Legal, social, cultural and political developments in mental health care in the UK: the Liverpool black mental health service users’ perspective

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Introduction

Documentary evidence suggests that attitudes among local health and social services professionals towards the concept of user involvement in health and social care remain deeply polarized, a position characterized by commentators simultaneously as praise and damnation. Perhaps user involvement in health and social care will enhance, and it appears to resonate with the logic of, participatory democracy, in localities where the centralization of power has posed questions as to the nature and purpose of local governance in public services provision. The problems experienced by Britain’s black and ethnic minorities within the mental health system have been the subject of exhaustive social inquiry. This essay attempts to explore the way in which legal, social, cultural, and political developments interface with mental health care practice in the UK, in order to assist those responsible for mental health services provision to deliver services that are in line with the Government’s expectation of a modernized mental health service that is safe, sound, and supportive. An exploration of these developments within the European, national (UK), and local (Liverpool) contexts is undertaken. An appropriate local response to national priorities will ostensibly cut a swathe through the barriers confronted by the ethnic minority mental health service user in the cross-cultural context, an important prerequisite for the implementation of genuine user involvement.

Keywords: black community, carer, counselling, human rights, supportive, user involvement

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The European dimension

The procedures governing the assessment, detention and treatment of individuals involved in the mental health services are enshrined within a legal framework, The Mental Health Act (1983). However the Act is also concerned with the safeguarding of individual rights. Indeed, the Mental Health Act Code of Practice (1999) (Department of Health 1999a), which provides detailed guidance on the Act, is unequivocal in its assertion that ‘people to whom the Act applies, including those being assessed for admission should receive recognition of their basic human rights under the European Convention on Human Rights’ (Department of Health 1999a, p. 3).

With the UK being one of the original signatories of the European Convention on Human Rights, its citizens, since 1966, have been entitled to approach the European Court of Human Rights in instances of perceived violations of their human rights. The implications of The Human Rights Act (1998), which incorporates the European Convention on Human Rights into UK law (Chester 1999), was at the forefront of the minds of those responsible for the reform of the Mental Health Act (1983), an essential plank in the Government’s new mental health National Service Framework for England (Department of Health 1998a). Under the Human Rights Act it is unlawful for public services to act in a way that is incompatible with a Convention right, except where this is required by an Act of Parliament. Incorporation of these rights into UK law has the effect of increasing the awareness of mental health service users and their carers or representatives of what constitutes breaches of their rights, and providing them with access to the courts in order to seek redress. In addition, increasing realization of their Convention rights is likely to encourage them to challenge some mental health practices. Indeed, a number of well publicized cases indicate that breaches of the European Convention on Human Rights do occur in the mental health services.

Article 5 protects citizens from unlawful arrest and detention and gives them the right to compensation if they are illegally held:

Article 5.1: Everyone has the right to liberty and security of person; no one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;
(b) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.

In the Bournwood case (R v Bournwood Community Mental NHS Trust 1997), however, Mr L, a 48-year-old-autistic and profoundly mentally retarded man, who had not been sectioned under the provisions of the Mental Health Act (1983), was detained in Bournwood Hospital for treatment of a mental disorder. Although the Trust argued that Mr L was informally admitted under Section 131 of the Mental Health Act (1983), as he did not resist when he was being taken to the hospital, the Court of Appeal took a different view. They held that Mr L had in fact been detained. They said,

...in our judgement a person is detained in law if those who have control over the premises in which he is have the intention that he shall not be permitted to leave the premises and have the ability to prevent him from leaving. We have concluded that this was and is the position of L. (House of Lords 1998, p. 3)

The decision was eventually overturned by the House of Lords, but not before a substantial number of mentally incapacitated individuals were detained throughout the UK.

Another notable case which highlighted an infringement of human rights within the mental health services was that of Stanley Johnson (1997). This concerned a patient who was made subject to a Hospital Order and a Restriction Order following his conviction for assault causing Actual Bodily Harm. In 1989, a Mental Health Review Tribunal found that he was no longer suffering from mental illness and he was granted conditional discharge with a deferral until suitable accommodation could be found. In January 1993, his absolute discharge was ordered on the basis of a report by his psychiatrist that he had not suffered from mental illness since 1987. The period of 3.5 years of detention as a result of a failure to provide a suitable placement in the community was held to be a violation of Article 5(1) of the European Convention on Human Rights (Mental Health Act Commission 1999a), and Mr Johnson was awarded substantial damages.

Hence it is quite clear that if mental health service providers wish to avoid compensation claims for unlawful detention, they will need to act to change practices in relation to these and similar situations. The above examples serve to highlight potential areas of conflict between the European Convention on Human Rights and contemporary mental health practice in the UK. However, the ramifications of the European dimension are considerably more widespread within health and social care practice than have been demonstrated. It has been suggested that the effect of
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the Human Rights Act will depend on the approach taken by the UK courts. However, there are some safeguards against a conservative interpretation of how these rights should apply in the UK. Section 2 of the Human Rights Act (1998) requires UK courts to take into consideration judgments and decisions of the European bodies, which have made pronouncements about Convention rights. Many UK judges are already showing a willingness to apply Convention rights when considering a whole range of issues (Mental Health Act Commission 1999a), and this trend is expected to accelerate. Where UK legislation is found to be in conflict with Convention rights, courts will be required to declare that the particular provision of the piece of legislation in question is incompatible with the Convention. The idea is that Parliament should then be able to give consideration to any changes to legislation that may prove necessary to bring it into line with the Convention.

The national (UK) dimension

This section of the article focuses the discussion at the national (UK) level, with the searchlight turned on the activities of the Mental Health Act Commission, a government-funded agency established in 1983 to protect the rights of persons detained in psychiatric hospitals and mental nursing homes. As well as policing the operations of the Mental Health Act (1983), the Commission investigates patients’ complaints, has direct access to Ministers and publishes a report of work every 2 years. The discussion will demonstrate that the role of the Commission extends well beyond its salient statutory role, into more specific areas such as the race and cultural dimension of mental health practice in the UK; necessarily so, because in the process of carrying out its statutory functions, the Commission has to confront the core issues affecting the ethnic minority community in the UK.

From its first biennial report onwards, the Commission has attempted to draw the attention of Ministers to the disproportionate number of black and ethnic minority persons detained in the mental health system, and the failure to receive treatments appropriate to their needs. For instance, the first biennial report (Mental Health Act Commission (1985) stated that ‘patients from Black and ethnic minority communities suffered disadvantages additional to those commonly experienced by mentally ill people, are detained disproportionately, and in some cases inappropriately’, and highlighted ‘the lack of commissioners from ethnic minority backgrounds’.

The second biennial report (Mental Health Act Commission (1987) highlighted the ‘alienation of black staff, the lack of ethnic monitoring, and the poor quality of the interpretation services’. The fifth biennial report (Mental Health Act Commission (1993) stated that ‘the Commission view with concern the disadvantages that continue to be experienced by people from Black and ethnic minority communities who come into contact with the mental health services’. The sixth biennial report (1993–95) stated ‘Black and ethnic minority groups continue to experience considerable disadvantages in the provision of mental health services because of the difficulty in obtaining treatment that is appropriate to their need’. The seventh biennial report (Mental Health Act Commission (1997) stated, provision for patients from ethnic minority communities often remain basic, insensitive, and piecemeal, leading to patients feeling alienated and isolated. It is dispiriting that the serious issue of inappropriate care and treatment of patients from Black and ethnic minority communities which were raised in previous biennial reports continue to cause concern and to be noted in reports of commission visits.

Finally in its eighth biennial report (Mental Health Act Commission (1999b) the Commission decided to adopt a

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Mental Health Act data (%)</th>
<th>Census data (%)</th>
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<tbody>
<tr>
<td></td>
<td>1996–97 (n = 29 426)¹</td>
<td>1997–98 (n = 33 552)²</td>
</tr>
<tr>
<td>White</td>
<td>84.0</td>
<td>83.3</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>5.4</td>
<td>6.2</td>
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<tr>
<td>Black African</td>
<td>2.7</td>
<td>2.5</td>
</tr>
<tr>
<td>Black Other</td>
<td>1.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Indian</td>
<td>1.7</td>
<td>1.6</td>
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<tr>
<td>Pakistani</td>
<td>1.3</td>
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<tr>
<td>Bangladeshi</td>
<td>0.4</td>
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<tr>
<td>Chinese</td>
<td>0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Other groups</td>
<td>2.4</td>
<td>2.5</td>
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¹Ethnicity not known (1996–97) = 2102 not included in the data.
²Ethnicity not known (1997–98) = 1505 not included in the data.
³Ethnicity not known (1998–99) = 1192 not included in the data.
more proactive strategy by targeting a wide cross-section of mental health services, three specific areas for investigation and data collection. These were ‘ethnic monitoring, racial harassment, and the use of interpreters’.

The collection of ethnic group data for all inpatients was made mandatory from April 1995 following the publication of the Department of Health directive EL (94) 77 (Department of Health 1994). Using the OPCS classification of nine ethnic groups, hospitals were asked to record the number of patients who had been made subject to a section of the Mental Health Act during the periods 1996–1997, 1997–1998 and 1998–1999. Table 1 depicts the breakdown of the figures where ethnicity is known for the past 3 years compared to the 1991 census data on ethnicity in England and Wales. The figures show that the use of the Mental Health Act for Black Caribbean and Black African ethnic groups is between five and six times greater than other groups in the population. The use for Asian groups is roughly in line with the census, while the use among whites is proportionately less than the population of whites indicated by the census figure. In its eighth biennial report, the Commission made reference to the fact that a number of research studies confirm the high use of the Act among the African Caribbean people and suggests that they are more likely to be seen by junior staff, be assessed as violent and to be given physical treatments, with higher doses of medication, and with a greater likelihood of its being administered intramuscularly (Mental Health Act Commission 1999b). These findings accord with the findings of similar studies discussed elsewhere in the article, and have prompted the Social Services Inspectorate to examine the role of Approved Social Workers with particular reference to the incidence of compulsory admissions of people from Black and ethnic minority backgrounds. With a number of inspections scheduled between December 1999 and March 2000, the findings, alongside the data being gathered by the Royal College of Psychiatrist Research Unit study on the way the Act is used, should provide valuable insights. These responses, together with a number of local and centrally funded initiatives within the ethnic minority communities across the UK (Liverpool, Manchester, Birmingham, London), including an unsuccessful attempt at establishing a centrally funded (£3.5 million) mental health unit (Ipamo Project) for Black and ethnic minorities in London, are all part of a co-ordinated response to the concerns outlined in the Mental Health Act Commission’s biennial reports and other studies relative to the mental health services treatment of service users from the Black and ethnic minority communities.

Racial harassment continues to pose a substantial threat to ethnic minority patients detained in these environments, forcing the Department of Health to draw up a plan to end racial harassment in the NHS by embarking on a zero tolerance campaign, which will challenge racial harassment for both staff and patients, with perpetrators facing the threat of prosecution (Department of Health 1999b).

On the use of interpreters, the Commission points out that it is always preferable for patients to communicate to a mental health professional that is able to understand their culture and language, and providers should seek to recruit staff from the relevant backgrounds. The principle of ensuring effective communication with patients is enshrined in section 13(2) of the Mental Health Act (1983), which states, ‘before making an application for the admission of a patient to hospital an Approved Social Worker should interview the patient in a suitable manner.’ Prominence is also given to issues of communication in the first chapter of the revised Code of Practice (Department of Health 1999a), where it states,

local Health Authorities and Trusts should ensure that the ASWs, doctors, nurses, and others receive sufficient guidance on the use of interpreters, and should make arrangements for there to be an easily accessible pool of trained interpreters. Authorities and Trusts should consider cooperating in making this provision.

Notwithstanding the fact that women service users from the Black and ethnic minority community are proportionately fewer in numbers in comparison than men, and evidence from the Department of Health (1998b) indicates a decline in population in these environments, evidence uncovered by the Mental Health Act Commission, which refers to all women mental health service users, suggests that mental health services environments continue to be adversarial, and pose a threat to their wellbeing (Mental Health Act Commission 1999b, pp. 242–246). In the face of this compelling evidence, arguments around the availability of cultural artifacts such as hair and skin care products, which tend to dominate discussions around culture-sensitive care in the popular media, pale into insignificance. The issue has prompted the Department of Health (2000) to publish guidelines with template designs on mixed sex accommodation for mental health services.

Having discussed the role of the Mental Health Act Commission relative to its impact on the core issues affecting mental health service users from the Black and ethnic minority community, including its statutory obligation to bring these matters to the attention of Ministers, it is perhaps appropriate to examine the role of central government, and its attempt to modernize the mental health services, ostensibly to achieve their transformation towards a safe, sound and supportive service. As the ensuing paragraphs will demonstrate, this approach can be the lynchpin of a genuine user involvement model.
The 1990s in the UK saw psychiatry attain unprecedented heights of public profile. Blazing headlines in the media such as, ‘hundreds of psychopaths on the streets’ (The Independent, 26 October 1998), and ‘a violent schizophrenic who stabbed his girlfriend 70 times with a pair of scissors had been allowed by hospital staff to take his own medication at home, it emerged today’ (Evening Standard, 13 November 1998), coupled with endless reportage of cases where psychiatric patients have been involved in violent incidents with members of the public, has ensured a swift political response. With the release of the Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital in January 1999, the Department of Health conducted a root and branch review of the mental health services in the UK, and the legal framework that underpins it (Department of Health 1999c).

Along with those recommendations are to be included a new NHS Charter (Department of Health 1998c), and the establishment of national priorities guidance for health and social care (Department of Health 1998d). Finally, the Home Office responded to the inquiry report from Ashworth Hospital with its own set of proposals for managing dangerous people with severe personality disorder (Department of Health & Home Office 1999). Although these reviews, reports and recommendations may be described as largely reactive, emerging at a time of heightened public awareness of the health and social care concerns they purport to address, their usefulness as mechanisms for addressing anomalies in the mental health services handling of Black and ethnic minority service users, repeatedly highlighted in the Mental Health Act Commission biennial reports and other studies, should not be discounted.

The document Modernising Mental Health Services outlines the Government’s strategy for a National Service Framework for mental health. It attracts an investment of nearly £700 million for reform, and describes the way in which it intends to achieve safe, sound and supportive mental health services in the future (Department of Health 1998a). An important component of its commitment to providing supportive services entails involving service users and carers. In order to bolster its view on the importance of user involvement, the document makes reference to a number of research reports which bear witness to the beneficial impact that user involvement can have, and recognizes the need for action as a means of delivering a better quality of care to women, people from Black and ethnic minority populations and socially disadvantaged groups. The Department of Health was concerned to point out that decisions about care and treatment should be a joint endeavour between staff and service users, and discussed with carers as well; that carers are partners alongside health and social services in providing care and support to people with mental health problems. The document commits to the future publication of a Carers Strategy, which will emphasize the benefits of involving carers in decisions and service planning which affect their lives, and those of the people they care for (p. 47), sentiments which mirror the intentions of this paper.

The Government’s proposals outlined in Reform of the Mental Health Act (1983) (Department of Health 1999c) arose from the need to modernize the legal framework, within which mental health care is delivered, proposals which will underpin the National Service Framework for mental health and contribute towards mental health services that are genuinely safe, sound and supportive. The document recommends that advocacy should be established as a statutory right (p. 66). This will clearly strengthen the role of organizations such as MIND, already well known across the UK for their ‘championing of service users’ rights’ role. It proposes that the Mental Health Act Commission should be reconstituted as independent of the Secretary of State, and answerable only to Parliament. Its role should be extended in a number of respects, including an extension of its remit to cover all patients (voluntary and involuntary) in hospital, and to extend its activities to cover detained persons in both hospital and community settings (p. 88). Perhaps these recommendations, if implemented, will assist in the transformation of the Mental Health Act Commission towards a more effective entity in the pursuance of its statutory functions. An independent body will strengthen the Commission’s thrust towards the fulfillment of its vision of an inspectorial agency within the special hospital setting, where its role is often eroded by the common perception among the staff who run these settings (and patients) that it is nothing more than a ‘toothless tiger’. Perhaps more significantly, (voluntary) mental health service users, whose rights are not currently specified within the Act, will ostensibly be empowered by their inclusion within its remit. Hence these changes will have important ramifications for mental health service users in both secure and community settings, including those from Black and ethnic minority communities.

The document Modernising Health and Social Services (Department of Health 1998d) outlines the Government’s national priorities for its public health agenda. It intends to achieve this by promoting better partnership working between health, social services and local government. Hence the document needs to be read in conjunction with the white paper, Modern Local Government: In Touch with the People, which sets out plans to strengthen council’s powers to enter into partnerships with bodies such as the NHS. The new legislation will place a duty on local authorities to promote the economic, social and environmental well-being of their population (p. 3).
In its drive to place responsibility for health promotion across the whole spectrum of public services, the Government recognizes that public health has been relatively neglected, and the rampant health inequalities, so extensively documented in the Black Report (Black et al. 1980), are widening. The key areas of the document, which contribute towards the stated aims of this article, are:

Targeting investment to improve facilities for both patients and staff, but in particular, the elimination of mixed sex wards to meet the objectives on standards of privacy and dignity for hospital patients by the year 2002 (p. 9), the implementation of which will have a direct impact on the environments in which women mental health service users are cared for, and more specifically, women mental health service users from Black and ethnic minority communities.

The elimination of local health inequality by the inclusion within the Health Improvement Programmes, targets aimed at ensuring fair access to services for black and ethnic minority groups (p. 15).

Strengthening the Regional Offices of the Social Services Inspectorate to enable more active monitoring and review of local Social Services Authorities (p. 63), will ostensibly impact on the concern expressed by the Mental Health Act Commission that the perception of, and the manner in which the Mental Health Act (1983) procedures are utilized by social workers, may be contributing to the high numbers of mental health service users detained in the mental health services.

These measures sit comfortably alongside the development of Primary Care Groups and Community Trusts (p. 19). Locally-based services will have a greater impact on reducing health inequalities by being more in touch with the needs of service users. With the knowledge that, in their current format, services provoke avoidance among service users from the Black community and fail to offer support during periods of crisis, including counselling services, these measures are long overdue. In the following paragraphs an attempt is made to focus the discussion on developments at a local (Liverpool) level. Clearly, an effective local response to the national priorities outlined in the previous paragraphs is crucial for the transformation of mental health practice, and the eradication of the anomalies that have now become an established tradition in the mental health treatment of service users from the Black and ethnic minority communities.

The local (Liverpool) dimension

In the ensuing paragraphs the discussion will focus on the extent to which the statutory organizations (purchasers and providers) in Liverpool have anticipated the Government’s expectation of a modernized mental health service that is safe, sound and supportive, and more specifically, its perception of user involvement as a statutory obligation.

In July 1997 the City of Liverpool Social Services Directorate and Liverpool Health Authority published a revised version of A Joint Agency Agreement for Mental Health Services and A Joint Strategy for Mental Health in Liverpool (Liverpool Health Authority and the City of Liverpool Social Services Directorate 1997). Its publication was hailed as the blueprint for the development of mental health services (inside cover). The document was drawn up by a subgroup consisting of representatives of purchasers of mental health services in Liverpool, providers of those services from public, private and voluntary agencies, and representatives of people who use those services. At the time of the strategy’s implementation, both the Liverpool Social Services and the Liverpool Health Authority presided over a joint mental health annual expenditure of £25874 500.

User involvement purportedly occupies a significant niche in the strategy, and during the 5 years leading up to its publication, the strategy claims that people who have experienced mental distress or illness have been involved in planning, developing, managing and monitoring services. It highlights an extensive list of projects that service users have been involved in, and in which they continue to be involved, and outlines the services’ intentions for the future development of user involvement (p. 3).

The strategy highlights a number of mental health needs assessments, conducted locally, which served to underpin its intentions, including a research project aimed at exploring people’s views and experiences of mental health services in Liverpool (Gibbings et al. 1995). Of the 83 respondents interviewed, 10 were from the Black and ethnic minority community, who were also interviewed by a Black interviewer. The sample was drawn from day centres and users of primary health care, and interviews were conducted between July 1993 and September 1994. According to the researchers, the study confirms the following six points:

The quality of life of people with mental health problems living in the community is determined as much by social and economic conditions as it is by the standards of health services. Respondents emphasized the importance of acceptable accommodation and adequate income maintenance. Like most other citizens, people with mental health problems prefer to have control over their own living and income arrangements. They both want to live outside of hospital and enjoy a reasonable standard of life in the community.
The latter is only achievable if people with mental health problems can be offered choices about their living and employment arrangements and can gain access to supportive relationships.

Professional services and their personnel (whether in the primary or secondary care sectors) are judged by ordinary expectations about humane considerations and civility. Service users rarely expect cures or dramatic expert interventions. Instead, they largely accept the need for medication and services and place a positive value on being treated with respect and on being offered a listening ear and practical support, especially when they experience acute periods of distress.

Respondents emphasize the need for mental health specialists to be readily accessible and for them to negotiate forms of interventions which are acceptable to service users. Inaccessible services, long waiting times and interventions imposed by experts are resented or are met with resignation. Respondents emphasized the need for 24-hour support, although views varied on the form this should take.

When respondents had been inpatients they commented on both environmental and staff characteristics. Dingy, dirty wards received criticism, as did insensitive and coercive staff interventions.

Respondents views about treatment were clear: talk is generally preferred to medication and electroconvulsive therapy, although medication was generally endorsed as being useful; treatment should be negotiated not imposed; alternatives should be made available in response to a problem and information made available to recipients about the nature and risks of treatments offered.

Respondents had a complex and multifactorial view about the origins and maintenance of their problems. They would prefer others to respect and empathize with this complex view.

The Mental Health Directorate at Aintree Hospitals (NHS) Trust is the largest acute psychiatric inpatient service provider in Liverpool. In 1995, concerns about the negative feedback received from service users and their carers, concentrated the minds of managers to commission a users’ view project, aimed at collecting the views of service users and incorporating the recommendations within practice. Forty-four mental health service users were interviewed and their responses analysed (Evans 1995). The responses indicated similar preoccupations with the issues which concerned service users in the study referred to in the joint strategy above.

In July 1997, following a highly critical Mental Health Act Commission report, the Purchasing Health Authorities of the mental health services at Aintree Hospitals (NHS) Trust commissioned the independent mental health consultants, Orangewood, to carry out a series of consultation exercises with service users, carers and staff, and to make recommendations. During that consultation, the Health Authorities committed to carrying out a further consultation after a period of time, to ascertain whether improvements had been made. The recommendations in the follow-up consultation (Orangewood 1999), reflected service users preoccupations in the first exercise (Orangewood 1997), and also mirrored the findings in Evans (1995) study.

The joint strategy for mental health in Liverpool has highlighted numerous laudable examples of evidence of user involvement. For instance, service user input into staff training, increased service user representation on the Joint Care Planning Team Mental Health Sub-group, a worker and budget for the joint forum, joint training for service user and staff, three stakeholders conferences, MIND advocacy project at Aintree Hospitals (NHS) Trust, and a Patients’ Council (Broadoak Hospital) (p. 3). These examples provide irrefutable evidence that the model of user involvement utilized within the statutory mental health services in Liverpool enables service users to contribute remarkably to the services’ structural formation. Its further development, however, will ostensibly enable them to contribute towards the transformation of mental health practice and the perception of those responsible for implementing its procedures. Evidence of this will become available when the core themes which underpin service users’ concerns, the recurrence of which have been consistent across all the service user consultations outlined above, begin to disappear. Support for this proposition is provided by the recurrence of these themes across both community and inpatient mental health services in Liverpool. The solution to this problem is not an impossible dream, but a necessary possibility, as the following consideration demonstrate.

In the service users’ experience of mental distress in Liverpool study (Gibbings et al. 1995), described in the joint strategy as one of the needs assessment which underpin its thinking, the researchers rightly point out, ‘within the limits of the method used the findings of the study are generally consistent with the themes identified in previous research on mental health service users’. A recurrent theme in the study, and an issue that has now assumed an aura of consistency in all similar studies in the City, is the services’ failure to offer opportunities for counselling to service users (Evans 1995, Gibbings et al. 1995, Orangewood 1999, Pierre 1999). This finding belies the fact that the Liverpool Psychotherapy and Consultation Service offers a comprehensive range of psychotherapies, including psychodynamic, systematic and behavioural techniques in individ-
ual, family or group settings through the expertise of a multidisciplinary team based at Mossley Hill Hospital (p. 4). In addition, the Psychology Service offers a full range of clinical psychology, including psychotherapy, psychological counselling, cognitive therapy and anxiety management, and an on-site service for general practitioners (GPs), also based at Mossley Hill Hospital (p. 4). Interestingly, the researchers highlight the lack of information about services as an enduring issue among service users, and that this could also apply to GPs, who tend to refer to the services they know. The researchers noted the high prevalence of anxiety and depression among females, and pointed to the increased workload for GPs in deprived areas, two of which (Breckfield/Vauxhall and Granby) were selected for this study, and raised the question as to how these busy inner city practices could be supported. Clearly, with respect to the problem outlined in the study (demand for counselling services), the solution would not require a colossal effort! Regrettably, the lack of GP support in the face of service users’ cry for help during periods of mental distress, flies in the face of evidence contained in the Government’s own Green Paper, “Modernising Mental Health Services” (Department of Health 1998a), which outlines its expectations for a safe, sound and supportive service. The quality of the relationship between patient and professional in psychological therapies can make as much as a 25% difference in outcome. Patients and service users value being involved and informed and a better standard of day to day practice in this area is clearly essential to the delivery of good quality care (Department of Health 1998a, p. 47).

In conclusion, the essence of the preceding discussions is that the empowerment of mental health service users and their carers (or representatives) is now shown to colonize the minds of mental health policymakers and other statutory bodies, which is seen to operate at European, national (UK) and local levels, whose role may hold the balance of power between the disempowered Black mental health service user and the presumed superiority of the mental health professional. The choice of material utilized in this article is in no way exhaustive. However, the above selection will ostensibly suffice in the author’s endeavour to highlight their importance for the purpose of advancing this important issue – which sees psychiatry in the cross-cultural context in the UK struggling to maintain its integrity as a caring profession – towards its stated aims.

References


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