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Barriers to mental healthcare for psychiatrists

AIMS AND METHOD

To determine the opinions of psychiatrists on mental illness among themselves and their colleagues a postal survey was conducted across the West Midlands.

RESULTS

Most psychiatrists (319/370, 86.2%) would be reluctant to disclose mental illness to colleagues or professional organisations (323/370, 87.3%). Their choices regarding disclosure and treatment would be influenced by issues of confidentiality (*n*=245, 66%), stigma (*n*=83, 22%) and career implications (*n*=128, 35%) rather than quality of care (*n*=60, 16%).

CLINICAL IMPLICATIONS

The stigma associated with mental illness remains prevalent among the psychiatric profession and may prevent those affected from seeking adequate treatment and support. Appropriate, confidential specialist psychiatric services should be provided for this vulnerable group, and for doctors as a whole, to ensure that their needs, and by extension those of their patients, are met.

In recent years the stigma associated with mental illness has increasingly been recognised as an important factor influencing the accessing of mental healthcare by the general population. This has led to a concerted effort to reduce stigma by promoting treatment in the community, anti-stigma campaigns, etc.

There has been less interest in the impact of stigma on the accessing of mental healthcare by medical professionals in general and psychiatrists in particular, despite the fact that this may be a particularly vulnerable group. It is well-recognised that doctors have high rates of mental illness (Caplan, 1994) but are often reluctant to seek help, which may explain the high rate of suicide among the profession (Richings *et al*, 1986). According to the General Medical Council, psychiatrists have one of the highest rates of psychiatric morbidity among hospital doctors and there is concern that this is not adequately recognised and managed. The British Medical Association (2005) estimates that 1 in 15 doctors, at some point in their lives, will have some kind of problem with alcohol or drugs.

Mental illness may be particularly stigmatising for those working in a stressful profession where vulnerabilities are not readily tolerated. There is evidence that avoidance of appropriate help-seeking behaviour by doctors starts as early as medical school and is linked to perceived norms, which dictate that a mental health problem may be viewed as a form of weakness with implications for subsequent successful career progression (Chew-Graham *et al*, 2003).

The aim of this study was to investigate the views of psychiatrists on the prevalence of mental illness among their colleagues, their own experiences of mental illness and their preferences for disclosure and treatment should they develop mental illness.

Method

The authors used their own clinical experience and discussion with colleagues to inform the design of a nine-item questionnaire (Table 1) which sought psychiatrists' views on mental illness among the profession. Ethical approval was obtained from the South Birmingham Ethics Committee. The questionnaire was piloted locally and then sent with a covering letter and stamped addressed return envelope to all 510 psychiatrists identified as working in the West Midlands region. Anonymity was maintained.

The questionnaire sought information on the respondents' perceptions of the prevalence of mental illness among psychiatrists compared with the general population and other medical professionals. Respondents were asked whether they had ever experienced mental illness, what their disclosure and treatment preferences would be should they develop mental health problems and what factors would influence these decisions. A free-text box was included for any additional comments.

The χ^2 test was used to determine whether there was an association between having experienced mental illness and the responses to the other questions. $P \leqslant 0.05$ was considered significant. The associated effect sizes of these tests (φ or Cramer's φ) were also computed. The significant two-sample χ^2 associations are reported.

Results

Completed questionnaires were returned by 370 of the 510 psychiatrists (a response rate of 72.6%); 195 respondents (52.7%) described themselves as consultants, 102 (27.6%) as senior house officers and 42 (11.4%) as specialist registrars. All questions were answered by all 370 respondents.

Roughly a third (124) of respondents considered that psychiatrists have a higher incidence of mental illness than the general population. Over a third (135) considered that they had a higher incidence of mental illness than other medical professionals (Table 1).

Disclosure of mental illness

In the event of developing a mental illness most respondents (*n*=240, 64.9%) would choose to disclose this to

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Table 1. Responses to questionnaire on attitudes to mental illness among doctors

	n (%)
Questionnaires	
Sent	510
Returned	370 (72.6)
Grade of respondent	
Consultant	195 (52.7)
SHO	102 (27.6)
SpR	42 (11.4)
Mental illness higher among psychiatrists	
than general population	124 (33.6)
than other doctors	135 (36.6)
Would you disclose mental illness	
to family/friends	240 (64.9)
to colleagues	51 (13.8)
to institution	47 (12.6)
to no one	32 (8.7)
Why would you not disclose mental illness?	
Career implications	128 (34.7)
Professional integrity	102 (27.5)
Stigma	83 (22.4)
Treatment preference for moderate depression	
Formal advice	162 (43.9)
Informal advice	114 (30.9)
Self-medication	73 (19.8)
No treatment	20 (5.4)
Choice of in-patient care	
Local private facility	171 (46.2)
Local NHS facility	15 (4.1)
Factors influencing choice	
Confidentiality	245 (66.2)
Quality of care	60 (16.3)
Previous mental illness[1]	81 (22)

SHO, senior house officer; SpR, specialist registrar; NHS, National Health Service.

1. This group less likely to disclose future psychiatric illness (Cramer's φ=0.174) and more likely to quote stigma as a reason for non-disclosure (Cramer's φ=0.154).

family and friends rather than to colleagues (*n*=51, 13.8%) or professional institutions (*n*=47, 12.6%); 32 (8.7%) would disclose this to no one. Career implications were the most frequent reason for failure to disclose mental illness (*n*=128, 34.7%), followed by professional integrity (*n*=102, 27.5%) and stigma (*n*=83, 22.4%).

Treatment preferences

As a first treatment preference for a moderate depressive disorder, less than half (*n*=162, 43.9%) would seek formal professional advice; 114 (30.9%) would choose informal professional advice, 73 (19.8%) self-medication and 20 (5.4%) no treatment. If they were to require in-patient treatment, 171 (46.2%) would choose a local private facility, with only 15 (4.1%) choosing a local National Health Service (NHS) facility. Overwhelmingly the most influential factor governing this choice was confidentiality, which was cited by 245 respondents (66.2%). Only 60 (16.3%) would make the decision based on the best quality of care.

Experience of mental illness

Eighty-one respondents (22%) indicated that they had, at some time, experienced a mental illness which had affected their personal, social and working life.

Those who had experienced mental illness were more likely to disclose future mental illness to no one (χ^2=10.719, d.f.=3, *P*=0.013; Cramer's φ=0.174) and were more likely to cite stigma, and less likely to cite career implications and professional integrity, as the most important reason for this decision than those who had not experienced mental illness (χ^2=8.395, d.f.=3, *P*=0.039, Cramer's φ=0.154).

Discussion

This is the first study to investigate the views of UK psychiatrists on their own and their colleagues' experiences of mental illness. As it was carried out in only one region of the UK, generalisability of the results cannot be assumed. Moreover, the responses may reflect what the respondents believe to be professionally desirable responses. None the less the findings are worthy of discussion.

The stigma associated with mental illness is well-recognised and remains prevalent. The Royal College of Psychiatrists has recognised the deleterious effect of discrimination and prejudice against people with mental illnesses and has attempted to address this with its Changing Minds campaign (Crisp *et al*, 2004). Psychiatrists should therefore be aware of the devastating effects of stigmatising those with mental illness, but that does not prevent them from suffering its consequences when coping with mental illness themselves (Hausman, 2002).

Mental illness is a broad term covering a variety of illnesses which differ from each other in many significant ways, not least in how they are perceived by others. As such they attract a variety of different reactions from the public and professionals and carry differing implications for the professional competence of those affected. The methodology of our study did not allow us to distinguish between different types of mental illness, but our findings suggest that psychiatrists recognise that such illnesses are not uncommon among the profession.

Psychiatrists will be well aware of the profound impact that such illnesses can have on both their personal lives and their professional competency. It is therefore particularly worrying that, in the event of developing such illnesses, the majority of psychiatrists would be reluctant to seek help. Moreover, in the event that they did seek help, treatment choice would be influenced by concerns over loss of confidentiality and stigma rather

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than perceived quality of care. This is consistent with the findings of a survey in the USA (Lehmann, 2001) which showed that half of all psychiatrists with a depressive illness would self-medicate rather than risk having mental illness recorded in their medical notes.

Stigma was cited more frequently as a factor influencing choice of future treatment by those who had personal experience of mental illness than by those who had not. This may reflect past experiences of those who had been mentally ill. There is some evidence (Hausman, 2002) that psychiatrists who suffer from mental illness experience isolation, a lack of compassion and discrimination by their own professional colleagues. It is recognised that psychiatrists often hold stigmatising and discriminatory attitudes towards their patients (Corker, 2001) and it is not surprising that these attitudes extend to their colleagues who experience mental illness. The Royal College of Psychiatrists (2001) acknowledges that doctors, including psychiatrists, are sometimes found to be prejudiced by patients and that it is likely that doctors' attitudes towards people with mental illnesses mirror those of the general population.

Failure to seek appropriate help when ill is prevalent among the wider medical profession (Forsythe *et al*, 1999). Again, issues of trust and concerns about confidentiality may act as barriers to medical practitioners seeking help for psychiatric illness (Thompson *et al*, 2001; Davidson & Schattner, 2003). Such attitudes are already prevalent among junior doctors (Shadbolt, 2002) and medical students (Hooper *et al*, 2005).

The culture of medicine may be a barrier to doctors seeking healthcare as it encourages an image of invincibility and denial of vulnerability (Thompson *et al*, 2001; Davidson & Schattner, 2003), and accords low priority to the mental health of its practitioners (Center *et al*, 2003). One of the authors (A.C.W.) runs specialist psychiatric clinics for doctors of all specialties and the views expressed by its attenders appear to be similar.

Recommendations

Our findings suggest that some psychiatrists, and presumably by extension other doctors, experience mental illness while practising without obtaining good and appropriate treatment, thus putting themselves and their patients at risk. Strategies aimed at challenging the culture of doctors' self-reliance should start in medical school and a 'no blame' culture in which doctors who are mentally ill are accepted and supported rather than stigmatised and punished should be encouraged. All doctors should be appropriately trained for consultations in which the patient is also a doctor.

We would advocate the provision of confidential specialist psychiatric services for doctors. These should be recognised and funded posts rather than simply being tagged on to existing clinical services. The provision of well-advertised but confidential referral pathways would be essential. There is some evidence that such a 'doctor's doctor' would be welcomed by senior NHS staff (Forsythe *et al*, 1999). We believe that there should also be specialised in-patient facilities available, either regionally or nationally and there is some evidence that out-of-area specialist care for psychiatric illness would be welcomed by medical practitioners (Forsythe *et al*, 1999).

Declaration of interest

None.

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