Service-user Recovery Evaluation (SeRvE) scale *continued*

Your personal religious beliefs and practices **during the last week**

If you believe in a God, higher power, divine spirit, force for good or anything similar, even if only a little, please write your preferred word in here:_____

Please substitute your word for X in the following questions, or circle 'n/a' (not applicable) if you think the question is not relevant to you

Disagree strongly (1), disagree somewhat (2), don't know (3), agree somewhat (4), agree strongly (5)

I feel I am loved by X	1	2	3	4	5	n/a
I feel that there is a part of X within me	1	2	3	4	5	n/a
My faith/spiritual belief is helpful to me	1	2	3	4	5	n/a
I feel anger towards me from X	1	2	3	4	5	n/a
I find it helpful to pray to X	1	2	3	4	5	n/a
I feel spiritual power/forces are controlling me or others	1	2	3	4	5	n/a
I find it helpful to attend religious services/rituals	1	2	3	4	5	n/a
I feel that X has a purpose for my life	1	2	3	4	5	n/a
My faith/spiritual belief gives me difficult thoughts	1	2	3	4	5	n/a

Thank you for completing this questionnaire

'We've got another one for you!' Liaison psychiatry's experience of stigma towards patients with mental illness and mental health professionals

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Aims and method To assess stigmatising attitudes towards mental illness and psychiatric professionals experienced by UK liaison psychiatry staff. A questionnaire asked about the impact of these events on patient care and for suggestions for tackling stigma in the general hospital.

Results Out of 72 multidisciplinary respondents, over three-quarters had experienced stigmatising attitudes towards mental illness by general hospital colleagues at least monthly. Two-thirds reported instances where stigmatisation had an adverse impact on patient care, and over a quarter reported stigmatising attitudes towards mental health professionals. Suggestions for combating stigma included educational initiatives, clear clinical communication, and the provision of high-quality liaison services.

Clinical implications Liaison psychiatry is well placed to both recognise and combat stigma in the general hospital. This can help to ensure that patient care is comprehensive, safe and respectful.

Declaration of interest None.

Stigma, originally a physical mark inflicted by branding, is any characteristic or attribute – including an illness – that marks an individual out as different and evokes a sanction. Stigmatisation more often arises from mental rather than physical illnesses and may result in prejudice and discrimination. 'Stigma by association' can also affect related occupations such as psychiatry.[1] It has been suggested that the biggest single obstacle to the development of mental healthcare and improvement in the quality of life of those with mental illness is stigmatisation.[2]

We tend to stigmatise what we do not understand and this serves to distance us from the stigmatised group. Examples of commonly held stigmatising beliefs about mental illness include:[3]

- individuals with mental illness are dangerous
- mental illness is feigned or imaginary
- mental illness reflects a weakness of character
- it is difficult to communicate with individuals with mental illness
- mental illness is self-inflicted
- mental illness is incurable.

Such beliefs may be held by health professionals, whose attitudes towards mental illness are similar to those of society as a whole.[4,5]

Within the general hospital there is a risk that prejudicial attitudes held by staff translate into discriminatory behaviour towards patients with mental illness. Liaison psychiatry staff working in general hospitals are well placed to notice such behaviour and its impact on care.

I sought to survey liaison psychiatry staff working in the UK about their experiences of stigmatising attitudes towards mental illness and mental health professionals encountered in a general hospital, and the impact of these on patient care. I also requested suggestions for tackling stigma in the general hospital.

Method

During a 3-month period in 2010 to 2011 a questionnaire was circulated by email to members of the Royal College of Psychiatrists' Faculty of Liaison Psychiatry and to an email network of UK liaison psychiatry staff. Those who received the email were asked to forward the questionnaire to colleagues working in their services, to achieve as wide a circulation as possible. Responses were anonymous.

The questionnaire enquired about the profession of respondents, the frequency that they encountered stigma (stigmatising attitudes and language towards mental illness in the workplace, stigmatising behaviour in the general hospital that adversely affects patient care, stigmatising attitudes and behaviours towards mental health professionals in general or liaison psychiatry in particular) and particular examples, and suggestions for challenging the stigma of mental illness within the general hospital.

Analysis

The frequencies of reported experiences of stigmatising attitudes and language were calculated. Written examples of and suggestions for combating stigma were subject to semi-quantitative analysis. Common themes in responses were identified and the frequencies that these occurred were calculated.

Results

Completed forms were received from 72 respondents: consultant liaison psychiatrists (43%), doctors in training or specialty doctors (or equivalent) (10%), liaison psychiatry nursing staff (42%), and others (e.g. psychologists, social workers) (6%).

Stigmatising attitudes and language towards mental illness

Attitudes and language stigmatising towards mental illness encountered by liaison psychiatry staff are summarised in Table 1.

The most common stigmatising term was the use of a de-personalising pronoun 'one' when referring to a patient, cited by 18% of respondents: for example, 'We've got another one for you', as an introduction to a referral by a general hospital colleague to liaison psychiatry. Other examples of stigmatising terms given included 'nutter', 'fruitcake', 'attention seeking' and 'manipulative'.

Examples of language that implied that patients with mental illness were less deserving of care than other patients were cited by 17% of respondents.

Stigmatising attitudes and behaviour towards mental health professionals

The most common themes regarding stigmatising behaviour directed at mental health staff (Table 1) were demeaning comments (29%), insinuations that mental health staff were psychologically unstable (11%), and disregarding the opinions of mental health staff in patient management (8%). Examples included:

- 'Who's madder, you or the patients?'
- 'You must be thick to go into psychiatry.'
- 'I can't believe anyone would choose to do psychiatry.'
- 'All you do is sit down and drink coffee.'
- 'All psychiatrists are gay, foreign or crazy women.'

Impact of stigma on patient care

Adverse effects of stigma on patient care were recalled as occurring between weekly and monthly in most instances (Table 1). The most common themes in examples given by respondents are listed in Table 2. Specific examples included:

Table 1 Frequency of stigmatisation experienced by liaison psychiatry staff and its impact on patient care

Experiencing stigmatising attitudes and language	Never, %	Less than annually, %	Between monthly and annually, %	Between weekly and monthly, %	Weekly or more often, %
Towards mental illness	0	4	19	50	26
Towards mental health professionals	9	27	37	18	10
Adverse impact on patient care	0	9	25	49	17

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Table 2 The most common themes in examples of the adverse impact of stigma on patient care

Theme	Respondents mentioning it, %
Patient deemed a low priority for care	53
Physical aspects of a patient's care neglected	40
Lack of respect shown towards a patient	28
Patient discharged prematurely	19
Inappropriate request to transfer a patient to a mental health facility	18
Inappropriate referral to liaison psychiatry because of psychiatric history, but no current problem	13

Table 3 The most common suggestions for tackling stigma in the general hospital

Theme	Respondents putting it forward, %
Education	74
Challenging individuals' use of stigmatising attitudes and language	32
Maintaining a high-profile liaison psychiatry service	28
Joint working between liaison psychiatry staff and general hospital colleagues	26
Liaison psychiatry staff maintaining high standards of professionalism	25
Clear communication about mental illness and patient care	18
Attachments to liaison psychiatry for general hospital staff and students	15
Demonstrating the benefits of liaison psychiatry	11%

- a patient being given a cold shower to terminate a dissociative state
- a patient with suicidal ideation being left in wet clothes after jumping into a river
- patients with suicidal ideation being moved to unsupervised or understaffed areas of a ward or emergency department
- a patient with a well-managed mental illness receiving inadequate initial investigations for physical symptoms, delaying the diagnosis and treatment of septicaemia by several days.

Combating stigma

The most popular suggestions by respondents for tackling stigma are presented in Table 3.

Under the theme of education, respondents made a number of suggestions, including the importance of mental health training for medical and nursing students and the inclusion of this in the induction of new hospital staff. There were also suggestions for educational opportunities in the daily work of liaison psychiatry services. These included offering attachments for hospital staff, joint working with other services and case presentations within the hospital academic programme. Examples of clear clinical communication included the preparation of clear and practical psychiatric management plans for patients, and avoiding psychiatric jargon in discussions with hospital colleagues.

Several respondents mentioned their involvement with the Time to Change campaign (www.time-to-change.org.uk), which aims to combat mental health discrimination. They also asserted that the presence of liaison psychiatry specialists within the hospital was destigmatising, as it helped to normalise mental illness.

A number of respondents suggested that maintaining high professional standards helped to dispel stigma. This included the provision of a high-profile, flexible and accessible service. Respondents commented that, 'it's both what you do and how you do it', and that, 'a good liaison service earns its respect'.

Discussion

This survey of UK liaison psychiatry staff uncovered a worrying pattern of stigmatising attitudes and language directed at both psychiatric patients and staff in general hospitals, and adversely affecting patient care. The frequency of such events is high, with 26% instances of stigma towards mental illness and 10% towards staff cited as occurring more than weekly (Table 1). Respondents made suggestions for combating the stigmatisation of mental illness by other general hospital staff, often based on initiatives from their own services.

Although the survey enquired about respondents' experiences of stigma towards 'mental illness', they tended to describe stigma towards 'patients with mental illness' as a group of people. This is consistent with the concept of mental illness as a stigmatising characteristic that evokes a sanction. Therefore, the findings of the study probably better reflect stigma towards patients with mental illness than mental illness itself.

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A number of respondents in the study questioned the significance of stigmatising language in the general hospital. For example, is it stigmatising to refer to a patient as 'one'? This may simply reflect the objectification of a referral between professionals. Terms that describe a patient's behaviour, such as 'attention seeking' and 'manipulative' are more ambiguous and could be an objective observation of behaviour that is familiar to general hospital staff and conveys useful information as part of the referral. Even more overtly pejorative expressions, such as 'nutter', could be seen as a way of using humour to alleviate stress in a challenging clinical environment. Whether such language is harmful depends in large part on how much it reflects underlying attitudes towards mental illness which may have an adverse impact on patient care.

Similarly, the importance of stigmatising language about mental health professionals can be questioned. Psychiatry is not unique among the health professions in being stereotyped; examples include the image of an orthopaedic surgeon as a gorilla.[6] However, if the views of hospital staff noted in this study are communicated to and shared by healthcare students, this may dissuade them from considering psychiatry as a career. Curtis-Barton & Eagles studied factors that discouraged medical students from pursuing a career in psychiatry and concluded that 'bad-mouthing' and the standing of psychiatry among medical colleagues detracted from the attractiveness of the specialty for students.[7]

Demeaning attitudes towards health professionals in the general hospital may also contribute to the experiences of several respondents who found that their opinion about a patient's care was disregarded by colleagues.

Impact on care

Instances of the impact of stigma on patient care often appeared to be subtle and difficult to measure, such as making patients with mental illness a low priority. However, respondents also identified more concrete instances where prejudicial attitudes translated into discriminatory and potentially risky care.

In a qualitative study of the experience of stigma in patients and health professionals in a New Zealand general hospital, Liggins & Hatcher concluded that mental illness can have a negative impact on care.[5] They suggested that the 'mind–body split' contributed to the invalidation of an individual's physical illness on the basis of psychological aspects of their presentation. This concurs with the conclusions of Graber *et al*,[8] who found that US family physicians were less likely to believe that a patient with physical symptoms had a serious illness and to order investigations when the patient had a psychiatric history.

Combating stigma

Education was the main theme in respondents' suggestions for combating stigma. Byrne[9] notes that many psychiatrists enjoy their role as educators and suggests that this component of the job should be extended from medical education to challenging healthcare discrimination, both within and beyond the health profession.

The importance of providing a high-quality liaison psychiatry service in helping to dispel stigma was stressed by several respondents. Lack of confidence in the ability of a service may be reflected in attitudes towards the patients that it manages. Conversely, a responsive and high-quality service may engender confidence in staff, who are then less likely to project negative feelings onto patients.

Limitations

A limitation of the study was that the response rate was unknown. Responses were sought by emailing the questionnaire out to a wide range of liaison psychiatry staff and inviting them to forward it to colleagues, to ensure a relatively high number of responses and increase the validity of the results. There is, however, a risk of bias, whereby respondents may have been more likely to reply if they could recall specific instances of stigmatisation, thereby overestimating the survey's findings.

Patients may be referred to liaison psychiatry for psychological and behavioural problems that are not necessarily attributable to mental illness; an example is poor concordance with treatment for physical illness. The findings may therefore overestimate stigma towards patients with mental illness and better reflect stigma towards patients referred to liaison psychiatry.

Whether some of the examples of language encountered by liaison staff are stigmatising can be debated. The study may therefore overestimate the frequency that stigmatising language towards mental illness is expressed in the general hospital. Whether such language is considered stigmatising depends on the context in which it is used and its interpretation. This could be explored further in a qualitative study that would include the interviewing of liaison staff.

Another potential criticism of the study was that it did not seek to establish stigmatising attitudes among liaison psychiatry staff. It is suggested that mental health staff may contribute to the stigmatisation of mental illness, for example being unduly pessimistic about a patient's prognosis or holding views about 'less deserving' patients.[1] The study does not intend to suggest that mental health staff are less likely to stigmatise mental illness; this is a potential area for future research.

Finally, the suggested strategies for combating stigma were not accompanied by evidence of their effectiveness other than the anecdotal reports of respondents. Further study would be required to measure the potential impact of such strategies.

Implications

The care of general hospital patients should not be hampered by stigmatising attitudes towards mental illness. Combating such stigma depends on reintegrating the mind and body in the thinking of health professionals and the provision of healthcare. Liaison psychiatry is well placed to both recognise and combat stigma. This can help to ensure that patient care is both safe and respectful, wherever it is delivered and whatever the nature of the problem.

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The Mental Health Clustering Tool for people with severe intellectual disability

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Aims and method We assessed 92% (117/127) of the patients in our community mental health learning disability team using the Mental Health Clustering Tool (MHCT) to establish whether their needs could be captured sufficiently well to enable assignment to a care cluster for payment by results in mental health. We explored the characteristics of those assigned to Cluster 0 to identify how they differed from those who could be assigned to Clusters 1–21.

Results As expected, nearly half of the case-load (48%) could not be assigned to any cluster except Cluster 0, the variance cluster, which is used when the needs of patients cannot be captured by the current 21 care clusters but a service is, or will be, provided.

Clinical implications The MHCT in its current form does not adequately capture the needs of people with more severe intellectual disability. An integrated mental health and learning disability clustering tool is in development. This is expected to include new rating scales and new clusters, however until the development is completed and validated it will not be possible to implement payment by results in mental health in learning disability services.

Declaration of interest None.

The organisational structure of the National Health Service (NHS) in England is undergoing major transformation. Reforms initiated by the last Labour government have been endorsed and extended by the Coalition government and will change how healthcare services are commissioned and regulated.

In the past, the NHS was funded via primary care trusts through the block contract payment mechanism. As part of the modernisation of the NHS, the Department of Health (England) introduced a payment by results system in the acute sector from 2003 to fund healthcare based on activity, with reimbursement according to national tariffs.[1] Acute medical specialties are reimbursed via the payment by results system[2] according to the numbers of patients in each Healthcare Resource Group reported to commissioners. This can disadvantage mental health services when the acute sector 'over perform' against expected activity and claim more funding than was budgeted from finite primary care trust resources. The payment by results process is being extended to mental health services, with 2012 as the introductory year for many adult and older adult services. Providers will be reimbursed according to their activity levels (and eventually outcomes), with the possibility of nationally set tariffs from 2014.

To support the extension of payment by results to secondary mental health services, the Department of Health