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COMMENTARY

Challenging healthcare discrimination

COMMENTARY ON … DISCRIMINATION AGAINST PEOPLE WITH MENTAL ILLNESS[†]

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[†] See pp. 53–59, this issue.

SUMMARY

Stigma-discrimination against people with mental health problems is more prevalent and damaging than the weaker 'stigma by association' experienced by mental healthcare professionals. Not only are patients reluctant to seek psychiatric help, but they are shunned by society and discriminated against by general healthcare services when they do. Other clinicians see psychiatric services as a last resort and government funding of these services is disproportionately low. Psychiatrists must engage in anti-stigma activities. I suggest ways in which, both in the clinical arena and in the wider context of education and society, psychiatrists can challenge clinicians' and the public's value judgements of psychiatric patients.

DECLARATION OF INTEREST

None.

Before responding to Professor Thornicroft's article (Thornicroft 2010, this issue), I reflected on the components of an ideal article about healthcare discrimination – its scope and purpose. A modern review of this area should highlight:

- some negative effects (unintended and otherwise) of psychiatric interventions
- evidence that specific actions/omissions by psychiatrists will reduce stigma-discrimination[a] against people with mental health problems
- broad recommendations to help psychiatrists to do 'everything they can to help people with mental illness' (Thornicroft 2010, this issue).

An added bonus would be to extend the ideal review's appeal beyond those colleagues already engaged in anti-stigma efforts (e.g. www.fairdeal4mentalhealth.co.uk).

Given the high proportion of people with mental health problems who do not receive treatment, Thornicroft *et al* propose four headings to describe barriers to mental healthcare: sociocultural, systemic, economic and individual. Although stigma-discrimination directly affect the latter two (economic and individual barriers to seeking help), it is less clear how sociocultural and systemic processes operate, and much less how to change them. That psychiatrists communicate the subjective experiences and consequences of psychosis poorly is a given (e.g. Table 2 in their article), but psychiatric systems do not fully explain ethnic variations in presenting voluntarily to mental healthcare. If barriers to seeking help lie within how psychiatrists practise and deliver mental healthcare, to where does the evidence point for best practice? Individual health beliefs ('This will soon pass', 'I'll fix this myself') and avoidance behaviours (resisting family pressure) seem universal to all medical (and other) problems. Two other factors cited (the expectation of avoidance by others and perceptions that mental healthcare treatments do not work) merit further exploration. Nor can we explain high drop-out rates from mental healthcare: as psychiatrists, we should recognise that in many areas, our treatments are less effective than we would wish, although service dissatisfaction rates highly, as Thornicroft *et al* discuss.

Healthcare discrimination

People do attempt to relieve mental health problems other than by seeking mental healthcare. Many attend primary care, and even allowing for the small proportion of patients who disguise/somatise their mental distress, general practitioners (GPs) lack the time, means or inclination to label these as mental health problems. This is discrimination in the sense of choosing one option over another, but a good starting point to engage the psychiatrist sceptical of the effects of stigma is overt health service discrimination. The battleground here is the gap between aspiration and practice in delivering physical healthcare to people with severe mental illness within primary care. This has been previously discussed in this journal (Lester 2005), and Thornicroft *et al* cite

[a] US and European writers in this area have solved the tension between social scientists, who write about stigma, and service users, who speak of discrimination, by combining the two into the shorthand 'stigma-discrimination'.

studies showing negative attitudes among GPs. Direct discrimination has been documented in organ transplantation (Byrne 2000) and in the investigation and treatment of people with severe mental illness who develop heart disease (Hippisley-Cox 2007). Thompson & Thompson (1997) listed widespread discrimination in health services, admitting that they had only scratched the surface: as laws tighten, discrimination becomes more subtle and covert. Clinician-focused analyses and solutions are well established (Royal College of Psychiatrists 2001), if largely unimplemented. The point here is that psychiatrists are well placed to challenge other clinicians' value judgements that make psychiatric patients the lowest priority (Fig. 1).

Levels of stigma

There has never been a full explanation of the findings of Phillips (1963) that public attitudes against people with mental health problems become progressively worse as the latter climb the mental healthcare referral ladder. Being a psychiatric in-patient is worse than seeing a psychiatrist, itself worse than consulting a clergyman about mental health problems. Is it that 'inmates' have lost control of themselves or that they are perceived to have lost their humanity? We do not know whether public antipathy to someone who has experienced psychosis would be less if they had home treatment rather than a brief hospital admission, albeit voluntary. Relevant to the Mental Health Act 2007 for England and Wales, Link *et al* (2008) concluded that out-patient psychiatry by coercion is more stigmatising than psychiatry by collaboration and, by comparison, also reduces service users' quality of life and self-esteem.

The belief noted by Thornicroft *et al* that psychiatrists' diagnoses are cavalier and that they throw useless but harmful pills at people would, if psychiatrists were the main drivers of stigma, reduce public antipathy to people with mental health problems. However, the origins and perpetuation of stigma extend beyond the profession of psychiatry. Schulze (2007) offers clearer explanations of these complex interactions: mental healthcare professionals may stigmatise – with more than 70% of studies showing that their attitudes are similar to or worse than those of the general public – but they have become self-aware. Rather than psychiatrists' social embarrassments, there are other issues: that referral to mental healthcare by colleagues is as a last resort, our lack of funds relative to other specialties, and community resistance to discharging people with mental health problems after recovery.

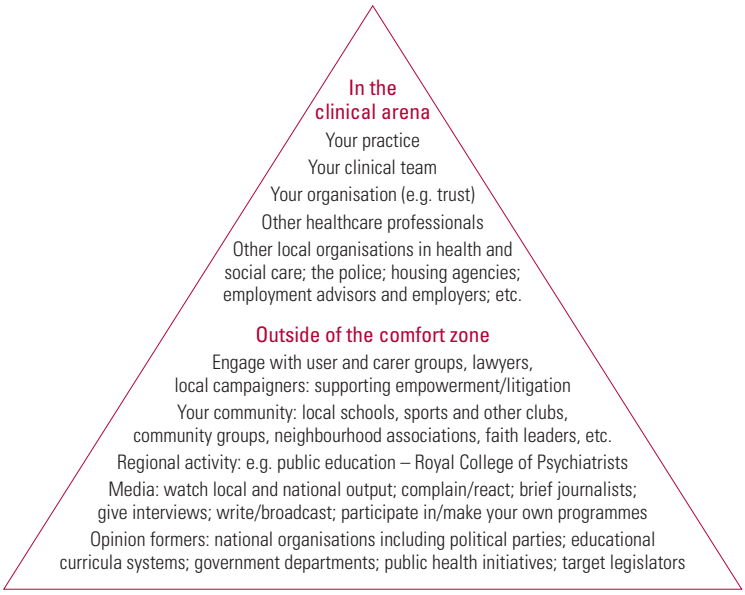

FIG 1 Levels of intervention by psychiatrists to reduce stigma-discrimination.

Words then actions

Predominant in the recommendations made by Thornicroft *et al* is a call to abandon the old language of 'chronic' and 'schizophrenic'. Language has always been problematic among professionals and in the wider public. We have words for racism, sexism, ageism, homophobia and so on, and near universal public acceptance that these are unacceptable belief systems. There is, however, no word for prejudice against people with mental health problems. Many service users resent the use of the word 'stigma' to describe their experiences, just as some colleagues resist the term 'service user'.

Beyond language, no other branch of medicine has so many unresolved theoretical disagreements (Estroff 2004) and few authors have provided a sound theoretical basis to understanding stigma-discrimination. An honourable exception here has been Bruce Link. In one important review, he sets out key stigma-discrimination processes (Link 2001). Relationships that matter are about power: person A cannot stigmatise or discriminate against person B without a power differential. When we concede more equality in our doctor–patient relationships, reduce the infantalisation of the care programme approach (CPA) and challenge the poverty trap of the Disability Living Allowance (DLA), only then will we reduce stigma. Fittingly then, a focus of the final section of the article by Thornicroft *et al* is removing barriers to employment. We may have emptied the institutions but modern Western psychiatry's mind–brain dichotomy has neglected

social dimensions and bequeathed asylum in the community.

Time to change

It is useful to understand attitudes but ultimately we need to examine and change behaviours. How do we engage all psychiatrists in anti-stigma activities? Thornicroft *et al* appeal to self-interest (low proportions presenting to mental healthcare, reduced funding, poor recruitment) and professional self-respect. We could also appeal to scientific sensibilities – the driving force for public prejudice is fear of violence (Estroff 2004) based on perceptions, not on reality – or to our sense of injustice (Corrigan 2005). As clinicians, we strive to do our best for the patient sitting opposite and improving that person's social inclusion should be the benchmark of our every action. In the clinic, it's hard to see the bigger picture (Fig. 1) and harder still to conceptualise links between micro and macro (Corrigan 2004). Many colleagues enjoy their role as educators and these activities could extend well beyond pliant medical students – the challenge is to promote multilevel actions by colleagues within and beyond the clinical arena (Fig. 1). In this, we have much to gain from collaborations with service users and carers, and many lessons to learn from contemporary anti-stigma initiatives (Estroff 2004).

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