Master Classes
Mental Health, ‘Race’ and Culture

5. Movements to reform psychiatry in the UK: How to make effective changes

RACIAL AND CULTURAL ISSUES FINDINGS IN ENGLAND

Black / Ethnic Minorities more often:

Diagnosed as schizophrenic

Compulsorily detained under M.H.Act

Admitted as 'Offender Patients'

Held by police under S. 136 of M.H.Act

Transferred to locked wards

Not referred for 'talking therapies'

Ref: Fernando, S. and Keating, F. (2009) *Mental Health in a Multi-ethnic Society.* 2nd edn. London and New York: Routledge.

MANY OFFICIAL REPORTS

- **MHAC REPORTS 1987 0NWARDS**
- **BLACKWOOD INQUIRY REPORT (SHSA,1993)**
- **DIALOGUE FOR CHANGE (NHS EXECUTIVE, 1994)**
- **CIRCLES OF FEAR (SAINSBURY CENTRE, 2002)**
- **INSIDE OUTSIDE (NIMHE, March 2003)**
- **DELIVERING RACE EQUALITY (DOH, October 2003)**
- **BENNETT INQUIRY REPORT (December 2003)**

EMPHASIS OF DRE

Community engagement to reach out to BME communities

not ‘development’ (i.e. empowerment)

Short term projects among BME communities

supervised by a university as ‘research’

Data collection (‘Count me in census’)

University research to explore problem areas

e.g. pathways to care, suicide rates

Race Equality Leads and Community Development Workers

With little power and virtually no support from the top

Focused Implementation Sites as examples but not accountable

ACTION GOALS FOR DRE
(BY 2010)

Reduce levels of fear of mental health services among BME communities and service users

Reduce rate of admission of people from BME communities

Reduce disproportionate rates of compulsory detention of BME service users

Reduce rates of seclusion in BME groups

Provide a balanced range of effective therapies, such as peer support services, psychotherapy and counselling, and culturally appropriates and effective pharmacological interventions

Ref: Department of Health (2005) Delivering Race Equality in Mental Health Care. An action plan for reform inside and outside services (Department of Health, London).

WHY DRE FAILED

Cultural sensitivity was leading issue addressed

- **Human rights, racism and discrimination played down or ignored**

No strategy to address racism although' 'race' in the title 'DRE'

- **Black visibility (via RELs and CDWs) but no power**

Looked to medical-type research to provide answers

- **Money diverted to 'research projects' and university departments**

Failed to challenge professional practice especially psychiatry

- **Institutional racism and limitations of 'medical model' ignored**

Seemed to see information gathering as an end in itself

- **Even more information seen as 'progress'**

Allowed regressive changes in legislation to go through

- **e.g. changes in Mental Health Act**

See Fernando, S. & Keating, F. (2009) Mental Health in Multi-ethnic Society (London: Routledge) pp. 235-258.

BARRIERS TO SYSTEMIC CHANGE (Crisis)

Post 9/11 lack of political will to tackle racism

Dominance of illness thinking about mental health

Emphasis on psychiatry as social control
- **‘Risk-assessments’ leading practice**

Powerful new (regressive) changes in legislation
- **Exacerbates / seemingly validates institutional racism**

Rhetoric on new approaches not matched by action

MENTAL HEALTH FOR ALL 4

Re-structuring systems of 'care'

- **Cultural understanding replace individual diagnosis**
  'multi-systems approach' (Boyd-Franklin and Shenouda, 1990)

- **User-choice within a wide range of support services**
  Choice and partnership (CAPA) working (Kingsbury and York, 2006)

- **Legal system promoting 'treatment' not custody**
  separate risk assessment from mental 'illness'

References

Boyd-Franklin, N. and Shenouda, N. T. (19900 'A Multisystems Approach to the Treatment of Black Inner-City Family with a Schizophrenic Mother' American journal of Orthopsychiatry, 60(2), 186-95.

Kingsbury, S. and York, A. (2006) *The 7 Helpful Habits of Effective CAMHS and The Choice and Partnership Approach', A Workbook for CAMHS,* 2nd edn Hampton Wick, Surrey: CAMHS Network.

See Fernando, S. (2010) *Mental Health, Race and Culture* third edition Palgrave/Macmillan pp. 174-184.

GUIDING PRINCIPLES IN SCOTTISH MENTAL HEALTH ACT*

1. Non-discrimination
2. Equality
3. Respect for diversity
4. Reciprocity
5. Informal care
6. Participation
7. Respect for carers
8. Least restrictive alternative
9. Benefit
10. Child welfare

*http://www.scotland.gov.uk/publications/2004/01/18753/31686

PARADIGM SHIFT UNREALISTIC
OVERALL PLAN UNLIKELY
AIM FOR SMALL CHANGES AT VARIOUS LEVELS

CHANGES IN PRACTICE

CHANGES IN PROFESSIONAL TRAINING

INVOLVING COMMUNITIES SELF-HELP AND EMPOWERMENT (VIA 'VOLUNTARY SECTOR')

REVISED LEGAL FRAMEWORK

<u>See</u> Fernando, S. and Keating, F. (2009) *Mental Health in a Multi-ethnic Society* (London and New York: Routledge) Esp. Chapters 2 and 19.

CHANGES IN LEGAL FRAMEWORK

Restrictions on definition of mental disorder

For purposes of sectioning mental disorder should not be construed by reason only of culturally appropriate beliefs and / or behaviours

Meaningful appeal against sectioning (MH Review Tribunals)

An amendment to Schedule 2 of the 1983 Act should ensure that (a) the legal persons appointed by the Lord Chancellor should have experience in the race relations field; and (b) the non-legal, non-medical persons appointed by the Lord Chancellor should have experience in anti-discriminatory practice.

An amendment to Section 78 (Procedure of Tribunals) should state that the Tribunal, in arriving at their decision, takes account of cultural diversity and institutional racism.

An amendment to Section 72 (Power of Tribunal) should enable a Tribunal to direct the detaining authority to seek additional information on cultural background of the patient.

Multicultural definition of 'appropriate treatment'

Appropriate treatment imposed compulsorily should take account of patient's culture, gender, sexuality, and social background

SUPPORT & MODIFY 'NEW APPROACHES' IN MH, ETHICAL PRACTICE AND HUMAN RIGHTS

Recovery Approach

Addressing Spirituality

Promoting Well-being

Supporting Resilience

Personalization agenda?

Support critical psychiatry (anti-narrow medical model)

Support social perspectives

Support and modify equality agenda

SHIFTING MODELS

Therapies aimed at specific problems

- **Anti-racist therapies**
- **Strategies for dealing with institutions**
- **Recovery approach (expanded)**

‘Cultural Consultancy’ by individuals who are racism-aware

Fusion therapies

- **e.g. Islamic psychotherapy / counselling**
- **Christian counselling**

Community-based approaches (‘Voluntary sector’)

- **Plurality of therapies with user-choice**
- **Inter-agency (indigenous-allopathic mixtures)**
- **‘Community psychology’ – wellbeing model**

CHANGES IN PROFESSIONAL TRAINING (esp. psychiatrists and psychologists)

Practical principles in training

Joint training of various disciplines
Social perspective of illness and health
Involving service users, religious organisations etc.

Curriculum principles

Study of (culturally) diverse forms of psychology
Cultural diversity of 'mental', 'spiritual', 'mind', illness etc.
Social construction of 'illness' and limitations of diagnoses
Racism in psychiatry – history and current
Concepts of 'liberation' (from suffering) / 'recovery'
Variety of interventions ('therapies')

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