

**Class 5 (07 December 2011) Movement to reform psychiatry in UK: How to make effective changes**

The first slide is one I started with in my first talk and one that dates back to 1988 when it was published in my very first book.

**Slide: Racial and Cultural issues. Findings in England**

If you are black (as compared to white) you are between ten and twenty times more likely to be diagnosed as 'schizophrenic'; more likely to be sectioned under the Mental Health Act – or since 2009 placed on a community treatment order; more likely to be deemed both mad and bad and so kept in forensic institutes such as Broadmoor; not referred to or accepted for counseling or psychotherapy but treated with drugs alone; and so on. So have there been attempts to redress these injustices?

**Slide: Many official reports**

The Mental Health Act Commission, created under the 1983 Mental Health Act, was very forthright in highlighting these issues from 1987 onwards. And agencies - even the Royal College of Psychiatrist - did seem to take note. In the early 1990s, after three deaths of young black patients at Broadmoor Hospital in similar circumstances (a quarrel between patients, black man placed in seclusion and given an injection leading to sudden death), an internal inquiry was ordered into the circumstances leading to the third death – that of Orville Blackwood. Chaired by an external professor (Herschell Prins), the inquiry report suggested that 'subtle racism' in the forensic psychiatry services had contributed to all the deaths and that action should be taken to address this. But nothing much was done at an official level, although some administrators and professionals within the service tried to institute 'cultural sensitivity' training and, I think there were some efforts made to recruit black nurses. A year later, a rather mild-mannered report, Dialogue for Change, suggested that changes were required throughout the mental health system. Ethnic monitoring came on stream in the early 1990s, although poorly implemented for many years after that. It was the shock of the Stephen Laurence report of 1999 suggesting that institutional racism was a social problem in all British institutions, and not just the police, that finally led to Dr Sashidharan, an outspoken critique of mental health services as racist, Sashi being asked to advise on what changes should be made. *Inside Outside* was the result and about the same time, the Sainsbury Centre for Mental Health produced *Circles of Fear* representing views of black service users on what was wrong.

Unfortunately, *Inside Outside* was followed not by an implementation plan but a new approach led by a person new to the scene. *Delivering Race Equality* (2003) or DRE modified a little after consultation to be re-issued in 2005, seemed to many of us as having diluted the thrust of *Inside Outside*, coming somewhat out of the blue without any consultation before-hand.

**Slide: Emphasis of DRE**

Addressing racism took a back seat and the emphasis of DRE focused on reaching out to BME communities; on data collection (as if we did not have enough); and on looking to Universities for research and supervision of short term projects to be carried out by BME communities or organisations. Some districts were selected to implement changes and

personnel were appointed to lead change, namely Race Equality Leads (RELs) and Community Development Workers (CDWs). The latter took a long time coming most not being in post for two or three years. Neither RELs nor CDWs were given much power or even direction on how they could bring about changes. But the revised version of DRE in 2005 did set what they called 'goals' by which the program should eventually be judged.

**Slide: Action goal for DRE**

Essentially these represent some of the problems identified during the past twenty years: Reducing the 'circles of fear'; reducing the disproportionate rates of sectioning, seclusion etc.; and enabling statutory services to offer a range of therapies that suit the needs of a multicultural society. None of these goals were achieved, but no real analysis was done as to why this was so. I believe DRE failed to make an impact on achieving changes for several reasons which were apparent from the beginning.

**Slide: Why DRE failed**

Before addressing what you see on this slide, I should say that some parts of the country and some professionals did indeed gain from activities under DRE but sustainability of these gains are very doubtful since systemic changes have not resulted (as far as I know) anywhere. Black and Asian people in advisory roles (as RELs and CDWs) generally worked hard and made some in-roads towards raising awareness of the problems and possible remedies, but most of their work was geared to supporting BME community groups. CDWs are now being rapidly phased out I believe. Certainly there was no attempt to influence the training of psychiatrists in any organised way. But the training system called Race Equality and Cultural Capability (RECC) developed by Pater Ferns and colleagues - initially at least within DRE - did in fact get taken up and made some impact on individuals.

To get back to the slide, leading with 'cultural sensitivity' rather than anti-racism' I think was a major drawback, although I can see how that came about, in a political context where the significance of institutional racism was played down from about late 2001 (when 9-11 occurred). Since mental health services are dominated by what goes for a medical – ostensibly 'scientific' - discipline, professional practices in psychology and psychiatry were not challenged but instead DRE looked to research projects done in a medical framework – projects that produced little to go on for changing systems of care and the system of psychiatry or psychology. In addition, for some reason, community projects were organised as 'research projects' under supervision of a university – paid handsomely for doing so. Towards the end, information gathering in what was called the 'Count me in Census' was perhaps the only lasting contribution made by DRE – i.e. adding to the figures we already had. And, most worrying of all, while DRE was going on, the government actually made changes in the Mental Health Act that were clearly opposed to what DRE was supposed to achieve -and DRE leads made no moves to oppose them or even comment on these changes.

So the barriers to changing the current situation are not easy reading.

**Slide: Barriers to systemic change**

The lack of a political will at the highest level is glaringly obvious. Even the lip-service seems to have all but disappeared. New approaches are being broached, such as the 'recovery model' and 'wellbeing model' of social and health care, but the dominance of the

illness model is stronger than ever at the hard end of psychiatry, i.e. forensic services and sectioning and now compulsory treatment in the community – all fields in which we see over-representation of black people as well as some other ethnic minorities.

The next slide is one I presented in a previous talk.

**Slide: Mental Health for all 4**

My view is that fairly fundamental changes are required in the system of mental health and social care if they are to be fair and just to all sections of our society. I suggest change is towards cultural understanding and away from diagnosis; and leading with user-choice within a range of different systems of therapy and support. But it may be that the way forward is also through campaigning for legal changes geared to human rights. The Scottish Mental Health Act for instance has a clear statement about rights of service users that is legally binding.

**Slide: Guiding principles in Scottish Mental Health Act**

The Scottish Act was implemented when the changes in the Act for England and Wales were being argued over in the early 2000s and its human rights sections could easily have been copied if the government wanted to do so. In fact under pressure, something similar was included in the Code of Practice – but significantly that is not legally enforceable and so cannot be the basis for a legal challenge for (say) improper sectioning or prolonged custody.

So let's get back to the practice of psychiatry itself which is of course central to the problems of race and culture:

**Slide: Paradigm shift on unrealistic**

In my view to be realistic in the present climate where racism takes a back seat politically, big changes to bring about racial justice in mental health are unlikely, and to aim for another major plan I believe is not feasible. However that does not mean that we should disengage from presenting argument for change at a national level by (for example) input into national mental health strategies (that Patrick Vernon of Afiya Trust is trying to do). But it is unrealistic to expect much. So perhaps we should aim more determinedly for relatively small changes at various levels.

We have to continue hammering away at changes in professional practice and training; and promote as much as possible self-help and empowerment via the 'voluntary sector'.

Maybe we could appeal to the (as it were) mother countries of our forebears (in the West Indies and Asia) to bring pressure on Britain to address inequalities – even getting it raised (say) at the Commonwealth Heads of State.

In Britain, ethnic minorities and other disadvantaged peoples have always looked to legal systems for justice perhaps because respect for the law has always been high in this country, unlike in many others. So pressing for amendments to the Mental Health Act could be a way forward - to enable (say) questioning of diagnoses or to enable questioning of proper training for people who conduct tribunals. In fact we could revive some of the changes we lobbied for when the changes in Mental Health Act were being considered:

**Slide: Changes in Legal Framework**

Restricting the definition of 'mental disorder' so that professionals are legally obliged to consider 'culture', which would inevitably mean allowing for racial bias. The Tribunal system could be altered with small amendments to legislation that focused on making the professionals in the system being better trained. And some alterations may be possible at the treatment end to make things a little better for cultural minorities.

I am sure you have heard of the new approaches.

**Slide: Support and Modify New Approaches**

The Recovery approach and addressing spirituality for example are clearly ones that a race and culture perspective would support except that they need modifying to take on board the sort of realities of racism and cultural insensitivity that I have been talking about. There is no time to go into all that here, but there is a growing literature in this, worth looking at if you are interested.

Then there are movements in mental health scene that we could form alliances with over specific issues. Critical Psychiatry Network (CPN) is one and Social Perspectives Network (SPN) another. And a balanced input into the equality agenda of course.

**Slide: Shifting models**

Other ways forward by a sort of nudging is by (say) campaigning for diversity in therapy. Some moves I know about are towards fusing different approaches – East and West or across religion and western psychology. May be therapies aimed at specific problems – say of people coping with racism in work situations or empowering people to deal with racism in the psychiatric system, being incorporated into advocacy. I think there is scope for work in involving communities in the way that *Inside Outside* originally intended (and DRE failed to follow through) – i.e. through 'community development' (which has an element of empowerment). What is left of the Community Development Workers (CDWs) appointed as part of DRE could be co-ordinated to work to specific aims that include building alliances between and within communities; there appears to be not enough working together among (say) Asian and African-Caribbean groups, and certainly room for working together among professionals, service users and the voluntary sector. Meanwhile of course the voluntary sector will I am sure continue to play a major part in (as it were) picking up the pieces and trying to make up for what the statutory sector on the whole fails to provide. But here funding is being cut back and we should campaign against such cuts.

However, we must bear in mind that most of the problems in the race and culture field are at the hard end of psychiatry where recovery approach has no place and the narrow medical model reigns supreme. So I am sure it is important to press on with trying to institute changes in the training of psychiatrists and psychologists. The human rights dimension should be emphasised because this rings a bell with people generally.

**Slide: Changes in professional training**

In this final slide I have listed some principles that hopefully psychiatric and psychology training may incorporate without feeling threatened as disciplines. Psychiatrists I know feel

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very threatened as a body (represented by the Royal College of Psychiatrists) at present and talk of a 'crisis' for the discipline and so any call to make changes results in a sort of 'trade-union' response. Trying to bring about more multidisciplinary training may help. The thing to remember too however that is putting training into practice is a major hurdle in the current mental health system. Mainly I think the problem arises from the heavy pressures that most professionals feel – the pressure to adhere to a narrow medical system and to make sure that patients do not upset the public – a particular problem for professionals trying to practice in a humane and sensitive way in the forensic services. But, in talking of training, we need to remember that for changes in training to be effective and have an impact at grass roots, rather than just being discussed as theories, changes in ways of working must be accompanied by political changes in the way systems work. It is systemic change that is sustained, otherwise, change of working practices, even if they occur as a result of training, just go back to default position of the system once the people concerned leave or become absorbed into the main system again.