WORKING IN MENTAL HEALTH WITH PEOPLE FROM BLACK, ASIAN AND MINORITY ETHNIC GROUPS

A practice guide for social workers and other professionals

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Working with Adults from Black, Asian and Minority Ethnic Backgrounds Who Have Mental Health Problems

Key points

- As a term 'Black, Asian and Minority Ethnic' (BAME) is interpreted differently by different people. For example, some people use the term to include white minorities such as eastern Europeans and some do not. In this text, BAME is used to include white minorities.
- BAME is a massively heterogeneous term, covering groups as culturally diverse as Japanese, Ugandans, black Jamaicans and Saudis to name a tiny fraction of the possibilities.
- Immigrants and so-called second and third generation immigrants (bearing in mind that people born in the UK are not actually 'immigrants') are included in the BAME category despite their obvious differences.
- BAME is a term that is often used interchangeably with race and it includes the concepts of both race and ethnicity.
- Race as a concept is considered to relate to biological differences between human groups while ethnicity as a concept is used additionally to include aspects such as geographical roots, language, religion and culture.
- Despite widespread use of the concept of race, its scientific foundations are extremely weak as a reliable way of categorising humans (Fernando 2017).
- The main value of the terminology of race and ethnicity is to maintain a sense of 'the other', i.e. groups other than white people, which allows a range of associations to be made, e.g. between particular ethnicities and attributes.
- In mental health, for example, it is likely that black people more than white people will be considered (consciously or unconsciously) as posing a higher risk of violence (Prins 2010).
- Because racial identity was imposed on non-white 'others' the term 'racialised minorities' will be used here, this being the main commonality in the otherwise heterogeneous grouping, BAME.
- Remember that racism is still pervasive in our society and that trauma and a sense of injustice are unavoidable issues in the care and support of BAME people with mental health problems.
- BAME people tend to be over-represented in more restrictive mental health services and under-represented in more therapeutic services.
- Practitioners should beware of unconscious biases and stereotypes and be able to reflect on these, e.g. in supervision.
- Skills to engage in conversations about difference are essential, as is the ability to listen knowledgeably and sensitively to what service users are saying and to avoid narrow interpretations of behaviour.
- Never assume that BAME people are avoidant when it comes to talking therapies, and focus wherever possible on planning for recovery.

Ethnic inequalities in mental health

'BAME' is a heterogeneous category covering a broad range of ethnicities, meaning that there are variations in data within it. For example, there is an over-representation of black African and black Caribbean people in psychiatric intensive care settings but the same is not true for people of Chinese origin. Therefore, sentences beginning 'BAME people are…' are often too imprecise.

It is important to be aware of factors that are linked to poorer mental health which some BAME groups face, and ethnic variations within mental health services.

Experience of factors that are antecedents of poor mental health (e.g. social and economic factors)

Examples include African, Caribbean, Bangladeshi, black African, Irish, Pakistani, Roma, Gypsies and Travellers. For example, on average, these groups have poorer housing, lower levels of eduction, higher

raters of unemployment and higher rates of poverty. This is well documented by the Equality and Human Rights Commission in biennial reports, most recently in *Is Britain Fairer? The State of Equality and Human Rights 2018* (EHRC 2018). The main report includes a lot of data and even more is contained in appendices. Examples of 2015/2016 data include:

Education attainment at school leaving age: White British pupils 63.9%; Pakistani 60.1%; black pupils 59.8%; Bangladeshi children 69.8% and Gypsy, Roma and Traveller pupils 11.8%.

Employment rates: White British rate 59.1%; Bangladeshi people 48.4%; Pakistani people 53.8%.

Poverty: Nationally, 3 in 10 children are living in poverty, whilst 1 in 2 Pakistani, Bangladeshi and black African children are living in poverty in Britain (this measure includes factors such as overcrowded homes).

Data show that the *general* pattern is that darker skinned ethnicities tend to be over-represented in the more restrictive aspects of mental health care and under-represented in the more therapeutic aspects. Here are some examples.

Higher rates than average for utilisation of services or for particular diagnoses (usually referred to as over-representation)

The *Independent Review of the Mental Health Act 1983: Supporting Documents* (DHSC 2018, updated 2019) contains detailed information set out here:

Detention: African people are three times more likely than white people to be compulsorily detained under the Mental Health Act; black Caribbean people are four times more likely.

Forensic services: Black people's admissions to low and medium secure hospitals is five times their proportion in the general population..

Community treatment orders: Black communities are 8 times more likely to be placed on CTOs than white communities.

Diagnosis for psychosis: Data show diagnosis rates at 3.2% for black men compared with 0.3% for white men and 1.3% for Asian men (McManus et al. 2016).

Lower rates than average for utilisation of services (usually referred to as under-representation)

Sizmur and McCulloch (2016) stated, 'For nearly all minority groups, the proportion receiving psychological treatment was lower than for the majority group' (p.79).

When BAME people do receive therapeutic services, they tend to fare worse than white communities do. Here are some cases in point.

Poorer outcomes derived from treatments and interventions in mental health

No reliable change from use of talking therapy services in 2017/2018: 26.2% for white people; 27.3% for black people; and for Asian or Asian British it was 28.4% (NHS Digital 2019).

Lengths of stay on acute inpatient wards are longer for black and Asian people, even when data are adjusted for differences in diagnoses (Newman et al. 2018).

It is important for practitioners in each locality to reflect on why these ethnic differences in mental health data might have arisen in their particular area. Because patterns of inequality do not emerge from deliberate action, each practitioner should ask, 'Is there anything in my practice that inadvertently leads to unwarranted differences for racialised minorities?'

Practice issues – receiving referrals

Referrals are made to mental health services from a variety of sources, often GPs but sometimes the police, for

example. Be actively curious about the choice of words and ideas used by a referrer. This may give you telltale signs of where someone is using a common description that may reflect unconscious stereotyping rather than reality.

> **Practitioners may, for example, hear phrases like these from referrers:**
>
> 'I felt uneasy around him' or 'He comes across as aggressive' – in relation to a black man.
>
> 'She has an extended family who are supportive' – in relation to an Asian woman.
>
> 'They don't seem to be psychologically minded/don't seem keen on discussing things' – in relation to people from black African, Caribbean or Asian backgrounds.
>
> 'I wonder if he's smoking cannabis and if this is having an impact?' – in relation to black Caribbean men.

These may be valid statements in individual cases, but research shows that they are more frequently used for racialised minorities, which indicates that unconscious stereotypes are often responsible (see Banaji and Greenwald 2013; Merino et al. 2018). A question to ask yourself is, 'Would these descriptions be used in this way if the person was white?'

Make it your regular practice to ask referrers to use specific descriptions where possible. It will make it easier for you to do so when it is about race. For example, if the referrer talks about a 'big black man', don't take this as a realistic estimate of the individual's size. Ask for a specific measure (or estimate) of height and body weight. If they use a word like 'aggressive' ask for a description of what happened, incuding the context.

Pay attention to what the referrer suggests as possible interventions and support that someone may benefit from. For example, notice if there is a difference in the extent to which racialised minorities are spoken of as potentially benefiting from talking therapies or support getting back to work as compared with white people. Notice this on a case by case basis and also trends and patterns.

Clarify whether an interpreter will be required if the person's first language is not English. Confirm the language and potentially the person's dialect and other factors that might affect their comfort with an interpreter, such as religion. Ask whether the person being referred has identified aspects of their culture which will be problematic if breached – for example, wearing shoes in the house, or being addressed by their first name by a young person.

Engaging with BAME groups

Unconscious bias

What we see and hear are different, depending on who is in front of us (Benaji & Greenwald 2013). If a black person says 'I hate this country', for instance, it is probable that it will be understood differently than if a white person says it. The unconscious mind blends the information we gather with our perceptions of the person and the group to which they belong. For example if young black man from an estate with documented significant social problems says '*I feel such rage*' during a home visit, it may trigger a concern that would not necessarily arise in the same way or to the same extent as if a young white woman from a middle class family used the identical words.

Our presence and who we are (our perceived identities) will have an impact on how people communicate with us. They will communicate differently with us depending on how we present ourselves as practitioners, how we are perceived by them or their own biases about who we are. Their attitude to us may on occasion be informed by 'hypervigilance', which arises when the person anxiously looks for evidence of discrimination because they

experience a sense of threat. Sometimes they may misattribute our actions to racism.

> **Case study: cultural misunderstandings**
>
> Abdul in his first meeting with Rebecca, a white social worker, desribes an incident when a white neighbour parked partially across his family's drive. He tells her about his complaint to a local councillor and how it escalated into a problematic dispute. Rebecca responds, 'I see it's really been a problem and I guess there is something about not blowing it up out of proportion.'

Abdul is offended as he perceives that Rebecca is a) belittling an incident that matters a lot to him, and b) making an Islamophobic slur by referring to him 'blowing things up'. He is subsequently perfunctory in his conversations with Rebecca, which she records as 'poor engagement' and Abdul not being someone who talks much.

The inadvertent consequence is that Rebecca does not consider Abdul for talking therapies or group therapy.

Conversations about difference

Even if you are from the same ethnic group as the person you are beginning to work with, it will be important to have a conversation with them about this perceived sameness, but also any differences there may be. Some of the conversation may be uncomfortable but avoiding naming something does not make it a non-issue.

Even if you are ethnically matched, you may still have marked differences arising from social class or from being trained as a mental health practitioner and practising with formal mental health diagnostic frameworks. The need for a conversation is all the greater if your ethnic background is different from that of the service user.

If you are – or appear to be – from a different ethnic group, it may help to explore what this means to the service user. Note that some people can interpret the fact that you introduce the subject of race as a sign that you have a problem with it. A good strategy is to couch your discussion in terms of research.

You might say:

'I am aware from my previous work and research that for some people race and racism are something they think about a lot. Since we don't know each other well, I don't want to make any assumptions. Is race something you are ok to discuss with me? As a [say] south Asian person, how do you feel about me asking this question? How do you feel about working with me given that difference between us?'

What if you are ethnically matched?

Conversation openers might be, 'How do you feel about working with me?' or 'Does the fact that we both look as if we could be [say] Muslims affect how you feel about us working together?' Or you could initiate the conversation by asking, 'Do you see us as more similar or more different (and why)?'

You might include the following key messages in your answers, elements of which will also be relevant if you are from different ethnic backgrounds:

'No two people from the same ethnicity or religion have identical experiences or see things in exactly the same way. That is why I am keen to listen closely to what you have to say.'

'I don't assume that I know what is important to you or your likes and dislikes just because we are from similar backgrounds.'

'It is rare for two people to work together and for there to be no surprises even if they are from similar ethnic backgrounds – some of which can be easy or good and some could be tricky. I assure you that I am committed to work through whatever emerges.'

'During my training (and professional practice) I have thought a lot about how my race and religion could affect how I see others and how others perceive me. Just to reassure you, I do not impose or judge people I work with on the basis of what my culture or religion says is good or bad.'

Mental health settings – assessments

The perceptions of black people that we have talked about can have significant repercussions in assessments. There can be a vicious circle: black men in particular may be perceived as threatening, which makes them more reluctant to use services so that they enter them only in a crisis, which in turn means that they are perceived as even more threatening.

Assessments depend on communicating successfully with a service user and avoiding unconscious stereotypes.

They also depend on gathering information from existing records and other agencies, where practitioners should beware of the kind of stereotypical language we have already encountered. They will need to weigh up the accuracy and reliability of information from the various sources, which will also include family and friends.

In particular, practitioners should consider the relationship between ethnicity, race and culture on the one hand and the assessment process on the other. Problems can arise in the following domains.

Service user voice

African–Caribbean men, in particular, often express concerns that their voices are not heard during assessments. Behaviour patterns may be narrowly interpreted during a risk assessment as 'violent' or 'threatening', yet the service user feels that their contribution to the practitioner's understanding of the situation has been ignored. For example, in the face of real or percieved prejudice in the past a black person may sound frustrated and possibly angry. For a worker who is hypervigilant to a sense of threat from black people, particularly black men (due to pre dominant narratives in society but also because of the patterns of they see in services, such as higher detention rates and higher representation in forensic services) the response may not immediately be empathic in response to injustice but rather an attempt to manage risk. If a worker intentionally engages more empathically with the hurt, frustation and anger based on an acceptance that the disadvantages based on race are real (see DHSC 2016, updated 2018, 1.14(d), which states that assessments should be based on people's circumstances), this can help to build a relationship that is more effective and one in which the person's voice can be heard.

Family and friends

Distorted perceptions of family and friends are also possible. Stereotypes of BAME families, such as 'They stick together', sometimes mean that they are seen as a potentially strong source of support, even if the service user is saying something different.

Alternatively, family carers may be seen as problematic, perhaps because of their passionate advocacy of the service user. It may be that the practitioner finds the carer's accent or diction difficult to understand, inferring that they are colluding with the service user in non-compliance.

A key personal strategy is to think 'cultural humility' and not just cultural awareness. The difference is the focus on self, and how our upbringing, our own culture and training shapes our thinking about what 'normal' is. Remind yourself that other groups have their own version of this and to notice if cultural arrogance creeps into your practice, leading you to consider your way of approaching things as *the* right way.

Weighing up information

The same rules apply as those when receiving referrals (see above). If there has been concern about the service user's level of arousal, investigate the basis of this claim and ask whether it has come about because the service user has reached crisis point through reluctance to enter the service in the first place. What support had the service user received before coming to your service's attention, have solutions been sought outside of statutory services and has there been any corroboration of the referrer's concern?

We have seen that BAME service users are sometimes assumed not to be amenable to talking therapies. Sizmur and McCulloch (2016) noted that BAME people say that they are less often referred to these therapies than white people. Practitioners should explore the possibility of talking therapies, where appropriate, and find out whether alternatives to Western psychological therapies might be considered, such as adapted forms of CBT for BAME groups   w(- see Rathod et al. 2010, 2012).

Another common assumption is that a BAME service user has a chip on their shoulder or is 'paranoid'. The grain of truth here is that race and the experience of racism frequently impact on service users much more than clinicians and social workers often acknowledge (Karlsen and Nazroo 2015). Practitioners should probe whether there are instances of racism that the service user regards as having shaped their outlook and ask about their specific impact.

> **Case study: stereotypical assumptions**
>
> An approved mental health professional (AMHP) is advised by a consultant psychiatrist that police 'back-up' is required for a Mental Health Act assessment. According to information passed on by a community psychiatric nurse, the psychiatrist says that the black male service user has a history of violence.

The AMHP contacts the psychiatrist to find out about this history of violence. When did it take place and what precipitated these incidents? But the psychiatrist is unable to provide any further information and, when the AMHP checks the file records, it becomes evident that there is no documented basis for the claim. When investigated further the AMHP discovered that the statement linked to an occasion when the young man became agitated about not being able to have a cigarette but no violence actually occurred.

What seems to have happened is that the common (albeit unspoken) belief about black men being more prone to violence in the organisation prevailed over the truth. Until the AMHP acted, there appeared to be an acceptance of a powerful and potentially damning piece of information without its validity being tested.

Mental health crises

When you meet someone in a crisis it can often feel like a tricky time to engage with ethnicity. It may even be an assessment under section 2 or 3 of the Mental Health Act, but there are still courses of action that practitioners should consider.

Some tips to help:

In a crisis try to identify if there is someone close to a racialised person (e.g. a relative or friend) who will understand the person's culture and faith and who can help to provide context. To take an example, someone might say they felt they 'weren't right' so they have been having baths in herbs picked from their garden. A practitioner might think such behaviour irrational until a word with the service user's family reveals that, in rural Jamaica where the family has its roots, it was not unusual for people to rely on bathing in herbs as a 'cure'.

Be mindful however, that racialised people in crisis may have subjects that they do not wish to speak about when family or friends are present. As an example, a Muslim South Asian man who is gay may not wish to discuss this openly in the presence of family.

It may be helpful to involve family or close friends to advocate during a crisis because people from racialised minorities report higher levels than white people of disatisfaction with their experience of mental health services. It can also be worth asking the person and their family or friend about what factors proved obstacles to them seeking earlier help. This will yield information that can help shape a care plan:

If it is linguistic barriers be sure to include the use of interpreters and translated information, e.g. about rights.

If it relates to mistrust of mental health services because they feel services are racist or biased, use this information to talk about your commitment to ensure equality for the person. This will help improve your relationship with them and raise the chances that they will engage with services.

Recovery-focused care planning

Given the significance attached to the negative aspects of BAME service users, the challenges for mental health services that accompany a focus on recovery can be immense. In this context, recovery-focused care planning should contain the following elements:

- Underpinning by comprehensive assessments involving a critical approach from practitioners (see above);
- Clarity about recovery goals;
- Clarity about the obstacles;
- Exploration of all options for recovery;
- Investment in the practitioner–service user relationship as a vehicle for change.

Clarity about goals and obstacles is essential. Care and support plans should be holistic and reflect all aspects of people's lives: physical, spiritual, identity, social, economic and mental. Whether the plan arises from the Mental Health Act Care Programme Approach or a Care Act assessment, these are the domains that should be addressed.

But how often does this happen where BAME service users are concerned? Studies have shown (e.g. Weich et al. 2014) that factors such as a narrow range of services and opportunities, a focus on risk management, low expectations, inadequate practitioner skill levels for exploring the impact of racism and disadvantage on people's lives, and loss of hope because so many service users are stuck in the system all detract from concentrating on the goal of recovery.

In addition, it is important to be clear about the obstacles that practitoners can carry within themselves. We have already mentioned unconscious stereotypes, impatience with accents and diction that the practitioner may find it difficult to understand, and feelings that may be at odds with the highest professional standards. These may be feelings that are hard to raise even with a trusted supervisor or mentor, but it is essential to reflect on them and try to work through them.

Exploring recovery options

Always start work with people from racialised minorities with possible options around psychological interventions, social interventions (group work, education, employment, volunteering, clubs and hobbies) that they consider as potentially inclusive for people of their ethnic background. This is important because black and Asian people feel that they are mainly treated with medication and are not supported in other ways.

Always ask someone to describe what a good intervention would look like in relation to their ethnic, cultural and spiritual needs. Studies have shown that BAME service users often prefer alternatives to mainstream mental health services and BAME-led local voluntary organisations are often a resource well worth practitoners' attention (Fernando 2017). Of course, it must not be assumed that a 'black' voluntary group – say, a day centre, counselling service or back-to-work scheme – is suitable just because the service user is black, or that an 'Asian' centre is suitable just because the service user has Asian heritage. Ethnic and cultural subdivisions have huge significance, e.g. whether the voluntary group is led by black Africans or Caribbeans, or whether it is Gujarati or Punjabi speaking.

But, once these considerations have been taken into account, there can be enormous mental health benefits arising from the linguistic and cultural similarity conferred by BAME-led voluntary groups. They can offer:

- A sense of shared identity and belonging;
- A shared recognition of difference in relation to the white majority or other ethnic groups;
- A preparedness to celebrate cultures and the knowledge to do so;
- More open discussion about the impact of race on experience and outcomes;
- Specific forms of therapy or support that keep race central.

Case study: Voluntary placement pitfalls

Hamza left university and began work for a national chain of computer retailers. While living with his parents, he begins searching for a flat of his own to rent, but every time he visits the flats he finds online he is told that someone else has pipped him to the post or that the deposit is much higher than the one advertised.

After a series of such setbacks, Hamza's mental health starts to deteriorate. He becomes aggressive, loses his job after becoming short-tempered with a customer, and starts to drink heavily. His brother Asif tells friends about the boys' strict upbringing by their father, how he was constantly disappointed by their failure to be sufficiently devout Muslims, and how they often seethed with anger but were silently compliant.

Increasingly volatile and unable to contain his emotions even in everyday situations, Hamza is admitted to a psychiatric hospital. He is assessed, diagnosed with bipolar affective disorder and after three weeks discharged on medication to live with his parents. The community mental health team (CMHT) oversees Hamza, and Susan is appointed to the role of care coordinator.

Following an assessment Susan concludes that Hamza is finding it hard to cope with living with his parents again, especially after his failure to find a flat, which he puts down to racism. Hamza is isolated and Susan fears that the situation will just compound his mental health problems. As part of their care planning, Susan suggests that Hamza might like the social contact provided by attending an Asian men's group, which meets regularly at a local day centre. They also prioritise finding a flat through the local authority housing depart-

ment and asking the psychiatrist to address Hamza's concerns about the effects of his medication.

Six months later, as part of a CMHT development exercise, two independent reviewers are appointed to review constructively selected cases from the team's caseload. A BAME mental health specialist called Trevor reviews Susan's handling of Hamza's case. Here is the outcome of their discussions:

Susan's view: 'I was determined to help Hamza find an exit from the mental health system and get back to ordinary life through social contact in the men's group and independent living in his own flat. My view was that a staged return to normality could be achieved by being mindful of Hamza's ethnicity and by looking to slowly reduce his reliance on medication.'

Hamza's view: 'I knew that things had gone wrong in my life and that I was having a bad time. But it was nothing I couldn't handle. I couldn't understand why mental health services had intervened, let alone why they had sent me to that men's group. They were all so much older, more my dad's generation and with his kind of outlook on life.'

Trevor's view: 'My feedback to Susan was that I could understand why she wanted to find options among BAME voluntary groups locally. If they're chosen properly, they can make a service user feel respected and understood in a way that often eludes white-dominated mainstream services. But this was the wrong choice and Susan's referral to the men's group could be seen as stereotypical. And, although she did priortise finding a flat, there was no real discussion of Hamza's claim that he had experienced racism during his previous search. It was as though these feelings were unimportant, leaving Hamza with a justifiable sense that they had been ignored. In my view, Susan wanted to deal with race but not with racism; she ended up falling short on both counts.'

Quality relationships

A dialogue about race can be a vital part of the relationship between practitioner and BAME service user. There is no skirting around it; it must be tackled head on, but this can only happen if practitioners have the confidence to build strong relationships in the first place (Sewell 2009). Race and racism can be sources of great anger and an abiding sense of injustice which contribute to mental health problems and must be addressed like any other traumatic experience.

There is no single theory which can give social care practitioners the set of skills necessary to build strong relationships, that can explore subjects such as race and racism, though *Relationship Based Social Work* (Ruch et al. 2018) is a good starting point. It is something that comes with practice and having the openness to engage with sensitive topics like race and racism without fear of the consequences. Practitioners will have to acquire an 'ear' for this topic while also dealing with the practicalities of day-to-day living. Here is an example.

Case study: Don't avoid the issue of race

Rebecca, a white social worker, is in conversation with Calvin, a black man in his early 30s. They have been working together for four years. Calvin asks Rebecca whether she has made progress on chasing his application to the housing association for a transfer to a flat in a different part of town. Rebecca said that she had managed to set up a meeting with a housing officer and was hoping that part of the time with Calvin could be spent preparing for this. As they discussed pressures that negatively affected Calvin's mental health and also his desire to move, Rebecca asked what factors were of concern to him. Having discussed this for 20 minutes Rebecca said that she noticed that Calvin did not refer to being black or any racism that he might have faced, and the relationship between this and his decision to request a transfer. Calvin replied, 'I don't know how to take you bringing up the race thing; I just want to move'. Rebecca replied, 'Even though I'm white and I don't know how it feels to you, I do know that racism does affect black people not just in how they feel but in ways such as opportunities in education, work or where they live. For me not to bring it up would be ignoring something that I know is real and significant and most probably impinges on your life.'

Conclusion

We have seen how ethnic inequalities can have a profound impact on people's mental health and how practitioners

should always be willing to engage in dialogue about the impact of life as part of a racialised minority. As part of this process, practitioners must be willing to confront their own preconceptions about race and the unconscious stereotypes that can invade even the most sincere attempts to handle it constructively.

Conversations about difference require humility and sensitive discussion, whether the practitioner is from the same ethnic group as the service user or a different one. If you raise it, you may be seen as having a preoccupation with it; if you fail to raise it, it may seem that the service user's profoundest feelings and possibly experiences have been overlooked. I have suggested a number of strategies which can be used in assessments and care planning, though they must be deployed in the context of sound relationships between the practitioner and service user.

In the end, practitioners must focus on shifting the emphasis of mental health care for BAME people from detention and restriction to therapy and positive outcomes in the community with its full range of possibilites. A fair and effective mental health system should be free of the injustices which still mar so much of our society.

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