6th Edition

Social Work and Mental Health

Malcolm Golightley
Robert Goemans
1: Values and Ethical Mental Health Social Work

Achieving a social work degree

This chapter will help you to develop the following capabilities from the Professional Capabilities Framework.

- **Professionalism**
  Identify and behave as a professional social worker committed to professional development.

- **Values and ethics**
  Apply social work ethical principles and values to guide professional practice.

- **Knowledge**
  Apply knowledge of social sciences, law and social work practice theory.

- **Critical reflection and analysis**
  Apply critical reflection and analysis to inform and provide a rationale for professional decision-making.

- **Intervention and skills**
  Use judgement and authority to intervene with individuals, families and communities to promote independence, provide support and prevent harm, neglect and abuse.

It will also introduce you to the following standards as set out in the 2016 social work subject benchmark statement:

- **5.3 Values and ethics.**
- **5.5 The nature of social work practice.**
Introduction

The World Health Organization (WHO) describes mental health as:

*a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.*

(European Commission Green Paper, 2005, p4)

Mental illness is harder to define, with many definitions focusing on medicalised understandings of emotional distress. However, as discussed in the next chapter, the concept of ‘madness as disease’ is based on poor science and little convincing evidence. The Mental Health Act avoids such controversy with a vague definition of mental disorder as *any disorder or disability of mind*. Social workers should be used to working in the grey areas of complexity and uncertainty, aware of the fact that what many people see as simple concepts are usually far from simple, and able to apply critical and analytical thinking to understand how different groups are disadvantaged by different ways of defining social issues. In navigating such murky waters, values and ethics become vital for deciding what direction to sail in.

This chapter examines the relationship between values, ethics, contemporary social work and social care practice in mental health services. Mental health services are at a crucial stage with recent moves towards more person-centred and psycho-socially oriented services, influenced by personalisation, the recovery model, creative use of psycho-social interventions, preventative services, and a focus on service-users’ and carers’ voices being heard (many of these being further promoted in the Care Act) halted through unprecedented cuts to service budgets, forcing a retrenchment back to long waiting lists, a focus on risk and few interventions other than medication. At the same time, the social work profession is appearing to be going through an identity crisis, with the loss of the College of Social Work, development of ‘fast-track’ specialist courses, the development of a new regulator, teaching partnerships, and the Knowledge and Skills Statements providing a watered-down alternative to the Professional Capabilities Framework.

Approximately one person in six at some time in their life will experience mental health problems that are sufficiently serious for them to seek help from a professional. It is usually the family doctor who is the first port of call and he or she in turn will refer people to the various agencies whose remit is to provide mental health services. These services include health, social care and social work agencies that are trying to work together to provide a seamless service for the user. Some GP practices have social workers attached to them and this often means that these workers will be doing direct work with service users, working in the community alongside other mental health professionals, or be working in a
psychiatric hospital. Social workers also come across mental health problems in addition to the ‘presenting problem’ that led to referral in the first place.

**Basic facts**

The following are extracted from the mental health policy *No Health Without Mental Health* (DoH 2011).

- At least one in four people will experience mental health problems at some point in their lives and one in six has a problem at any one time.
- One in ten children between 5 and 16 years have a mental health problem and many will continue throughout their adult life to have similar problems.
- Half of those with lifetime mental health problems experienced symptoms by the age of 14, three-quarters before their mid-20s.
- 10–13% of 15–16-year-olds have self-harmed.
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers have experienced post-natal depression.
- About one in 100 people have a severe mental health problem.
- 60% of people living in hostels have a personality disorder.
- Some 90% of all prisoners are estimated to have a diagnosable mental health problem or a substance use problem.

Of course, you need to treat all such statistics with caution, but even if there are some discrepancies with the above, they still show mental health to be one of the most pressing issues that we as a society are facing, and you and I as social workers are working with.

**A strategy for the mental health of the European Union**

In January 2005 the World Health Organization held a conference for European Ministers to start a process of drawing up a framework for comprehensive action and political commitment for mental health. The subsequent Green Paper is an important contribution to setting up a series of actions that may prove to be a significant initiative. The purpose was to stimulate debate within Europe and to engage a broad range of institutions, health professionals, social care professionals, research communities and service users, in discussions about how best to improve public mental health.
Three areas for improvement are identified.

*Mental ill health affects every fourth citizen and can lead to suicide, a cause of too many deaths.*

*Mental ill health causes significant losses and burdens to the economic, social, educational as well as criminal and justice systems.*

*Stigmatisation, discrimination and non-respect for the human rights and the dignity of mentally ill and disabled people still exist, challenging core European values.*

(European Commission Green Paper, 2005)

The Paper goes on to describe how mental health is a growing challenge to the EU and to support the WHO view that by 2020, depression will be the highest ranking cause of disease in the developed world (WHO, 2001). Other statistics include the following statement.

*Currently, in the EU, some 58,000 citizens die from suicide every year, more than from the annual deaths from road accidents, homicide or HIV/AIDS.*

(Green Paper 2005, p4)

Clearly, there are significant inequalities within member states, and this reflects the richness and diverse nature of the EU, but nevertheless the paper proposes that a strategy would be focused on prevention of mental ill health, the improvement of the quality of life for people with mental health, and the development of a mental health information and research system for the EU.

### Mental health strategy in the UK

Each of the countries that make up the UK is responsible for developing its own strategy for dealing with mental health problems. The most important policy documents are listed below (all of these will be available on the relevant government website).

**England**

- 2012 – Suicide prevention strategy for England
- 2014 – Mental health crisis care concordat
- 2014 – NHS five-year forward view
- 2015 – Future in mind: promoting, protecting and improving our children and young people’s mental health and well-being
- 2016 – Implementing the five-year forward view for mental health
Scotland

Mental health strategy 2012–15
Suicide prevention strategy 2013–16
Mental Health (Scotland) Act 2015
Due 2016 – Mental Health in Scotland – a 10-year vision (at time of publication (early 2017) this has been out for consultation, but the final publication of the strategy is still awaited)

Wales

2012 – Together for mental health: a strategy for mental health and wellbeing in Wales
Mental Health (Wales) measure 2010

Northern Ireland

2011 – Service framework for mental health and wellbeing
2014 – Regional mental health care pathway: ‘You in mind’
2015 – Towards a better future: The trans-generational impact of the troubles on mental health

The strategy for England

Following the general election of 2010, the newly formed Coalition Government published No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages (February 2011), which, alongside the Implementation Framework of July 2012, set out the key objectives of the government’s approach to mental health. One of the central objectives of this strategy was the concept of ‘parity of esteem’, which means that mental health conditions should be given equal priority and value to physical health conditions.

The objectives in this strategy were updated in the NHS Five Year Forward View, which was published in October 2014 and highlighted how far we are from achieving these objectives.

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually — roughly the cost of the entire NHS. Physical and mental health are closely linked — people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people — one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.
An independent mental health taskforce, chaired by Paul Farmer, Chief Executive of Mind, was tasked by NHS England to assess the state of mental health services in the NHS and set a strategy for improvement. This taskforce was independent of government and involved representatives of health and care organisations as well as people with experience of using services or as carers, and published their report *The Five Year Forward View for Mental Health: A report from the independent mental health taskforce to the NHS in England* in February 2016. This was followed in July 2016 by NHS England’s *Implementation Plan* which sets out the actions it proposes to take to deliver the *Five Year Forward View* proposals.

The implementation plan identified the following common principles that should be followed as local areas develop plans to meet the set objectives:

- co-production with people with lived experience of services, their families and carers;
- working in partnership with local public, private and voluntary sector organisations, recognising the contributions of each to improving mental health and well-being;
- identifying needs and intervening at the earliest appropriate opportunity to reduce the likelihood of escalation and distress and support recovery;
- designing and delivering person-centred care, underpinned by evidence, which supports people to lead fuller, happier lives; and
- underpinning the commitments through outcome-focused, intelligent and data-driven commissioning.

In addition to this strategy, there have been a few other important initiatives that have had an impact on how mental health services are delivered. One example is the *Mental Health Crisis Care Concordat*, which was agreed in 2014 and obliges services to work together to provide better care during crisis or emergency situations. While there has been no new money attached to the concordat, local multi-agency agreements have been put in place which have focused the minds of commissioners and senior managers to prioritise crisis services and be more creative with existing resources. Some examples of initiatives which have come out of this include ‘triage cars’ often staffed by paramedics and psychiatric nurses, shorter wait times for ambulances to convey people to mental health wards, and information-sharing protocols so that police officers can receive information from mental health teams about vulnerable people more easily.

One of the key tasks for the reformed services is to combat the effects of social exclusion and to provide a service that is user-focused. The idea is that through a combination of policy initiatives people will feel that they have a greater sense of belonging to a community, and services will form new partnerships between the providers and recipients of services. Thus, various initiatives have been put in place to meet the needs of specific populations such as women, people who are deaf, and black and minority ethnic groups.
This more inclusive approach has a focus on community-based services, which has been a trend over the last three decades, but the new strategy takes this further with local commissioning of services and a focus on outcome evaluation against various targets. As this focus on local services continues, the danger is that services will become more fragmented. With decentralised structures, there is a need to establish general standards against which these communities’ services can be judged, and these are already in place.

These standards need to be seen alongside the more specific inspection standards for the Care Quality Commission (CQC), which in 2009 replaced the Healthcare Commission (which replaced the Commission for Social Care Inspection (CSCI), the successor in April 2004 to the National Care Standards Commission (NCSC)). It is worth looking at some of the reports that the CQC has published about the quality of mental health services. Their most recent report, The State of Health Care and Adult Social Care in England 2015/16: Mental health, which is available on their website, states that our ratings suggest that care for people with mental health problems is not good enough and needs to be improved. This is borne out in their rating of 64 per cent of NHS mental health trusts as requiring improvement.

It is clear that there is a considerable quality problem with mental health services that has been exacerbated by the recent unprecedented cuts to both health and social care services. Mental health services have been the focus of increased political, public and media attention over recent years, but this has not translated into improvements in how services are delivered. A November 2015 briefing from the think tank The King’s Fund, entitled Mental Health under Pressure noted that While increased political support and a stronger policy focus is welcome, parity of esteem for mental health remains a long way off. An article from The Independent from January 2016 also noted that while the changes in strategy described above had promised an additional £1 billion for mental health services, given that mental health services received 13 per cent of the NHS budget, as mental illness accounted for 23 per cent of the disease burden for the UK, an additional £11 billion would be needed to achieve real parity of esteem. The same article also pointed out that while the budgets of mental health services had been cut by 8 per cent in real terms over the last five years, demand for these services had risen by 20 per cent in that time.

A further indication of the problems within mental health services can be seen by the increase in admissions to hospital, with admissions under section 2 of the Mental Health Act rising from 27,904 in 2010/11 to 40,063 in 2014/15. A survey by the AMHP Leads Network indicated that one of the implications of this was a staggering 236 per cent increase in the use of out-of-area beds since 2011/12, with 48 per cent of AMHPs saying they had carried out assessments of people who were willing to attend hospital informally and therefore not needing compulsory admission, but who ended up being sectioned as there were no local beds available and they refused to be admitted to an out-of-area bed. During the period 1998–2012, following a concerted effort to reduce in-patient care and replace this with Crisis Resolution Teams in the community, the numbers of psychiatric
beds had been reduced by 39 per cent. With the cuts that have taken place to community services since then, the means for keeping people out of hospital have failed, and it is not an over-dramatisation to say that the system is breaking down.

As a social worker, it is vital to develop a critical understanding of policy, and you should reflect on the gap between the ‘warm words’ of the government’s published policies and the cold realities of life for vulnerable people unable to access a service that meets their needs.

Meeting tough outcomes is a challenge to agencies as well as to individual practitioners. As a social worker, you may be working with service users and communities as well as other professionals to plan, implement and evaluate mental health services. The emphases on user empowerment, community development and non-discriminatory services are all part of the tool-kit that you, as a social worker, will be expected to develop.

Before you can begin to consider yourself an effective mental health social worker, you need to understand the values that underpin professional practice and how they are reflected in agency policy and practice, and endorsed in governmental policies. You need to understand the part that you will play as a social worker/social care worker in the modernising agenda. It is important that, as a developing professional, your practice demonstrates commitment to promoting equality. Regardless of the language of different policies, the aim is to modernise services and to promote the integration of health and social care services within mental health trusts so that they provide a seamless provision for service users, although this may be at a price to the profession of social work. The emphasis on professional collaboration and integration has sparked concerns that the distinctive contribution of social work in mental health services might be diminished (SCIE research briefing 26, 2008).

The strategy for Wales

Similar to the strategy for England but adjusted to better meet the needs of the Welsh people is *Together for Mental Health*, published in 2012, the Welsh government’s five-year vision for the NHS that good health is vital to the creation of a prosperous, successful and sustainable Wales. Addressing the disadvantages faced by people with mental illness and ensuring equal access to care and treatment is essential to this. *Together for Mental Health* builds on developments in mental health services over the last ten years, including the legal requirements of The Mental Health (Wales) Measure 2010. It takes this work forward, providing a long-term commitment to improve mental health and well-being backed by significant funding.

At its heart, the strategy is to improve mental health among the population and to improve services for people of all ages, including children and young people. Central to this approach is the idea of recovery and the route to this will be through more effective partnerships, both with the general population and through an effective network of services.
The Welsh strategy has six high-level outcomes:

- The mental health and well-being of the whole population is improved.
- The impact of mental health problems and/or mental illness on individuals of all ages, their families and carers, communities and the economy more widely, is better recognised and reduced.
- Inequalities, stigma and discrimination suffered by people experiencing mental health problems and mental illness are reduced.
- Individuals have a better experience of the support and treatment they receive and have an increased feeling of input and control over related decisions.
- Access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result.
- The values, attitudes and skills of those treating or supporting individuals of all ages with mental health problems or mental illness are improved.

(Welsh Government, 2012, p7)

If you want to read more, then access: http://wales.gov.uk/docs/dhss/publications/130328mhsummaryen.pdf

For the 10-year strategy, see: http://wales.gov.uk/docs/dhss/publications/121031tmhfinalen.pdf

The strategy for Scotland

In Scotland, the Mental Health Strategy 2012–15, launched in August 2012, and sharing many of the characteristics of the other countries, supported and adopts the three Quality Ambitions for Scotland that health and care is person-centred, safe and effective. There are 7 key themes and 36 specific commitments to be delivered over the period to 2015 and these cover the full spectrum of mental health improvement, prevention, care, services and recovery. This strategy is due to be replaced and a new strategy is currently finishing the consultation stage prior to being published. In December 2016, the Scottish Government published a document entitled Mental Health in Scotland – a 10-year vision: Analysis of responses to the public engagement exercise. The new strategy will be based on a framework of eight priorities which, at present, are as follows.

1. Focus on prevention and early intervention for pregnant women and new mothers.
2. Focus on prevention and early intervention for infants, children and young people.
3. Introduce new models of supporting mental health in primary care.
4. Support people to manage their own mental health.
5. Improve access to mental health services and make them more efficient, effective and safe – which is also part of early intervention.
6. Improve the physical health of people with severe and enduring mental health problems to address premature mortality.

7. Focus on ‘All of Me’: ensure parity between mental health and physical health.

8. Realise the human rights of people with mental health problems.

The responses document outlined the following additional areas that the consultation process had identified as requiring a greater focus in the new strategy.

- Developing a truly transformational approach, with an ambitious strategic vision supported by a clear plan of action and a robust, outcomes-focused monitoring and evaluation framework.

- Strengthening the links between the Mental Health Strategy and other relevant strategies, policy and legislation.

- The impact of social and economic disadvantage and how tackling this can contribute to better mental health and well-being. The strategy should also place greater emphasis on overall well-being.

- The development of a whole systems approach to care, with an emphasis on integration and multi-agency working, and placing even greater focus and expectations on approaches to prevention and early intervention.

The final new strategy is likely to have been published by the time this book is in print and it will be worth taking a close look to see what changes were made in the final drafting.

If you want to read more, then access: https://consult.scotland.gov.uk/mental-health-unit/mental-health-in-scotland-a-10-year-vision/

**The strategy for Northern Ireland**

In Northern Ireland the strategy goes back to 2009 when the NI Executive envisaged a 15-year plan to improve mental health and services for people with mental health problems. This cross-departmental Action Plan sets out the key actions that will be taken forward in response to the Bamford Review recommendations. The main aim is to protect and preserve the mental health of the population as a whole, where possible to promote better mental health for everyone, and to improve the lives of those with a learning disability or a mental health need.

*To make the Bamford vision a reality, the NI Executive will promote the mental wellbeing of the population as a whole. The Executive will also promote the health and wellbeing, and maximise the independence and full participation of people of all ages with a mental health need or a learning disability, underpinned by legislation and public*
services to include reform and modernisation of mental health and learning disability services. People with a mental health need or a learning disability using public services should expect to:

be encouraged and supported to look after their own health, both mental and physical, and build up emotional resilience;

be supported, as far as possible, in their own homes and communities, making best use of self-directed help; be supported, through effective collaboration between Government Departments and their agencies, in their life choices and in day to day activities of engaging in education, training, work and leisure;

be consulted on and be able to influence the provision of services to meet their needs;

be encouraged to access help at as early a stage as possible; and

be supported towards personal fulfillment and full citizenship.

(Department of Health, Social Services and Public Safety, 2012)


The importance of values

Social work is fundamentally a moral activity. Social workers often refer to values; indeed, Clark (2000) suggests that values are the staple diet of social workers, although the word is used indiscriminately when principles or ethics might be more accurate. Clark suggests that there are four core values:

1. The worth and uniqueness of each individual.
2. The entitlement to justice.
3. The essentiality of community.
4. The claim to freedom.

Values, knowledge and skills are interconnected in everyday practice, even though this is not always apparent. Figure 1.1 shows how these are connected to each other.

Since April 2005 the title of social worker has become legally protected and hence only those who are registered can call themselves social workers. The Health and Care Professions Council (HCPC), which took over as the regulatory body in 2012, declare that they will prosecute anyone who makes a false claim to be a social worker. The register also permits easy
confirmation that someone is currently registered and not subject to disciplinary matters. The HCPC publish Standards of Conduct, Performance and Ethics which cover all the professions they regulate, as well as Standards of Proficiency which are specific to each profession. In addition to these documents, the College of Social Work developed a Professional Capabilities Framework (PCF) that sets out what you need to achieve in order to be awarded a social work degree. While the college is no longer in existence, the PCF is still widely used and is now overseen by the British Association of Social Workers (BASW). The overall aim is to drive up the standards of social work and those who practise as social workers (see Appendix 1, p260). Values, of course, underpin practice, and the relationship to skills and knowledge is illustrated in Figure 1.1.

![Figure 1.1 Values, knowledge and skills: the foundations of good practice](image)

You might at this point ask why we need a *Code of Professional Practice*, and this becomes apparent when you begin to learn about the role that social workers have alongside other professionals who deliver mental health services. At times, people with mental health problems can be in such a vulnerable state that they may even require admission to hospital against their wishes. They need to be assured that nationally agreed standards of service delivery are being adhered to and that the service provider can be held accountable when services fall short. Different professions have their own codes of practice and conduct, which have three common themes:

- the avoidance of possible harm to services users;
- the promotion of possible good to service users;
- the protection of the profession and the resolution of conflicts.
Code of Practice

The HCPC has published a code of practice that sets out the Standards of Conduct, Performance and Ethics (2016a) that are expected of you as a student and later as a qualified registered social worker (legislation is currently passing through parliament which will allow the government to set up a new regulator for social work, which will supersede the HCPC and set new standards, with 2018 identified as the start date for the new regulator). Although students are not registered, you will need to apply for registration once qualified and in order for you to legally call yourself a social worker. This acts as a framework in which you practise, and in my opinion you should work within this irrespective of your status. Having read this, you could be forgiven for thinking that practice is like walking on eggshells, but in reality the essence of your practice should be to make informed, reasonable and professional judgements in a rational manner (with your service users as your prime concern) that enables you to justify any decisions if you are asked to do so. In any event, if you are worried about a situation which might put a person at risk, you must speak to someone in a position of responsibility, such as your supervisor, line manager or practice educator.

The HCPC’s Standards of Conduct, Performance and Ethics contain the following headings – refer to the full document for more detailed descriptions of what you are signing up for.

1. Promote and protect the interests of service users and carers
   - Treat service users and carers with respect: including treating people as individuals, respecting their privacy and dignity, and working in partnership with them.
   - Make sure you have consent.
   - Challenge discrimination, including not allowing your personal views to affect your professional relationships and challenging colleagues.
   - Maintain appropriate boundaries and keep your relationships with service users and carers professional.

2. Communicate appropriately and effectively
   - Communicate with service users and carers, including the need to be polite and considerate, to listen to service users and carers, and take account of their needs and wishes.
   - Work with colleagues, including working in partnership and sharing information appropriately.
   - You must use all forms of communication appropriately and responsibly, including social media and networking websites.

3. Work within the limits of your knowledge and skills
   - Keep within your scope of practice.
   - Maintain and develop your knowledge and skills.
4. Delegate appropriately
   • Delegation, oversight and support, including only delegating work to appropriate people, and providing supervision and support.

5. Respect confidentiality
   • You must treat information about service users as confidential.
   • You must only disclose confidential information if: you have permission; the law allows it; it is in the service user's best interests; or it is in the public interest, such as if it is necessary to protect public safety or prevent harm to other people.

6. Manage risk
   • You must take all reasonable steps to reduce the risk of harm to service users, carers and colleagues as far as possible.
   • You must not do anything, or allow someone else to do anything, which could put the health or safety of a service user, carer or colleague at unacceptable risk.
   • Manage your health.

7. Report concerns about safety
   • Report concerns.
   • Follow up concerns.

8. Be open when things go wrong
   • Openness with service users and carers.
   • Deal with concerns and complaints.

9. Be honest and trustworthy
   • Personal and professional behaviour, including ensuring your conduct justifies trust and confidence in you and your profession.
   • Important information about your conduct and competence, including issues such as police cautions or disciplinary action which must be declared to the regulator.

10. Keep records of your work
    • Keep accurate records.
    • Keep records secure.

While the HCPC do not register students, they do provide additional Guidance on Conduct and Ethics for Students (2016), which students will need to work within and which provides further details about how the standards outlined above apply to students. Breaches of either of these codes by students are likely to lead to action from your university in line with their Fitness to Practice procedures and are likely to lead to termination of your studies.
How are you going to be guided by values and ethics?

Activity 1.1

Look at your Code of Practice, the basics of which are set out above. Taking all the aspects, reorder them to fit into the framework proposed earlier:

- ones that avoid possible harm to service users;
- ones that promote possible good to service users;
- ones that protect the profession and resolve conflicts.

What is the balance between these? To what extent are these about risk management?

Values in action

Implicit in the *Code of Professional Social Work Practice* is the importance of recognising and respecting diversity. This is more than valuing people irrespective of their gender, skin colour or ability. It also involves valuing and respecting that people think and behave differently. People of all ethnic backgrounds and countries experience mental disorder and the service user population is made up of people just like you and me.

Conventionally and stereotypically, medical practice has remained the dominant partner through its claim to be a series of technical activities that can be evidenced by rigorous research. Advances in medication have reinforced the idea that an individual’s mental disorder can be managed, and that the key process is diagnosis followed by treatment monitoring and evaluation. In this process the danger is that the treated are subservient to those in charge of treatment.

Social workers need to work with medical and health colleagues to provide an effective service, but they also need to be at the forefront of processes that empower service users. Implicit in this approach are some ordinary but powerful principles.

The first is that in order to empower someone, we need to work with them rather than do things to them. Empowerment means partnership, openness and honesty.

The second principle is that the service user has an explanation of their disorder. That needs understanding and to achieve this we need to find ways of active listening that respect the user and enable us to do our job. This may mean having to use imaginative ways of communicating. It might mean trying to use a common language, which could be sign
language, or working meaningfully with interpreters. It should mean engaging in clear, uncomplicated language that everyone can understand.

The third principle is that service users value being able to engage with professionals on a personal level. This could mean that social workers should learn to use ‘limited’ self-disclosure to help build up professional relationships that are also person-to-person, not expert-to-amateur (Blackburn and Golightley, 2004). Being able to walk in the other person’s shoes is an important part of an empowering approach.

The fourth principle is that the service user is the expert in their own mental health problem. They may not know the answers but they certainly experience the effect or symptoms. They alone have experienced the disintegration of ‘normality’ as they know it, and their explanation should be put alongside the professional view and the two views evaluated against each other. If your world is upside down or inside out, it cannot be understood by people who only see things one way up or right side out. If a service user is hearing voices, the social worker must not dismiss these but try to understand when they arrive, what they feel like and how best they can be managed. It is also important not to go too far the other way, as losing objectivity, ‘colluding’ with unhelpful beliefs and possibly running the risk of missing dangerous behaviour will not help to provide the service user with what they want either.

By working with service users to value their experiences, and by seeing the problem through their eyes, the prospect is opened up to work in a manner that is holistic and empowering.

The significance of social work perspectives and values

In a very interesting publication by SCIE (research briefing, 26 July 2008) research has been drawn together to show the value that service users place on non-stigmatising help and access to services that are provided by social workers. They write as follows.

Similarly, analysis of the ‘essential capabilities’ required to practise in mental health also emphasises the importance of a professional value base which promotes dignity, human worth and social justice … indeed, research exploring community care practices found that social workers frequently identified empowerment as a fundamental principle in their practice, both as a goal and as an underpinning value.

(SCIE research briefing, no. 26, 2008, p4)

This is such a clear statement that sums up a perspective that is unique to social work and when put alongside an understanding of the impact of social exclusion, and social injustice and oppression, puts social workers in a good position to be able to work positively with people who are susceptible to discriminatory practices, including lesbian, gay and transgender, and black and minority ethnic communities.
Ethical dilemmas

Health and social care workers face dilemmas on a daily basis. There are usually two components that help us to think about ethical dilemmas. First, there may be competing views about what should be done. How would you respond to a service user when they want to stop taking their medicine? This is an ethical dilemma and people would argue strongly for one position or the other. This contrasts with a view that medicine should be given with or without service user consent, if it were necessary to prevent death or serious harm occurring. In this instance, this is not an ethical issue as there is widespread agreement (so long as it is possible to agree a definition of exactly what is ‘necessary to prevent death or serious harm occurring’ means, as well as agreeing that the proposed intervention will achieve this: nothing is ever simple). Even so, some people claim this should not happen, usually on religious grounds.

The second characteristic is that it must have a distinct moral component to it, such as the avoidance of lying, the primacy of life, self-determination and confidentiality. These characteristics are sometimes referred to as ‘normative principles’.

Resolving ethical dilemmas takes more than just referring to these normative principles or the various codes of conduct. It requires professional judgements after weighing up one principle against another. The following activity will help you to think further about the ethical dilemmas.

Activity 1.2

Sanjay is a long-term service user who has recurring bouts of depression, which are serious enough to warrant his treatment with anti-depressants. In the past when his mood has been very low, he has talked about ‘ending it all’. As his social worker, you visit regularly and he tells you in confidence that he has stopped his medication and is going to experiment with herbal medicine, which is more usual in his culture. He has asked your opinion about this action and told you to keep this conversation confidential. Should you respect his wishes? Jot down what your response would be and what the issues are. Now compare with the following paragraphs.

Comment

If anyone wants to stop taking medication, this is their right under common law. In certain circumstances, and provided that they are detained under the Mental Health Act 1983, they can be made to have treatment against their wishes. Sanjay can stop his medication, although whether this is a good thing is open to debate.

(Continued)
Arguments against keeping confidences or keeping matters confidential derive from
different sources. First, there is a principle of paternalism usually derived from the
possession of ‘expert’ knowledge. Put crudely, the professional knows best. Second,
there is a principle of autonomy where the person has freedom over their own body,
which is essentially a moral principle. Individuals are experts in their own mental
health condition and as such they know best. Resolution of this requires you to
balance the strength of one principle against the other. In practice, you would
probably seek to encourage Sanjay to sit with the others involved in his treatment
and to talk through his and your concerns, and try to get to a position where his
shift to herbal remedies is informed by evidence, monitored and reviewed.

You would need to take into account the extent to which the service user has the
capacity to be able to make such a decision, the quality of the information on
which this is based, if there was any coercion on the service user when making this
decision (from either side) and any legal issues that could change the nature of the
discussion.

One way that service users can be helped to make good quality decisions is
through patient advocacy services. By using advocates who are independent of
the mental health team, but who have specific knowledge of mental health and
mental health services, the quality of service user decisions can be enhanced.

Ethnicity and mental health

The discrimination that is experienced by people with mental health problems can be
intensified if that person happens to be from a black or minority ethnic community. A service
user talks about her experience of using mental health services as a black person.

Coming to mental health services was like the last straw … you come to services
disempowered already, they strip you of your dignity … you become the dregs of society.

(Keating and Robertson, 2002, p18)

This is a commonly held experience of black service users. When put together with the
perception that when black people are seen as difficult they are likely to be over-medicated,
there is little wonder that this has become a priority area.

Research since the 1970s has highlighted the overrepresentation of black people within
mental health services, yet despite all the information gathered on this, very little
has been done to change this situation or to fully understand what is causing it. This overrepresentation is not just about who becomes mentally ill in this society, but also about how they are treated in the system: black people are around twice as likely to be diagnosed with conditions such as schizophrenia (e.g. Bhugra et al., 1997), yet they are around six times more likely to be sectioned (Audini and Lelliott, 2002). This means that even if the prevalence of mental illness was the same for all groups, these groups would still be treated differently by the system. There is a range of important social factors influencing this situation that social workers need to be very aware of, that are often described under the label of ‘pathways into care’, indicating that the journey from coping in society to being a patient on a psychiatric ward can be very different for people with different skin colours. One of the major differences in this journey that research has highlighted is that it is a much longer journey for black people: black people are twice as likely to live on their own (Burnett et al., 1999), have greater distrust of services (Sandamas and Hogman, 2000), and are more likely to be perceived as dangerous (e.g. Nacro, 2007), meaning that by the time they are seen in mental health services, they are likely to be at a more advanced stage of their condition – a factor that will reinforce various stereotypes. The research shows that GPs are much more likely to be involved in a white person’s admission to hospital (e.g. Mann et al., 2014), while police are much more likely to be involved in the admission of a black person (e.g. Morgan et al., 2005), again likely to be a factor of the different ‘pathways into care’.

Discrimination has been a source of concern to many practitioners over the years. Evidence has suggested that on one hand the UK’s black and minority ethnic population are overrepresented in secondary care (hospital admissions, etc.) while on the other hand underrepresented in primary care that specifically addresses the needs of black and minority ethnic communities. Of particular concern has been the overrepresentation of African-Caribbean people who have been detained against their will and who are being treated in Medium Secure Hospitals (MSUs). Evidence collected by the Mental Health Act Commission shows that 30 per cent of the population resident in MSUs were from predominantly African-Caribbean ethnic groups, which is well over the proportion that might be expected when compared with the population at large. African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups, but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia (Mental Health Foundation).

Fundamental to developing better social work practice is having better quality of information and using it more intelligently than is evident at present. A starting point is for you to become familiar with population data and information about ethnic minorities.
Activity 1.3

The proportion of black and minority ethnic groups in the UK rose from 6 per cent to 9 per cent over the period 1991–2001. The African-Caribbean population in England and Wales is about 2 per cent. This does vary considerably depending on where you live and work. Commonly, members of the public at large overestimate the numbers of black and minority ethnic populations – for example, an Ipsos MORI poll reported in *The Guardian* on 14 December 2016 demonstrated that people in the UK estimated the Muslim population of the country at 15 per cent when it is in fact 4.8 per cent. This phenomenon was worse in France, where people estimated the proportion of Muslim residents as 31 per cent compared to the reality of 8 per cent. Write down why you think some groups are thought to be larger than they actually are, what influences this perception and some of the implications of this.

Comment

You probably came up with the idea that the media plays a big role here with some of the less sophisticated newspapers in particular promoting the idea that we are being overpopulated with asylum seekers, drug users and the like. Mental health is not the only area where we see statistics that ought to concern us: we are surely all aware of some of the irresponsible headlines seen in the tabloid press recently – for example, regarding the Syrian refugee crisis or the EU referendum.

Providing mental health services that are, and need to be seen to be, responsive to the needs of individuals requires that they should reflect the rich diversity that makes up our society. However, in the late 1980s it became apparent that although moves were being made to promote patient-centred services, this did nothing to address the specific needs of the black and minority ethnic communities.

Although these views were commonly held throughout health and social care, social work was one of the few professions that placed special emphasis on training in anti-racist and anti-discriminatory practice. At the policy level, the government’s *Modernisation Plan* and the *National Service Framework for Mental Health* (1999) set out in Standard One the need to combat discrimination against individuals and groups with mental health problems and promote their social inclusion. This has built on the legal foundation laid down in the Human Rights Act 1998, the introduction of the Race Relations (Amendment) Act 2000 and the Equality Act 2010.
More recently, the Department of Health embarked on an impressive and ambitious change agenda called *Delivering Race Equality: A Framework for Action* (October 2003). This programme formally came to a conclusion in March 2010. It is disappointing that it was stopped while much remains to be done. However, there are valuable lessons that we have learnt and Luis Appleby wrote in the Foreword to the evaluation of the programme:

> DRE’s work has informed New Horizons: towards a shared vision for mental health, our new vision for mental health in England, which builds on the 1999 National Service Framework for Mental Health (NSF). New Horizons and its associated equality impact assessment described the evidence for the – often very serious – inequalities in mental health among some ethnic groups. The roots of these inequalities lay in social, not biological, factors so the responsibility for remedial action extends to all the agencies that influence public mental health and well-being.

*(DoH, 2009)*

The present approach falls out of the Health and Social Care Act 2012 where the concentration now comes under the umbrella term ‘reducing inequalities in health’ and further information is provided through some helpful ‘fact sheets’. This particular one is Factsheet C2 which provides details regarding health inequalities and the Health and Social Care Act 2012. It is part of a wide range of factsheets on the Act, all available at: www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets

It is very worrying that today little is being done to replace the equality initiatives described above. Similar concerns were expressed by Suman Fernando who was one of the first authors to explore the links between ethnicity and mental health.

> “They have walked away from it completely,” he says of the coalition’s attitude to addressing racial disparities in mental health diagnosis and treatment. “You can’t mention equalities {within the Department of Health}. There is a sense that race is off the agenda. It’s the idea of “post-race”. That is what they are saying, {But} that’s not the case, and it’s very worrying.”

*(O’Hara, 2012)*

The current government has done little to address Fernando’s fears, and the DRE project remains unreplaced. While it is rather a crude measure, the 2011 strategy, *No Health without Mental Health* used the word ‘black’ 6 times and the word ‘inequality’ 15 times in its 103 pages; the new *Five Year Forward View* implementation strategy, at 50 pages long, only uses each of those words once, perhaps showing the extent to which this issue has dropped off the government’s agenda.
What does this mean for mental health social work practice?

James Nazroo (1999) suggests that different rates of diagnosis of mental illness between black and minority ethnic people represent one of the most controversial issues that present-day services face. In practical terms you need to examine the reasons why minority groups such as African-Caribbean men are six times more likely to be compulsorily detained than white people, why Asian women are more likely to be depressed than their white counterparts, and why minority ethnic groups are less likely to seek early help from primary care.

Mental health is a significant area of social work practice, which will bring you face to face with people who may be vulnerable and confused. As a social worker, you need to work together with other professionals in a way that is person-centered and upholds human rights. This is far from straightforward, with tension and conflict possible at virtually every stage of your work. Such tension can exist between, for example:

- the wishes of the service user and their families;
- the need to protect the public and the need to promote service user independence;
- and, as you saw earlier, the right to refuse treatment and the need to have treatment.

In trying to work with these tensions you will often find yourself playing a crucial role in any decision-making context.

Anti-oppressive practice

Social work has a history of attempts to practise in ways that are anti-oppressive. One of the key figures in the literature is Lena Dominelli whose original book *Anti-Racist Social Work* (1988) not only provides well-argued discussion about these issues, but also gives strategies for the implementation of anti-racist social work. These ideas, although almost three decades old, still have relevance for you as a practitioner as mental health care is the only aspect of care provision and treatment that, if refused, can result in that person’s compulsory admission to hospital through a legally authorised pathway. Indeed, recent research suggests that service users value the non-stigmatising help and access to services that social workers provide, and that these are entirely in line with the core values of social work. There is widespread agreement that if intervention is to be effective, these must be underpinned by social perspectives that help our understanding of the social origins of mental disorder and the role that discrimination plays (SCIE, research briefing no. 26, 2008). Social workers, after suitable post-qualifying training, can be a major part of such procedures and can also be involved in other aspects such as providing advocacy, reports for tribunals, arranging diversion into community resources, etc.
Activity 1.4

Think of a situation where, in practical terms, you will have to take culture into account when working with someone from a black or minority ethnic background.

Comment

There will be lots of examples that you could give and one is when compiling a Social Circumstances Report for a Mental Health Tribunal. Tribunals take place when someone has been detained in a psychiatric facility and wishes to appeal against this detention. The tribunals consider various reports, including ones compiled by social workers. These are formal reports that are presented to the tribunal and they are a part of the mechanism by which compulsorily detained patients can be discharged from hospital. These reports provide the tribunal with the cultural background of the service user and describe past patterns of behaviour that can help to determine the likely success of aftercare, together with other salient details such as accommodation and employment opportunities.

The Mental Health Act Code of Practice sets out as a guiding principle that all people should be respected for their diverse backgrounds as individuals and includes the following statements.

People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation, and culture. There must be no unlawful discrimination.

(DoH, 2015a, p24)

Non-discrimination and equality – working to eliminate discrimination by embedding equality through systems, processes and outputs. All forms of discrimination in the realisation of rights must be prohibited, prevented and eliminated. It also requires the prioritisation of those in the most marginalised situations who face the biggest barriers to realising their rights.

(DoH, 2015a, p30)

NHS commissioners must, in the exercise of their functions, have due regard to the need to reduce health inequalities between patients with respect to (i) their ability to access health services and (ii) the outcomes achieved for them by the provision of health services.

(DoH, 2015a, p32)
These points clearly acknowledge how important understanding the different needs of different people is within mental health care, and how such needs are shaped by the dynamics in society relating to identities such as gender or ethnicity.

Are black and minority ethnic people the only community who get poorer services than the majority population? The answer is a qualified no. Other groups include older people, children and adolescents, women and people who are deaf. All these groups are covered in this book, but working with mental health users who are deaf raises some interesting parallels with working with black and minority ethnic users, as well as some challenges for you to face in your practice.

**Gender and mental health**

The issues discussed around ethnicity above show how the way society defines the identity of a group of people profoundly affects the way that group is able to operate in society, with a consequent effect on their experiences of social deprivation and mental illness. These same dynamics have an equally important effect on gender and mental health, in that it is clear that social expectations around gender norms and roles fundamentally influence people’s experience of mental distress. To take a simple example, imagine a reality TV programme involving contestants leaving after performing badly, such as *Big Brother* or *The Great British Bake Off*. I am sure you have seen contestants interviewed after leaving these programmes: female contestants are invariably in floods of tears while male contestants stoically reflect on their performance – it is rare to see a male contestant cry, and it is interesting to reflect on how they would be perceived by the public and in the media if they did. Such differences in what is seen as acceptable behaviour for men and women are very prevalent and fixed in our society, and hugely influential in where the line between ‘sane’ and ‘insane’ is drawn for each gender.

As Elaine Showalter points out in her excellent book *The Female Malady* from 1987, *Women, within our dualistic systems of language and representation, are typically situated on the side of irrationality, silence, nature, and body, while men are situated on the side of reason, discourse, culture, and mind*. If you find some of this argument challenging, consider the roles defined for men and women in films, in the media and in everyday interaction, and ask yourself how these roles are defined by concepts such as ‘sensitivity’, ‘emotionality’, ‘logic’ or ‘strength’. There is much written about the sociology of gender, looking at what influences our perceptions of ‘masculinity’ and ‘femininity’, or, in other words, the set of behaviours seen as socially acceptable for men and for women. We know as little about the extent to which gender is biologically or socially constructed as we do about whether madness is biologically or socially constructed, but what unites the two is the idea of social norms: ultimately madness is about existing outside of these socially desired norms, and if these norms are in different places for females and males, then it should be no surprise that women and men will experience mental illness differently. If we consider that 1 in 4 women and 1 in 10 men will receive a diagnosis of depression, then we can start to understand the effects of this gender dynamic on people’s lives.
Deaf people and mental health

Case study

There are limited specialist services available for deaf people who have severe mental illness. This was highlighted by the Independent Inquiry into the care and treatment of Daniel Joseph (Mischon, 2000), which was commissioned by some of the London Health Authorities. Daniel was profoundly deaf and was admitted to hospital from the courts having been made subject to a hospital order with restrictions after pleading guilty to manslaughter with diminished responsibility. Concern over his treatment resulted in successive governments consulting about services across the spectrum for service users who are deaf.

People who are deaf, like black and minority ethnic people, report that mental health services are difficult to access and often do not cater for their specific needs. To raise our awareness of the specific needs of minority communities, the Department of Health consultation paper A Sign of the Times: Modernising mental health services for people who are deaf (DoH, 2002a), though now rather old, is worth consulting. Developing awareness of specific communities is an important but only a first step towards developing appropriate and responsive services.

According to statistics compiled by the British Deaf Association (2016), there are 151,000 non-professional users of British Sign Language, 87,000 of whom are deaf, although Action on Hearing Loss (formerly RNID) estimates that 1 in 6 people, or 11 million, have hearing loss, including deafness and tinnitus (Action on Hearing Loss, 2016). Research indicates that mental health problems are significantly higher for deaf people, particularly for children who have twice the rates of emotional and behavioural problems, and that difficulties accessing services and information are common (Fellinger et al., 2012).

Members of the deaf community experience mental health problems just like people from any other community. However, because of the difference in language and culture between those who are assessing deaf service users and the service users themselves, misdiagnosis can result, and as a consequence deaf people can receive services and treatment that are inappropriate. Good practice needs to take into consideration the requirements of the Equality Act 2010 which makes it clear that mental health services have to take reasonable steps to facilitate the uptake of services by people who are deaf and who have mental health problems (sometimes referred to as people with dual diagnosis). This includes the use of an interpreter at the various stages of assessment and provision of services (Fellinger et al., 2012).

Culture is a central feature of a person’s identity and that at the very least must be taken into consideration when working with service users from black and minority ethnic communities or when working with service users who are deaf.
Does the relative social exclusion that deaf people experience contribute to their mental health problems? This is reported as being a factor in the relationship between the psychological health of deaf people and their subsequent call upon mental health services. In other words, being deaf might increase your vulnerability to mental health problems (Ridgeway, 1997). In Chapter 2, explanations are given of the cause and manifestation of mental health problems and in particular the role that stress plays in mental health.

Until recently, mental health services seemed to be based around the assumptions that users were all from a hearing population that is predominantly white British. Both of these assumptions are well off the mark, and need to be challenged and changed. To meet the NSF Standard One, services need to be provided that are sensitised to the needs of different people. In reality, the respect for the person’s cultural identity is the predominant value that ought to underpin your practice.

The Case Study below shows how services can respond in an ideal way. However, having a person who can effectively communicate in the same language as the service user is often a matter of luck and there is a need for more services of this nature. A deaf person who communicates through sign language is likely to find that being in an environment where fluent signers are is more conducive to their recovery than being in a hearing world. Of course, once the specialist worker leaves the prison, Shaz is left still having to cope with the traumas of prison, which is essentially a hearing world. This still leaves you having to explore with Shaz and the interpreter what specific needs she might have in respect to her deafness.

Case study

Shaz is a deaf person who lives alone and, at the age of 32, has very few connections with the deaf community. She is a fluent user of British Sign Language but since her remand to prison on theft charges her health has suffered. Over the last ten years or so she has been treated for depression and has taken anti-depressants. The stress of being in prison has caused her more distress to the extent that she would like to see a social worker. However, the prison service does not have a person who can sign and therefore they must seek outside specialist support. By chance, the local community mental health team has a member of staff who can sign, and she accompanies the social worker to the prison and carries out an assessment with the prison doctor.

Learning disability and mental health

People who have a learning disability can experience a range of mental health problems just like the rest of us. However, the presence of learning disability may prevent professionals and carers recognising the symptoms of mental health problems such as depression. It is important for carers and professionals to look beyond stereotypes and seek explanations for behaviour that has typically changed. Finding out what is wrong will call for quality communication and
observation skills, and working in a partnership with carers and service users. There are some informative guides published by the Royal College of Psychiatrists and the likes of MENCAP, most of which you can download from their websites.

There are few research and evaluation studies in the field of learning disability and mental health – ‘dual diagnosis’ is the technical term often used. This tends to maintain this important area as low priority yet government policy expounded in the White Paper *Valuing People* urges people with learning difficulties to use mainstream NHS services (DoH, 2001a). This, of course, includes mental health services.

The coexistence of mental health problems alongside learning disability may be one of the explanations of the existence of challenging behaviour. Such behaviour may not be a characteristic of learning disability but may be as a result of mental health problems. This is a theme picked up in an article in the *British Journal of Psychiatry*, which showed that there was *some evidence for a statistical association between challenging behaviour and psychiatric disorder* (Moss et al., 2000, p454). It concluded that depression was four times more prevalent in people with learning disability who exhibited challenging behaviour than for people with learning disability itself. This finding, although needing to be treated with some caution, is important as depression is so often overlooked in people with learning disability.

Working with service users who have this form of dual diagnosis often will mean mobilising community resources to provide support and connection with others in the community. This idea of connectedness is described by Peter Gilbert: *Mental distress and mental illness is so often about a disconnection, false connections or an over concentration on one aspect of our lives* (2003, p22). Like any other service user, you as a social worker will want to access the whole person and how they draw support or otherwise from their families, carers and the community. Facilitating better connections within the community may be the most appropriate intervention that you can make.

The National Institute for Health and Care Excellence (NICE) published guidelines in September 2016 entitled ‘Mental health problems in people with learning disabilities: prevention, assessment and management’ which are available on their website. These guidelines promote involving people in discussions and decisions about their care, increased training and supervision for staff, better support for families and carers, and the provision of an annual health check, as well as providing guidance on psychological, pharmacological and occupational interventions.

**Culturally competent practice: transforming social work**

Cultural competence is a bringing together of some of the big ideas covered in this chapter. It is a combination of:
Social Work and Mental Health

- awareness;
- knowledge of anti-oppressive practice;
- values-based practice;
- interpersonal skills that will provide you with the basic building blocks of a practice that is appropriate; and sensitivity to working with service users who may not always be from your own culture.

A culturally competent service can be defined as one that is perceived by minority ethnic users as being appropriate to their cultural and religious beliefs, and responsive to their needs.

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Case study

Christopher Clunis – inadequate care and treatment?

Christopher Clunis was a young African-Caribbean man who had a history of severe mental illness. He had been diagnosed as having paranoid schizophrenia when he lived in Jamaica. In December 1992 he attacked and killed Jonathan Zito who was completely unknown to him.

The subsequent Inquiry has been widely reported and some of the findings reveal the perils of professional practice that is not culturally relevant.

The Inquiry team concluded that:

*The added factor of his blackness may have contributed to the diffident manner in which some professionals treated him and it may have caused them to defer against his best interests, to his own expressed wishes.*

(Ritchie et al., 1994, p4)

and

*Young black males should not be type-cast as suffering from schizophrenia unless the clinical indications warrant it and clinicians and others who care for black mentally ill people should not be too ready to ascribe odd behaviour to the abuse of drugs.*

(Ritchie et al., 1994, p129)

This case study shows the extent to which stereotypical views can permeate professional practice and it highlights the dangers of seeing people only by the colour of their skin. Looking beyond this in a critical manner is the hallmark of good practice. At this point it is appropriate to examine the ways in which our practice can be transformed.

It should be clear that services need to become more relevant to the needs of black and minority ethnic groups and other minority groups such as people who are deaf. Service users
frequently point out that the services that they are receiving show little understanding of their culture. But changing this is not a simple matter. You also need to recognise that this is a sensitive issue influenced by your own ethnicity and skin colour. Social workers who are skilled in anti-oppressive practice and using a values-based practice approach are clearly further on than those who are not, but there is no room for complacency as many of the explanations of service variability show that racism permeates organisations.

It is questionable whether we can be competent in cultures that are not our own and, in any case, the range of diverse cultures in the UK makes competence in all cultures an unrealistic proposition. An alternative to understanding different cultures is to recruit more social workers and other professionals from these minority communities to ensure cultural congruence or, in other words, proportionate representation of professionals from all groups. However, this can only be a limited strategy, for although positive action strategies when recruiting staff and adopting equal opportunities interview methods are vitally important, they are in themselves insufficient.

But what if you are a black social worker working with white service users or the other way around? What kind of approach can you adopt? To what extent do your stereotypes distort your assessment and decision-making processes? The National Institute for Mental Health England (NIMHE) has recommended that all staff working in this area receive compulsory training in cultural awareness to help eradicate racism and discrimination. Although there are many such courses around, quite a few of these promote awareness rather than competency. Awareness is just one stage in developing culturally competent practice.

Components of culturally competent practice

The idea of being able to work with a diverse range of cultures is not entirely new but has gained momentum and acceptance of late. Walker (2003a) uses the idea of cultural competence building on the work of Kim (1995), while Patel et al. in Engaging and Changing (2003) refer to practice as being culturally sensitive, whereas Fulford (2004b), describes value based practice. Some of the common themes are blended together into five components of culturally competent practice and each of these is explored below.

Capacity for your own cultural awareness

This should start with an honest understanding of your own culture and the impact this has on your professional practice. You need to be aware of your own attitudes, values and beliefs before you can be aware of the attitudes and beliefs of others.

Capacity for awareness of other cultures

It is a widely held view that self-awareness is one of the core components of a practice that is culturally competent (O’Hagan, 2001; Poole, 1998, etc.) but after that it is necessary
for you to develop your own capacity for understanding the other cultures and putting this understanding into practice. This requires you to make a realistic assessment of your knowledge and understanding of working with people and of their cultures.

**Understanding of diversity and difference**

Community engagement is currently being promoted as the main way that professionals can increase their understanding of specific needs of communities. Social workers should respect diversity and build upon people’s strengths and the collective strengths of the communities. Effective work with and across cultures requires that you understand and value difference both at the individual and at the community level. This also means recognising and accepting your own personal and professional limitations.

**Transferring skills from one service user culture to another**

At the heart of much of professional practice is the idea that skills that are learned from work with one type of problem can be transferred to another. This means that the skills you have in assessing white people who have depression can also be used when working with Asian people who have depression. But, as we have seen earlier, effective assessment requires you to understand the context in which the person is living. However, social work skills such as empowering practice are key components of this transforming practice.

**Being able to recognise the impact of structural racism and discrimination**

Both the Health and Social Care Act 2012 and the Care Act 2014 have at their centre the well-being of the individual and dictate a clear duty that local authorities must promote the individual’s well-being in all decisions made with and about them. ‘Well-being’ is described in terms of the most important outcomes for people who use care and support for carers. This means that all providers of mental health services, including GPs and primary care workers, will be involved in some way or other in helping to deliver a service that is culturally appropriate and responsive to all groups in society.

**Is it possible to achieve cultural competence?**

The action plan called Delivering Race Equality in Mental Health Care was the main driver behind the attempt to achieve a culturally more responsive and capable workforce. An interesting article in *The Guardian* should give cause for some healthy scepticism, a small extract of which follows.

*Joanna Bennett, who leads research on workforce development at the Sainsbury Centre for Mental Health, has completed a review of race-related training and thinks that the picture is of ‘a lot of fragmentation, different approaches and different models’.*
She says: ‘There is no agreed definition of cultural competence and no evidence that it works in producing better services for black and minority ethnic users. We should be looking at structural processes and power relationships in the way services are delivered.’

Bennett, a psychiatric nurse and former lecturer in mental health at Middlesex University, is the sister of David (Rocky) Bennett, who died while in the care of mental health services. In evidence to the inquiry into his death, she warned against services focusing on ‘cultural matching’ in favour of staff spending more time talking to patients and their families. Taking time to respect an individual, and ask what was troubling him and what he needed, was likely to be more effective than talking about culture, ethnicity and cultural competence (The Guardian, Wednesday, 12 April 2006).

The significance of the above is that following the inquiry into the death of Bennett, who had schizophrenia and who died during a restraint procedure at a medium secure unit, training for cultural competence was one of the high-priority training recommendations. This followed the discovery during the inquiry that very little attempt had been made to understand let alone relate to the racial and cultural needs of David Bennett.

Achieving cultural competence may well require more than individuals alone can achieve although, as Joanna Bennett points out, getting the basis right will go a long way towards providing a more user-focused service.

Promoting your own mental health

As you go through your course you are likely to be living a multitude of roles and having to meet numerous deadlines and expectations. These could include working to supplement your bursary or grant; balancing family life with college demands; worrying about passing assignments, and much more. Stress plays a big part in our own mental health and concern has risen in recent years over the increase in reported mental health problems for students in colleges and universities. In my experience, social work students are no different from the majority of students studying on a variety of courses.

Students come to study at UK universities from all over the world and, as a consequence, the student community is as diverse as if not more so than the community at large. While many students can draw upon a range of personal resources, some are a long way from the support systems that have previously nurtured them. There are cultural differences, which also may mean that they are unwilling to talk about personal issues with comparative strangers. It could also be that those who could offer help and may be concerned do not recognise the signs or mistakenly interpret these signs as cultural differences.

It might be that you recognise some of these elements in yourself and that you are reluctant to seek help, partly because of the possible impact on your studies. If this is becoming a serious problem, you should seek help as social work is a stressful career and you need early on to develop strategies that will enhance your own mental health for dealing with such stresses.
It is unlawful for universities to treat students with mental health problems or physical difficulties that have a substantial, adverse and long-term (more than 12 months) effect on the student’s ability to carry out normal day-to-day activity, less favourably by excluding them temporarily or permanently if this is due to their actual mental health. Consequently, a university should not exclude a student if their disruptive behaviour is primarily caused by mental health that falls into the realm of the Equality Act 2010.

**Stress-busting tip**

**The boxes technique**

Think of a problem that you are currently dealing with (or have been recently) that has been causing you some concern, and how your mind goes over and over the problem. If that happens to you, it can become stressful and unproductive. It can also prevent you from getting on with other things as your mind is focused on seemingly difficult problems. In time, if this continues it can produce stress and perhaps sleepless nights. The following is one technique for controlling and organising these problems that has been tried and tested by many students over the years.

1. Close your eyes and imagine that your mind is divided into a series of boxes and that each box has a lid.
2. Take each problem and place it into its own box.
3. Firmly place a lid on each box.
4. You now have your problems under control.
5. Only allow yourself to remove one lid at a time.
6. You can now focus all your attention on your released problem.
7. You may feel that some of the lids on the other boxes starting to rise; if so, be firm and replace them, telling yourself that you will focus on them at a later time. Persistent lid risers need a heavy weight to be placed on them.
8. This technique really does work better with practice and students report that it is a good stress buster.

**Research summary**

The Mental Health Foundation commissioned research to overview current research and mental health initiatives related to student mental health. Among the findings was that clinical depression was reported in 12 per cent of male students and 15 per cent of females. This is an increase over the last time such estimates were made in 1987.
Student counsellors also reported an increase in the proportion of students with severe mental health problems or disorder. At the extreme end, suicide among students has risen from 2.4 per 100,000 to 9.7. This is over the ten-year period 1983–1993/4.

(Fox et al., 2001)

Chapter summary

We have seen the impact that values and ethics have on mental health social work. These values are set down by the professional bodies and, in the case of social work, by the Health and Care Professions Council.

Transforming social work in the twenty-first century requires workers to be able to recognise their own prejudices and biases and to move beyond these to develop a practice that is culturally competent, demonstrated by the worker’s awareness of the service user’s culture, including religion and traits. It also means looking after your own mental health and recognising that we all are susceptible to various mental health problems.

Transforming practice means also engaging in more than the rhetoric of anti-oppressive practice and value-based practice. It means demonstrating that these major ideas have influenced everyday mental health work. This means seeing the person not just as the mental health problem that they exhibit and not being influenced by stereotypes. Listening to what users have to say about their experiences is an important part of this process.

Further reading


Gives specific practice guidelines when working with service users who are detained in psychiatric hospitals or units. It covers a range of activities including medication, other forms of treatment, control and restraint and what constitutes an emergency. This is essential reading for those who intend to practise in a mental health setting. NHS Trusts are advised to ensure that all staff undertake training in the meaning of The Code.


A consultation document that set out the nine building blocks of improved practice for mental health services.
Websites

The Collaborating Centre for Values-Based Practice in Health and Social Care provides a hub for a variety of organisations and individuals developing more values-based approaches to working in mental health (as well as other areas). Their website contains some useful ideas and resources and can be accessed at http://valuesbasedpractice.org/

GOV.UK Mental health service reform lists recent government initiatives and is available at: www.gov.uk/government/policies/mental-health-service-reform

The Internet Encyclopedia of Philosophy has several pages concerned with the field of ethics and is a good place to visit for more information about ‘normative principles in applied ethics’.

The King’s Fund is an independent think tank analysing health and social care policy. Their website is: www.kingsfund.org.uk/

The Mental Health Foundation provides information on different ethnic minority groups and their mental health.

NHS England: documents relating to the Mental Health Taskforce and the Five Year Forward View can be found at: www.england.nhs.uk/mentalhealth/taskforce/

RNID: fact sheet Introducing British Sign Language can be downloaded free from www.ucl.ac.uk/library

www.gov.uk/guidance/equality-act-2010-guidance provides easy access to the Equality Act 2010 with many examples of mental impairment.