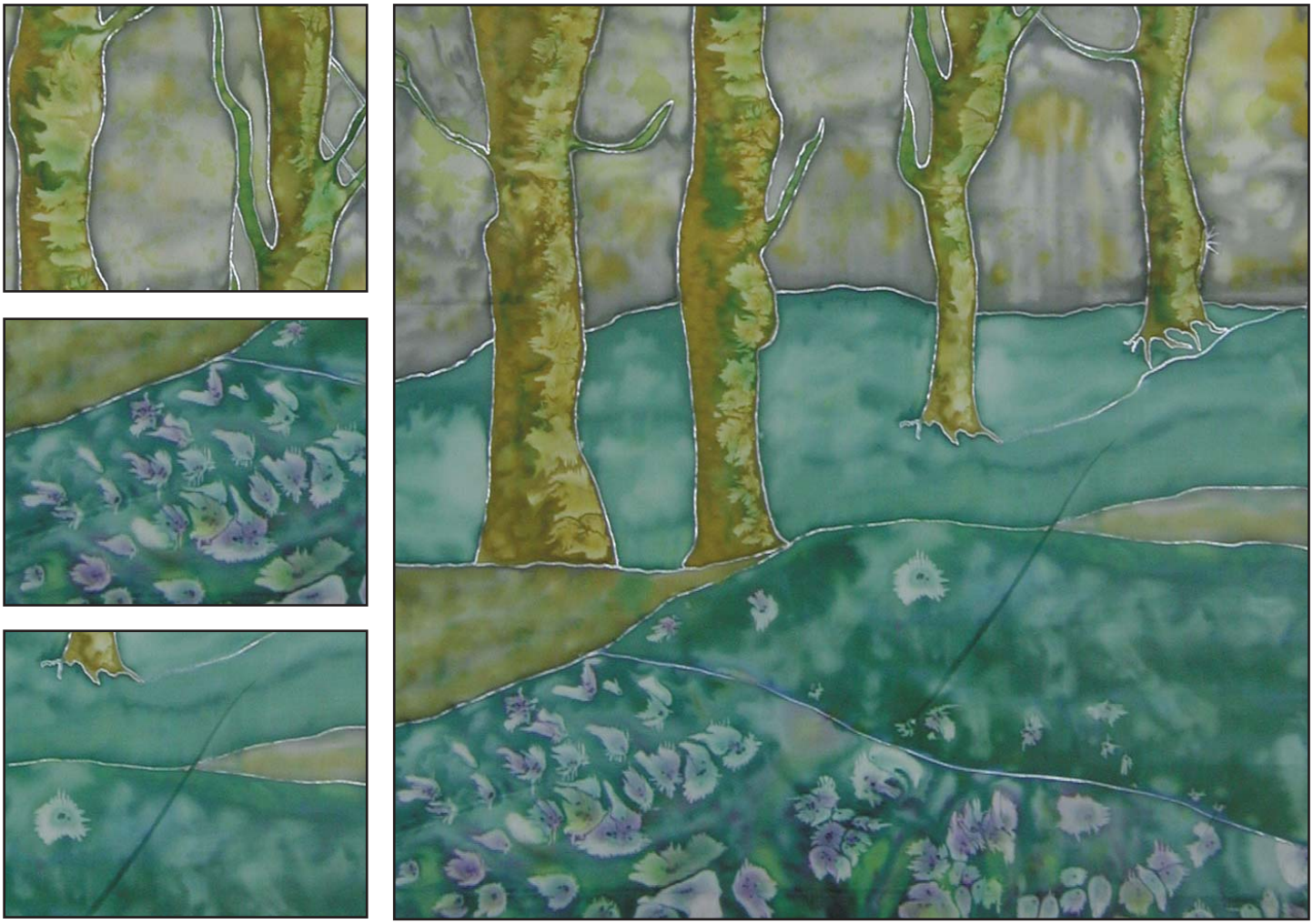
NHS

National Institute for
Mental Health in England

# Cases for Change

## Anti-discriminatory Practice



mental health questions? **ask NIMHE**

## Cases for Change

Mental health services in England are experiencing a period of unprecedented change. The pace of this change is potentially matched only by the pace at which information about both effective and less effective practice in mental health care is emerging. Over the past five years an incredible wealth of published literature has continued to remind all those engaged in developing mental health services of the reasons why fundamental change is necessary and of how services might be improved to better meet the needs of service users.

In addition to the evidence emerging from the research literature, it is important to recognise the role that publications appearing beyond the peer-reviewed journals have also had in informing the many cases for change that exist in adult mental health care today. These include publications reporting non-research based service reviews and the expert opinion of groups and organisations representing the interests of mental health service users, carers and professionals.

For those engaged daily in supporting change in local mental health services it can be difficult to feel well informed of the context of evidence and opinion within which current mental health policy has been established. With this in mind, in late 2001 the National Institute for Mental Health in England (NIMHE) commissioned a review of recent literature on adult mental health services with a view to producing an accessible summary of the emerging cases for change.

Cases for Change comprises ten booklets.

- **Introduction:** describes the background and methodology of the review and also summarises the findings and suggests areas for future research/policy development.
- **Policy Context:** describes the context of the review with an overview of recent mental health policy.

The following seven booklets each consider a different aspect of mental health service provision:

- **Primary Care**
- **Community Services**
- **Hospital Services**
- **Forensic Mental Health Services**
- **Partnership Working Across Health & Social Care**
- **User Involvement**
- **Anti-discriminatory Practice**
- **Emerging Areas of Service Provision:** reviews the literature that does not fit neatly into any of the previous topics.

The review collates evidence from over 650 documents published between January 1997 and February 2002 concerning adult mental health service delivery and/or policy in England. With the information collected synthesised into a number of key themes or issues, the review aims to describe how we got to where we are today and sets out the cases for change from the evidence base.

The articles highlighted at the beginning of each booklet as The Nature of the Evidence are those that are particularly relevant to the cases for change cited in the booklet concerned. Each document within the review has been classified using the "hierarchy of evidence" adopted in the *National Service Framework for Mental Health (NSF)* (Department of Health, 1999a):

- Type 1 evidence represents at least one good systematic review, including at least one randomised controlled trial.
- Type 2 evidence represents at least one good randomised controlled trial.
- Type 3 evidence represents at least one well-designed intervention study without randomisation.
- Type 4 evidence represents at least one well-designed observational study.
- Type 5 evidence represents expert opinion, including the opinion of services users and carers.

At the end of each of the main booklets, there are critical commentaries by service users and practitioners/managers/policy analysts from across England. These commentaries are intended to emphasise that different groups of people have different priorities and identify different cases for change. All contributors have been encouraged to be as challenging as possible and, where they disagree with interpretations, to say so.

Each booklet can be read independently or alongside one another to bring together a full picture of the development of mental health services. We hope this will be helpful in enhancing our understanding of the history as well as emphasising the need to develop future individual services within the context of an integrated system of care and support.

Cases for Change should be seen as a starting point and as a means to an end rather than an end in itself. By summarising the key issues that have emerged from the literature and by emphasising the diversity of opinion that exists within mental health services, Cases for Change may help to encourage debate about the best way forward and the way in which different view points can be balanced to achieve mutually beneficial outcomes.

Cases for Change has been written by a multi-disciplinary research team based at the University of Birmingham with the active support and encouragement of Susannah Rix at NIMHE Eastern, the guidance of the Expert Panel, and service users and practitioners who have provided written commentaries for the main sections of the review. Our thanks also to colleagues in the mental health group at the Department of Health for their editorial input to help finalise the publication.

The research team comprised:

- Jon Glasby, a qualified social worker and a lecturer at the Health Services Management Centre.
- Helen Lester, a GP, national primary care career scientist and Co-Director of the University of Birmingham's Interdisciplinary Centre for Mental Health.
- James Briscoe, a consultant psychiatrist and senior lecturer in the University of Birmingham's Department of Primary Care.
- Marion Clark, a former teacher who worked on this study as a user consultant.
- Steve Rose, Library and Information Services Manager at the Health Services Management Centre at the time of this review and now Health Care Libraries Manager, University of Oxford.
- Liz England, a clinical research fellow in the University of Birmingham's Department of Primary Care.

## Four Seasons

These original artworks were designed and painted by a team at The Hollies in Ipswich, Suffolk. Working together the group generates ideas, energy and input. The community spirit engendered provides a platform that allows creativity to shine through. The group experience builds confidence and develops a sense of esteem. *"This kind of work may not cure our problems, but this is the first year I have not been admitted to hospital".*

The Hollies is a Social Enterprise developing meaningful work opportunities for people who have used mental health services. Social Enterprise can and does create real jobs. The pictures illustrate a theme of constant change and renewal in nature. They reflect the changes that can evolve through Social Enterprise and working together.

**For more information, contact Jeremy Beckett, Local Health Partnerships NHS Trust on 01473 329093 or email jeremy.beckett@lhp.nhs.uk**

# Anti-discriminatory Practice

## The Nature of the Evidence

| | Number of Articles |
|---|---|
| Type I | 1 |
| Type II | 0 |
| Type III | 0 |
| Type IV | 16 |
| Type V | 44 |

## Background

Traditionally, the British welfare state has ignored issues of discrimination, seeing its role as providing a range of standard services to those in need, irrespective of who these recipients are (Dominelli, 1988). In many ways, this is particularly true of the NHS, which has prided itself on offering health care to everyone on the basis of clinical need alone. Unfortunately, however, we know from the wider sociological literature that different groups of people do not always start from a level playing field. We live in a society that likes to categorise people according to a range of social divisions: whether or not they are male or female, what colour their skin is, how old they are, their sexuality, whether or not they are disabled. How we categorise people can then help to shape how we respond to them, treating some groups more or less favourably than others. As Geoff Payne explains (2000, p.1):

*"It is impossible even to begin to think about people without immediately encountering 'social divisions'. We automatically perceive other human beings as being male or female, black or white, older or younger, richer or poorer, sick or well, or friend or foe. In forming a perception of them, we place them in pigeon-holes, adapting our behaviour and attitude to them in terms of the slots into which we have placed them."*

As a result, it is naïve to assume that we can respond in the same way to all people:

- As a result of our tendency to make assumptions about people based on their gender, ethnicity, age and other characteristics, we will often find ourselves treating different groups of people very differently (either consciously or sub-consciously).
- The services which the welfare state provides have often been designed from the point of view of dominant groups of people within society (typically white males). As an example, many day centres for older people have served very traditional English meals and have produced all their information in English, without recognising that people from particular minority ethnic communities may have particular dietary needs (such as Halal meat for Muslims) and may not necessarily speak English. Thus, a service which was probably designed to meet the needs of all local older people has perhaps inadvertently discriminated against people from certain minority groups.
- Discrimination does not only exist in health and social care, but is also widespread throughout society. For example, an Asian disabled person may find himself living in poor housing due to discriminatory employment practices and a failure by local housing services to provide accessible information in community languages. As a result, it is not appropriate to provide a standard level of service to everyone as different groups may well have a much greater need for support due to the discrimination they have faced.

One of the earliest disciplines to recognise and respond to issues of discrimination has been social work (see, for example, Dominelli, 1988; Thompson, 2001). Building on the civil rights movement of the 1960s, the school of radical social work has emphasised the importance of political, economic and social factors in shaping the lives of social care service users. While this analysis often tended to focus on social class, the debate has since expanded to include issues such as race, gender, sexuality and disability (see Thompson, 2001 for a more detailed description). More recently still, issues of discrimination have begun to be taken on board by other disciplines and are now a key feature of a number of government policies.

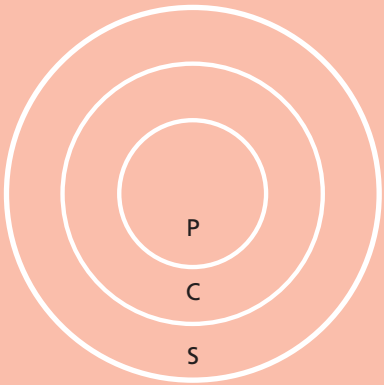
While many textbooks have typically focused on the experiences of different groups of people, there is a danger that each group can see itself in isolation and vie for position as the group that is most discriminated against. As a result, this approach is increasingly being replaced by a new way of understanding and responding to discrimination – anti-discriminatory practice. Instead of focusing on one particular aspect of discrimination (such as racism or sexism), it is important to emphasise the concept of 'multiple oppressions' (a recognition that some groups face a range of different forms of discrimination at once and that the target should not only be sexism or racism by themselves, but discrimination itself in whatever form this takes). This has been most forcibly demonstrated by Neil Thompson (2001), whose introduction to Anti-discriminatory practice is one of the standard textbooks in this area (see Further Information at the end of this booklet).

Crucially, Thompson sees discrimination as operating at a number of different levels, each reinforcing and being reinforced by other levels (see figure 1). Thus, discrimination can exist at the personal (P) level (of individual thoughts, actions, feelings and attitudes). However, this aspect of discrimination takes place within a cultural context (the C level of common values and shared ways of seeing, thinking and doing). This in turn is embedded in a structural (S) level (the established social order and accepted social divisions). As a result, action is needed at all three levels if discrimination is to be tackled – focusing on the individual alone will not be enough. This concept is revisited at the end of this booklet.

## Cases for Change

If discrimination exists in health and social care and in wider society more generally, it should come as no surprise to find that

Figure 1 Thompson's (2001) PCS Model of Discrimination




P: the Personal level
C: the Cultural level
S: the Structural level

similar issues also exist in mental health services. In particular, the Cases for Change literature draws attention to the experiences of three main groups:

- Women.
- People from minority ethnic communities.
- Gay men, lesbians and bisexual people.

**Women:**

The vast majority of documents reviewed suggest that women are likely to have extremely negative experiences of various aspects of mental health care (see figure 2). Above all, a recurring theme in the literature is the risk of abuse or harassment while staying on mixed psychiatric wards. A substantial proportion of women using mental health services are thought to have experienced physical or sexual abuse as children and/or as adults (see, for example, Fleischmann, 2000; Killapsy et al., 2000; Payne, 1998; Warner and Ford, 1998a) and there is a clear danger that such abuse may be replicated in hospital after women have been admitted to mixed wards. This has been a crucial issue for some time (Feinnman, 1988) and accusations of sexual assault have continued to emerge (see, for example, Cohen, 1992; Copperman and Burrows, 1992).

That sexual harassment is still common is demonstrated by the 1996 national visit of 118 mental health trusts carried out by the Mental Health Act Commission and the Sainsbury Centre for Mental Health (Warner and Ford, 1998a). Here, the researchers found that 162 out of 291 mixed wards (56%) reported problems of sexual harassment of women patients, ranging from sexual assault in a small number of cases to exploitation, inappropriate touching, exposure and sexually disinhibited behaviour (see figures 3 and 4). While ward staff identified a range of policies and practices designed to protect women, only 34 wards had written procedures and only 26 of these were able to supply a copy to the researchers. Some policies were out of date and others were not always enforced due to pressures on hospital wards. Thus, there was sometimes insufficient female staff to have a female worker on duty each shift, male patients who had persistently harassed women patients could not always be transferred to another ward and male patients were placed in women-only areas if no beds were available elsewhere. Also of concern was the layout of some wards, which made it difficult to observe patients at all times and which did not always allow sufficient space to defuse potential tensions. Although male and female members of staff made similar responses to the research, there were some interesting differences (Warner and Ford, 1998a, p.226):

*"A female nurse who rated the degree of harassment as 'a major problem' was reported to have said: 'Some of the male patients can be verbally offensive, making suggestions about women's bodies and what they would like to do to the women'. Her male colleague on the same ward rated it: 'Not much of a problem'. On another ward, a female nurse was reported to have said: 'Male patients harass female staff'; her male colleague said: 'Female patients harass male patients by bullying and encouraging relationships'. Both of them rated sexual harassment as being 'not much of a problem".*

While many of the articles reviewed as part of the Cases for Change focus on the issue of single versus mixed-sex hospital wards, it is clear that there are other equally significant issues at stake concerning the way in which mental health services respond to the needs of women. As Sarah Payne (1998) demonstrates in her summary of women's experiences of mental health services:

- Women are more likely than men to be treated for a mental health problem and to be admitted to hospital at some point in their lives (particularly for depression and anxiety). Until recently, women were more likely than men to be compulsorily admitted to hospital and are still more likely to receive certain forms of treatment (such as electroconvulsive therapy), while men are more likely to be referred by their GP to specialist services.
- Despite the fact that women form the majority of mental health service users, many of the key decision-makers in health and social care are male managers and male clinicians, with relatively little representation from women.
- Women may be more heavily represented in the mental health statistics because particular pressures in their lives put them at greater risk of mental health problems, but also because of discriminatory attitudes and practice within health and social care. As an example, there is evidence to suggest that members of the medical profession may hold stereotypical views about women and that women who behave in approved, female ways (e.g. paying attention to their hair/appearance and helping to clean the ward) may be more likely to be discharged from hospital.

At the same time, other commentators emphasise a range of additional issues:

- Some mental health workers may lack awareness of gender issues, with Black and Shillitoe (1997) citing examples of

**Figure 2 Women's Experiences of Mental Health Services**

**The Cases for Change literature is almost unanimous in its emphasis on the negative experience of women receiving mental health services. For example:**

*"Two-thirds of the users of mental health services are women. The majority of service planners and managers are men. This immediately raises key questions, such as how can male managers know what women want? And are mental health services meeting the needs of the majority of users?"*

**(Black and Shillitoe, 1997, p.27)**

*"Studies in the UK and US show that at least 50 per cent of women using mental health services have been sexually or physically abused as children and/or as adults. On psychiatric wards they have to mix with men, who have good opportunities for getting away with harassment and assault. Both female and male mental health service users are in acute stages of distress when they are admitted to hospital. Women's vulnerability to assault is increased when they have reached a crisis point in their lives. During stays in hospital most people are disoriented and have very low self-esteem. The side effects of medication also play a role as they can cause drowsiness, apathy, confusion and physical debilitation. In these circumstances women might not be able to fend off unwanted sexual advances. Having a mental health problem makes it more likely that women will not be believed if they make a complaint about sexual harassment or abuse. Sometimes an accusation is thought to be part of a woman's illness. Therefore many women stay quiet about what happens to them in hospital."*

**(Fleischmann, 2000, p.20)**

| Figure 3 Sexual Harassment of Women Patients in Mixed-sex Wards (n = 162) | |
|---|---|
| Type of problem | Number of wards reporting |
| Sexual assault | 6 (4%) |
| Touching female patients | 12 (7%) |
| Exposure/nudity of male patients | 21 (13%) |
| Watching or following female patients | 31 (19%) |
| Verbal harassment | 43 (26%) |
| Exploitation of vulnerable women | 60 (37%) |
| Disinhibited behaviour and remarks | 67 (43%) |

| Figure 4 Policies or Practices Concerning Women's Safety (n = 212) | |
|---|---|
| Policy/Practice | Number of wards reporting |
| Staff-related policies or practices: | |
| • Choice of female keyworker | 90 (42%) |
| • Use of chaperones with male staff | 27 (13%) |
| • Female staff to provide intimate care | 24 (11%) |
| • Female staff on each shift | 22 (10%) |
| • Observation by female staff | 11 (5%) |
| Practice-related policies or practice: | |
| • Policy for vulnerable women | 22 (10%) |
| • Transfer of harassing male patients | 20 (9%) |
| • Policy on harassment | 10 (5%) |
| Organisational and structural policies or practices: | |
| • Women-only areas | 42 (20%) |
| • Security measures | 20 (9%) |
| Source for both figures: Warner and Ford, 1998a, p.226 | |

male workers entering women's rooms unannounced.

- Women with children admitted to hospital may need to make alternative child care arrangements, often at short notice and sometimes involving the placement of their children in the care of the local authority (Killapsy et al., 2000).
- The needs of men with mental health problems may take precedence over those of women as men are believed to engage in more problematic behaviours (such as failing to comply with medication or becoming violent) (Mallon, 2001).
- Women often feel that they have insufficient privacy in hospital. During the two national visits carried out by the Mental Health Act Commission and the Sainsbury Centre for Mental Health, for example, only 3 per cent of wards were women-only and many women did not have access to self-contained facilities for washing, sleeping or going to the toilet (Ford et al., 1998; Warner and Ford, 1998a).
- Where women complain of sexual harassment, there may be insufficient attempts to prevent it happening again. This was a key finding to emerge from a survey of hospital patients conducted by Mind, which found that almost one in six patients had experienced sexual harassment, but that 72 per cent of those who complained felt that no action was taken (Baker, 2000).

In response to issues such as these, the literature proposes a number of possible solutions. Most prominent of all is the call for more women-only spaces within mental health services, for segregated accommodation in hospital and for specialist women-only services (see figure 5 for a good practice example). Certainly, this is the direction of current policy, with a pledge to eliminate mixed-sex accommodation (Department of Health, 1999a, p.50). However, a number of issues still remain:

- The discussion about the relative merits of single- and mixed-sex provision has existed for some years and thinking has changed over time. Traditionally, hospital services were strictly segregated, with mixed wards only developing in the 1970s in response to suggestions that this might promote a more normal atmosphere which is a more accurate reflection of life outside hospital (Fleischmann, 2000; McMillan, 1997a; Warner and Ford, 1998a). At the current time, the emphasis is on developing services where privacy, dignity and safety are paramount through appropriate women-only areas.
- There has been insufficient research into the outcomes of different types of service provision for men and women (Kohen, 1999).
- Some people (male and female) may prefer mixed provision and are hostile to the idea of single-sex services (Batcup, 1997; Black and Shillitoe, 1997).

Responding to women's needs will require a range of concerted actions which cover issues about the physical environment as well as developing the skills and expertise of practioners working with women with mental health needs (see later in the booklet for further discussion).

### People from minority ethnic communities:

Throughout the literature contained in this review, there is overwhelming evidence to suggest that 'black' people experience mental health services in a very different way to white people. In particular, 'black' people are over-represented in mental health services, tend to receive more coercive forms of treatment (such as compulsory hospital admissions, admission via contact with the police and forensic services) and suggest that existing services are too culturally insensitive to meet their needs (see figure 6 for a summary of the key issues). This may be the result of a whole host of factors, including racism and the experience of social disadvantage (see figure 7).

As a result of the experiences set out in figure 6, there have been a number of attempts to promote more culturally sensitive mental health services (see, for example, Department of Health, 1999a). As the *Mental Health Act Code of Practice* suggests (Department of Health/Welsh Office, 1999, p.3):

*"[People should] be given respect for their… diverse backgrounds as individuals and be assured that account will be taken*

**Figure 5 Specialist Services for Women: Drayton Park**

Drayton Park in London is cited as a good practice example by a range of documents in the Cases for Change review (Killapsy et al., 2000; McMillan, 1997b; Payne, 1998). According to Camden and Islington Mental Health NHS Trust (2001):

*"Drayton Park is an alternative to hospital admission for women…. It has been open since December 1995. The service recognises the need for women to have a safe place in which they can recover from crises and it focuses on issues that cause mental health problems for women. It was inspired and supported nationally by government recommendations and work such as the [1994 Mind] Stress on Women campaign. In 1999, it became a Beacon Service as part of the NHS Learning Network… A management advisory group consisting of women who have used services and women who work in mental health organisations within Camden and Islington guided [Drayton Park] in its first few years. This group maintained an alternative focus and supported the project in its development stages. In 1999, users of the service, in partnership with staff developed a Women's User Forum. This group has taken over some aspects of the advisory group along with other responsibilities."*

**Figure 6 'Black' People's Experiences of Mental Health Services**

Bahl (1999, pp.10-11) identifies the following key issues:

African-Caribbean population:

- African-Caribbean people in Britain have higher admission rates to psychiatric hospitals and are diagnosed as having schizophrenia 3-6 times more often than the white population.
- Rates of schizophrenia in second-generation British-born black people may be greater than the rates in the first generation.
- Black people are over-represented among patients compulsorily detained in psychiatric hospitals under the Mental Health Act, and also through police admissions.

Asian population:

- Some studies show higher hospital admission rates among Asian people than those for the British-born population.
- The balance of evidence… suggests that Asian people have rates of psychiatric morbidity similar to or lower than the indigenous population… It is not known whether these patterns reflect genuinely lower psychiatric morbidity or differences in detection rates, reluctance of Asian people to present themselves as having mental health problems, or differences in the manner of presentation.
- Suicide rates are low in some subgroups born on the Indian subcontinent, whereas women born in India or east Africa show a significant excess.
- The rate of suicides among first-generation Asian women is greatest among the young. The rate in girls aged 15-24 years who were born on the Indian subcontinent is more than double the national average and at ages 25-34 years is 60% higher in those who were born in India.
- Young Asian women also have high rates of attempted suicide and are clearly a high-risk group…

Other key issues include (Bahl, 1999; Commander et al., 1999; Parkman et al., 1997):

- Excessive use of drug therapy for African-Caribbean people.
- On discharge, 'black' patients may be less likely to remain in contact with services or to be seen by senior clinicians.
- Independent of diagnosis, 'black' people are more likely to have contact with the police and with forensic services, and are more likely to be treated in intensive care facilities if detained under the Mental Health Act.

*of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any one of these characteristics."*

While the needs of 'black' service users have received greater attention in recent policy documents, there is widespread evidence to suggest that many 'black' people continue to have very negative experiences of mental health services. That this is the case is demonstrated in a number of key studies:

- A national visit conducted by the Mental Health Act Commission and the Sainsbury Centre for Mental Health in 1999 found that many patients from minority ethnic communities were not receiving care sensitive to their cultural backgrounds (Warner et al., 2000). Despite several examples of good practice, three-quarters of units had no policy on dealing with racial harassment, two-thirds had no policy on race equality training and a similar number had used patients' relatives or friends to interpret for them. While half the units had a policy on the provision and use of interpreters, only three-quarters used interpreters who were trained in interpreting and some unit managers did not know if the interpreters they worked with were trained or not. Although the vast majority of units recorded the ethnicity of patients, this information was seldom put to great use. Similar and additional issues have also been identified in a number of regional studies undertaken by the Mental Health Act Commission in conjunction with the University of Central Lancashire (Bingley et al., 2000a, 2000b).
- The National Schizophrenia Fellowship (2000) (now Rethink) has carried out a survey of 450 people with mental health problems from a range of different ethnic backgrounds. This found that people from minority ethnic communities, particularly African-Caribbean people, had more negative experiences of mental health services than other groups. In particular, 'black' service users were more dissatisfied with the care they received than white respondents, were more likely to feel that their cultural needs had not been met, were more likely to disagree with the diagnosis they had been given, experienced far more detentions under the Mental Health Act and had been forcibly restrained more often. As one participant observed (National Schizophrenia Fellowship, 2000, p.1):

*"I am treated unfairly because of the colour of my skin, although I was born in London. This is not fair."*

- Wilson and Francis' (1997, p.33) survey of 100 African and African-Caribbean users across England and Wales found that:

*"a significant proportion of [respondents] feel they are largely misunderstood within the mental health system – either because they are feared, stereotyped or ignored. The stereotypes interact in complex ways and appear to have a powerful impact, as people are seen as black, as mad, as dangerous, as inadequate. This can reduce people's trust in the services on offer, and potentially damage their sense of identity and thus their mental health."*

- A more in-depth qualitative study conducted by Pierre (1999) paints a similar picture of disputed diagnoses, lack of consultation and information, physical and verbal abuse from hospital staff and a failure by staff to challenge racism from other patients.

In addition to these studies, other key issues have been found to include:

- Discriminatory attitudes among mental health workers. As Webbe (1998, p.12) observes, many practitioners have preconceptions of 'black' people as "big, black and dangerous." Whereas mental illness is often equated with "danger", 'black' mental illness if equated with "danger x 2" (see also Browne, 1997).
- A frequent complaint from 'black' service users is the lack of accessible information about the services available, the nature of their mental health problem and their legal rights (see, for example, Arshad and Johal, 1999; Grant-Pearce and Deane, 1999; Li et al., 1999).
- The importance of primary care as an arena in which mental health problems can be identified at an early stage before a crisis has occurred. Unfortunately, this opportunity is often lost as a result of the failure of some GPs to diagnose mental health problems in 'black' patients and lower rates of GP registration for some minority ethnic communities compared to the rest of the population (see, for example, Bahl, 1999; Browne, 1997; Koffman et al., 1997; Thornicroft et al., 1999).
- A failure to appreciate the importance of religious beliefs in shaping people's attitudes to mental health and their willingness to seek help from western services (Copsey, 1997a, 1997b).
- A lack of understanding of or knowledge about mental health issues in particular minority ethnic communities (see, for example, Li et al., 1999; Tabassum et al., 2000).
- A lack of 'black' staff in mental health services (Pierre, 1999). Often, the small numbers of 'black' staff that do exist can experience just as much discrimination as 'black' service users (Webbe, 1998).
- Often, ethnicity can interact with gender. Thus, Asian women may have different needs than white women and than Asian men (see, for example, Arshad and Johal, 1999; Tabassum et al., 2000).

Above all, there is evidence to suggest that all of these factors combine to create a "vicious circle" (Parkman et al., 1997, p.264), whereby 'black' people have negative experiences of mental health services and are therefore less inclined to seek help at early stage in the future or to comply with medication. This can then lead to relapse and readmission to hospital, where existing negative expectations are reinforced.

In seeking to respond to issues such as these, people have proposed a range of solutions. At a very basic level, the provision of effective interpretation services with workers trained in mental health issues could help to make services more accessible (Tabassum et al., 2000; Warner et al., 2000). In addition, a key contribution has been made by the voluntary sector, which has traditionally been able to provide more flexible, responsive and culturally sensitive services (Bhui et al., 2000; La Grenade, 1999; Sashidharan, 1999). However, developing specialist culturally sensitive services is only part of the solution, and several commentators emphasise the mixed messages that this can create. Rather than promoting the needs of 'black' service users, there is a danger that specialist services can marginalise people from minority ethnic communities yet further, suggesting to workers that ethnicity is a fringe rather than a mainstream issue. Often, moreover, there is a tendency for workers to assume that ethnicity will be addressed by 'black' staff – an approach which many 'black' workers feel can deskill them and fails to recognise the importance of ethnicity for all workers irrespective of their own skin colour (La Grenade, 1999).

To ensure that culturally sensitive services become a mainstream feature of mental health services rather than an 'optional extra', the majority of documents emphasise the central importance of training. For some commentators, this would enable staff to explore their own attitudes to people from minority ethnic communities, understand the health beliefs and lifestyles of different communities and provide more culturally sensitive services (see, for example, Bahl, 1999; Koffman et al., 1997; Webbe, 1998). Another key issue is the need for meaningful two-way communication between service providers and minority ethnic communities to ensure that minority ethnic users are involved in the planning and provision of services (Pierre, 1999). Other potential methods of improving the experiences of 'black' users is the focus team approach advocated by Bhui and Bhugra (1999) – whereby each team is responsible for familiarising itself with a particular community and allowing the community to access their skills and knowledge (see also Copsey, 1997a,

**Figure 7 'Black' People and Schizophrenia**

Sharpely et al's (2001) review of the literature on the increased rate of schizophrenia among African-Caribbean people in England highlights a wide range of potential hypotheses:

- African-Caribbean people may be misdiagnosed as having schizophrenia.
- Biological factors such as genetic predisposition, prenatal and perinatal complications, certain risk factors in childhood and use of cannabis may play a role.
- Social factors such as social disadvantage, concentration in inner-city areas, a reluctance to seek GP support, patients' and relatives' opinions and the experience of racism may all be significant.
- Psychological factors such as the experience of adverse life events or low self-esteem brought about by racism, unemployment and deprivation may also be a contributing factor.

1997b). Above all, however, a number of commentators emphasise that good quality, responsive mental health services will benefit all service users, irrespective of their ethnicity. Thus, for Bhui and Bhugra (1999, p.231) "all services need to be local, accessible, comprehensive, flexible and consumer-orientated, empowering those using the services." For La Grenade (1999, p.188), moreover, good services should be "available, affordable, accessible, adaptable and acceptable" - principles that may well apply to 'black' people and white people alike.

Unfortunately, our knowledge of 'black' people's experiences of mental health – although extremely well documented – is limited by two key shortcomings in the current literature. First, the majority of documents focus on the African-Caribbean community, with much fewer attempts to consider groups such as south-east Asian people. With a few notable exceptions (see, for example, Li et al., 1999), moreover, the needs of refugees and asylum seekers, Irish people and smaller minority ethnic communities such as Chinese or Vietnamese people have been almost entirely overlooked (Bahl, 1999; Bhui et al., 2000). Second, and even more fundamentally, is the tendency for the majority of documents focusing on ethnicity and mental health to describe ethnic differences in service provision. Often, these studies are written by research or health professionals without necessarily considering the experiences and views of service users from different minority ethnic communities (Thornicroft et al 1999, p.163).

### Gay men, lesbians and bisexual people:

In contrast to the extensive body of literature concerning the experiences of women and of people from minority ethnic communities, only three documents in this review focus on gay men/lesbians/bisexual people who use mental health services. The first document, published by Mind, explores previous literature and reports the findings of interviews with 55 lesbian, gay and bisexual service users drawn from across the country (Golding, 1997). The second, initially a masters dissertation, explores the experiences of lesbians and gay men as cited in the wider literature before focusing in on the results of interviews held with a small number of gay/lesbian practitioners and service users (n=8) (Price 1997). The third document is a Department of Health-funded project based on interviews and focus groups with 35 service users and 35 mental health workers (McFarlane, 1998).

Despite the paucity of evidence in this area, these three contributions are extremely powerful and suggest that lesbian, gay and bisexual people may experience considerable discrimination in mental health services (see figure 8).

Overall, the particular forms of discrimination addressed in this booklet have a number of themes and issues in common. For example:

- Individual forms of discrimination can interact. Thus, 'black' women may have very different experiences to white women, while gay, lesbian or bisexual service users may face additional discrimination due to their age, physical ability, religion or ethnicity.
- While specialist services that are sensitive to the needs of a particular marginalised group of people may be welcome, this may actually hinder change in more mainstream services. There is also an additional danger that staff from a particular group may be perceived as the 'expert' on a particular issue (e.g. 'black' staff members as 'experts' on ethnicity and gay staff as 'the gay expert'). This not only de-skills and exploits these staff members, but also takes the responsibility away from other workers for making services more responsive to the needs of service users from particular backgrounds.

Many of the negative experiences cited above are longstanding issues which have yet to be resolved perhaps because the issues concerned are so complex and deep-seated that they are extremely difficult to put right. As discussed in the beginning of this booklet, discrimination is a universal human phenomenon, prevelant in mental health, social care and our society as a whole. Discrimination cannot be tackled simply by changing the way individuals behave. Instead, attempts to root out discrimination in mental health services need to be accompanied by efforts to root out discrimination in wider society at a personal, cultural and structural level. Discrimination, in short, is pervasive and multi-faceted, and only an equally multi-faceted response will suffice. Of course, this is not to deny that mental health services can do a range of things to tackle discrimination. However, it may mean that changes within mental health should take place alongside more widespread and fundamental action to ensure that services and wider society function in a non-discriminatory manner.

## Further Information

For those interested in exploring these issues in more detail, the following are useful sources of additional information:

- The two national visits undertaken by the Mental Health Act Commission and the Sainsbury Centre for Mental Health provide an accessible overview of the experiences of women and of minority ethnic communities within inpatient mental health services (Warner and Ford, 1998a; Warner et al., 2000). With regard to ethnicity, additional work undertaken by the Mental Health Commission in the West Midlands and Greater Manchester (Bingley et al., 2000a, 2000b) provides a useful insight into the different perceptions of minority ethnic communities and service providers.
- Kaye, the former chief executive of the Special Hospitals Service Authority, outlines a series of 'hallmarks' or key criteria against which to judge secure services for women (Kaye, 1998).
- Voluntary agencies such as Mind (Wilson and Francis, 1997) and the National Schizophrenia Fellowship (2000) not only report extremely powerful findings from the views and experiences of 'black' service users, but also offer detailed recommendations for change.
- Copsey's (1997a, 1997b) work on religion and mental health highlights the importance of religious beliefs in shaping people's approach to mental health and provides practical advice on how to make current services more responsive to the needs of different religious groups.
- A number of introductory textbooks and/or edited collections provide easily accessible starting points (see, for example, Bhui and Olajide, 1999; Kaye and Lingiah, 2000; Kohen, 2000).
- The three sexuality documents cited above provide very accessible introductions to the issues at stake and the findings they report are extremely powerful reminders of the need for services to change (see Golding, 1997; McFarlane, 1998; Price, 1997). Good practice guidance in working with lesbians, gay men and bisexuals in mental health services is available via the website of PACE, a London-based counselling and mental health project working to promote lesbian and gay health and well-being (www.pacehealth.org.uk).

- After the literature review on which this report is based was completed, the Sainsbury Centre for Mental Health (2002b) published a review of the relationship between mental health services and African and Caribbean communities. Entitled Circles of Fear, the report and a briefing paper are available online.

Outside mental health services, Neil Thompson's (2001) introductory textbook on Anti-discriminatory practice is a seminal text and a good starting point for those who wish to move beyond individual manifestations of discrimination (sexism, racism etc.) to understand and tackle discrimination as a whole.

**Figure 8 The Experiences of Lesbian, Gay and Bisexual Service Users**

Traditionally, homosexuality has been seen as a type of mental illness, and was only declassified as such in 1973 (by the American Psychiatric Association) and in 1992 (by the World Health Organization).

Golding's (1997) interviews with 55 gay, lesbian and bisexual service users identified some positive experiences of mental health care, but also found that:

- 78% expressed reservations about feeling 'safe' enough to disclose their sexuality within a mainstream mental health service.
- 60% said that they had denied their sexuality or let workers assuming that they were heterosexual go unchallenged.
- 73% said they had experienced some sort of prejudice or discrimination in connection with their sexuality.
- 88% of people experiencing discrimination felt unable to challenge it, largely because of feelings of fear or vulnerability.
- 51% said that their sexuality had been inappropriately used to explain the cause of their mental distress.
- 64% said they had needed to ask for information about lesbian, gay or bisexual organisations and/or support services.
- 75% felt that positive changes needed to be made in mental health services.
- 71% did not know if the services they used had equal opportunities policies or codes of practice relating to sexuality.

Price's (1997) literature review and in-depth interviews emphasises:

- The prevalence of suicide and self-harm within the gay/lesbian community.
- The discriminatory nature of the 'nearest' relative regulations, which discriminate against gay or lesbian partners.
- Hospital inpatients feeling as if they are discouraged from being 'out' or having lesbian or gay visitors.
- The distress caused by homophobia and harassment.

McFarlane's (1998) research with 35 service users and 35 mental health workers concluded that that (p.117-121):

- The majority of respondents experiences or identified discrimination as having an impact on their mental health.
- Equal opportunity of access for those wishing to use mental health services is currently not available.
- Good practice varies within and between services and quality depends on the awareness and commitment of individual staff members.
- The safety of lesbians, gay men and bisexuals who use mental health services is an issue needing urgent attention. Women in particular feared or experienced intimidation, sexual harassment or sexual assault.
- Attitudes held by some workers to anyone with a mental health problem could affect access, treatment, the quality or relevance of the service received and the hopes and aspirations of service users.
- There is a lack of awareness and understanding of mental health problems in the lesbian, gay and bisexual communities.
- The majority of participants want choice (that is, the opportunity to choose from a variety of equitable mainstream services and from a range of specialist lesbian, gay and bisexual services).
- Training was identified as a major strategy to help to implement improvements.

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# Anti-discriminatory Practice

## Critical Commentary

This chapter makes a number of important points: mental health services have been designed for a typical white male; mental health services do discriminate against women; this discrimination is doubled if you are a woman from a minority ethnic community; discrimination is tripled if you are also a lesbian. However, I do have a number of additional comments:

1. Services have often pigeon holed people into categories of 'White European' and 'Black.' Although mental health workers have now begun to realise that Asian culture is vastly different to Black culture, it is still not correct to stereotype people. Thus, one individual from the White European community does not have the same culture as an individual from the same category – they may have Sunday lunch at a different time, have different food and drink a different kind of drink.

2. Mental health workers who lack awareness on gender issues can easily be corrected by making it a core requirement that new workers have to attend training which looks at racism, discrimination, sexism and homophobia. Workers who have been employed for longer periods should also have to attend refresher training.

3. I do not agree with the view the government had in the 1970s that mixed gender environment was normal social behaviour. For White European communities it is, but not for many Asian communities, and mixed wards for many Asian groups failed from the word go.

4. There is no doubt in my mind that racism is imbedded in mental health services. Staff and patients display racist behaviours and are racist verbally to individuals from a minority ethnic community. There is most definitely a lack of resources and information offered to minority ethnic service users, family members or carers. There is a lack of minority ethnic workers and a lack of specialist care. Interpreters/translators must also be trained on racism, discrimination, sexism and homophobia before working with vulnerable people.

5. The chapter makes very little reference to people who are disabled, are deaf or have learning difficulties.

**Saira Saddal, service user, Client Partnerships, Birmingham**

## Critical Commentary

This is a very exciting chapter as it highlights successfully the complex needs of the diverse population in our communities, which is challenging and at times overwhelming as a service provider. In my experience of managing a service for women, targeting a specific group allows professionals to explore and address some of the other complexities relating to women such as race, sexuality, caring for children, issues from violence and abuse.

Women who use the Drayton Park Mental Health Crisis Project for Women do reveal and explore their experiences of discrimination and oppression. The feedback from women is that in many mixed service settings it is not possible to work on these issues, which for them are a major factor in their lives and problems. They report that in many residential settings, including acute inpatient units, survival in that environment becomes the priority and their own issues are lost. Drayton Park continuously examines the service we offer, changing and adapting to the new and differing needs of our users. This does not mean that the response is always the right one, but the will is there in the team to learn from mistakes and from feedback to make improvements.

The point is made above that there is a danger that specialist services for women or a particular ethnic group are seen as expert and other services are then 'excused' from developing environments and approaches that care for or acknowledge the differing needs of all users. This is a vital point, but people must be offered a choice of services if they are oppressed or unsafe within general mental health services, until those services have addressed and developed their response. The environment, attitudes and skill base need to be examined and support to change be provided by the wider organisation and by government policy. The current system is failing to recognise the impact and level of trauma experienced by those who suffer discrimination, abuse and violence, which compounds and cause mental health problems in our society. Government policy such as Privacy, Dignity and Safety in Mixed Sex Accommodation (NHS Executive, 1999) makes broad statements which do not direct services to any particular course of action. The National Women's Strategy, which will be launched later this year from the Department of Health, promises to be a clearer guide on what must be changed to improve services from women.

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