed that belief in such differential treatment was positively related to a belief that PWS need medication for the rest of their lives, and to perceptions of others' need for social distance, and of dangerousness. Dangerousness was, in turn, positively related to the belief that PWS need medication for their lives, and to a perception of the need for social distance, but negatively related to perceived capacity to report health problems. Analyses of indirect effects showed that the relationships of belief in discriminatory treatment with belief in medication for life and with perceived social distance were mediated by perceived dangerousness. GPs' attitudes about PWS appear closely with their beliefs on discriminatory behaviours in hospital, and the mediating role of dangerousness perceptions. Providing GPs with education about schizophrenia treatments and prognosis, and countering stereotypes about dangerousness, could be helpful to reduce GPs beliefs in the need for discriminatory treatment of PWS.

Key-words: stigma, general practitioners, schizophrenia, general hospital, discriminatory behaviors, dangerousness

INTRODUCTION

People diagnosed with schizophrenia (PWS) have higher risks of morbidity (Leucht, Burkard, Henderson, Maj & Sartorius, 2007) and higher mortality for some physical diseases (Capasso, Lineberry, Bostwick, Decker & Sauver, 2008; Howard et al., 2010; Vancampfort et al., 2015) than the general population, and an average life expectancy nearly 25 years shorter (Saha, Chant & McGrath, 2007). Despite the high prevalence of cardiovascular and metabolic diseases in PWS, partly related to long-term use of antipsychotic medications and partly to sub-optimal lifestyles, PWS receive fewer general medical checkups, blood pressure and cholesterol checks (Happel, Scott & Platania-Phung, 2012; Roberts, Roalfe, Wilson & Lester, 2007). Moreover, PWS have less opportunity to be educated on how to manage at risk behaviors such as use of tobacco and alcohol, and to be included in weight-reduction programs (Sullivan et al, 2015).

Health care inequalities in PWS are also related to negative attitudes from health professionals towards these people (Corrigan et al., 2014; Henderson et al., 2014), who are frequently viewed as dangerous and suffering from an incurable illness. Despite the majority of PWS being not violent (Fazel, Gulati, Linsell, Geddes & Grann, 2009), perception of dangerousness is a major cause of stigma towards them (Jorm, Reavley & Ross, 2012; Read, Haslam & Magliano, 2013). These stereotypical views of PWS, particularly the irreversibility of the condition, are reinforced by promotion of a biogenetic model of this disorder (Kvaale, Gottdiener & Haslam, 2013; Read et al., 2013). These stereotypes can have important effects on clinical practice and doctor-client relationships (Corrigan et al., 2014; Happell et al. 2012; Henderson et al., 2014; Solar, 2002; Ucock et al., 2006). It has been reported that the presence, or even the suspicion, of a mental illness had a negative impact on hospital staff attitudes toward patients (Liggins & Hatcher, 2005), and that complaints of physical problems by psychiatric patients made the staff feel uncomfortable in dealing with those clients. Even more serious is the evidence that physicians tend to minimize the medical needs of PWS, to associate patients' physical complaints with the mental illness (Shefer, Henderson, Howard, Murray & Thornicroft, 2014), and to underestimate medical symptom severity (Henderson et al., 2014; Jones, Howard & Thornicroft, 2008; Thornicroft, Rose & Kassam, 2007). Other studies have found that when people with severe mental disorders are in hospital for physical health problems, staff sometimes treat them with disrespect (Harangozo et al., 2014), keep them apart from the other patients, or transfer them to a psychiatric unit as soon as possible (Liggins & Hatcher, 2005). Moreover, health professionals who expressed stigmatizing attitudes towards PWS were more skeptical about adherence to treatment of these clients and less likely to refer PWS to an appropriate medical specialist (Corrigan et al., 2014; Sullivan et al., 2015). All this can, in turn, lead to poor help-seeking behavior for health problems by people on the receiving end of the prejudice (Horsfall, Cleary & Hunt, 2010; Thornicroft et al., 2007).

General Practitioners (GPs) play a key-role in the diagnosis and treatment of medical and psychiatric problems in PWS (Simon, Lauber, Ludewig, Braun-Scharm, Umbrecht, Swiss Early Psychosis Project, 2005; Skeate, Jackson, Birchwood, & Jones, 2002). Studies reveal that GPs have different roles in different health care systems, and that their role is changing (Planner et al., 2014). Several efforts are visible, especially in the United States and United Kingdom, to trial collaborative care models with the aim of improving the physical health of consumers with mental illness. For instance, in the US, there is an evolution toward integrating general health care and mental health services (Miller and Druss, 2013), as also outlined in the 2016 Mental Health Reform Act (NAMI, 2016). Moreover, in the US, the introduction of the Affordable Health Care for America Act (HR 3962, reported by Planner et al., 2014) by extending health insurance coverage to an extra 4 millions of people with severe mental illness, has encouraged the involvement of GPs in the management of people with mental health problems. In the United Kingdom, primary care is centrally involved in the care of people with serious mental illness. Historically, people with severe mental illness tend to consult primary care practitioners more frequently and are in contact with primary care services for a longer cumulative time, than patients without mental health problems (Reilly et al., 2012). However, despite the fact that, in UK, GPs often have the primary responsibility for treatment of PWS and for referral when their condition becomes more complicated, the need of extending GPs' training in mental illness to improve support for PWS managed by primary care has been recently outlined (The Schizophrenia Commission, 2012). In Italy, one of the countries with the longest experience of community care, the importance of integrating primary care and mental health services has only recently been acknowledged (Berardi et al., 2014). In the absence of specific national government health policies, only two Regions have implemented explicit policies of integration between mental health services and primary care in Italy (Berardi et al., 2014).

Data on the utilization of general practice services shows that in some countries most PWS have regular contact with their GP and receive adequate levels of care for their mental or somatic problems (Oud et al., 2010; Hetlevik, Solheim, & Gjesdal, 2015; Irfan, Caldas de Almeida, Irfan, Raza, & Farooq, 2015), while in others they do not (Roberts et al., 2007; Oud et al., 2010). For instance, a five-year study in the Netherland (Oud et al., 2010), found that 734 persons with psychotic disorders contacted GPs more frequently than people with other mental disorders or without any mental disorder, and that they received the physical health care they needed. Data from a cross-sectional study carried out in England, covering all service contacts from 1st April 2008 to 31st March 2009 (Reilly et al., 2012), reported an estimated national rate of PWS seen only in primary care in the period of 56.8% (95% C.I. 52.3% to 61.2%). Another study comparing routine practices and evidence-based NICE guidelines to promote recovery in schizophrenia in 19 Italian Mental Health Services (MHS) (Semisa et al. 2008), reported that in 10 MHSs (55.5%), collaboration between MHS staff and GPs occurred for only 50% of PWS. Other studies found that PWS receive less attention for

their physical health needs from their GPs than do other clients. A survey among 200 PWS in Hungary revealed that 44% of PWS had never used a GP service, although 28% had wished to but did not receive that service (Harangozo et al., 2005). Another study of 114 GPs in Pakistan (Irfan et al., 2015) reported that 88% of them had poor or no knowledge of schizophrenia and 72% had poor or no practice skills regarding this disorder.

Moreover, GPs co-ordinate health care provisions, collaborate with other primary care professionals, and manage the interface with other specialties and hospital care. However, the closeness of this collaboration varies from country to country. For instance, in the US, direct communication between hospital physicians and primary care physicians occurs infrequently (Kripalani et al., 2007). In Italy, the collaboration between GPs and general hospital wards is determined by the National Health Law (229/99; Agenas, 2016): when a client is hospitalized, the GP usually provides a written report on the client's clinical conditions, can be contacted by the hospitalists during the clinical assessment and the hospitalization, and receive a report at discharge. In the UK, as in most countries where general practice/family medicine is well established, GPs act as the 'gatekeeper' to secondary services, including referral to hospital (UK National Health Service, 2016) but have varying levels of contact with hospital staff and influence over their decisions (Saltman et al., 2006).

Studies reveal that some GPs are reluctant to treat PWS and give them less attention than other clients (Mittal et al., 2014; Oud et al., 2010; Roberts et al., 2007; Sullivan et al., 2015). Moreover, some GPs tend to interpret physical problems in PWS as psychiatric symptoms, and also perceive them as chronically ill (Ucok et al., 2006) and dangerous (Adewuya & Oguntade, 2007; Parker, Chen, Kua, Loh & Jorm, 2001). Studies also find that, compared to people with depression, GPs more often consider pain complaints to be psychological rather than physical in origin in PWS (Lam, Lam, Lam & Ku, 2013), and were more skeptical about recovery (Parker et al., 2001). Furthermore, it has been shown that applying the diagnostic label "schizophrenia" to a person is associated with GPs' having a higher perception of dangerousness and higher reluctance to work with a client, compared to no label usage (Lawrie et al., 1998, Mittal et al., 2014, Sullivan et al., 2015). Given the crucial role of GPs in coordinating care, it seems worthwhile examining GPs' attitudes towards PWS and to explore whether these attitudes may have an influence on the behaviors adopted with these clients in different health contexts.

In 2014, a study carried out in a randomly selected sample of 387 _____ GPs, investigated whether the diagnosis 'schizophrenia', actively or passively used, would influence GPs' attitudes towards people with this disorder (Magliano et al., unpublished data). The study revealed that GPs were influenced in their views by the "schizophrenia" label, regardless of whether they reach the diagnosis themselves - after reading a undiagnosed ICD-10 clinical description of this disorder - or are just responding to being told the diagnosis. In particular, compared to the 65 GPs who did not name the ICD-10 clinical description as "schizophrenia", the 322 who actively or passively used this term were more sceptical

about recovery and more convinced of the need for pharmacological treatment for life, had more restrictive beliefs about how PWS should be treated in non-psychiatric hospital wards and perceived PWS as more dangerous to themselves and the others, and as kept at greater social distance by other people.

The current paper is based on data from the sample of the 322 GPs who, actively or passively, used the label “schizophrenia”. We investigated the relationships’ of GPs views about PWS with beliefs about discriminatory behaviors that should be adopted with PWS in non-psychiatric hospital wards, and whether these relationships were mediated by perception of dangerousness of PWS. In particular, we hypothesized that GPs who were more convinced that PWS should be treated differently from other patients in ordinary hospital wards would:

- a) be more convinced that PWS are dangerous
- b) more firmly believe that PWS are kept at distance by others
- c) be more pessimistic about the possibility of recovery from this disorder
- d) be more convinced that PWS should take medication for rest of their lives
- e) be more skeptical about the capacity of PWS to report their health problems to medical doctors
- f) more firmly believe that PWS have no insight into their condition.

We also tested whether any relationships between factors b-f and GPs’ views about differential conduct towards PWS in hospital were mediated by their perception of dangerousness in PWS.

METHODS

Study design

From June 2013 to March 2014, 430 randomly selected GPs working in the _____ central health district were contacted personally or by phone by a research and invited to participate in a study on their views about schizophrenia. Eligible participants corresponded to 50% of registered GPs working in the district (population approximately one million). They were selected from the health district official GP lists, using SPSS random case selection command. GPs did not receive any incentive for their participation. Of the 430 contacted GPs, 43 (10%) refused to participate in the study (reasons: not interested 62%, no time 12%, personal reasons 12%, unknown 14%;), leaving a sample of 387 participants. Of the 387 GPs who gave their informed consent to participate (90.0%), 192 at random completed the revised version of the Opinion on mental illness Questionnaire (OQ) after reading a ICD-10 clinical description of schizophrenia and making a diagnosis, and 195 just in relation to ‘PWS’ (without reading the clinical description). The questionnaire was self-administered in the presence of the researcher at the GP’s office or was sent by mail, according to GP preference. Information on GPs’ demographic variables, professional background and contact with

PWS was also collected. The study was approved by the Research Ethical Board of the _____ University of _____. Authors complied with APA ethical standards in the treatment of their sample.

Three-hundred and twenty-two GPs completed the questionnaire, actively or passively using the label “schizophrenia”, and were included in this secondary analysis study (i.e., the 65 GPs who did not identify schizophrenia in the ICD-10 clinical description were excluded from the analysis). The 322 participants were mainly male (257, 79.8%) and married (282, 88.1%). They had a mean age of 58.2 ± 5.3 years. The majority (309, 96.0%) had achieved a MD degree more than 20 years ago and had a post graduate medical training (239, 74.2%). Two-hundred and fifty-six GPs (79.5%) stated they treated patients with ‘schizophrenia’.

Measures

The revised version of the Opinion Questionnaire (OQ) to be applied in health contexts (Magliano et al., 2014) included: a) 16 yes/no items exploring factors involved in the development of schizophrenia; b) 4 yes/no items about which professionals should treat PWS; c) 23 items grouped into 10 factors addressing: 1) usefulness of pharmacological treatments; 2) usefulness of psychological therapies; 3) need of long-term pharmacological therapies (i.e, beliefs that PWS should take drugs permanently, and that they become unwell again or dangerous if they stop the drugs) ; 4) possibility of recovery; 5) insight of PWS; 6) capacity of PWS to report their health conditions to medical doctors; 7) perception of others’ need for social distance from PWS (i.e., conviction that other people are reluctant to be in contact with PWS because of fear, perception of unpredictability, poor understanding of the problems experienced by PWS, and difficulties in approaching them); 8) dangerousness; 9) discriminatory treatment of PWS in non-psychiatric hospital wards (i.e., conviction that PWS should be separated from other patients; can create discomfort to other patients; should be supervised, and should always be examined by a psychiatrist); 10) difficulties of PWS in having romantic relationships. Section c items are rated on a 3-point scales, from 1= “not true” to 3= “completely true”. The psychometric properties of section C of the OQ were preliminary tested on the global sample of 387 GPs and found to be satisfactory (Confirmatory Factor Analysis: model $\chi^2 = 320.35$, df 188, N= 387, $p < 0.05$; NNFI=0.95; CFI=0.97; RMSEA=0.04 (0.03; 0.05); SRMR=0.04; all factor loadings significant for $p < 0.001$; Cronbach’s alpha values of the factors ranging from 0.65 to 0.83). For the purpose of this study, factors 3-9 were used.

Data Analysis

Pearson’s Correlations coefficients were computed to explore bivariate relations between OQ factors 3-9. Structural Equation Model (SEM) was used to investigate the relationships of GPs’ views on schizophrenia (OQ factors 3-8) with beliefs about discriminatory treatment in hospital wards (factor 9). Direct effects, and indirect effects mediated

by perception of dangerousness (factor 8) of GPs' views of schizophrenia (factors 3-7) on beliefs about discriminatory treatment (factor 9) were examined. In the SEM, factors 3-8 were observed variables and factor 9 was the latent variable (measured by the following four items "*In a non-psychiatric hospital ward, PWS create discomfort to other patients*", "*...should be separated from other patients*", "*...psychiatric advice should always be requested*", and "*... PWS should be supervised*"). The Maximum Likelihood method was used to compute path coefficients and the following fit indices: χ^2 , Comparative Fit Index (CFI), Tucker-Lewis Index (TLI), and Root Mean Square Error of Approximation (RMSEA). A value of CFI and TLI > 0.90 is considered a satisfactory fit (Bentler, 1990). RMSEA values from 0 to 0.05 indicate excellent fit, and from 0.06 to 0.08 indicate acceptable fit (Brown & Cudeck, 1993). Statistical significance was set at $p < 0.05$. Univariate analyses were performed using SPSS version 21 (IBM, 2012) and SEM was computed using MPLUS 4.2 software (Muthén & Muthén, 2006).

RESULTS

Forty-two percent of GPs thought it was 'completely true' that "*PWS must take drugs all their life*", 22.9% that it was completely true that "*PWS are reliable in referring their physical problems to medical doctors*", and 44.5% that "*PWS are kept at distance by the others*" (Table 1). Thirty percent firmly believed that "*PWS are dangerous to themselves*", and 25.0% that "*PWS are dangerous to others*". Seventy-four percent were fully convinced that "*When PWS are admitted to non-psychiatric wards, psychiatric advice should always be requested*", 31.4% that "*In non-psychiatric hospital wards, PWS should be supervised (for instance, by an additional nurse)*", 29.7% that "*In a non-psychiatric hospital ward, PWS create discomfort to other patients*", and 18.4% that "*In a non-psychiatric hospital ward, PWS should be separated from other patients*".

As shown by the correlations reported in Table 2, GPs who more firmly viewed schizophrenia as an incurable illness requiring drug treatment for life, and PWS as having poor insight and are kept at a social distance by others, were more convinced that PWS are dangerous and they should be discriminated in hospital wards. Moreover, GPs who more firmly believed that PWS are dangerous were more skeptical about their capacities in reporting health problems, and more convinced that PWS should be subject to discriminatory treatment in hospital wards.

As reported in Figure 1, the model generated by SEM had a good fit and explained 18% of the variance for perception of dangerousness and 21% of the variance for behaviors to be adopted in medical hospitals. In particular, SEM revealed that belief in discriminatory treatment in hospital was positively related to a belief that PWS need medication for the rest of their life, and to perceptions of need for social distance and of dangerousness. Dangerousness was, in turn, positively related to the belief that PWS need medication for life, and to a perception of need for social distance, but negatively related to perceived capacity to report health problems. Furthermore, SEM analyses of indirect

effects showed that the relationships of belief in discriminatory treatment with belief in medication for life ($\beta = .06, p < 0.01$) and with perceived social distance ($\beta = 0.03, p < 0.05$) were mediated by perceived dangerousness.

DISCUSSION

Interpretation of the results

The results of this study show that beliefs about discriminatory treatment for PWS in hospital are common among GPs, and that these beliefs are significantly related to perceptions of dangerousness and social distance, scepticism about capacities of PWS to report their health problems accurately, and the need of medication for life. These results also support the central role of dangerousness in mediating the above-mentioned relationships. The results also reveal that beliefs about drug therapies for life and about social distance from PWS are related to discriminatory behaviours in hospital, both directly and indirectly via dangerousness.

A notable percentage of GPs believed that PWS should be treated differently from other hospital patients. In particular, 18.4% of GPs firmly believed that PWS should be separated from other patients and 31.4% that they should be supervised. In clinical practice, GPs collaborate with hospital physicians. Therefore, GPs' beliefs on how their clients should be treated may significantly influence the decisions of hospital colleagues about PWS. The finding that 42% of GPs were fully convinced that PWS should take psychiatric drugs for life may be related to the adherence of some GPs to a biogenetic model of mental disorders (Read et al., 2013). This is also evidenced by the high percentage of GPs who reported heredity (85.4%) among the factors involved in the development of schizophrenia (Magliano et al., unpublished data). It is also likely that the high percentage of GPs who completely agreed with the need of drugs for life is related to the frequent exposure of GPs to pharmacological 'education' of the kind provided by pharmaceutical companies (Read & Cain, 2013; Usher & Skinner, 2010), along with limited education on recovery in schizophrenia. These beliefs may have a relevant impact on the type of information that GPs provide to PWS and their relatives, which may in turn influence PWS adherence to treatment and the recovery process. It is equally worrying that only 22.9% of GPs firmly believed that PWS are reliable in referring their physical problems to medical doctors. GPs' scepticism about the ability of PWS to accurately report their health problems, may lead GPs to give poor relevance to patients' somatic complaints. This, in its turn, may influence diagnostic process and treatments provision (Henderson et al., 2014).

SEM showed that perceived dangerousness was related to belief in life long medication, perception of social distance by other people, and reliability of PWS in reporting health problems. Dangerousness was also associated with GPs' beliefs on discriminatory behaviors in hospital. The close relationship between GPs' perception of social distance from PWS in other people and GPs' own perception of dangerousness and discriminatory behaviors to be used with PWS in hospital can be explained by the influence of social context on the individuals' beliefs. As member of the society, GPs

acknowledge that other people are frightened and do not understand the difficulties experienced by PWS (Jorm et al., 2012; Kvaale et al., 2013; Magliano, Fiorillo, De Rosa, Malangone & Maj, 2004; Read et al., 2013). This, in turn, may contribute to the GP's own perception of dangerousness and beliefs about the approach that should be adopted in hospital wards.

The results of this study outline the close relationships of GPs' attitudes about PWS with their beliefs on discriminatory behaviours in hospital contexts, and the mediating role of dangerousness perceptions. Providing GPs with education on successful treatments (eg., CBT and Family Psychoeducational Interventions (Mueser, Deavers, Penn & Cassisi, 2013)) and positive prognosis in schizophrenia (Levine, Lurie, Kohn & Levav, 2011; Tibaldi & Govers, 2012; Varese et al., 2012; Warner, 2009), and countering non evidence-based stereotypes about dangerousness (Corrigan 2014; Magliano et al., 2014), could be helpful to reduce the proportion of GPs who believe in discriminatory behavior towards people on the basis of a diagnosis of schizophrenia. This, in its turn, may increase the probability that PWS are treated the same as other citizens in non-psychiatric hospital contexts.

Strengths and limitations of the study

This is the first study carried out in _____ that has examined the relationship between GPs' views of PWS and beliefs about discriminatory behaviours in hospital within the framework of a multifactorial model. Among the strengths of the study there are the inclusion of a relatively large and randomly selected sample, the face-to-face data collection and the low refusal rate. The use of a validated self-reported questionnaire is a further strength, also facilitating the replication of the survey in other health contexts. However, the study has a number of limitations requiring caution in the interpretation of its results. In particular, it should be considered that: a) the mean age of the sample is quite high, so the results may be not representative of younger GPs; b) the inclusion of GPs from only one metropolitan area located in _____, where healthcare resources are poorer (Magliano et al., 2002), may limit the generalisability of the results to other geographical contexts; c) the cross-sectional design of the study does not permit inferences regarding the effects of examined variables; d) there is a lack of information on whether those GPs who did not agree to participate in the study were likely to be similar in their beliefs to those who did complete the survey. One might expect that GPs who refused to participate for lack of interest in the survey might have more negative attitudes about PWS; e) the results are reports of GP attitudes and not on actual observations of GP behaviours, therefore they may not reflect GPs' actual behaviours with PWS in clinical practice; f) the study does not provide information on direct experience of GPs with PWS, on GPs' behaviours with these clients at their own medical office, and on GPs' actual collaboration with hospital physicians; g) the generalisability of the study to countries where GPs have little or no contact with hospital staff is minimal (Kripalani et al., 2007); h) the survey did not investigate hospital staff attitudes and discriminatory behaviours

toward PWS. Most limitations will be addressed in further studies, at their planning stage, in which we will examine both attitudes and actual behaviours towards PWS among a range of primary healthcare professionals and general hospital personnel.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interests concerning this article.

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Table 1. GPs views of people diagnosed with schizophrenia (N=322)

Items	“Not true”		“Partially true”		“Completely true”	
	N	%	N	%	N	%
PWS* can recover	39	13.0	195	65.0	66	22.0
PWS must take drugs over the life	39	13.0	135	45.0	126	42.0
If stop taking drugs, PWS become dangerous	61	20.5	168	56.4	69	23.1
If stop taking drugs, PWS become unwell again	24	7.7	148	47.7	138	44.6
PWS do not realize that they are ill	38	12.2	172	55.1	102	32.7
PWS do not realize when they become unwell	41	13.1	146	46.5	127	40.4
PWS are unpredictable	30	9.7	156	50.3	124	40.0
PWS are kept at distance by the others	39	12.5	148	47.3	126	40.2
People does not know how to behave with PWS	12	3.8	122	38.6	182	57.6
People does not understand the difficulties experienced by PWS	8	2.5	104	32.7	206	64.8
People is frightened by PWS	13	4.1	91	28.9	211	67.0
PWS are dangerous to themselves	27	8.6	190	60.9	95	30.4
PWS are dangerous to others	28	8.9	207	65.7	80	25.4
In a non-psychiatric hospital ward, PWS create discomfort to other patients	49	16.3	162	54.0	89	29.7
In a non-psychiatric hospital ward, PWS should be separated from other patients	135	46.0	104	35.5	54	18.4
When PWS are admitted to non-psychiatric wards, psychiatric advice should always be requested	17	5.4	65	20.5	235	74.1
In non-psychiatric hospital wards, PWS should be supervised (for instance, by additional nurse)	80	27.6	119	41.0	91	31.4
PWS are reliable in referring their mental problems to medical doctors	61	19.7	194	62.6	55	17.7
PWS are reliable in referring their physical problems to medical doctors	49	15.6	193	61.5	72	22.9

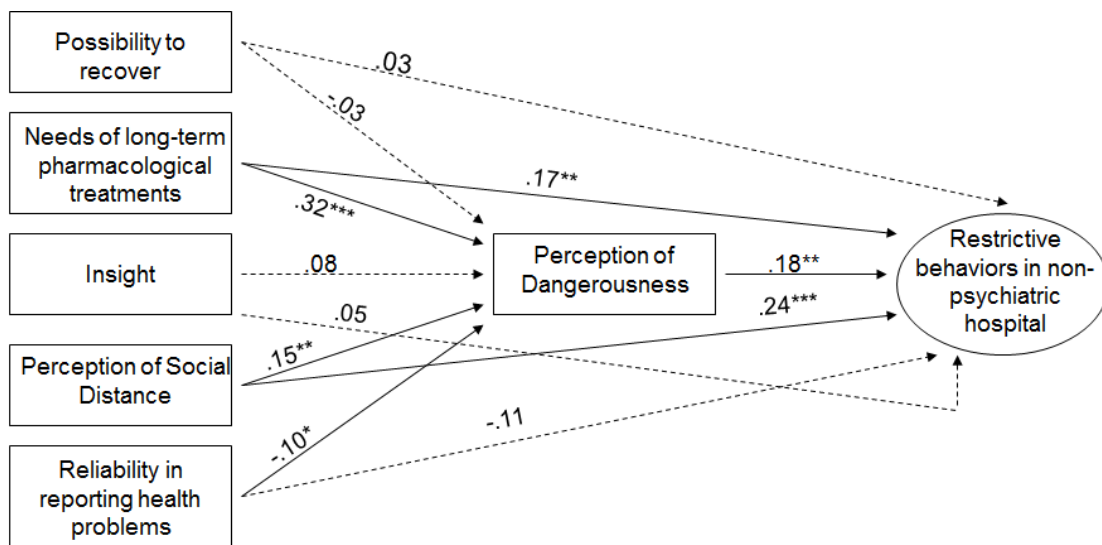
*People With Schizophrenia

Table 2. Correlations among the OQ factors

OQ factors	1	2	3	4	5	6	7
1. Possibility to recover	-						
2. Needs of long-term drug therapies	-.26***	-					
3. Insight	-.07	.12*	-				
4. Perception of social distance	.05	.19***	.21***	-			
5. Reliability in reporting health problems	.04	-.05	-.11*	-.07	-		
6. Perception of dangerousness	-.12*	.37***	.16**	.23***	-.14*	-	
7. Restrictive behaviors in non-psychiatric hospital wards	-.03	.25***	.14*	.29***	-.16**	.29***	-

* p<.05; ** p<.01; *** p<.001

Figure 1. Relations between GPs' views of schizophrenia, perception of dangerousness and behaviors to be adopted in non-psychiatric hospital wards.



* $p < .05$ ** $p < .01$ *** $p < .001$; Model fit indices: $\chi^2 = 13.72$, $df = 20$, $p = .84$, $RMSEA = .0$ (.0; .03), $TLI = 1$, $CFI = 1$. Significant correlations between need of long-term drug treatments with possibility to recover ($\beta = -.26$, $p < .001$), insight ($\beta = .12$, $p < .05$), and perception of social distance ($\beta = .19$, $p < .001$); between insight with perception of social distance ($\beta = .21$, $p < .001$) and PWS reliability in reporting health problems ($\beta = -.11$, $p < .05$).