Leading race equality in mental health

Hári Sewell

Independent Consultant and Former Executive Director in the NHS, UK

Abstract

The national policy *Delivering Race Equality in Mental Health* (Department of Health, 2005) is in its fifth and final year. Evidence suggests that the changes that were hoped for have not been achieved. This has raised the question as to whether the objectives were unattainable or whether the implementation is yet to see the leadership that is required to bring change in a field fraught with emotion and soured optimism. Drawing on engaging leadership theories and the concept of organisational incompetence this paper highlights key requirements for change, including giving a focus on what has gone well, for example through using appreciative inquiry, and on pursuing possibilities beyond those prescribed through performance management.

Key words

Race equality; mental health; DRE; appreciative inquiry; change.

Leading race equality in mental health

The government's race equality programme in mental health is in its fifth and final year (Depatment of Health, 2005). The headline figures demonstrate that society, public services and other providers have struggled to turn the tide on disparities in experience and outcomes for people from black and minority ethnic (BME) backgrounds. Twenty-three per cent of all admissions in the 2008 inpatient census were of people from BME backgrounds, which is double the representation in the general population identified by the national statistics office. Rates of admissions for black groups were three or more times higher than average – with a rate 10 times higher for black other groups. These figures (except for in the black other group) represent a deterioration since the national censuses began in 2005 (Commission for Healthcare Audit and Inspection, 2008).

It is all too easy to criticise others who are thought to have failed to fulfil their obligations – as Ott and Shafritz (1994: 371) state, '*there are always scapegoats to be sought, found and punished publicly*' – but the real challenge is to add intelligent debate about what should happen next. This paper attempts to provide some insight into what can be done to bring improved outcomes as opposed to just providing an analysis of errors and ascribing blame.

Whenever a review is undertaken into errors in health and social care delivery, regulatory bodies typically include criticisms of leadership in their analysis or meta-analysis of failings. Hambleton (2005) presents a good analysis of the two theoretical constructs of active (individual) failures and latent failures, developed by James Reason (1990) and others. The former relates to actions of individuals that are obvious breaches. The latter being more dispersed failures 'further upstream'. Even where there are accounts of

individual breaches, accountability rests with leaders, and Peter Gilbert quotes the previous Mayor of New York, Rudi Giulani, who said '*More than anyone, leaders should welcome being held accountable*' (Gilbert, 2005: 2).

Strong leaders embrace the full responsibility of their challenge to provide equitable and ethical services. Success is measured by delivering against values as much as about gaining straight greens on a dashboard; as Peter Senge states, they never arrive at some arbitrary endpoint of achievement (Senge, 1990).

Understanding leadership

Many leadership manuals discuss at length the difference between leadership and management. Halfway through the last century Peter Drucker made the statement, '*What is needed, also, is management's assumption of leadership*' (Drucker, 1950: 86). Concepts of management and leadership are nothing but frameworks; ways of giving focus to particular approaches. Gilbert (2005) sets out an analysis of the respective foci of leadership and management but makes the point that it is a myth that once leadership is attained management is no longer required. In summary, Gilbert's analysis highlights the focus of management on tasks, processes and measurable and deductive matters while leadership has as its focus people, vision, direction, questioning and inspiring others.

A leader must be able to manage effectively if changes are to be delivered in reality. Alban-Metcalfe and Alimo-Metcalfe (2009) provide an outline review of the five stages in the development of leadership theory. These include the great man theories; behavioural theories; situational and contingency models; a focus on defining organisational reality and, more latterly, engaging leadership. The changes in conceptualisation and emphasis reflect the changing environment as much as the accumulation of a greater body of evidence. A manager may thrive while they are not faced with any tough challenges but as soon as judgement is required in difficult times an absence of leadership qualities and skill leaves them drifting and buffeted by events. Senge (1990) makes the point that management that relies on the adoption of a codified set of behaviours is insufficient; a point emphasised in the Alban-Metcalfe and Alimo-Metcalfe (2009) article. It is against these considerations

that leadership of the diversity and race equality agenda must be considered.

Leadership in Delivering Race Equality in Mental Health

The ultimate aim of *Delivering Race Equality in Mental Health* (Department of Health, 2005) is to achieve experiences and outcomes as close to equality as possible across all ethnic groups. Change will not be achieved by repeating the same things year on year, particularly when history has shown that the content and level of action do not achieve the stated aim. As Trevor Phillips stated in the National Equalities Review: '*The strong evidence of differential health outcomes should point to a response by healthcare professionals that recognises and provides for such differences*' (Cabinet Office, 2007: 76).

In short, the challenge is to provide a response that is proportionate to the degree of disparity in experience and outcome. It is possible, probable even, that equality in outcome and experience will not be completely achieved within the tenure of current organisational leaders. Leaders must, however, be able to demonstrate that they have taken actions that are proportionate to the degree of need, otherwise it becomes difficult to resist the accusations of institutional racism.

There is now a belief among key leaders that the term *institutional racism* has become unhelpful and should be avoided. For example, Mailonline, the internet-based version of the Daily Mail, reported on 19 January 2009 that '*equality chief Trevor Philips says the whole corrosive concept should be abandoned*' (Daily Mail, 2009), and related headlines appeared in press and other media outlets, such as the British Broadcasting Corporation (BBC). These reports were based on the speech by Phillips, the Chairman of the Equality and Human Rights Commission, which was broadcast on the Commission's website 10 years after the publication of the McPherson report into the death of Stephen Lawrence. In the speech, Phillips said about the claim of institutional racism in the police that it was '*a badge of shame that has hung over the service ever since*'. He went on to say, '*So today, ten years on, is the accusation still valid? I don't think so*' (the speech is no longer available online but transcribed sections can be seen at Guardian.co.uk: Guardian, 2009). Key figures at the national level in mental health have

subsequently voiced similar concerns. The term *institutional racism* is used here, however, to clarify that a failure to act with sufficient urgency, accuracy and intensity leaves leaders unable to defend against such a charge. This is particularly so as organisations still struggle to articulate – with any conviction and evidence – an alternative analysis. Good research studies into ethnic disparities routinely consider compounding factors such as class and urbanicity, however they also consistently then conclude that race does matter (Cooper *et al*, 2008; Singh *et al*, 2007). Herein lies the tension. Unequal experiences and outcomes are related to race but there is no single theoretical or conceptual framework for articulating the cause. A construct still under development is that of toxic interaction theory, first documented in Sewell (2009). This idea relates to the toxic effect of the collision of the experiences of white people with those of people from BME groups. People from BME groups experience the cumulative effect of what Chester Pierce defined as 'micro-aggressions' (the small, often non-verbal forms of discrimination which in isolation appear minor and difficult to attribute to race or ethnicity) (Pierce *et al*, 1978; Sue *et al*, 2008). Toxic interaction theory identifies that there is a psychologically damaging consequence of the interaction between people from BME groups and white people but does not *assume* active or individual negative behaviour. Toxic interaction theory does, however, locate a responsibility on the part of white people to acknowledge the toxicity and to take active steps to reduce it.

Toxic interaction theory combines the concept of damage arising from individual (often inadvertent) acts along with the toxic societal relationships between blacks and whites alluded to by Bobby E Wright (1984). Toxic interaction theory deals with the psychological effects but does not ignore the reality of social and physical forms of disadvantage for example in housing, employment, education and in the criminal justice system.

Failures to achieve more equal outcomes for BME groups in mental health occur through passive, insidious, cumulative and sometimes purely unfortunate alignments of gaps in protective measures. The parallel with the analysis by Reason (1990) about the function of latent failures is clear. Tensions arise between identifying causes of failures in either individuals or in organisations. In addition, leaders are faced with an unenviable challenge of trying to contain inevitable unrest associated with race. Delivering progress is often seen as the concern of a few who are worthy of blame for failing to do so. Success can in reality only be achieved by making the subject central to performance requirements dispersed through the organisation. Further, leaders in mental health services are asked to remain optimistic that they can improve proportionate rates of recovery for people from BME backgrounds, despite their own erosion of hope. Their confidence has been dented by a history of statistics pointing to persistent disparities without evidence that the actions of mental health services can make a difference (Department of Health, 2003). Barack Obama eloquently described the erosion of hope as follows.

> 'They had lost whatever confidence they might have once had in their ability to reverse the deterioration they saw all around them. With that loss of confidence came the loss in the capacity for outrage. The idea of responsibility – their own, that of others – slowly eroded, replaced with gallows humour and low expectations.' (Obama, 2004: 230)

Leadership requires mere mortals to override their human inclinations, in pursuit of a justice of which they are convinced. The task of leaders in delivering race equality is to apply the learning from the development of management theory as documented by Alban-Metcalfe and Alimo-Metcalfe (2009) with the renewed focus on engagement. Attention must also be paid to the concept of organisational incompetence. Ott and Shafritz (1994: 371) state:

> 'Organisational incompetence cannot be seen directly. It is a condition or state of being that exists in people's minds and emotions. All that can be seen is evidence or indicators of incompetence'.

Organisational incompetence provides a language for the persistence of disparities in experience and outcome for people of BME backgrounds in mental health services given the context of thwarted expectations of politicians, staff, communities and service users.

Distilling the essence of the Alban-Metcalfe and Alimo-Metcalfe (2009) emphasis on engaging leadership, and the Ott and Shafritz (1994) concept of organisational incompetence, it is clear that leaders in race equality need to:

- have clear values
- model behaviours of equity and antidiscrimination
- communicate aims and objectives clearly and enable these to be delivered using engagement rather than instructions
- contain anxiety in organisations by celebrating questioning rather than suppressing it
- develop and utilise feedback mechanisms through organisational governance structures to consider feedback that is challenging but also celebratory of positive experiences and outcomes
- focus on performance outcomes as platforms (milestones) for further development rather than ends in themselves.

Clear values

Strong leaders have values that are consistent across personal and professional contexts (Covey, 1989). Matters of equalities pose a particular challenge because people who are personally affected by discrimination often develop antennae to detect any hint of discrimination or inconsistency in others. These antennae may not be reliable but they are usually highly sensitive; often if discrimination is not named or commented on it is not because it had not been apparent, but rather because the observer elects to avoid or ignore the situation, either through fatigue or some form of self-preservation. Where value systems appear to be fragmented or inconsistent, people from BME groups will not be surprised. Survival in a mixed world often requires people of BME backgrounds to contain frustrations articulated so well by Patricia Williams, who gave the BBC Reith Lecture in 1987. She spoke of:

> 'The paralysing anxiety of well-meaning "white guilt" and the smouldering unhappiness of blacks who dare not speak their minds.'
> (Williams, 1997: 59)

On occasions where leaders feel misconstrued or that they have made a mistake, they are required to have the nerve to discuss matters openly. Authentic values will not always equate to perfect behaviours. Relationships must be nurtured as they remain the carriers for change (Sewell, 2009). As Eva Castillo (2007) of Merrill Lynch EMEA Global Wealth Management states, '*relationships are built on trust, integrity and results*'.

Model behaviours of equity and antidiscrimination

Effective leadership of race equality requires the conscious demonstration in behaviours of good performance. An effective leader will try to capture the imagination of others (Gilbert, 2005). A chief executive or senior manager will need others in the organisation to see and remember examples of specific actions taken in support of race equality. Just doing what is required by policy or law is not enough. Supporting a board report that is part of a compliance framework communicates little about the personal commitment of the leader.

Perhaps the most telling example of modelling leadership in race equality is the preparedness of the leader to name aspects of workforce management or service delivery where there are possible indicators of discrimination. Doing so without undermining any section of the workforce or the trust of those looking on expecting improvements demands that a leader demonstrates that they are relentlessly seeking solutions. Staff and colleagues must see evidence that they are requesting improvement on specific aspects of race equality such as fair distribution of BME staff in the workforce or progress in reducing inpatient admissions of people from BME backgrounds. Leaders need to show that they actively follow up progress, perhaps doing so by occasionally attending a more operational problem-solving meeting that is not part of the board governance structure.

Whichever way intent is manifested, the leader must demonstrate that they are prioritising race equality. They must demonstrate that the race equality agenda is something to which they are committed rather than it being an inconvenient imposition on their already heavy bureaucratic burden. Staff will infer more from behaviours than leaders of organisations realise. Staff and stakeholders will also make inferences

from the absence of actions. The assumption of organisational incompetence, as a consequence of an organisation's inability to demonstrate success, means that efforts need to be visible in the first instance and ultimately these must translate to positive outcomes. Leaders with roles further away from the frontline will find it less easy to guarantee systematic change at the service user interface. Leaders must, therefore, embed the practice of tackling racial inequality in their own everyday working lives so that they are able to be transformational and transparently ethical.

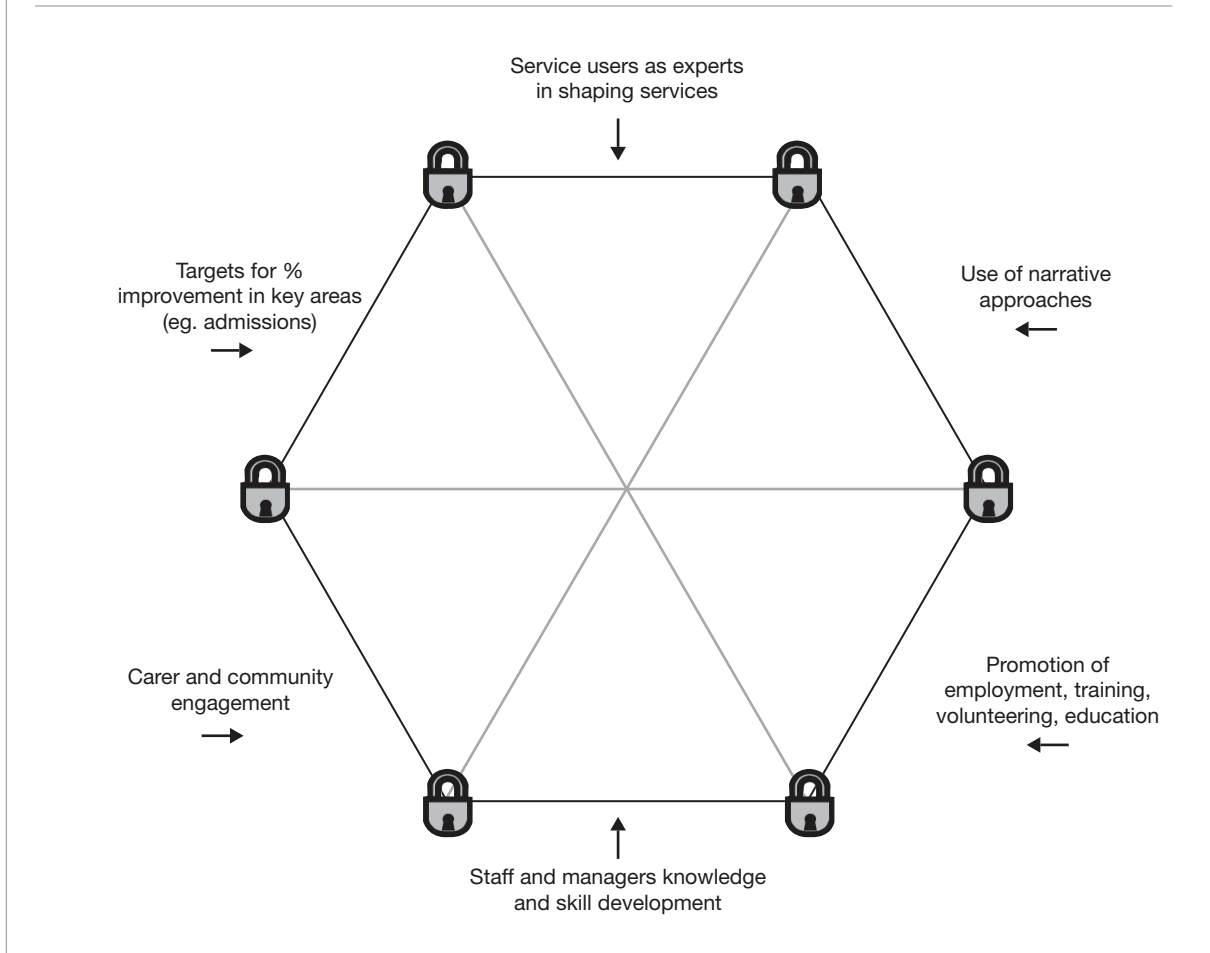## Communicate aims and objectives clearly and enable these to be delivered

Communication is undermined if there is inconsistency between what is being said and what is being done (Lapakko, 1997). Consistency between values, behaviour and communication is the key to securing buy-in of staff. Providing resources to enable delivery and removing obstacles are the keys to achieving widespread improvements in outcomes (Waal, 2007). The same management and leadership challenges are applicable in the arena of race equality as any other aspect of service delivery. The compounding factor is lack of an evidence-base about what works in reducing disparities, and the consequential loss of confidence as described earlier with the quote from Obama (2004). Further, there is a lack of consensus about delivering a set of actions or a service model based on reasonable assumptions and hypotheses by experts in the field. *The National Service Framework* (NSF) *for Mental Health* (Department of Health, 1999) established a model configuration of services for local populations. Though evidence existed for each component of service, there was not an evidence base for the particular configuration as a template. There was, however, sufficient consensus and national leadership to achieve close to universal adoption of the NSF model across the country. There is not yet a consensus about a specific set of actions or service models that mental health trusts will deliver in order to reduce the disparities in experience and outcomes for people from BME backgrounds. Identifying a lack of consensus is not to deny the clear policy and service proposals in *Delivering Race Equality in Mental Health* (Department of Health, 2005).

This article offers a potential solution to the problem of a weak evidence base about what works in achieving improvements in key target areas and also the lack of consensus. This solution may be to identify a set of interdependent actions which, if delivered consistently and together in the same service delivery system (SDS) – eg. community team and wards working together – will achieve measurable improvements over time. Lessons may be learned from cancer care, for example, where a *combination* of interventions is considered to be essential. A site that provides good cancer care would need to provide good surgery, good radiotherapy or chemotherapy and good information, counselling and support. It would be nonsense, for example, to describe one UK region as being ahead of others because it had one NHS trust that was great at surgery and another several miles away that was excellent at chemotherapy and another in the same region that was outstanding at counselling and carer support. Being in the same region but outside the same delivery system would offer no particular benefit. Race equality initiatives have, however, become fragmented. Sites are held up as examples of positive practice if they have some good initiatives that are only part of an essential package.

Consensus is yet to be developed in relation to race equality, that in the absence of evidence in relation to improved outcomes, there is a set of inputs that must all exist together. Commitment to a consistent set of inputs or processes in different sites across the country will enable evaluation of a model which, if it delivers improved outcomes, will legitimately be deemed as best practice. Based on the content of *Delivering Race Equality in Mental Health* (Department of Health, 2005) and many research papers, there are six components of services that could be considered to be interdependent if mental health services are to see evidence of improved outcomes. The 'locked hexagon' model being proposed here represents the six interdependent elements that should be preserved as a single package of measures (see *Figure 1*, over the page). Even if initially this model is preserved only by some SDSs within an organisation, the imperative of preserving the 'locked hexagon' must be maintained.

This model is described more fully in a service review in Sewell (2009: 177–179). The development of the unified model set out here will require commitment and leadership.

Figure 1: The locked hexagon model of essential unified components required to achieve improved outcomes for BME groups

Service users as experts
in shaping services
↓

Targets for %
improvement in key areas
(eg. admissions)
→

Use of narrative
approaches
←

Carer and community
engagement
→

Promotion of
employment, training,
volunteering, education
←

Staff and managers knowledge
and skill development
↑

Celebrating questioning

Organisations that grow and mature are those that question and challenge internally. As Peter Senge states:

'The discipline of mental models starts with turning the mirror inward; learning to unearth our internal pictures of the world, to bring them to the surface and hold them rigorously to scrutiny. It also includes the ability to carry on "learningful" conversations that balance inquiry and advocacy, where people expose their own thinking effectively and make that thinking open to the influence of others.' (Senge, 1990: 9)

People in organisations have strong views about many matters related to equalities. Race and ethnicity are particularly potent subjects, fuelled by collective experiences and histories of widespread and systematic atrocities. Sometimes

the physical differences of people in the same room demonstrate that the conversation is not about ideas but about people who continue to bear the consequences of the past. Opposite views can arouse passions that turn debate into confrontation – whether acknowledged or not. Discussions about race are however often suppressed.

'Conversations about race so quickly devolve into anxious bouts of wondering why we are not talking about something – anything – else, like hard work or personal responsibility or birth order or class or God or the good old glories of the human spirit. All these are worthy topics of conversation, surely, but can we consider for just one moment, race.' (Williams, 1997: 61)

Leaders of organisations face a challenge in that they are required to prevent unresolved

tensions and destructive divisions without stifling discussion and debate. The values of the leader will drive the extent to which they are prepared to tolerate – or even encourage – debate. The reality is that deep down many leaders are scared of opening up pain and difference that they feel unable to contain or manage.

> '*Such leaders help people throughout the organization develop systemic understandings. Accepting this responsibility is the antidote to one of the most common downfalls of otherwise gifted teachers – losing their commitment to the truth.*' (Senge, 1990: 356)

Develop and utilise feedback mechanisms through organisational governance structures

The truth in most debates around race inequalities is that there are examples of efforts that demonstrate the capacity and commitment of individuals to tackle inequalities and to achieve improved outcomes. Cathartic though it may be to vent outrage, growth is more possible through recognition that those being challenged can deliver improvements. Leaders may benefit from employing the tools of 'appreciative inquiry' (Cooperrider & Srivastva, 1987). This approach invests time and energy in learning from what has gone well and is pertinent in a field so fraught with soured optimism, anger and divisions. Leaders need to be skilled in highlighting both the gravity of the inequities and the enabling celebration of change that was achieved.

Rather than relying on feedback received by chance, leaders need to embed mechanisms that systematically enable organisational learning and development. Since the publication of *A First Class Service: Quality in the new NHS policy* (Department of Health, 1998) NHS organisations have been required to establish such systems. Peck (2005) sets out models for organisational learning and as well as critical appreciative inquiry that includes use of systems theory, psychodynamic approaches and narrative approaches. Both the models and the approaches need to be clear and, above all, they need to be utilised.

Focus on outcomes as platforms (milestones) for further development

The burgeoning of performance management in public sector organisations can prove illusory.

The recent investigations into the tragic death of Baby Peter highlight that it is possible to attain an assurance of having arrived at acceptable standards where, in fact, there is evidence to suggest otherwise (Care Quality Commission, 2009). Lord Laming, who was commissioned by the House of Commons to undertake a review of child protection concluded (following discussions with local authorities) that the exiting performance indicators were not fit for purpose. He stated that this was '*because current indicators focus on process and timescales*' and were '*unclear in their impact upon positive outcomes*' (Laming, 2009: 15).

Leadership requires clarity about the goal being pursued and the constant elevating of standards towards ever-increasing achievements along a range of continuums whether that is volume, cost, quality, effectiveness, responsiveness or efficiency.

Leaders must be able to state what they hope to achieve in their settings in relation to delivering race equality in mental health. The production of a single equality scheme or support for a black service user forum may be part of a jigsaw or processes but the intended outcome must be clear. A clear position is needed nationally. Either mental health services can reduce (not necessary close) the inequality gap for people from BME backgrounds expressed in service utilisation, or they state that this is an unattainable objective. Influential studies such as the AESOP Study (Aetiology and Ethnicity of Schizophrenia and Other Psychoses: www.psychiatry.com.ac.uk/aesop) point to socio-economic factors as critical determinants in the excess service utilisation. These findings, along with the persistence of the high levels of admissions found in the national census, have led to the questioning among significant figures in mental health around whether service utilisation is a reflection of need rather than failures in services.

David Fillingham, in his foreword to Edward Peck's *Organisational Development in Healthcare: Approaches, innovations, achievements*, refers to the Kaiser quote '*hospitalisation is system failure*' (Fillingham, 2005: viii). However harsh this analysis may seem as a general principle, it is fully acknowledged in mental health services that repeat admissions represent the inability of the entire system to achieve one of its primary goals, ie. to help people to sustain their life in community settings. Rates of admission increase for BME groups once they enter mental health services. Singh and colleagues (2007) found an increase in the proportion of BME groups with each sequential

repeat admission. If services are to accept that they are unable to close the gap on inequalities, are they to also accept that the treatments and interventions are less effective for this group? Based on the meta-analysis by Singh and colleagues (2007), it is clear that the disparities at first admission are not even maintained; they become worse.

If a belief still remains that mental health services are able to make a positive difference once people from BME groups enter the system, leaders must be able to articulate the nature of this difference. As Burrell and Morgan (1979) state in their book on organisational analysis, the sociology of radical change that informs organisational leadership is: '*concerned with what is possible rather than what is; with alternatives rather than the acceptance of the status quo*' (Burrell & Morgan, 1979: 17).

Delivering demonstrable race equality, or at least improvement, requires that leaders recognise not just the width of the gap measured, by admission figures or other data, but also the scale of the challenge systematically and organsationally. Leaders need to articulate exactly the outcomes that they intend to pursue, unless of course there is a consensus that the aim of reducing race inequalities should be abandoned.

Conclusion

Leadership of race equality in mental health services requires qualities and skills that may be difficult to possess in the current performance-driven culture of public services. The findings from research and the annual census of inpatients, which show the persistence of disparities, requires leaders to state with clarity whether there is a belief that disparities in service utilisation can be reduced. The case for concluding otherwise would be sound only if services could demonstrate that all possible efforts had been made to reduce inequalities and that disparities had persisted despite this. The challenge from the Equalities Review indicates that services have not yet implemented a response that is proportionate to the degree of disparity. Leaders are therefore required to pay attention to the challenges in their organisations as much as those inherent in the lives of those they serve.

Perhaps, however, it is the fusion of stronger leadership and more accountability through performance management that will finally turn the tide. If not, the principle of delivering race equality will end in February 2010 with the government policy of the same name.

Implications for leadership in practice

- The rigours of good leadership need to be applied to delivering race equality as for any aspect of public services.
- Passivity on this agenda embeds disparities in services and weakens the defence against claims of institutional racism.
- The behaviours of leaders in relation to race equality are scrutinised by many for any sign of a disconnection between what is articulated and what is done when off-guard. Integrity requires that leaders live integrated lives.
- Leaders must be conscious in their demonstration of their commitment to achieve improved outcomes for people of BME backgrounds.
- Questioning must be celebrated. It is clear that there are no simple solutions to the complex problems of race inequality in mental health.
- The locked hexagon model provides a framework that has a high probability of generating improvements in race equality in mental health.

Address for correspondence

Hári Sewell
Independent Consultant
Tel: 07737 281123
Email: hari@harisewell.com
Web: www.harisewell.com

References

Alban-Metcalfe J & Alimo-Metcalfe B (2009) Engaging leadership part one: competences are like Brighton Pier. *The International Journal of Leadership in Public Care* **5** (1) 10–18.

Burrell G & Morgan G (1979) *Sociological Paradigms and Organisational Analysis*. Hampshire: Ashgate.

Cabinet Office (2007) *Fairness and Freedom: The Final Report of the Equalities Review*. London: Cabinet Office.

Care Quality Commission (2009) *Review of the Involvement and Action of Health Bodies in to the Case of Baby P*. London: CQC.

Castillo E (2007) Endorsement. In: S D'Souza (2007) *Brilliant Networking*. Essex: Pearson Education Ltd.

Commission for Healthcare Audit and Inspection (2008) *Count Me In 2008: Results of the 2008 National Census of Inpatients in Mental Health and Learning Disability Services on England and Wales.* London: Commission for Healthcare Audit and Inspection.

Cooper C, Morgan C, Byrne M, Dazzan P, Morgan K, Hutchinson G, Doody GA, Harrison G, Leff J, Jones P, Ismail K, Bebbington P & Fearon P (2008) Perceptions of disadvantage, ethnicity and psychosis. *British Journal of Psychiatry* **192** (3) 185–190.

Cooperrider D & Srivastva S (1987) Appreciative inquiry in organizational life. *Research in Organizational Change and Development* **1** 129–169.

Covey S (1989) *The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change.* New York: Fireside.

Daily Mail (2009) *'Why Britain is now the LEAST racist country in Europe,'* available from: http://www.dailymail.co.uk/debate/article-1121442/TREVOR-PHILLIPS-Why-Britain-LEAST-racist-country-Europe.html (accessed June 2009).

Department of Health (1998) *A First Class Service: Quality in the new NHS policy.* London: DH.

Department of Health (1999) *The National Service Framework for Mental Health.* London: DH.

Department of Health (2003) *Inside Outside: Improving mental health for black and minority communities in England.* London: DH.

Department of Health (2005) *Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside services and the Government's response to the death of David Bennett.* London: DH.

Drucker P (1950) Management must change. *Harvard Business Review* **28** 2.

Fillingham D (2005) Foreword. In: E Peck (2005) *Organisational Development in Healthcare: Approaches, innovations, achievements.* Oxford. Radcliffe Publishing.

Gilbert P (2005) *Leadership: Being effective and remaining human.* Dorset: Russell House Publishing.

Guardian (2009) *'Not so clever Trevor,'* available from: http://www.guardian.co.uk/commentisfree/2009/jan/19/race-equality (accessed June 2009).

Hambleton M (2005) Applying root cause analysis and failure mode and effect analysis to our compliance programmes. *Journal of Healthcare Compliance* **7** (2).

Laming (2009) *The Protection of Children in England: A progress report.* London: TSO.

Lapakko D (1997) Three cheers for language: a closer examination of a widely cited study. *Communication Education* **46** 63–67.

Obama B (2004) *Dreams From My Father.* New York, NY: Three Rivers Press.

Ott J & Shafritz J (1994) Toward a definition of organizational incompetence: a neglected variable in organization theory. *Public Administration Review* **54** (4) 370–377.

Peck E (Ed) (2005) *Organisational Development in Healthcare: Approaches, innovations, achievements.* Oxford: Radcliffe Publishing.

Pierce C, Carew J, Pierce-Gonzalez D & Wills D (1978) An experiment in racism: TV commercials. In: C Pierce (Ed) *Television and Education* (pp62–88). Beverly Hills, CA: Sage.

Reason J (1990) *Human Error.* Cambridge: Cambridge University Press.

Senge PM (1990) *The Fifth Discipline. The art and practice of the learning organization.* London: Random House.

Sewell H (2009) *Working with Ethnicity Race and Culture in Mental Health: A handbook for practitioners.* London: Jessica Kingsley Publishers.

Singh S, Greenwood N, White S & Churchill R (2007) Ethnicity and the Mental Health Act 1983. *British Journal of Psychiatry* **191** (8) 99–105.

Sue DW, Nadal KL, Capodilupo CM, Lin AI, Torino GC & Rivera DP (2008) Racial microaggressions against black Americans: implications for counselling (Innovations in Multicultural Research). *Journal of Counseling and Development* **86** (3) 330–338.

Waal A de (2007) *Strategic Performance Management: A managerial and behavioural approach.* Hampshire: Palgrave Macmillan.

Williams P (1997) *Seeing a Colour-Blind Future.* London: Virago Press.

Wright BE (1984) *The Psychopathic Racial Personality and Other Essays by Bobby E Wright.* Chicago, IL: Third World Press.

Hári Sewell

Hári Sewell is an independent consultant and former executive director in the NHS and is a writer and speaker in the specialist area of ethnicity, race and culture in mental health. He has worked as an expert panellist with the Department of Health and the Royal College of Psychiatrists. He is Associate Editor of the Journal *Ethnicity and Inequalities in Health and Social Care* and is on the editorial board of *Journal of Integrated Care.* Hári chairs the national Social Care Strategic Network (Mental Health) and is part of the Marmot Review of Health Inequalities post 2010. His book, *Working with Ethnicity, Race and Culture in Mental Health: A handbook for practitioners*, was published in October 2008.