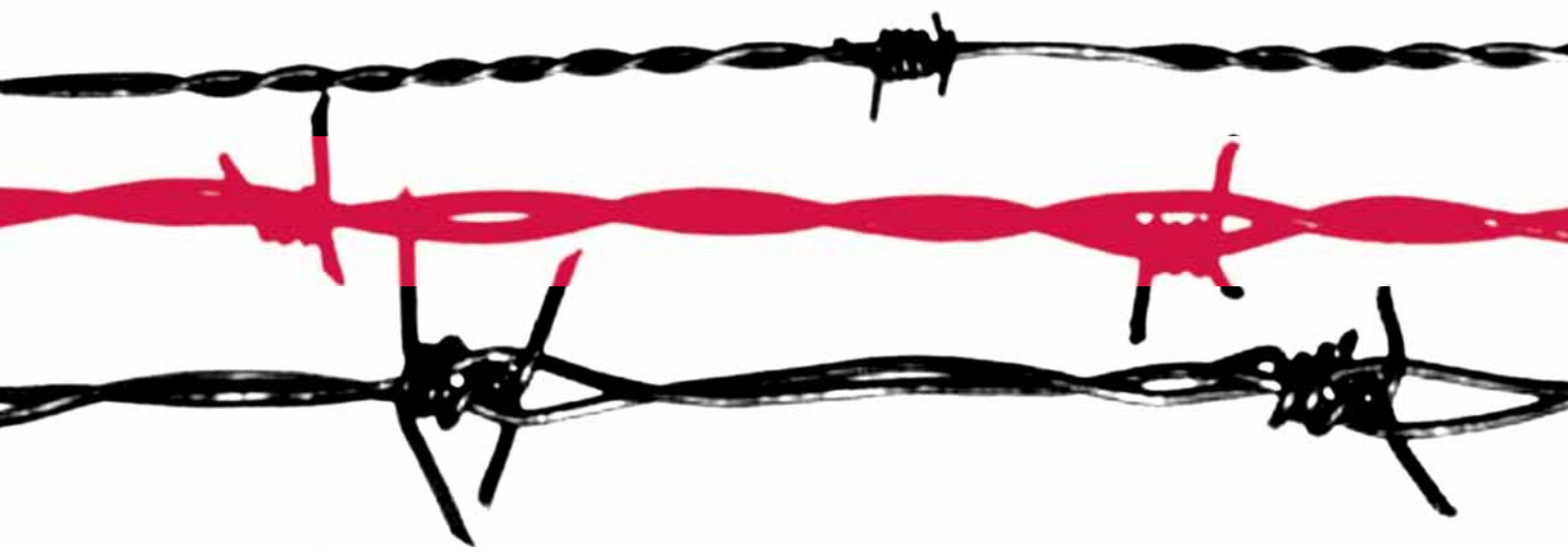


Bringing about changes in mental health care needs a political movement, with strategies designed to change people's attitudes and societal structures – in this case the system of psychiatry and psychology. Perhaps there is a way of combining this with research. Currently, we are some way from doing that, says **Suman Fernando**.

Research – who gains?



I was invited recently to a seminar for identifying 'gaps in research to inform policy and practice in mental health care for Black and ethnic minority groups'. When I questioned why black and minority ethnic (BME) service users and voluntary organisations were not invited to it, I was told that 'they' will be invited to a later meeting once consensus had been achieved among researchers on the 'evidence base'. It struck me that there was something wrong here.

So-called ethnic issues in mental health are well known. BME people often identify them as cultural insensitivity and/or institutional racism. The government calls them racial inequalities. Medical-type research and statistical analyses around these issues have been reported in a host of peer-reviewed papers. Much has been written about what is wrong and also about possible ways of changing systems of service delivery, ways of making psychiatric assessments and so on. But the status quo comes out trumps in the end. It is all very difficult, it seems. And so we

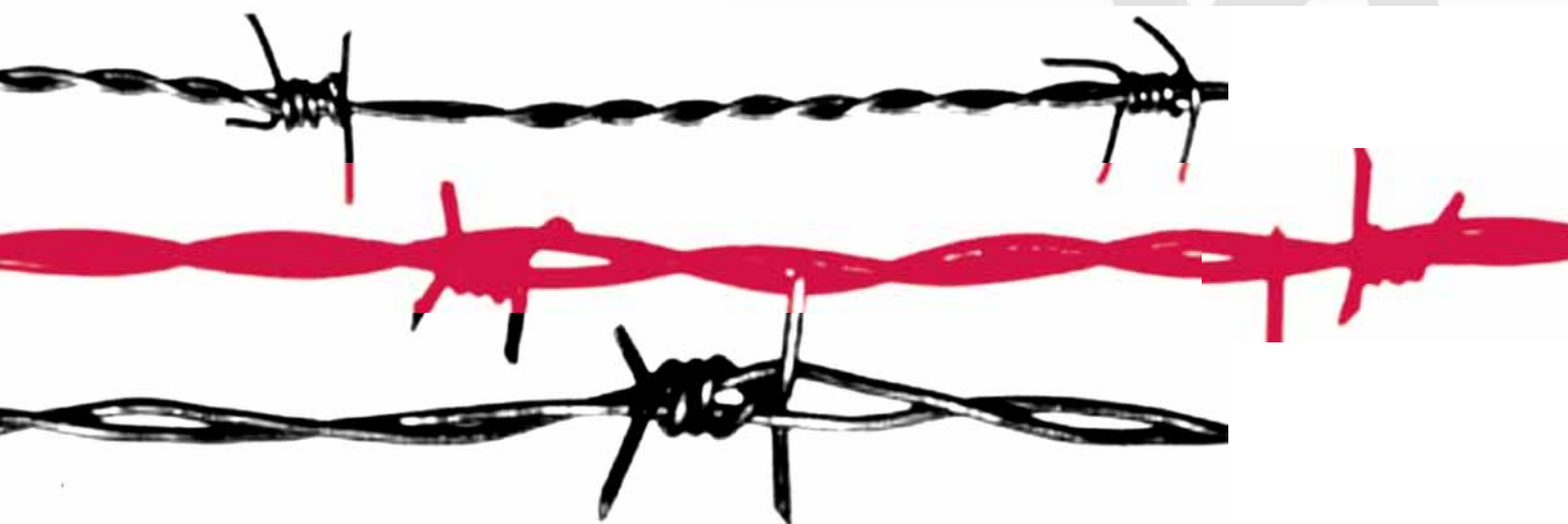
keep turning to research, searching for the evidence base, counting heads, always using diagnoses as a benchmark.

Today, the question is being asked by service users as to the use of all this research. Why this relentless search for knowledge of a medical and psychological kind – more recently talked about as 'evidence'? Who benefits from it? What is going on?

I suggest that looking back on how and why mental health services have changed in the past may be instructive – and services have undoubtedly changed for the better in many ways over the past hundred years. But first a word about knowledge. In our society, it is the written word that is generally accepted as the basis for knowledge – and not just that, but words written in what are accredited journals and sometimes in books that are well reviewed by important people. So when professionals talk of 'evidence-based practice' the only evidence that is taken as valid are papers written in these journals. What service users say

about the services, about diagnostic habits reflecting prejudices and stereotypes, about how they experience therapy, what outcome means to someone struggling with problems of living; these are not 'evidence'. The gold standard for a research paper is peer review, and the greater the prestige of the journal publishing the paper, the more power it carries. The connection to improving services is often tenuous.

Now to a historical approach to service development. A hundred years ago, 'mental patients' in asylums were subject to horrendous 'treatments' and they were often kept chained and shackled. These treatments were not abandoned because of research on their efficacy but because they were considered inhumane. Much closer to present times, community care was preferred to institutional care for similar reasons: not because of



objective evidence that it cured 'mental illness' but because it was ethically preferable.

A few obnoxious treatments were indeed abandoned because of research findings, but these were exceptions. One was insulin coma therapy, which was the process of inducing regular (usually daily) comas in people deemed to suffer from 'schizophrenia'. This was abandoned when it was shown that what was apparently therapeutic was having a special nurse attending the 'patient' while they recovered from the coma, not the coma itself.

The medications we have today were not developed as a result of biochemical research into 'mental illness' revealing ways of reversing 'pathology' but as a result of random observations that some 'symptoms' were alleviated by a particular chemical.

The ground-breaking changes in mental health care of the late 1950s to the mid-1970s were the therapeutic community movement for inpatients and crisis intervention in the community as an alternative to inpatient care. Neither came out of research findings but rather from perceptive and humane professionals hearing what service users preferred and relating that to family and community intervention models. Research came later, evaluating outcomes, cost-effectiveness and so on.

These stories illustrate two things: first, the political nature of how research is commissioned and how research papers achieve power to become evidence. So research is not always meant to benefit service users. Second, history teaches us that seldom have mental health services changed for the better because of research. The changes have come about as a result of ethical considerations, attending to human rights and the values of a civilised society, and listening to what people affected by the services have to say about their preferences.