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’

MANY OFFICIAL REPORTS

- MHAC REPORTS 1987 ONWARDS
- 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

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

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
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

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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