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COMMUNITY ATTITUDES TOWARDS DISCRIMINATORY PRACTICE AGAINST PEOPLE WITH SEVERE MENTAL ILLNESS IN HONG KONG

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ABSTRACT

Background: The existing literature on community attitudes towards people with severe mental illness (SMI) tends to be rather general and impressionistic, with apparently conflicting findings which have yet to be adequately understood.
Aims: This article undertakes to examine the community's level of tolerance towards discriminatory practice against people with SMI in three domains: family relations, employment and health care.
Methods: Structured interviews with a representative sample of 507 citizens were carried out using the computer-assisted telephone interview system (CATI).
Results: Our survey reveals some expected common misunderstandings about mental illness, with the older age group showing the greatest toleration towards discrimination. However, respondents showed a strong objection to discriminatory behaviour which people with SMI commonly face in health care and employment, whereas greater toleration towards discrimination was found in the family domain.
Conclusions: The coexistence of misunderstandings about mental illness and public rejection of discriminatory practice against people with SMI suggests that community attitudes are multi-dimensional and more amendable than expected. The findings of this study call for target-specific educational strategies for community education, as well as accompanying policy initiatives to end discriminatory practice, if people with SMI are to be truly taken as our fellow citizens.

Key words: citizenship, discrimination, public attitude

INTRODUCTION

No culture or society is exempted from the problem of mental illness. The World Health Organization (2001) estimates that 450 million people around the world suffer from mental and behavioural disorders, and it is widely believed that every fourth person will suffer from mental illness at some time in life. Often, the debilitating effects of mental illness are exacerbated by stigma and discrimination (Pinel, 1999; Corrigan, 2004; Dinos *et al.*, 2004), and, moreover, because treatment and rehabilitation may last for many years, with upheavals and readmission, mental illness has adverse effects on the emotional and socio-economic

capabilities of relatives who care for those with illness (Stengard, 2002; Provencher *et al*., 2003; Saunders, 2003; Corrigan & Miller, 2004; Ivarsson *et al*., 2004; Karp, 2004; Ostman, 2004).

In spite of the tremendous pain suffered by the person and his or her family, and the fact that they are also our fellow citizens, people with SMI are largely invisible to the outside world. The issues surrounding people with SMI are more apparent, of course, and are often met with strong community opposition in such crucial areas as the setting-up of welfare facilities (Cowan, 2002). Almost every society has struggled with the negative impact of mental illness, and the widespread fear that people with mental illness may be dangerous and unpredictable continues to obstruct moves towards caring more humanely for them (Sussman, 1997). What is even more astonishing is the recent finding that the attitudes of mental health professionals are not very different from those of the general population (Lauber *et al*., 2006).

Ever since the 1950s, community attitudes towards people with SMI have been of interest to researchers. Early findings demonstrated the existence of predominantly negative public attitudes towards them (Cumming & Cumming, 1957; Nunnally, 1961; Roman & Floyd, 1981; Albrecht *et al*., 1982; Link *et al*., 1987, 1989) though even at this time a minority of studies (Bentz *et al*., 1969; Rabkin, 1972; Siassi *et al*., 1973; Phelan *et al*., 2000) found that little or no clear-cut prejudice existed. Later studies were even more mixed. Some found community attitudes relatively unchanged over a decade (Huxley, 1993), whereas others found increasing acceptance (Martin *et al*., 2000). Others again revealed socio-economic differences in attitudes reflecting differences in age and education. Even here, however, the findings were strikingly contradictory: one study found that the older and less educated the respondents were, the more negative were their attitudes (Ojanen, 1992); another study, undertaken in the United Kingdom, showed that stigmatising opinions were more common among younger than among older people (Yamey, 1999).

The most commonly used measurement tool in studies in this area is the 'opinions about mental illness' scale developed by Cohen & Struening (1962, 1965) based on five variables: Authoritarianism, Benevolence, Social Restrictiveness, Mental Hygiene Ideology and Interpersonal Etiology. Other tools with widespread acceptance in the research community include Baker & Schulberg's Community Mental Health Ideology Scale (1967) and Taylor & Dear's Community Attitudes to Mental Illness Scale (1981). Studies deploying these scales generally conclude that community attitudes are mixed in nature, and consist largely of dimensions relating to control, confinement and humane treatment (Hayward & Bright, 1997).

In a recent review of population studies on public beliefs about and attitudes towards people with mental illness (Angermeyer & Dietrich, 2006), 15 years after Bhugra's first review on the topic (1989), it has been noticed that the 61 studies published between 1990 and 2004 were mostly from Europe. Only 15% of these studies were from non-Western countries and there has been only one population study (initial study and a two-year follow-up) in a Chinese community. The first Taiwan population study on community attitudes (Song *et al*., 2005), which fell outside Angermeyer & Dietrich's review period, found, apart from a general negative view on normalisation, that the population held relatively higher levels of benevolence and tolerance to rehabilitation in the community. However,

this study looked at general attitudes, and the authors cautioned that benevolent thoughts do not necessarily guarantee the acceptance of rehabilitation in the community or treating the mentally ill as fellow citizens.

The first local large-scale public survey to be undertaken in Hong Kong (Chou *et al.*, 1996) found that only 81% of respondents were aware that mental illness was not contagious, indicating that, less than a decade ago, almost every fifth Hong Kong person believed that mental illness could be 'caught', much as one can 'catch' influenza. Certainly the results of this study justify the conclusion that attitudes towards mental patients and mental health facilities remained predominantly negative, some 43% of respondents agreeing with the proposition that psychiatric facilities should be kept far away from the community, a result that suggested strongly that the 'NIMBY' (Not In My Back Yard) phenomenon was quite common in Hong Kong. Unlike previous overseas findings, this study found that popular views of mental patients and their rehabilitation facilities were only weakly associated with such socio-economic factors as age, education level and household income. Two years later (Chou & Mak, 1998), a follow-up study by the same group of investigators found that public attitudes towards mental patients had become slightly more negative, irrespective of the fact that their knowledge of mental illness had improved slightly.

Basically, most studies in Chinese communities translated and used standard inventories and emphasised the summative nature of the measurement scale. These studies do not address local cultural and structural issues where the public attitudes are being shaped. It was inclination, not actual behaviour, that they measured. The theoretical underpinning of these communal surveys denotes on the one hand the importance of public opinion in the shaping of a more accepting environment for this particular group of citizens, but, on the other hand, provides few clues as to how discriminatory practice can be removed to restore the full citizenship status of people with SMI. The present study is designed to be an example of how the public might achieve a better acceptance through talking about the discriminatory practices that adversely affect the health, well-being and social and political status of people with mental illness.

Rather than being based on hypothetical questions about how people with SMI should be treated and SMI's associated risk of social desirability, this study asked how acceptable respondents considered a range of stigmatising practices that could easily be found in the community. These practices appear to contravene most definitions of full citizenship, so it follows that those who believe that people with SMI should be treated equally to others in terms of citizens' rights would be likely to oppose stigmatising treatment. This double-negative approach was considered more reliable as a reflection of the extent to which members of the community perceived people with SMI as having the same or similar rights as their fellow citizens.

It is perhaps helpful to highlight the context of public mental health care under which this study was carried out. For the near to 7 million population of Hong Kong, there are about 160 qualified psychiatrists and another 96 not yet qualified, 171 psychiatric social workers, 1910 psychiatric nurses, and 5000 psychiatric beds. The annual number of psychiatric out-patient consultations exceeds half a million, and there are 25,000 new psychiatric cases every year. While most new cases enjoy a 45-minute diagnostic interview, each follow-up or maintenance consultation is usually about 10 minutes long (Hong Kong Legislative

Council, 2005a). Not all atypicals (newer anti-psychotics) are available in the Health Authority's central drug list (Hong Kong Legislative Council, 2005b) and the prescription of those available requires special permission from senior doctors. For those patients who need psychotherapy, it now takes a stunning period of 12 months to meet the clinical psychologist for the first time, and an interval of several months for every follow-up session. In Hong Kong, the Equal Opportunity Commission (EOC) has been charged with the duty to implement three ordinances including the Disability Discrimination Ordinance (DDO). However, the shift of the work focus of the EOC to reconciliation in recent years has rendered the implementation of the DDO difficult, if not impossible. In September 2002, of the 290 mental illness-related complaints lodged under the DDO, 192 were in the employment field, involving workplace harassment by co-workers and victimisation. But legal action was initiated in only three cases. In 2003, of the 141 cases followed up by the EOC in relation to the DDO, legal action was taken in only two cases. In 2004, only 168 of 477 complaints were followed up and subsequently legal action was taken in only five cases. This may perhaps be just another illustration of the structural tolerance of unfairness to people with mental illness in Hong Kong (Lee *et al.*, 2005a).

METHODOLOGY

In order to gauge the public's awareness of mental health and care to people with SMI, a representative telephone survey using a computer-assisted telephone interview system (CATI) was conducted. The system has been used elsewhere for public opinion survey (Lauber *et al.*, 2006) and was considered as having reduced risk of measurement error caused by interviewers' verbal behaviour and data processing. Training was provided to the interviewers on how to use the system, and how to communicate with the respondents. The system made 1073 randomised and connected calls, and 566 respondents either refused to answer or hung up during the telephone interview. A total of 507 citizens aged 18 or above (47%) completed the interview. Apart from socio-demographic data, the questionnaire probes public attitudes towards people with SMI in relation to health care, family support, employment and, in a separate module, political participation. The question type for the first three areas is consistent: asking respondents to indicate their level of agreement/toleration of existing discrimination practice on people with SMI. These items were drawn from the concrete concerns in a stigma study (Lee *et al.*, 2005a). It was the specific attitude to, rather than the fluid general impression of, mental illness that this study measured. A four-point Likert scale was used in preference to a five-point scale, to avoid possible gravitation to a neutral '3' (1 'acceptable'; 2 'barely acceptable'; 3 'unacceptable'; 4 'very unacceptable'), which is an especially strong possibility in Chinese culture, where caution and courtesy are socially desirable. Indexes for the three domains (family, health care and treatment, and employment) were the overall average score of the corresponding items of the domain. The higher the average score, the greater would be the intolerance towards the discriminated practice. Paired *t*-tests were used to contrast the domain indexes. One-way ANOVAs on the indexes were also used to compare multiple levels such as age groups and self-perceived socio-economic classes.

Description of subjects

There were slightly more women (56.8%) than men (43.2%) in the study. The numbers in the 18–24 age range group (18.5%) exceeded the corresponding proportion (12.3%) in the 2001 Census whereas the 65-or-above group was underrepresented when compared with Census data. This phenomenon might be because the older age group might have a greater chance of staying in care facilities and therefore a lower chance of being sampled. Nevertheless, the majority of subjects were in the 25–44 (46.0%) and 45–64 (29.2%) age groups, which were in fact very close to the Census composition (46.3% and 27.4%, respectively). Judging from the random process of data collection and the comparable age composition against the 2001 Census, the sample of this population study is considered largely representative.

Two-thirds of the subjects were married (66.1%) and one-third were single, widowed or separated. Slightly more than one-third had received only lower secondary or primary school education and 40% allegedly had upper secondary school education. One-fifth (20.2%) had received tertiary or university education while the two extremes of illiterates (2.2%) and postgraduates (3.8%) remained the smallest proportions. With regard to occupation, 58.5% of subjects were in gainful full- or part-time employment. Students (12.8%), home-makers (17.9%) and retired people (6.5%) made up another one-third. About one-third (34.0%) of the subjects identified their socio-economic status as lower class, 45% as middle-lower class, one-fifth (20.0%) as middle-upper class and none as upper class (refer to Table 1 for details).

FINDINGS

The study demonstrated an overwhelming belief on the part of the public that the patient's family has the duty to accompany him or her to psychiatric consultations and to supervise the taking of medication according to instructions (Q8), and a majority view that people with SMI should live with their family (Q9) and that children in the family should meet the patient's psychiatrist (Q7). It might be considered that the public were over-cautious in some areas, though possibly out of goodwill. Public opinions about family members (Q4) and spouses (Q6) were more or less equally split between those who regarded them as likely also to be mentally ill and those who did not. There were five situations where the respondents showed less toleration: where the spouse also had mental health problems (Q5), where the family experienced discrimination because of the existence of the person with SMI (Q1), where the person with SMI was unable to have filial piety to his or her parents (Q3), where the family was looked down on because of the person with SMI (Q2), and where the family was unwilling to get along with the neighbours of the person with SMI (Q10) (refer to Table 2 for details).

In the healthcare domain, a picture of strong fear on the part of the public emerged. The majority of respondents considered it either acceptable (22.6%) or fairly acceptable (51.6%) that when people with SMI felt physically unwell, they should consult psychiatrists rather than GPs. Opinions were more split with regard to the fact that some people with SMI had irreversible side-effects as a result of taking traditional anti-psychotic medication. Concerning other overtly discriminatory practice in health care, the majority of respondents showed non-acceptance. These included the suggestion that poor people with SMI should

Table 1
Socio-demographic characteristics of respondents

	N	**%**
Gender (*N* = 507)		
Male	219	43.2
Female	288	56.8
Age range (*N* = 504)		
18–24	93	18.5
25–44	232	46.0
45–64	147	29.2
65 or above	32	6.3
Marital status		
Single	161	31.8
Married	335	66.0
Widow(er)	3	0.6
Separated/divorced	8	1.6
Education level		
No formal education	11	2.2
Primary school	73	14.5
Lower secondary school	97	19.3
Upper secondary school	201	40.0
Tertiary/university degree	102	20.2
Postgraduate or above	19	3.8
Occupation		
Administration or management	37	7.3
Professional	49	9.7
Skilled labour	47	9.3
Semi-skilled labour	63	12.4
Unskilled labour	50	9.9
Student	65	12.8
Home-makers	91	17.9
Retired	33	6.5
Unemployed	22	4.3
Part-time worker	50	9.9
Self-Reported SES (*N* = 456)		
Lower class	155	34.0
Middle-lower class	205	45.0
Middle-upper class	96	21.0

get poor drugs (Q23), that they should have to pay for better drugs (Q24), that they should be restricted to 10-minute consultations (Q21), that the side-effects of medication should not be explained (Q28), that cheaper drugs with more side-effects should be prescribed in order to save government finance (Q25), and that there should be cut-backs in psychiatric beds (Q26) (refer to Table 3 for details).

In the employment domain, there was majority acceptance (ACC: 9.1%; FACC: 51.9%) that people with SMI should not conceal their illness when applying for jobs (Q20). Opinions were more split on whether they should apply for posts in the uniformed disciplinary forces

Table 2
Attitudes toward discriminatory practice in family domain

Question items	ACC %	FACC %	UACC %	VUAC %
Q1. Family discriminated against because of people with SMI ($N = 496$)	14.3	19.0	55.8	10.9
Q2. Family being looked down upon because of people with SMI ($N = 498$)	8.4	9.2	67.1	15.3
Q3. People with SMI unable to have filial piety to parents ($N = 464$)	2.8	23.3	65.7	8.2
Q4. Family members weird in thoughts and behaviour ($N = 488$)	5.1	49.8	40.4	4.7
Q5. Spouse of people with SMI also had mental health problem ($N = 469$)	2.8	35.2	53.7	8.3
Q6. Spouse would become mentally ill ($N = 478$)	0.4	40.8	54.0	4.8
Q7. Children in the family should consult psychiatrist ($N = 497$)	7.6	55.5	34.2	2.6
Q8. Family has the duty to accompany people with SMI for psychiatric consultation, and taking medication according to instructions ($N = 503$)	32.8	65.4	1.6	0.2
Q9. People with SMI should live with family, and not alone ($N = 485$)	19.0	61.9	17.5	1.6
Q10. Unwilling to get along with neighbour of people with SMI ($N = 493$)	1.6	14.4	78.3	5.7

ACC = acceptable; FACC = fairly acceptable; UACC = unacceptable; VUAC = very unacceptable

(police, fire brigade and customs) (Q16) or work as professionals (Q18), and whether it was legitimate for their job applications to be rejected on the grounds of their mental illness (Q13). But respondents indicated little support for lower wages to be given to people with SMI (Q11), for them to be subject to dismissal, no doubt with an excuse, when their illness came to light (Q12), for them not to be promoted on the grounds of mental illness (Q14), for them to be discriminated against in the interests of others at times of unemployment (Q19), for colleagues to distance themselves from people with SMI, and for the idea that people with SMI should not work anyway (Q17) (refer to Table 4 for details).

Overall mean scores were taken for the three domains. The range was from 1 to 4, and the lower the score the stronger the acceptance of discrimination against people with SMI. The family domain had the lowest mean score ($M = 2.50$; $SD = 0.26$) and although the mean scores for the health care ($M = 2.64$; $SD = 0.36$) and employment domains ($M = 2.67$; $SD = 0.36$) were very close, paired t-tests of the family domain with the other two domains did reveal significant differences. In general, the respondents were more accepting of discrimination against people with SMI in the area of family domain than in the healthcare and employment domain (see Table 5 for details).

There was no indication of a gender difference in the domain index of family ($F(1, 505) = 0.79$), employment ($F(1, 505) = 2.28$) and health care ($F(1, 505) = 3.07$). It was observed that the higher the self-reported social class, the greater the mean score for

Table 3
Attitudes toward discriminatory practice in health care and treatment domain

Question items	ACC %	FACC %	UACC %	VUAC %
Q21. People with SMI usually had 10 minutes' consultation time with their psychiatrists ($N = 469$)	14.3	17.3	53.3	15.1
Q22. About 20% of people with SMI had irreversible side-effects due to traditional antipsychotic medication ($N = 470$)	24.5	29.6	40.0	6.0
Q23. The poor cannot afford atypical medication and can only be prescribed traditional antipsychotic medication ($N = 483$)	15.9	24.6	48.4	11.0
Q24. The health authority has taken the more expensive atypical medication as 'non-essential' drugs for people with SMI and asked them to pay for it ($N = 479$)	15.4	16.9	52.2	15.4
Q25. In times of stringent government finance, people with SMI have to be prescribed with cheaper drugs, though with more side-effects ($N = 488$)	9.0	17.8	54.3	18.9
Q26. In times of stringent government finance, the number of psychiatric beds had to be cut back ($N = 490$)	9.4	13.7	63.1	13.9
Q27. When people with SMI feel physically unwell, they should consult psychiatrists rather than GPs ($N = 496$)	22.6	51.6	23.6	2.2
Q28. Psychiatrist does not have a duty to explain to people with SMI and their family the effects and side-effects of the drugs ($N = 504$)	6.7	23.0	46.2	24.2

ACC = acceptable; FACC = fairly acceptable; UACC = unacceptable; VUAC = very unacceptable

family and employment domain (indicating less acceptance of discrimination), but the opposite trend was true for the healthcare domain, where rising class was associated with increasing acceptance of discrimination. Self-reported social class made a significant impact on the family domain ($F(3, 500) = 4.63$; $p < 0.05$) but not on the employment or healthcare domains. Increasing age also has a statistical significance on decreasing mean scores (increasing acceptance of discrimination) in both the family ($F(2, 453) = 10.12$; $p < 0.001$) and the employment domain ($F(2, 453) = 8.10$; $p < 0.001$). The most tolerant group of discriminated practice was also the oldest age group (65 or above) (see Table 6).

DISCUSSION

Most respondents actually knew little about mental illness and rehabilitation, and their attitudes were consequently shaped by misconceptions and negative stereotypes about mental illness. For example, more than half of all respondents (55%) believed that the behaviour and thinking of family members of people with SMI were 'weird'; nearly a quarter (38%) thought that siblings of people with SMI would also develop psychiatric problems; while 41% opined that this would also be the case for their spouses. Almost three-quarters (74%) of respondents

Table 4
Attitudes toward discriminatory practice in employment domain

Question items	ACC %	FACC %	UACC %	VUAC %
Q11. Wages of people with SMI should be lower than others ($N = 479$)	2.5	29.6	66.6	1.3
Q12. Some employees were fired with an excuse when they were found out as people with SMI ($N = 490$)	7.8	20.8	57.8	13.7
Q13. Their applications for jobs would easily be turned down when employers know that they are people with SMI ($N = 480$)	19.0	25.2	50.0	5.8
Q14. The chance of promotion is zero when the boss found out that they were people with SMI ($N = 490$)	14.3	14.3	62.7	8.8
Q15. When found out no colleague likes to work with people with SMI ($N = 498$)	12.7	11.0	68.5	7.8
Q16. Family members of people with SMI should not apply for jobs in discipline groups like police, fire brigade and custom office ($N = 496$)	8.1	39.5	42.9	9.5
Q17. People with SMI should not work ($N = 495$)	3.0	12.7	69.7	14.5
Q18. People with SMI should not work as a professional (engineer, accountant, lawyer etc.) ($N = 479$)	7.7	36.7	52.2	3.3
Q19. Because of the poor economy, jobs should be for others rather than for people with SMI ($N = 486$)	2.9	25.1	63.0	9.1
Q20. When people with SMI applied for jobs, they should not hide their SMI identity ($N = 486$)	9.1	51.9	34.6	4.5

ACC = acceptable; FACC = fairly acceptable; UACC = unacceptable; VUAC = very unacceptable

were of the opinion that people with SMI should see a psychiatrist, not a general practitioner, should they feel unwell, and almost one-third (32%) accepted that people with SMI should earn less than other people for doing the same work, apparently because they believed that people with SMI would be less competent or reliable. Moreover, 29% of respondents

Table 5
List of indexes and paired *t*-test of difference

$N = 507$	Mean	SD
Family Dimension Index (FAM_DEX)[*]	2.50	0.26
Health Dimension Index (HEA_DEX)[*]	2.64	0.36
Employment Dimension Index (EMP_DEX)[*]	2.67	0.43
	t	significance
FAM_DEX and HEA_DEX	−8.81	$p < 0.001$
FAM_DEX and EMP_DEX	−8.06	$p < 0.001$
EMP_DEX and HEA_DEX	−1.30	$p = 0.194$

[*] Missing cases were replaced by mean score of the item

Table 6
Analysis of variance of gender, age group and self-reported social class on domain indexes

		FAM_DEX		EMP_DEX		HEA_DEX	
Gender	*N*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Male	219	2.51	0.28	2.61	0.35	2.63	0.43
Female	288	2.49	0.24	2.66	0.37	2.70	0.43
		F = 0.79		*F* = 2.28		*F* = 3.07	
Self-reported social class	*N*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Lower class	155	2.45	0.25	2.61	0.36	2.70	0.47
Middle-lower class	205	2.52	0.26	2.64	0.34	2.66	0.41
Middle-upper class	96	2.55	0.26	2.70	0.36	2.63	0.44
		F = 4.63*		*F* = 2.05		*F* = 0.74	
Age groups	*N*	*M*	*SD*	*M*	*SD*	*M*	*SD*
18–24	93	2.59	0.28	2.77	0.33	2.68	0.39
25–44	232	2.52	0.23	2.65	0.34	2.67	0.44
45–64	147	2.44	0.26	2.60	0.37	2.67	0.45
65 or above	32	2.36	0.33	2.46	0.34	2.61	0.34
		F = 10.12***		*F* = 8.10***		*F* = 0.91	

found it acceptable for employers to find an excuse to dismiss employees who had suffered from mental illness in the past and about 20% considered it acceptable for people with SMI not to be offered a position because of their condition.

To the extent that citizenship implies a sense of belonging and a process of identity-building, discrimination and negative social attitudes are central to the experience of social exclusion for people with SMI and their families, seriously undermining their rights and autonomy and those of their families. Being patronised, avoided, ignored, abandoned, mocked, assumed to be incompetent, treated as an inconvenience or regarded as unfit for employment, people with SMI and their families can easily be denied access to full membership of the community.

In this study the older age groups show higher levels of discrimination. This is understandable as this group is more likely to be composed of early immigrants from mainland China, who are less educated and less likely to be targeted by government information campaigns in relation to illness and mental health. It may be appropriate, therefore, for a new balance to be struck between such campaigns, which are currently targeted primarily at younger age groups who are more willing to attend, and developing new strategies designed in their language, form and message to gain the support of older people. While most people would agree that no educational programme is suitable for all people, this understanding has not been translated into practical action in the form of programme design and policy development.

On the other hand, the survey also identified sufficiently strong public sympathy for people with SMI and their families, and a sufficiently strong consciousness of non-discriminatory principles, for there to be grounds for optimism with respect to the rehabilitation of formerly hospitalised people with SMI into society. For example, a majority of respondents (77%)

disapproved of discrimination against family members of people with SMI, 82% thought that disrespect towards people with SMI and their families was unacceptable, and 74% rejected the suggestion that people with SMI could not fulfil their filial obligation to their parents.

In the employment domain, the majority view is that people with SMI should not suffer discrimination in terms of salary levels, promotion opportunities, dismissal procedures and isolation by colleagues. The public appears inclined to accept a level playing field where competence is the key measure. However, there has been less statutory protection than expected. In Hong Kong, the Equal Opportunity Commission (EOC) has been charged with the duty of implementing three ordinances including the Disability Discrimination Ordinance (DDO). However, the shift of focus to reconciliation in recent years has rendered the implementation of the DDO difficult, if not impossible. For those who dared to complain against discrimination in the employment field such as workplace harassment and victimisation because of mental illness, legal action was taken in less than 2% of the cases.

While it may well be the case that statutory protection does not of itself achieve a caring community, excessive emphasis on reconciliation has provided an increasingly strong justification for tolerating forms of overt discrimination, which, this study suggests, are unacceptable to a majority of the public. An ordinance without proper enforcement speaks of inadequate governmental resolve to create a true sense of integration between the able-bodied and disabled. Citizenship is no more than rhetoric if it is not backed by appropriate policy initiatives.

Public empathy towards people with SMI is most remarkable in the area of health care, where the experience of not being taken seriously by service providers is widespread. As many as 68% of respondents felt that it was unacceptable and very unacceptable for people with SMI to be given little time by their psychiatrists for follow-up consultation. More than two-thirds of respondents agreed that the hospital authority should subsidise newer, more expensive, psychiatric medicines. In addition, about 73% of respondents did not regard budgetary constraints facing the government to be a justifiable reason for continuing to use cheaper conventional medications that have more side-effects. According to public opinion, people with SMI should receive quality medical treatment and services, including adequate consultation time, inpatient psychiatric beds, information about side-effects of medication and new drugs with fewer side-effects. On average, more than 80% of respondents held the government and psychiatrists responsible for the well-being of people with SMI and their families.

Long waiting times, short consultation times, cheaper treatment, often with more side-effects, and the self-purchase of newer drugs are but a few reflections of the imbalance of current health care for people with SMI. The existing mode of health care for people with SMI places too much emphasis on symptom control, neglecting the fact that medical practice for people with SMI can in itself become a possible source of discrimination (Sartorius, 2002; Lee *et al*., 2005a). The right to health care is based on the belief that each person should have an equal opportunity to develop his or her conception of life plan (Romer, 1988). However, in Hong Kong, and, no doubt, elsewhere, particularly in Asia, the right to equal access to healthcare services was guaranteed while the availability of better services is often restricted if not denied. It is high time that modern health care was aligned not just to technical advances but to moral values and humane application. Let Asian countries not only be

proud of the adoption of the medical advancement and setting up of model healthcare facilities in their capitals, but also of the precious citizenship values that uphold these advances.

Unfortunately, however, these public expectations do not always meet with appropriate service provision and policy. In the face of increasing managerial and financial pressures, psychiatrists have in some cases come to resemble prescribing machines designed for efficiency and cost-saving and not for giving primacy to the interests of their patients. A super-hostel for 200 people with SMI was built and managed with pride at its economy of scale. The 5-year Programme Plan on Rehabilitation has long been abandoned as a yardstick measure of service shortfalls. All these factors have conveyed a message loud and clear to the public that people with SMI could, with impunity, be given an inferior service. However, it now appears that this approach is no longer acceptable to a majority of the public.

It is doubtful whether this new climate of support and empathy has been brought about by the fragmented and often uncoordinated education programmes of government departments and NGOs. But for whatever reason, instead of the commonly quoted NIMBY phenomenon, this study has found the public less willing to accept overtly discriminatory practice in the employment and healthcare domains than one might have expected and, certainly, than would have been the case a decade or more ago. It is significant that as discriminating practice becomes more and more apparent to the public, the tolerance of it has reduced. There is, though, a long way to go, as the study also makes plain that over-cautiously patronising ideas still exist, maybe out of goodwill, such as the view that the patient's family should accompany him or her for consultation, and that the children of people with SMI should see the psychiatrist.

Obviously, the public's view on the family's duty to care for people with SMI is consistent with the general emphasis on family responsibilities in Chinese culture. To many respondents, their irrational fear of people with SMI being left alone could be eased only by reiterating the family's duty to care. The trouble is, however, that many families take up the caring duty without proper support from the government. Families of people with SMI need support in order to enable them to provide quality care for their ill member. People are not, after all, bottomless wells of love and sympathy. If families are not properly supported, their support for the person with SMI in their family might be weakened and they might join in the discrimination against them (Lee *et al.*, 2005b), or even abandon them (Biehl, 2004). Policy initiatives should move from education about the aetiology of mental illness and symptom manifestation, to rebuilding family relations, non-discriminating medical treatment and practice, and increasing chances of gainful employment and equal opportunities in work situations. On the other hand, the public's toleration of discrimination against the family will continue if governmental or other forms of support to the family continue to be lacking.

Support need not, however, necessarily be directly governmental, and the suggestion has been made that a greater role could be played by NGOs in meeting the needs of people with SMI (Crabtree & Chong, 2000). If this possibility came about, however, precisely the same point would apply: that in addition to the direct delivery of service to people with SMI, NGOs also need to develop and implement effective ways of supporting and empowering patients' families.

CONCLUSION

For the most part, the existing literature and discussion on citizenship and mental illness fall into one of the following main categories: perspectives on service users (Chamberlin, 1998), perspectives of service users (Barnes, 1999; Pierre, 2000; Bolzan & Gale, 2002; Wilton, 2004), or the relevance of citizenship to programme planning (Rowe *et al.*, 2001). The first category is predominantly about the attitudes of the general public towards mental illness and people with SMI, and the present article contends that this literature incorrectly takes as its starting point the assumption that public attitudes exist, and need, first, to be uncovered and then changed on the grounds that the public has no part to play in the debate but has simply to be brought to an increased acceptance of people with SMI. Such an approach is, the present authors believe, both paternalistic and exclusionary, leaving the concern to professionals and, to a much lesser degree given their lesser role in agenda-setting and negotiating, to people with SMI themselves.

This belief is in no way intended to imply that it is for the public to determine how people with SMI should be treated in terms of citizenship rights, but acknowledges, rather, that people with SMI and the discrimination against them are also issues that concern the public. A significant proportion of respondents (41%) claimed to know one or more than one person affected by mental illness, in addition, no doubt, to others who had not yet reached the stage of clinical diagnosis. If citizenship is truly a 'community' and 'partnership' concern (Barnes, 1999), the public should have equal access to the discussion. For too long, the public has been denied this opportunity because of the fear of communal opposition to the setting up of psychiatric facilities. The issues of people with SMI have been seen as taboos, and policy-makers have traded community participation and discussion for convenient administration. Mental illness remains mystified and taboo, and has never been fully placed on the public agenda.

Underpinning this study is the belief that community care can never be realised without a caring community, but that, instead of waiting patiently for such a community to come along at some unknown future point of time, it should be brought about through active co-construction by all the parties involved in the community. In the midst of widespread confusion, misunderstanding and anxiety about people with SMI, the public responded in a generally sympathetic manner when they were shown the unfairness of the treatment that people with SMI receive in the areas of employment and psychiatric health care, and when faced with making choices about the justice of such treatment. This finding points to the urgent need to rectify problems in these areas, and suggests that less political courage may be required to do so than has hitherto been assumed. We are mindful that it has already been a decade since our last policy paper on rehabilitation (Hong Kong Government, 1995) announced its goal of equal opportunity and full participation, and no one was ever sure how the goal was to be realised through the existing service infrastructure.

As a whole, therefore, there is little evidence of systematic discrimination, stigmatisation and rejection of people with SMI by the public in Hong Kong. Rather, public attitudes appear now to be more fluid and multi-dimensional than most studies have concluded. It goes without saying that there is still inadequate understanding and toleration with regard to what people with SMI and their families have to endure – in short, socio-cultural, occupational and institutional barriers to full participation in economic and social life, particularly

in times of economic downturn. However, we believe that while these barriers are not insurmountable, much more needs to be done by mental health professionals and others to change public attitudes through public awareness, social mobilisation and political leadership, if the rights of people with SMI are to be secured and enhanced.

This study has several limitations. It is quantitative in nature, although much of the discussion, which reflects an authorial value position, might be thought to go beyond what can be justified by data analysis. In future studies, qualitative data, including the service users' perspective, will paint a fuller picture of what citizenship means to people with SMI themselves. In addition, this study has not explored many aspects of citizenship, although it broadly accepts the likelihood that people with SMI experience degrees of exclusion 'across every area of social and economic life, from holidays to work, driving cars to raising children' (Sayce, 2000: 60). Public attitudes towards discriminated practice still may differ from their actual response when facing it. As Angermeyer & Dietrich (2006) rightly point out about the possible divergence between attitude and behaviour, 'this is a very difficult area of research' which may require a separate research and method. Finally, the public attitude may be just one perspective and can never be complete without comparing the views of people with SMI. Further research studies in this line will provide important clues to the impact of community atmosphere on people with SMI and how far stigma has been internalised.

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