National Programme for Improving Mental Health and Well-Being

Addressing Mental Health Inequalities in Scotland

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SCOTTISH EXECUTIVE

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Written by
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Acknowledgements

The authors would like to thank the speakers and delegates who contributed to the *Equal Minds* conference held in Edinburgh in October 2003. Their knowledge and enthusiasm were the important catalysts for this report. Our thanks also to the small group of people who convened in June 2004 and who helped to maintain the momentum.

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Key to Abbreviations

BME   People from black and minority ethnic communities

CRE   Commission for Racial Equality

DDA   Disability Discrimination Act 1995

DH   Department of Health

DRC   Disability Rights Commission

EOC   Equal Opportunities Commission

ISD   Information and Statistics Division, NHS National Services Scotland

LGBT   Lesbian, Gay, Bisexual and Transgender people

SDC   Scottish Development Centre for Mental Health

SEU   Social Exclusion Unit of the Office of the Deputy Prime Minister

WHO   World Health Organization

Joint Ministerial Foreword

The Scottish Executive has a vision of an open, just and inclusive Scotland where respect and understanding are fostered and where everyone is encouraged and enabled to live, work and take part in society to their full potential, free from prejudice and discrimination.

Work on mental health issues and well-being is an important part of our wider work to promote equality. People with mental health issues do face discrimination – but they may also face it by virtue of their gender, language, age, social origin, ethnicity, other/multiple disability, religion or belief, or sexual orientation. We want to encourage greater understanding of how these issues relate, we want to open the debate about how services should respond, and we want to raise awareness amongst mental health practitioners and service users.

In October 2003, with financial support from the Scottish Executive's National Programme for Improving Mental Health & Well-being, the Scottish Development Centre for Mental Health held a major national conference on the theme of inequalities, equalities and mental health.

Material and discussions from the conference have been used to develop this extensive resource document. *Equal Minds* includes an overview of published literature. It identifies key issues and challenges in understanding and addressing discrimination and inequality in mental health. It will inform discussions on policy, planning and practice at a local and national level in Scotland, both in specialist mental health fields and in the areas of equality and inclusion.

We think it is a valuable resource and we both support this work and take joint ownership of the document in the hope that it does serve to influence debate. We hope it will be well-used by those in the NHS, local authorities and the voluntary sector, and that it will support the emerging Community Health Partnerships in tackling health inequalities at local level.

Lewis MacDonald MSP
Deputy Minister for Health & Community Care

Malcolm Chisholm MSP
Minister for Communities

Chapter One
Introduction and Background

Introduction

How does being a woman or a man, being young or old, or from an ethnic minority community affect mental health? How does poverty and deprivation affect well-being? What does having a mental health problem have on the chances of being discriminated against? These were the questions which formed the basis for the *Equal Minds* conference held by the Scottish Development Centre for Mental Health (SDC) in Edinburgh in October 2003, around which this working paper has been developed.

The conference started from the belief that poverty, deprivation, discrimination and inequality are fundamentally unjust, detrimental to individual and community mental health and well-being, and can undermine the recovery of people who experience mental health problems. The conference provided a space in which to bring together some of the evidence for these claims and look at ways of breaking this vicious circle of social injustice.

The National Programme for Improving Mental Health and Well-Being (The National Programme), which financially supported the conference, subsequently commissioned the SDC to prepare this working paper with a view to developing the discussions held at the conference: bringing together further evidence of mental health inequality in Scotland and exploring the implications for policy and practice.

Although funded by the National Programme the views expressed are those of the authors.

Why Now?

The questions the conference raised are not new so why raise them now? First, the questions may have been asked, and the evidence collected, but the 'injuries' (Rogers and Pilgrim, 2003) to mental health and well-being arising from poverty, deprivation, discrimination and inequality, are still being sustained: addressing the hurt continues to be a challenge.

Secondly, the political and policy environment suggests an increased willingness to face up to this challenge. Under the umbrella policy of Social Justice 'A Scotland where everyone Matters' (Scottish Executive, 1999) the policy field of vision has focused increasingly on tackling the causes of social injustice, in addition to responding to the effects. In health policy this is reflected in the increasing emphasis being given to measures for achieving improvements in health and reducing health inequalities (Scottish Executive, 2003a).

This widening policy field of vision is mirrored in the approaches being taken toward mental health. From a largely (though not exclusively) service orientation, embodied in the Framework for Mental Health Services (Scottish Office, 1997) increasing attention is being given to improving community and individual mental health and well-being through promotion and prevention. The key catalyst is the National Programme, launched in October 2001. The Programme's aims for the three years 2003–2006 are to: raise awareness and promote mental health and well-being; eliminate stigma and discrimination; prevent suicide; and promote support and recovery (Scottish Executive, 2003b). To improve mental health means, of necessity, having to look at, and tackle, the sources of injustice and inequality which undermine individual and community mental health and well-being as well as the discrimination and disadvantage experienced by people who have mental health problems.

Thirdly, the legislative context underpins and reinforces the importance of the equalities and anti-discrimination message. This includes recent employment directives (relating to sexual orientation and religion/beliefs), amendments to the race relations legislation, proposed changes to the Disability Discrimination Act, together with the proposal to establish a UK-wide Commission for Equalities and Human Rights as well as a Scottish Commission for Human Rights. Specifically in relation to mental health, the principles behind the Mental Health (Care and Treatment) (Scotland) Act 2003, similarly reinforce the significance of ensuring equality and respecting diversity in responding to the needs of people with mental health problems.

What is meant by Mental Health Inequality?

The World Health Organization defines health inequality as 'differences in health status or in the distribution of health determinants between different population groups' (http://www.who.int/hia/about/glos/en/index1.html). The focus is therefore on both the causes and the effects of differential health status. Adopting this formulation in the context of mental health means considering the unequal distribution of the factors which are detrimental to mental health and well-being and/or promotive of positive mental health; and the distribution of mental illness/mental health problems between different population groups.

Drawing from Melzer, D. *et al* (2004, p. 9), inequality and inequity might occur in the distribution of:

Mental illness or mental health problems

Personal and social factors causing mental illness and mental health problems

Personal and social factors that increase resistance to mental illness and mental health problems

Personal and social factors that facilitate recovery

Personal and social factors that handicap individuals with mental illness and mental health problems

And/or access to services that help to prevent mental illness

And/or access to services that limit morbidity in duration or severity of mental illness and mental health problems

And/or access to services that diminish social disadvantage

Unequal distributions result not only from individual/genetic factors, or specific traumatic events, but the accumulation of 'insults' or 'injuries' (Rogers and Pilgrim, 2003) to mental health sustained through social, economic, ecological and environmental disadvantages. These disadvantages are not randomly distributed: some people and communities are exposed to greater risk than others. While epidemiological data suggest that 1 in 4 people may experience a mental health problem, it is not any 1 in 4. As Rogers and Pilgrim argue 'Mental health problems are not distributed in a non-random way in society. They reflect social divisions (of class, age, race and gender), and sometimes make a direct contribution to social inequalities (for example when patients suffer stigma and labour market disadvantage)' (2003, p.16).

This suggests there are three main social and economic influences on population mental health and well-being:

Class or socio-economic status. The experience of poverty and economic inequality are associated with poorer mental health and well-being.

Social identity. Social identities are those aspects of ourselves to which society attaches significance. This can include our gender, our ethnicity, our sexual orientation, our age, our religion or beliefs or whether we have a disability.

We all have a number of different 'social identities', e.g. as a white woman who is a lesbian or as an older black man. Some of these identities we ascribe to ourselves, others are ascribed to us.

Some aspects of social identity are viewed by ourselves and society as positive and, as such, can be protective or resilience factors in the face of difficulties. However, other aspects of our social identities can expose us to discrimination, stigma and prejudice in the form of, for example, racism, homophobia, sexism and ageism. The experience of discrimination, prejudice and stigma can undermine our mental health and well-being, both directly and indirectly through the experience of inequality, poverty and deprivation with which they are associated.

Experience of a mental health problem or mental illness. The discrimination, prejudice and stigma which someone may face because they have had or are experiencing a mental health problem or a mental illness may expose them to the risk of poverty, deprivation and inequality.

Mainstreaming Equality: Mainstreaming Mental Health

'Mainstreaming equality is essentially concerned with the integration of equal opportunities principles, strategies and practices into the every day work of Government and other public bodies from the outset … It is a long-term strategy to frame policies in terms of the realities of people's daily lives, and to change government organisational cultures and structures accordingly ... It entails re-thinking 'mainstream' policy making and service provision to accommodate gender, race, disability and other dimensions of discrimination and disadvantage, including class, sexuality and religion.' (MacKay and Bilton, 2003)

The Scottish Executive's Equalities Strategy (2000a) is based on a principle of 'mainstreaming'. This is seen as a long-term strategy for integrating and embedding an equalities perspective throughout the work of the Government and other public bodies. The aim is to ensure that 'policy-making is fully sensitive to the diverse needs and experiences of people'.

To begin to work through the policy and practice implications of the different sources of mental health inequality, the working paper both adopts and adapts the idea of mainstreaming. It is suggested that to achieve mentally healthy policy and practice there is a need to:

- Mainstream mental health improvement goals in policies and practices aimed at achieving social justice and closing the opportunity gap (and in ways that take into account the unequal distribution of mental health risk factors within and across different social groups).

And

- Mainstream social justice/equalities goals within mental health policies and services.

The Working Paper: Approach and Structure

Approach

The working paper draws on published and unpublished 'grey' literature, and includes policy statements as well as research studies. Material was identified through a combination of database and website searches and citations in the literature. It was not possible, however, within the scope of the project to cover all areas in extensive depth. Further, it was not intended to be a Cochrane-type review ranking different types of research evidence. Rather it was concerned to identify from a broad overview of the material key themes and issues. Attention is also drawn to areas where there appear to be gaps in research or where the available data is contradictory or ambiguous.

The presentations and discussions at the *Equal Minds* conference were drawn on both to contribute to the evidence base but also to inform the analysis. Early thoughts and ideas were further exchanged and developed in the course of a small 'roundtable' discussion with people with experience and knowledge in the fields of equalities, social inclusion and mental health.

Working paper structure

Chapter 2 provides a brief overview of the policy and legislative context. Facts and figures indicating the extent of poverty and deprivation in Scotland and the nature of health inequalities, including mental health inequalities are described in Chapter 3.

Having set the population and policy context, Chapter 4 presents evidence indicating how poverty, deprivation, inequality and discrimination can affect mental health, well-being and recovery and the factors that can protect people from 'injury'.

Chapters 5 to 8 begin to follow through in more detail the implications of this evidence for policy and practice in relation to: women and men, people from black and minority ethnic communities, lesbian, gay, bisexual and transgender people, and people with disabilities, including people with mental health problems. The implications for younger people and older people are discussed across each of these sections.

The final chapter sketches out some of the implications for policy and practice.

Chapter Two
Policy and Legal Context

Policy Context

The concept of *healthy public policy*, introduced in the Ottawa Charter, (WHO, 1986) maintains that to realise the twin goals of improving population health and reducing health inequality requires action across policy domains. This implies 'directing [policy makers] to be aware of the health consequences of their decisions and to accept their responsibilities for health (Ottawa Charter, p.2, WHO, 1986). Adapting this concept, to achieve *mentally healthy public policy* implies mainstreaming responsibility for mental health improvement and redressing mental health inequalities across health services (including physical health care) and into other non-health domains.

To understand this within the current policy climate in Scotland it is useful to think of a layering of interlinked and mutually reinforcing policies.

At a 'global' level overarching policies establish the broader anti-poverty, social justice and inequalities policy agenda. In Scotland this is articulated through the Social Justice strategy which aims to reduce the causes of poverty and sources of injustice, 'by improving public services for all, by tackling the social, educational and economic barriers that create inequality and by working to end poverty' (Scottish Executive, 2002b, p.5). As part of this agenda a Cabinet Delivery Group on Closing the Opportunity Gap has agreed a high level objective to reducing the health gap between the most affluent and the most deprived communities.

Equal opportunities legislation remains a power reserved to the UK Parliament. Under the Scotland Act 1998, however the Scottish parliament has the power to encourage equal opportunities, and to place duties on Scottish and cross-border public bodies to have due regard to equal opportunities legislation in their work in devolved areas. The equalities strategy, published in 2000 sets out the Executive's aims for encouraging equal opportunities (Scottish Executive, 2000a).

The next 'layer' of policies are those relating to specific areas which individually, jointly and cumulatively contribute to these overarching objectives for example, components of policies relating to community regeneration, housing, education, children/young people, employment, transport and health.

At the third level are activities within specific policy domains. In the area of health policy there are two potential routes for contributing to social justice goals: via health care and services and through programmes for health improvement. Policies for health improvement specifically include the aim of reducing health inequalities including mental health inequalities (Scottish Executive, 2003a). In 2004 A Joint Ministerial Steering Group on Health Improvement and Inequalities was established between Scottish Ministers and COSLA's political leaders, to provide political input engagement and strategic leadership to promote health improvement and tackle health inequalities.

As described in Chapter 1 above, the catalyst for mental health improvement in Scotland is the National Programme for Improving Mental Health and Well-Being.

Linking the different policy domains is a strategy such as *Healthy Working Lives* (Scottish Executive, 2004b). This seeks to improve health and reduce health inequalities through workplace policies on health and safety, and strategies for enhancing the employability of people who, for health reasons may be at risk of losing their work, or find it difficult to return to employment.

Vehicles for achieving cross-cutting objectives, including health improvement and reducing health inequalities, include Community Planning and Community Health Partnerships (CHPs).

Community Planning is intended to promote joined up working between organisations in order to develop a shared strategic vision for a geographical community, providing enhanced opportunities for community participation and encouraging more integrated service delivery across organisational boundaries (Scottish Executive, 2004c).

Through community planning structures health boards, local authorities and their partners in the community and voluntary sector are expected to work jointly to develop proposals to improve the health and well-being of the local community.

Separate from, but linking in with Community Planning processes, the roles of CHPs include improving local population health and providing accessible and integrated services to local communities (Scottish Executive, 2004d). In relation to mental health services CHPs are seen as having a key role in achieving the objectives and outcomes of current national mental health policy programmes. CHPs will be required to promote the mental health and well-being of their local populations and the physical health of those with mental health problems and their carers (Scottish Executive, 2004e).

Legal Context

The legal frameworks supporting equalities and outlawing discrimination or abuses of human rights comprise:

- Legislation intended to protect civil and political rights, such as the Human Rights Act 1998. This enshrines the principles of the European Convention of Human Rights within UK law.

- Equalities and anti-discrimination legislation such as the Sex Discrimination Act 1978, Race Relations Act 1976 and Race Relations Amendment Act 2000 and Disability Discrimination Act 1995.

- Legislation intended to protect the rights of vulnerable people such as the Mental Health (Scotland) Act 1984, its successor, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

- Legislation intended to promote the well being of citizens, for example the Local Government in Scotland Act 2003.

European Convention on Human Rights (ECHR) the Human Rights Act 1998 and the Scotland Act 1998

The ECHR is a series of civil and political rights intended to protect the individual against abuse of power by the state. The Human Rights Act 1998 incorporates into UK law many of the provisions, or 'convention rights' of the ECHR. All public authorities must comply with the rights and standards set out in the Human Rights Act. Under the Scotland Act 1998 the Scottish Parliament and the Scottish Executive are under a legal duty to comply with the convention rights.

There are 16 convention rights in the Human Rights Act. The convention rights with particular implications for the care and treatment of people with mental disorder include:

- Article 2 – The right to life

- Article 3 – Freedom from torture, inhuman and degrading treatment

- Article 5 – The right to liberty and security of the person

- Article 8 – The right to respect for private and family life, home and correspondence

- Article 14 – Prohibition of discrimination in the enjoyment of convention rights

- Protocol 1, Article 1 – The right to peaceful enjoyment of possessions and protection of property

A guide to human rights for the voluntary sector is currently in preparation by the Scottish Human Rights Trust. Commissioned by the Scottish Executive and due for publication in the next few months this summarises the implications of human rights legislation for people with a mental disorder, people with disabilities, children and young people and in relation to sexual orientation and gender identity.

Equalities and anti-discrimination legislation

Equalities and anti-discrimination legislation encompasses sex, race, disability, sexual orientation, religion and belief. Some pieces of legislation relate specifically to employment and training, others extend to access to goods and services.

The Race Relations Amendment Act 2000 also places a duty on public authorities to promote race equality. A draft Disability Discrimination Bill, published by the UK government in December 2003 includes proposals for a similar duty to be placed on public bodies to promote equality of opportunity for disabled people.

In July 2003 the UK Government consulted on proposals for the implementation of proposals outlawing age discrimination in employment and vocational training (DTI, 2003). Responses to the consultation are currently being considered with a view to developing new legislation to come into force on 1 October 2006.

Table 2.1 summarises some of the key pieces of UK anti-discrimination legislation. This draws on a factsheet produced by the Women and Equality Unit (http://www.womenandequalityunit.gov.uk). Although not included here the information sheet also includes relevant European Treaties and Conventions and International obligations.

Table 2.1 Key pieces of UK anti-discrimination legislation

Legislation/year	Area covered
Equal Pay Act 1970 (as amended)	Gives an individual a right to the same contractual pay and benefits as a person of the opposite sex in the same employment where the man and the woman are doing like work; work rated as equivalent; work that is proved to be of equal value.
Sex Discrimination Act 1975 (as amended)	Prohibits sex discrimination against individuals in the areas of employment, education and the provision of goods, facilities and services and in the disposal or management of premises.
Sex Discrimination Act (Gender Reassignment) Regulations 1999	Prevents discrimination against transsexual people on the grounds of sex in pay and treatment in employment and vocational training.
Race Relations Act 1976	Makes it unlawful to treat another person less favourably than another on racial grounds. This includes race, colour, nationality (including citizenship) and national or ethnic origin.
Race Relations (Amendment) Act 2000	Outlaws direct and indirect discrimination and victimisation in all public authority functions not previously covered by the Race Relations Act. Places a general duty on specified public authorities to promote race equality.
Race Relations Act 1976 (Amendment) Regulations 2003	Implements European Community Article 13 Race Directive. The Regulations enhance the Race Relations Act by, for example, amending the definition of indirect discrimination and changing the way in which the burden of proof applies. The Regulations extend protection from discrimination on the grounds of race and ethnic or national origins. These apply in the fields of employment and training, social protection and social advantage, education, the provision of goods, facilities and services and housing.

Table 2.1 continued

Legislation/year	Area covered
Disability Discrimination Act 1995	Prohibits discrimination against disabled people in the areas of employment, the provision of goods, facilities, services and premises, education; and provides for regulations to be made to improve access to public transport.
Employment Equality (Sexual Orientation) Regulations 2003	These regulations outlaw discrimination (direct, indirect, harassment and victimisation) in employment and vocational training on the grounds of sexual orientation. Apply to discrimination of the grounds of sexual orientation to persons of the same sex, the opposite sex, and the same and opposite sex.
Employment Equality (Religion or Belief) Regulations 2003	These regulations outlaw discrimination (direct, indirect, harassment and victimisation) in employment and vocational training on the grounds of religion or belief. Apply to discrimination of the grounds of religion, religious belief or similar philosophical belief.

Source: Women and Equality Unit, *Key Anti-Discrimination Legislation and International Obligations,* (http://www.womenandequalityunit.gov.uk/)

Protecting and promoting the rights of vulnerable people

The Mental Health (Care and Treatment) Act 2003

The Mental Health (Care and Treatment) Act 2003 specifies the grounds under which someone with a mental disorder can be detained in hospital or given treatment compulsorily. It also builds in safeguards to protect people's rights, including people who are not formally detained. These include the right to independent advocacy, the right to nominate a named person who would be informed, or act on behalf of a patient, the right to make an advance statement and the right of appeal against detention in conditions of excessive security. The system of tribunals and the additional safeguards required before some treatments can be administered provide important structures for protecting rights.[1]

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1 For more information on the implementation of the Act see
   www.scotland.gov.uk/health/mentalhealthylaw

The Act also places a duty on local authorities to provide for people with a mental disorder who are not in hospital services to promote their well-being and social development.

Underpinning the Act are 10 principles developed by the Millan Committee set up to review the operation of the Mental Health (Scotland) Act 1984. These include principles of non-discrimination, equality, respect for diversity and reciprocity (Scottish Executive, 2001a).

The Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act 2000 is intended to safeguard the interests of adults who are not able to take some or all decisions for themselves. The Act covers people with dementia, adults with a learning disability, head injury or severe mental illness, and people with severe communication difficulties caused by physical disability. The Act introduces a range of different provisions to enable decision-making in relation to the financial affairs of an adult with incapacity and/or their health and welfare.[2]

Local Government in Scotland Act 2003

Under Part 3 of the Local Government in Scotland Act 2003 local authorities have the power to promote or improve the well being of their area and/or the people within their area. Guidance issued in 2004 includes as examples of the possible ways in which this power can be used: improving mental, social and physical health; tackling poverty and deprivation; reducing inequalities and promoting equalities; encouraging participation and community capacity building (Scottish Executive (2004f).

Antisocial Behaviour etc (Scotland) Act 2004

For many of the groups of people described in the following chapters, including people with mental health problems, one source of disadvantage is fear of harm or abuse (DRC/Capability Scotland, 2004; Mind, 2004). Although not specific to these groups of people one indirect source of protection may come from the Antisocial Behaviour etc. (Scotland) Act 2004. Under this piece of legislation local authorities, together with the relevant Chief Constable, are required to prepare a strategy for dealing with anti-social behaviour in the Council area. The strategy will set out the nature of anti-social behaviour in the area, the services available for preventing and tackling this behaviour, including for victims, and new services required to fill gaps in provision (Scottish Executive, 2004g). For the purposes of the Act, someone who acts or pursues a course of conduct that causes or is likely to cause alarm or distress is engaging in antisocial behaviour (section 143).

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2 More detail on the different provisions of the Act can be found on the Scottish Executive Adults with Incapacity website: www.scotland.gov.uk/Topics/Justice/Civil/16360/4927. For research on part 5 of the Act covering medical treatment and research see Davidson, S *et al* (2004) *Review of the Implementation of Part 5 of the Adults with Incapacity (Scotland) Act 2000*, Edinburgh: Scottish Executive. Analyses of the implementation of Parts 2, 3 and 6 can be found in Killeen, J *et al* (2004), *the Adults with Incapacity (Scotland) Act 2000: Learning from Experience*, Edinburgh: Scottish Executive.

Hate Crime Working Group

In England recent amendments to the Criminal Justice Act 2003 introduced tougher sentences for offences aggravated by hostility towards the victim because of his or her sexual orientation or disability, including mental health (SEU, 2004). In Scotland an amendment to the Criminal Justice (Scotland) Bill 2003, proposed creating an offence in which crimes aggravated by prejudice against social groups on the basis of age, disability, gender or sexual orientation received a higher sentence or punishment. The amendment was not adopted, but the Scottish Executive set up a Hate Crime Working Group to look at the matter more closely. The Group, which reported in September 2004, included among its recommendations that 'the Scottish Executive should introduce a statutory aggravation as soon as possible for crimes motivated by malice or ill-will towards an individual based on their sexual orientation, transgender identity or disability' (Scottish Executive, 2004q).

A Commission for Equalities and Human Rights

Following separate exercises in Scotland on proposals for a Scottish Human Rights Commission (Scottish Executive, 2003c) and across Great Britain on a new Commission for Equality and Human Rights (CEHR) (DTI, 2001; DTI, 2002), in May 2004, the Department of Trade and Industry published the white paper Fairness for All: *A New Commission for Equality and Human Rights* (Cm 6185). This set out proposals for a single Commission bringing together the work of the three existing equality commissions: the Commission for Racial Equality, the Equal Opportunities Commission and the Disability Rights Commission, and taking responsibility for promoting human rights. It is envisaged that the core functions of the CEHR would comprise:

- Encouraging awareness and good practice in equalities and diversity.

- Promoting equality of opportunity.

- Working towards eliminating unlawful discrimination and harassment.

- Promoting awareness and understanding of human rights.

- Promoting good relations among different communities and between these communities and wider society.

The Commission would have a GB-wide remit but it is anticipated that a Scottish Commissioner and Committee will be established to plan and oversee the CEHR's work in Scotland. The Scottish Human Rights Commission would also have responsibility for human rights in relation to devolved matters (Scottish Executive news release, Sec444c/ 12 May 2004).

Chapter Three

The Scottish Effect and Mental Health – Some Facts and Figures

Scotland comprises a population of 5.1m people, of whom 52% are women and 48% men (EOC, 2004). People from black and minority ethnic communities constitute 2.0% of the population. On the one hand, the population structure presents a dynamic picture with Scottish Executive initiatives such as *Fresh Talent* which aims to encourage people to come and live and work in Scotland, likely to increase the heterogeneity of the population.

On the other hand, life expectancy for women in Scotland is the lowest in the EU, and for men the second lowest. The overall position is due to high mortality among adults of working age (Scottish Executive, 2004h). Census data, for example, indicate that 37% of households in Scotland contain at least one resident with a limiting long-term illness, health problem or disability (Scottish Executive, 2004i). Specifically in relation to mental illness, in 2001, 30,000 people were admitted to hospital with a mental illness, of these 52% were men and 48% women (Scottish Executive, 2004i).

Drawing on the available data, Table 3.1 indicates the patterns of general health, mental health and service usage for women and men in Scotland.

Table 3.1 Indicators of general health, mental health and service usage by men and women in Scotland

Indicator (Source)	Women	Men
GENERAL HEALTH		
Scottish Life Expectancy (Scottish Executive 2004h)	Scottish life expectancy for women is the lowest in the European Union	Scottish life expectancy for men is the second lowest in European Union
Life expectancy at Birth (years) (Clark *et al*, 2004)		
Total population	78.7	73.7
Most deprived quintile	76.4 years	69.1 years
Least deprived quintile	81.1 years	77.1 years
Health Life Expectancy at Birth: Years absence of Limiting Long-standing Illness (LLI) (Clark *et al*, 2004)		
Total population	57.5	54.5
Most deprived areas	50.6 years	46.0 years
Most affluent areas	63.8 years	62.3 years

Table 3.1 Indicators of general health, mental health and service usage by men and women in Scotland – continued

Indicator (Source)	Women	Men
GENERAL HEALTH		
Percentage of 16–44 year olds (2001) Self-reported health not good (Scottish Executive 2003d)		
Most deprived areas	11.0%	7.3%
Most affluent areas	5.20%	4.46%
Percentage of 45–64 year olds (2001)		
Self-reported health not good (Scottish Executive 2003d)		
Most deprived areas	25.1%	25.6%
Most affluent areas	10.4%	9.0%
MENTAL HEALTH		
Percentage of 16–64 year olds GHQ12 score of 4 or more (1998). (Scottish Executive, 2003d)		
Most deprived quintile	24.52	16.17
Most affluent quintile	17.92	11.25
Suicide rates per 100,000 population aged 10–24 (Scotland 1999/2001) (Scottish Executive, 2003d)		
Most deprived quintile	4.37	25.82
Most affluent quintile	1.13	6.6
Anxiety: GP incidence and prevalence rates per 1,000 population (year ending December 2002) (all ages) (ISD website)		
Consultation rate	144.1	70.8
Incidence rate	58.4	27.4
Prevalence rate	75.7	35.8
Depression: GP incidence and prevalence rates per 1,000 population (year ending December 2002) (all ages) (ISD website)		
Consultation rate	191.5	82.2
Incidence rate	43.8	18.1
Prevalence rate	71.1	30.8

Table 3.1 Indicators of general health, mental health and service usage by men and women in Scotland – continued

Indicator (Source)	Women	Men
MENTAL HEALTH – continued		
Prevalence rate per 1000 population for neurotic disorders by ethnicity and sex (England/Scotland/ Wales) (Singleton *et al*, 2001)		
White	192	134
Black	178	117
South Asian	229	156
Other	249	167
Prevalence rate per 1,000 for personality disorder (England/Scotland/Wales data) (Singleton *et al* 2001)	34	54
Proportion of discharges from mental illness specialities in Scottish hospitals for 7 diagnosis (main diagnosis on discharge) for year ending March 2001 (ISD website)		
Mood (affective) disorders	35%	21%
Neurotic and stress-related disorders	8%	5%
Schizophrenia	9%	21%
Other psychotic disorders	5%	6%
Alcohol or drug-related	10%	22%
Dementia	19%	15%
Other	13%	11%

Table 3.1 Indicators of general health, mental health and service usage by men and women in Scotland – continued

Indicator (Source)	Women	Men
MENTAL HEALTH SERVICE USE		
Five most common reasons for consulting a GP, by contact rate per 1000 population (year end Dec 2002) (ISD website)	Depression and Affective Disorder is the second most common reason	Depression and Affective Disorder is the fifth most common reason
Admissions to mental illness hospitals in Scotland (all admissions) by specialty year ending 31 March 2001 (ISD website):		
All specialities	14,522 (100%)	15,664 (100%)
General Psychiatry	10,024 (69%)	12,112 (77.3)
Child Psychiatry	20 (0.1)	20 (0.1)
Adolescent Psychiatry	56 (0.4)	54 (0.3)
Forensic Psychiatry	44 (0.3)	372 (2.4)
Psychiatry of old age	4378 (30.1)	3106 (19.8)
Formal admissions as a proportion of all admissions to mental illness specialties in Scottish Hospitals (2001) (ISD website)	11.2	16.9

Key Points

- Women in Scotland have a longer life expectancy, and longer healthy life expectancy than men, but have higher rates of poor self reported health.

- For women and men in Scotland, rates of poor self-reported health are higher in the most deprived areas compared with the most affluent areas.

- For both men and women the risk of developing a mental health problem is greater among those in deprived areas. This is replicated across the UK: adults in the poorest one-fifth are twice as likely to be at risk of developing mental illness as those on average incomes (Palmer *et al*, 2003).

- Poverty, unemployment and social isolation are associated with the first incidence and prevalence of schizophrenia. First admission rates to specialist psychiatric care for people with schizophrenia are higher among those resident in deprived areas (ISD, 2001).

- In the UK, people with mental health problems are almost three times more likely to be unemployed than all other disabled people (Smith and Twomey, 2002). The Disability Rights Commission (DRC) estimates the national unemployment rate for people with mental health problems to be around 72% (DRC, 2001).

- In Scotland, as in the rest of the UK (Palmer *et al*, 2003) mental health problems affect more women than men.

- Women experience higher rates of depressive disorders than men; studies in the US have pointed to the link between poverty, inequality and discrimination as sources of depression (Belle and Doucet, 2003); there is a clear link between abuse by a partner and depression among women (Hegarty *et al*, 2004).

- In Scotland twice as many suicides occur among people from the most deprived areas (Blamey *et al*, 2002).

- Suicide is the leading cause of death among young men in Scotland, and is twice the rate in England. The rate for young men aged between 10–24 is higher among those from deprived communities compared with those from affluent communities (Scottish Executive (2003d).

- A study in Edinburgh found that the young gay and bisexual men in their sample were 4.1 times more likely to have seriously considered suicide than men in the general population (Hutchison *et al*, 2003).

- For both women and men, the experience of childhood sexual abuse can have implications for mental health in adulthood (Scottish Executive, 2004j).

- Across Great Britain, children of families in Social Class V are approximately three times more likely to have a mental health problem than those in Social Class I (Melzer *et al*, 2000).

- A Scottish study of children looked after and accommodated by the local authority found rates of depression and conduct disorder five times higher than the average rates (Dimigen *et al*, 1999).

Chapter Four
Defining Mental Health and Well-Being

Introduction

What people understand by mental health and well being are influenced by age, class and gender, as well as by people's experiences, expectations, and cultural and religious beliefs. Most definitions used by health and other professionals draw on the definition of health drawn up by the World Health Organization in 1948 and included within 1986 Ottawa Charter for health promotion:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. (Ottawa Charter for Health Promotion. WHO, Geneva, 1986)

There is general agreement that mental health is more than an absence of mental illness.

'mental health is the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others' dignity and worth'.

The definition of mental health as a 'positive sense of well-being' challenges the idea that mental health is the opposite of mental illness.

Mental health influences how we think and feel about ourselves, about our future and about others and how we interpret events. It affects our capacity to learn, to communicate and to form, sustain and end relationships. It also influences our ability to cope with change, transition and life events (Scottish Executive, 2004k).

What affects Mental Health and Well-Being?

Protective factors

There is now a considerable amount of evidence about the factors that promote and protect mental health and well-being and those which are associated with risk of poor mental health. Table 4.1 summarises the protective factors for positive mental health. As the following chapters discuss in more detail, risk and resilience factors are differentially distributed: influenced by aspects of social identity including gender, ethnicity, sexual orientation and age, and by the experience of disability.

Table 4.1 Protective factors for positive mental health

Individual	Community	Workplace	Societal/Structural
Feeling safe	Stable and supportive environment	Feeling safe, not bullied or harassed	Socio-economic conditions: income, financial security
Self-determination	Participation and influence: local democracy	Decision-making latitude	Participation and influence
Resilience and problem solving skills	Cultural life		Tolerance and trust Absence of discrimination
Feeling in control	Opportunities for lifelong learning	Job control	Respect for diversity
Confiding relationships	Social capital: networks, supports and resources	Reasonable adjustment	
Access to social networks	Tolerance and trust	Social support – vertical and horizontal	
Financial security	Amenities and services	Effort reward balance	Economic stability Absence of marked social and economic inequalities
Meaningful activity and roles	Hopefulness	Opportunities for development and learning	
Creativity	Opportunity for arts and creative activities		
Spirituality	Access to faith groups	Respect for diversity	Tolerance and respect for diversity

Whilst protective factors are associated with positive mental health outcomes, the strength of association and level of evidence for causation varies. This means that no causal relationship can be assumed for either a single or combination of factors. Generally, the protective factors can be summarised as:

1. Psycho-social, life and coping skills of individuals, e.g. increasing a sense of self-esteem and autonomy.

2. Social support as a buffer against adverse life events, e.g. self-help groups, someone to talk to.

3. Access to resources and services which protect mental well-being, e.g. increasing benefit uptake and increasing opportunities for physical, creative and learning activities.

Risk factors

These are factors that increase the likelihood of experiencing poorer mental health and that are associated with poorer outcomes for people with mental health problems. Again, however, the strength of the association and level of evidence for causation varies so no causal relationship can be assumed for any individual or combination of factors. Generally, the risk factors can be summarised as:

1. The incidence or the impact of negative life events and experiences for individuals, e.g abuse, relationship breakdown, long term illness or disability

2. Social isolation and exclusion

3. The impact of deprivation and structural inequalities in health

In order to explore the implications for policy and practice of mental health inequalities it may be helpful to look in more detail at three distinct risk factors: economic disadvantage and employment status; mental health and physical health; social capital and social support. Again, consideration needs to be given to how these factors are distributed and impact at individual, family and community levels, but also on specific social groups.

Economic disadvantage and employment status

Economic disadvantage

The association between the economic disadvantage and experience of poorer mental health and well being can be identified in relation to:

- Material deprivation.

- Exclusion and discrimination.

- Educational attainment.

- Employment – not only un/employment rates per se, but also security of employment and quality of working experience.

- Environmental/ecological factors: e.g. quality of living and working environment, safety.

- Adverse life events e.g. relationship breakdown, financial crisis.

Data from a number of large scale studies point to the association between experience of common mental disorders and a range of markers of socio-economic status (Gordon *et al*, 2000; Ellaway, 2003; Melzer *et al* 2004).

Table 4.2: Prevalence of common mental disorders and socio-economic disadvantage

	Men (%)	Women (%)	All (%)
Housing			
Owner	9.3	16.3	
Renter	18.2	25.0	
Car access			
None	19.0	26.0	
One	11.3	18.9	
Employed	9.5	16.4	11.8
Unemployed	20.3	38.1	25.9
Inactive	19.5	22.0	21.2
A level +	10.4	17.6	
None	13.0	21.1	

Source: Melzer et al*, 2004*

Mental distress can be viewed as the psychological consequences of demoralisation, despair and discrimination experienced by individuals and communities (Rogers and Pilgrim, 2003). The way people feel and think is affected by the circumstances in which they live and work, which are in turn the product of economic and political conditions in society. Structural inequality can lead to people feeling distressed and hopeless and to unfairness being construed as in some way of their own making. Living in conditions which are themselves detrimental to health can lead to unhealthier life styles – smoking, unhealthy diet – further compounding inequalities in chances of reasonable mental health and well-being (Labonte, 1998). Financial pressures are the most frequently cited causes of depression (IMS and Mental Health Survey, in Bundy, 2001).

People with mental health problems are more likely to be in debt and have difficulties managing money than other members of the general population (SEU, 2004). Those who have a long term mental health problem are likely to be trapped in poverty for longer periods than other people and persistent low incomes make it more difficult for individuals to take part in social activities that would alleviate isolation. Lack of practical support and assistance with finance matters and benefit claims can reinforce the vicious cycle of poverty, exclusion and poor mental health (Cullen, 2004; SEU, 2004).

Employment status and mental health

Having a job is likely to be more beneficial for your health and your mental health than not having one, but this will depend on a range of factors. Unemployment tends to be detrimental to mental health, as a result of the interaction of objective (material) factors and subjective (psychosocial) factors. Financial difficulties, poor nutrition and physical health interact with and may be exacerbated by feelings of anxiety and depression engendered by hopelessness and powerlessness.

However, it should not be assumed that employment is good for mental health and unemployment detrimental. Unsatisfactory or insecure jobs can be as harmful to health as unemployment (Ferrie *et al*, 1999, in Wilkinson and Marmot, 2003). Anxiety about job security, lack of job control, perceived effort-reward imbalance, negative relationships in the workplace, including bullying and harassment can have negative mental health consequences (Marmot *et al*, 1991). For some people who are unemployed, social support, alternative opportunities to play a meaningful role or access to leisure activities can off-set the potentially detrimental effects of unemployment on mental health (Rogers and Pilgrim, 2003).

There is a strong case, in developing and implementing anti-poverty strategies, for making a clearer link between the experience of unemployment, poverty and mental ill health. The profile of people with a disability has been changing over the last decade. Now, mental health and stress related problems are among the main reasons why people move out of employment and on to incapacity benefit. You are far less likely to be working if you have a mental health problem than any other condition. This has prompted commentators to argue that anti-poverty strategies have to incorporate a response to this trend towards increasing experiences of mental ill health (Regan and Robertson, 2004).

People with an identified mental health problem are more likely to be excluded from work. Those with a common mental disorder are four to five times more likely to be unemployed, twice as likely to be on income support and four to five times more likely to be getting invalidity benefits, compared to the general population. People with a diagnosis of a psychotic illness have only a one in four chance of being in employment (Jenkins and Singh, 2001, in Rogers and Pilgrim, 2003). People with experience of mental health problems may also have lower levels of educational attainment and weaker social networks which amplify the negative consequences of unemployment or unsatisfactory employment.

Physical health and mental health

It is well known and widely recognised that social and economic conditions impact on health throughout life, with the result that if you are poorer you are more likely to experience worse health and to die younger. Both material and psychosocial causes contribute to these differences in health and mental health. Poverty and disadvantage may impact on physical health by affecting mental health, the experience of disadvantage and exclusion mediated through feelings of hopelessness, anxiety and powerlessness which lead to physical health consequences.

> 'It is not simply that poor material circumstances are harmful to health: the social meaning of being poor, unemployed, socially excluded or otherwise stigmatised also matters. As social beings we need not only good material conditions but, from early childhood onwards, we need to feel valued and appreciated. We need friends … more sociable societies … to feel useful … to exercise a significant degree of control over meaningful work. Without these we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness, [which all rebound on physical health]' (Wilkinson and Marmot, 2003, p. 9).

There is now a substantial and growing body of evidence that demonstrates the impact of mental health on physical health to the extent that it has been suggested that initiatives which aim to promote physical well being to the exclusion of mental and social well being may be 'doomed to failure' (Stewart-Brown, 1998).

At population level physical and mental health status are influenced by a range of socio-economic factors including: income, employment, poverty, education and access to community resources (Yen and Syme, 1999; Kawachi and Marmot, 1998; Baum, 1998) and demographic factors such as gender, age and ethnicity.

Social circumstances can cause long-term stress and continuing anxiety, low self-esteem, social isolation, lack of control over work and job prospects can have a major impact on health including mental health. Stress biology can help illuminate the mechanisms by which emotional distress exacerbates susceptibility to physical illness. How people feel (stressed, depressed, isolated, scared, excluded) has a direct effect on the immune system and the cardio-vascular system. Mental health status has been also shown to have an impact on recovery rates from myocardial infarction (Friedli, 2002).

From a different perspective it is also known that the physical health of those experiencing mental health problems, particularly those with long term and serious mental health problems, tends to be poor. People with severe and enduring mental illness (schizophrenia, psychosis, and bi-polar disorder) have a significantly increased risk of death due to infections and/or respiratory disease (Harris and Barraclough, 1998).

Explanations for this poor health record include the possible consequences of a psychiatric illness on lifestyle, which may make someone more likely to die from diseases, rather than trauma or by suicide (Kendler, 1986). This may be compounded by the paucity of health care provision to take preventive action to address known risk factors. Several primary care studies have found that despite physical health risk factors being recorded in GP records, very few attempts to intervene were apparent (Kendrick *et al*, 1995; Kendrick *et al*, 1994). In addition there is considerably less health promotion activity conducted within primary care targeted at those with severe and enduring mental health problems compared with what is available for the general population,

despite known increased health risk factors and significantly higher than average GP consultation rates among this group (Brown *et al*, 2000).

Many people with long-term, serious mental health problems also face poverty and disadvantage and their poor physical health may therefore be mediated through feelings of demoralisation and hopelessness that arise from prolonged experiences of exclusion (Wilkinson and Marmot, 2003).

Social dimensions: poverty and social exclusion

Social support is an important protective factor for mental health and for physical health that can act as a buffer to protect against adverse life events.

It has long been recognised that poverty and surviving on a low income have social consequences which can lead to exclusion from social activities and opportunities and this effect still continues: the proportion of adults reporting a severe lack of social support and poorer GHQ scores increases as income decreases (Erens and Primatesta, 2000).

In local communities that enjoy a higher quality of life, residents are more likely to experience a greater sense of belonging, less isolation, greater access to leisure opportunities, more neighbourliness and security. Poorer mental health is associated with perceptions that the neighbourhood is in decline, less neighbourliness and fewer leisure opportunities (Huxley and Rogers, 2001).

Those living in deprived communities tend to have lower self esteem, are more likely to report feeling lonely and that life is not worth living and to have a lower sense of being in control over what happens in their life than those living in a more affluent area. In addition, residents in more deprived communities are more likely to report problems in the local environment (Ellaway, 2003).

People who are more socially connected and have more social support enjoy better general health and suffer less from mental health problems. People with lower social capital tend to be those who live in the most deprived areas, on lower incomes, and to have lower education levels (Palmer *et al*, 2003).

Reduced social and economic inequalities and social exclusion appear to be associated with greater social cohesion and better standards of health (Wilkinson and Marmot, 2003). An individuals health may have more to do with their relative position within society than with absolute standards of living (Kawachi *et al*, 1999). Communities rich in social capital have better mental and physical health (HDA, 2002).

Cycles of Injustice

In considering the nature and distribution of mental health inequalities it is important to be aware of changes over time within and between generations. The effects of exclusion and disadvantage are deep seated and can be played out throughout the life cycle and indeed across generations. First, it is important to note that mental health is maintained or diminished by different influences at different points in the life cycle: for children, secure attachment and freedom from abuse and neglect are critical; in later life, physical health and social isolation assume greater relevance for mental health.

Secondly, there is evidence that experience of disadvantage can have cumulative effects over time. Emotionally disturbed children tend to accrue additional disadvantages of poor school performance or exclusion, low academic achievement, labour market disadvantage and poor mental health status in later life (Rogers and Pilgrim, 2003).

Social exclusion can pass from generation to generation and affect life chances. Children's futures are still greatly affected by the circumstances of their parents. This means that limited opportunities are not only experienced by those in the most extreme disadvantage; people within relatively strong communities not traditionally seen as excluded can experience disadvantage and poor opportunities that cascade down generations. There is evidence of a clear association, for example, between: parental income, children's educational attainment and subsequent earnings; life expectancy and parental social class; and likelihood of teenage pregnancy and social class (SEU, 2004).

Our experience of mental health and well-being is influenced by a wide variety of factors associated with our identity (e.g. age, gender, sexual orientation, ethnicity), our make-up, current circumstances, past experiences and future prospects. This multiplicity of influences can lead to cumulative advantages and disadvantages in mental health outcomes. Figure 4.1 summarises these multiple and mutually reinforcing influences.

Figure 4.1: Cycles of injustice
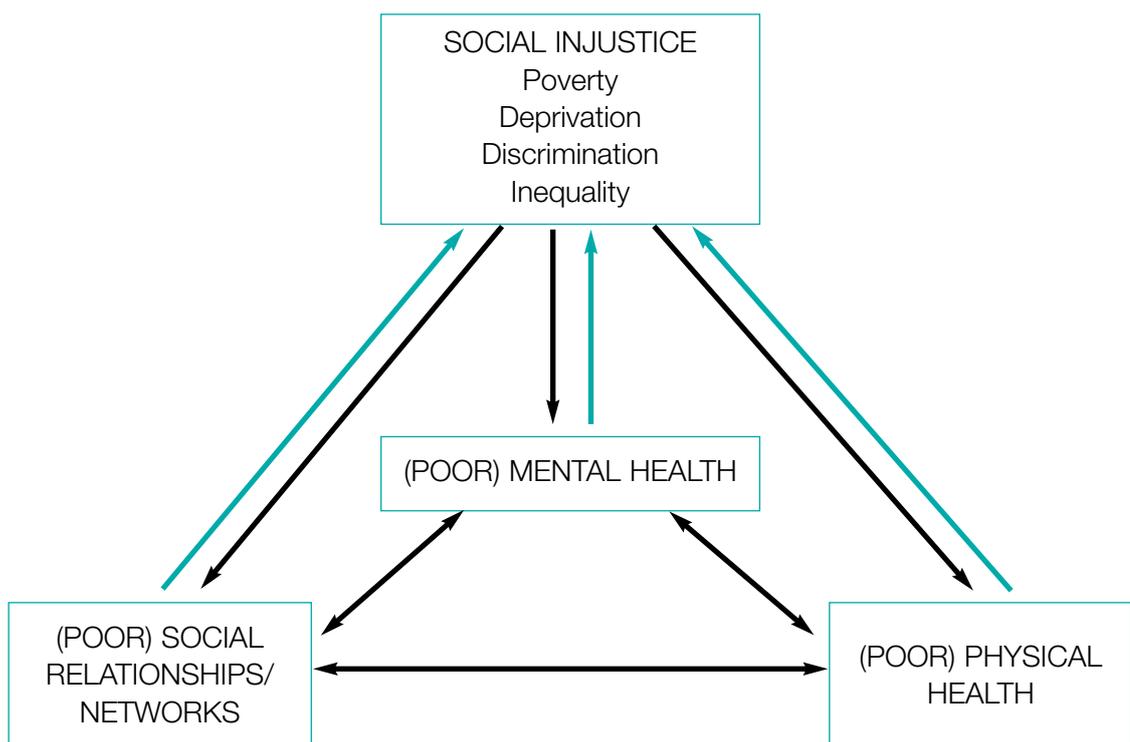
Implications for Policy and Practice

Mental health promotion

Improving mental health and well-being can make a contribution to reducing health inequalities. Reducing structural barriers to mental health and promoting policies that protect mental well-being will benefit those who do and those who do not currently have mental health problems and the many people who move between periods of mental health and mental ill-health (Friedli, 2002). This means that it is important that policies and interventions actively seek to promote mental health as well as to prevent mental ill health, in order to address mental health inequalities.

Employment and mental health

There are strong arguments for focusing on mental health in areas of public policy that relate to employment and employability, on the grounds of public interest, economic gain and social benefits for individuals and communities.

The scale and cost – financial and human – of economic inactivity amongst people with mental health problems, and the financial cost of poor workplace mental health, provide powerful incentives.

Key areas for priority action:

- Benefits levels that assure a decent standard of living and that ease return to work.

- Access to advice on benefits and financial issues, including debt management.

- Measures to enhance job satisfaction and job control through attention to job design and to management practices.

- Support for re-entry to the labour market for those who are unemployed.

- Action to promote job retention to minimise absence and job loss through ill health.

Healthy Working Lives, the Scottish Executive strategy to promote health in the workplace (2004b), includes proposals to fund pilot job retention projects for people with mental health problems. The projects will be funded through the National Programme for Improving Mental Health and Well Being.

Physical and mental health

The relationship between physical and mental health has two strands.

Addressing mental health to improve overall health and well-being

There is a strong evidence base to support the investment of resources in the promotion of mental health and well-being and the prevention of mental health problems, as an integral part of efforts to improve physical health. Poor mental health is a risk factor for the development of, and recovery from, a range of chronic physical conditions. The evidence therefore strongly supports the development of initiatives that take a pro-active approach to tackling the mental health need of those with chronic physical illnesses and the development of social and emotional support at a population level.

Addressing the physical health of those experiencing mental health problems

Developments are required to address the physical health of those with a severe mental illness to ensure that mental health services include or facilitate access to health promotion services as well as providing care and treatment for mental health problems.

Possible examples include the development of a register, call and recall systems, regular liaison between primary care professionals and the Community Mental Health Team and regular review/audit of care that is provided. It has been suggested that as a minimum, every person with a severe mental illness should have an annual health check and be offered advice about reducing smoking (Cohen and Hove, 2001).

Social inclusion and community regeneration

In tackling inequalities in mental health in Scotland, community regeneration and social inclusion programmes stand to make a significant contribution. Regeneration initiatives have tended to give attention to physical redevelopment of local areas to the neglect of psychosocial factors.

Despite the range of initiatives developed across the UK as part of the Government's drive to tackle social exclusion, and considerable improvement noted in a range of areas, some groups of people have not benefited as much as others, principally those who face the greatest obstacles (SEU, 2004). Features of effective 'delivery mechanisms' that appear to work well and increase participation among the most vulnerable groups include:

- Individually tailored approaches that seek to match the needs and characteristics of specific communities. This is important as community characteristics can themselves impact on the effectiveness of interventions to strengthen mental health.

- Effective multi-agency working to provide joined up responses and more customised services which fit with the particular characteristics and requirements of local communities.

- Efforts to make services more accessible through one stop shops, outreach, using trusted service providers and intermediaries such as voluntary and community groups.

- Providing alternative, acceptable environments to deliver services in settings where excluded people feel comfortable.

- Flexible timescales and stable provision to allow providers to carry out long-term planning and to ensure continuity in personnel so that relationships can develop and be sustained.

- Tackling the stigma which may stand in the way of access and service take up.

(SDC, 2003; SEU, 2004).

Local Community Planning Partnerships are responsible for ensuring a strategic approach to community learning and community development to build capacity of individuals, groups and communities and to support them in take their place at the heart of local planning and service delivery (Scottish Executive, 2004d). This needs to encompass work to promote the community participation of the most excluded groups, including people with mental health problems.

This Chapter has drawn attention to the factors that both protect and put at risk individual and population mental health and well-being. To reiterate the point made earlier, the risk factors of economic disadvantage, physical ill-health and social exclusion can be differently distributed across different social groups. Actions targeted at improving mental health need to 'mainstream' consideration of the implications for these different groups. The following sections explore in more detail the nature of these implications.

Chapter Five
Gender and Mental Health

Introduction

'It will not be possible to address the needs of women and men equitably, appropriately and effectively if gender is not considered' (DHa, 2003, p. 9)

Gender is 'fundamental to our sense of who we are, the roles we adopt, the way in which we experience and perceive others and in which they perceive us' ((DHa, 2003, p9). 'Gender' here refers to the socially, as opposed to biologically, determined characteristics of men and women. These characteristics have, historically, also been a fundamental source of inequality and discrimination.

But, while gender is a major determinant of inequality, differences based on, for example, wealth, ethnicity or sexual orientation will mean that there are also differences between men and among women.

To explore the ways in which gender is associated with mental health inequality the following sections draw on evidence illustrating the differences in the risks to mental health and well-being to which men and women are exposed, the resilience factors upon which they can draw, the patterns of mental health problems they experience and the ways in which services respond.

Unpacking the different influences and experiences will help in thinking about gender sensitive strategies for improving the mental health and well-being of men and of women, as well as for considering how services can be sensitive to gender, including different ways of experiencing recovery.

Gender and Mental Health: Some Indicators

Table 3.1 in Chapter 3 compares indicators of general and mental health for men and women in Scotland. Key mental health indicators of difference include:

- In Scotland, as in the rest of the UK (Palmer *et al*, 2003) mental health problems affect more women than men.

- The incidence and prevalence of depression and anxiety is higher among women than men (ISD, http://www.isdscotland.org/isd/); Melzer *et al*, 2001). This same pattern is consistent across ethnic groups (Nazroo, 1997; Melzer *et al*, 2001; Melzer *et al*, 2004).

- Anxiety – specifically fear of going out at night among aged over 60 is four times more prevalent among women than men; and 1.5 times more prevalent among women on low incomes as other women (Palmer *et al*, 2003).

- Based on community samples (Melzer *et al*, 2001) and hospital discharge figures (ISD, http://www.isdscotland.org/isd/) rates of schizophrenia and of alcohol and drug abuse are higher among men than women.

- In Scotland there are, however, rising levels of alcohol-related harm among women – especially among young women (Scottish Executive, 2003e).

- Suicide was the leading cause of death among Scots men aged 15–34 in 2000 (ISD, http://www.isdscotland.org/isd/).

- Asian women aged between 15–35 years are two to three times more vulnerable to suicide and self-harm than their non-Asian counterparts (Soni-Raleigh, 1996, in Bhardwaj, 2001).

Mental Health Inequalities: Why does Gender Matter?

There are four main reasons why it is important to understand the impact of gender on mental health.

First, there are clear and consistent differences in the patterns of mental health problems experienced by men and women. For example:

- The age of onset of schizophrenia is earlier for men than for women. There are even debates around whether the forms of schizophrenia that occur in males and females are the same disorder (Piccinelli and Gomez Homen, 1997).

- Higher proportions of women experience depression and anxiety.

- Patterns of suicide and self-harm are different between men and women.

- Substance misuse is more prevalent among men.

- The prevalence of eating disorders such as anorexia nervosa is higher among women.

- The experience of perinatal mental health problems among women.

Secondly, there are differences in the distribution of the risk factors associated with mental health problems (Piccinelli and Gomez Homen, 1997). As discussed in Chapter 4 epidemiological studies have identified clear associations between socio-economic and environmental factors and mental health problems, whether as risk factors or as the social effects of experiencing a mental illness (for example, Melzer *et al*, 2004). What is important to understand is that these risk factors are not equally distributed between women and men. According to the Scottish Executive Strategic Group for Women: 'inequality between women and men is both a widespread and persistent feature of contemporary Scottish society' (Scottish Executive, 2003f). For example:

- Across the UK, and in Scotland, women are more likely than men to be living in poverty (Bradshaw *et al*, 2003): those most at risk are female lone parents and retired women living alone.

- Across all professions in Scotland there are higher proportions of women in lower grades than in higher grades.

- Across Britain, on five out of seven indicators women experienced higher levels of social exclusion than men (Gordon *et al*, 2000, in Bradshaw *et al*, 2003).

- Some studies have suggested that women experience more life events and difficulties than men (Piccinelli and Gomez Homen, 1997; Astbury and Cabral, 2000; Belle and Doucet, 2003).

- Women are at much greater risk of experiencing domestic abuse than men: one Scottish study found that domestic violence against men comprised only 6–7% of the incidence of domestic violence (Gadd et al, 2002).

- Estimates suggest that 20–25% of women have experienced childhood sexual abuse, compared with 5–10% of men (Scottish Executive, 2004j).

Thirdly, how men and women experience and respond to these factors are not necessarily the same.

For example, while living on a low income for an extended period can cause stress and difficulty in personal and family relationships, one study found that women were more likely than men to feel isolated and depressed by their lack of money. Younger women in particular felt the effects of social isolation. In later life, however women tend to have better social relationships and to be less isolated than men (Yeandle et al, 2003).

Women may also be more prepared to acknowledge that they have difficulties, to express these difficulties in different ways, and to seek help more readily than men (Busfield, 1996; Rogers and Pilgrim, 2003).

Fourthly, how services respond, in terms of patterns of diagnosis, care and treatment pathways may also be different between men and women. Studies have shown how clinicians have different conceptions of female and male mental health (Busfield, 1996). Access to specific treatments such as psychotherapy or anti-depressants may also be different between men and women. Women and men may also respond differently to treatments and experience different outcomes (Piccinelli and Gomez-Homen, 1997).

Given the differences in patterns of mental health problems, the distribution of risk factors, the different ways in which men and women respond to these factors and to the experience of mental distress, the following two sections look separately at the experiences and outcomes for women and for men.

Women and Mental Health: Risk Factors

Ways for explaining the pattern of mental health problems among women have taken three directions:

- Analysis of the ways in which mental health and mental health problems are defined and diagnostic labels applied.

- The social and economic status of women.

- Women's experience of violence and abuse.

It is clear, however, that no single explanation can account for women's higher rates of mental health problems overall, or the different patterns of diagnosed mental disorder between men and women (Piccinelli and Wilkinson, 2000).

Conceptual analysis

Much of the social science literature has drawn attention to, and challenged, some of the assumptions relating to women's apparent 'vulnerability' to mental health problems. It has been argued, for example, that how mental disorder is understood, the diagnostic categories used and the way these labels are applied are 'gendered' (Busfield, 1996), that is they are based on assumptions about the social roles of men and women. In effect to be a woman (or a man) can be a risk factor in itself.

Socio-economic status

Social and economic factors have consistently been associated with what have been called 'the mental health consequences of women's everyday life' (Williams *et al*, 1993, in Barnes *et al*, 2002). As already described, statistically more women are in poverty than men. Linked with this is women's experience of:

- Low income in jobs over which they may have limited autonomy and control.

- Social exclusion and social isolation (Yeandle *et al*, 2003).

- Being responsible for managing limited household income and debt (EOC, 2003), within a context in which household income may not be equally shared.

- Living in communities which are themselves characterised by impoverishment, potentially providing only negative support, or resulting in 'stress contagion' or contributing to social isolation (Belle and Doucet, 2003).

- Limited autonomy and decision-making autonomy over severe life events (Astbury and Cabral, 2000); powerlessness, for example in dealing with employers, landlords and government bureaucracies (Belle and Doucet, 2003).

As primary carers women's poverty can also impact on the mental health and well-being of children. The recent Social Exclusion report describes how low household income in childhood can create cycles of deprivation (SEU, 2004).

Social and reproductive roles

Women's social roles, particularly as primary carer for children and/or other dependants impact in a number of ways:

- Economically restricting women's opportunities for well-paid full-time work (and with implications for future pension rights).

- Through 'role overload' (Piccinelli and Wilkinson, 2000) where women undertake both employment and household/childrearing responsibilities.

- Through social isolation.

The compounding effects of poverty and role expectations are highlighted in one study of women from black and ethnic minority communities. For the women interviewed: 'Pride in the home, as good home-makers is crucial to "who they are" as wives, mothers and daughters. Therefore living in cramped, unhygienic and unsuitable conditions over which they have no control means that an essential part of who they are as "women" is negated – this results in constant stress' (Mirza and Sheridan, 2003, p. 14).

It is perhaps not surprising that marriage has been found to be more beneficial to the psychological well-being of men, than for women (Piccinelli and Gomez Homen, 1997; Mcrae and Brody, 1989, in Williams, 2002).

In addition to social roles, reproductive roles are also implicated in women's mental health. According to data reproduced in the Scottish Intercollegiate Guidelines Network (SIGN, 2003), for every 1,000 live births, 100–150 women will suffer a depressive illness and one or two women will develop a puerperal psychosis. Unpublished data for Scotland, indicates 186 women who gave birth in 1999 had an admission to a psychiatric hospital in Scotland in the following 12 months.

Discrimination

The experience of discrimination not only contributes to poverty and economic inequality but also puts at risk mental health and well-being. Women can experience the double or multiple jeopardy of economic and social discrimination based on gender and other personal characteristics with social significance. As Zappone argues, 'disrepecting individuals based on the basis of one or two more aspects of their identity creates substantial barriers for their health and well-being' (2003). For example:

- Studies of women from black and minority ethnic communities and asylum seekers have described the day to day experience of racial harassment (Wilson, 2001; Ferguson and Barclay, 2002; Essien, 2003; Mirza and Sheridan, 2003).

- The 'double oppression' experienced by women with disabilities, including in accessing health services is described by Breslin (2003).

- A review of the mental health risks faced by women in mid life argues that inequality can impact on mental health through inequitable access to resources known to affect mental health; discrimination, exploitation and oppression; and serious abuse of power including sexual and physical abuse (Milne and Williams, 2003).

- Young lesbian and bisexual women interviewed by Loudes (2003), described the prevalence of mental health problems among lesbians and the lack of support available. Those interviewed felt that mental health problems were linked to lack of acceptance, the pressures of having to hide one's sexual orientation and the pressures from being openly lesbian.

Women's experience of violence and abuse

According to one review 'Violence against women, whether by their intimate partners or men not known to them, is probably the most prevalent … gender-based cause of depression in women' (Astbury and Cabral, 2000, p. 65).

In Scotland, in 2002, police returned details of 36,010 incidents of domestic abuse. In 90% of cases where the information was recorded the victim was female and the perpetrator male (Scottish Executive, 2003h). Although not specific to women in low income families, one American study found that 83% of the low-income mothers in their study had been physically or sexually assaulted in their lifetimes (Bassuk, *et al*, 1998, in Belle and Doucet, 2003).

Figures cited earlier also suggest that where data are available girls are more vulnerable to childhood sexual abuse and that women who have been sexually abused as children represent a considerable proportion of those requiring acute psychiatric care and treatment (Nelson, 2001). However, this experience may go undetected by health services (Nelson, 2001; Scottish Executive, 2004).

Women who are refugees or asylum seekers may have been victims of torture (Wilson, 1993, in Wilson, 2001), including sexual assault and rape.

Women in secure settings

Although not a 'risk' factor per se women in secure settings, whether secure in-patient settings such as the State Hospital or prisons, have often experienced multiple disadvantages, including experience of sexual abuse and domestic violence. According to the most recent Inspection Report for HMP and YOI Cornton Vale, for example, 80% of prisoners within the prison have a history of mental illness; over 90% of admissions have addiction problems and over 60% have a history of being abused (HMIP, 2004).

For the period 2002–2003, women comprised just over 4% of the average daily prisoner population in Scotland. Although HMP Cornton Vale provides for the largest number, four other prisons in Scotland also accommodate women prisoners.

Women also comprise only a small minority of the State Hospital population – only 6% of the total, but have different characteristics and needs to that of the male population (State Hospital, 2002).

In a review of literature on women and secure psychiatric services Lart *et al* (1999) describe the key characteristics of women in secure settings:

- They make up less than one-fifth of the population in secure settings in Britain, but comprise a heterogeneous group in terms of personal characteristics and forensic and psychiatric histories.

- They are less likely to have committed serious criminal offences than men, but more likely to have experienced previous psychiatric admission.

- They have a different pattern of diagnosis to men: women are more likely to be diagnosed as having a personality disorder, or borderline personality disorder, than men.

From the views of women in secure settings, interviewed as part of the process of developing a women's mental health strategy in England and Wales, the authors obtained the impression that 'secure settings are driven by an ethos of control and containment rather than rehabilitation, and that activities for women are patients are restricted because of the needs of the male majority' (DH, 2002).

Women and Mental Health: Resilience Factors

The WHO identifies three main factors protective against development of mental health problems, especially depression, in women (Astbury and Cabral, 2000):

- Having sufficient autonomy to exercise control in response to severe events.

- Access to some material resources that allow the possibility of making choices in the face of severe events.

- Psychological support from family, friends or health providers is powerfully protective.

Other studies have described the personal and social strategies upon which women from black and minority communities draw (Wilson, 2001; Essien, 2003; Mirza and Sheridan, 2003).

Women and Mental Health: Preventing and Responding to Risk

Mental health improvement

Barnes *et al* (2002) found no research that addressed issues around mental health promotion or prevention that took a gender perspective.

Responding to mental health problems

A UK-based survey by Williams *et al* (2001, in Williams, 2002) concludes that mental health services:

- Do not meet women's mental health needs.

- Can replicate inequalities.

- Can be unsafe for women.

- Can be insensitive to the effects of gender and other social inequalities, such as race, class and age.

Other studies have highlighted the experiences of women using mental health services:

- In their literature review Barnes *et al* (2002) highlight the issues for women in in-patient care including considerations of safety and security, the availability of single sex wards, and women-centred approaches to therapy and treatment.

- A study of the mental health needs of asylum seekers in Glasgow (Ferguson and Barclay, 2002) although not a specifically gendered analysis includes the experiences of women. For example, some female respondents felt strongly that they were not able to discuss their health problems – particularly their mental health problems with a male doctor, as a result these problems were not addressed. The lack of interpreting services, or the provision of a male interpreter was also experienced as distressing, particular when issues of an intimate nature were involved.

- A study of black women in Bradford concludes that 'culturally aware services that are user friendly, and personal support, would go some way toward eradicating the fear and hopelessness they encounter when in contact with mental health services, and the stigma and shame they feel from their own communities and wider society' (Essian, 2003, p. 29).

- MIND research into the experiences of lesbian, gay and bisexual people, found that only eight out of 22 lesbians, and two out of eight bisexual women felt 'safe' disclosing their sexuality within any 'mainstream mental health service' (Golding, 1997).

- Two studies found that older women could experience 'double jeopardy' based on ageism and sexism. This double jeopardy can be influential on the risks of experiencing mental health problems, but also may result in inadequate or inappropriate treatment (Padgett, Burns and Grau 1998; Curtis, 1996, in Barnes *et al*, 2002).

There does not appear to have been any Scotland-wide research to indicate the experiences of women with mental health problems who use services. However, in England and Wales, women consulted as part of the process of developing a strategic approach to mental health care said they wanted were services that:

- Kept them safe.

- Promoted empowerment, choice and self-determination.

- Placed importance on the underlying causes and context of their distress in addition to their symptoms.

- Addressed important issues relating to their roles as mothers, the need for safe accommodation and access to education, training and work opportunities.

- Valued their strengths, abilities and potential for recovery.

(DH, 2002a)

Men and Mental Health: Introduction

There has not been such an extensive social science or policy literature in relation to men's mental health as found in relation to women. However, as the information presented above and in Chapter 3 suggests, the mental and physical health profiles of men are distinct from those of women. Men, for example:

- Tend to experience an earlier onset of schizophrenia with poorer clinical outcomes (Piccinelli and Gomez Homen, 1997).

- Have higher levels of suicide than women, at all ages, but with particularly high rates among younger and older men (DH, 2001; WHO, 2003; Samaritans, 2003).

- Have lower levels of diagnosed depression (Piccinelli and Gomez Homen, 1997; Singleton *et al*, 2001). It has, however, been suggested that men may suffer from depression just as often as women, but that it goes unrecognised and/or men are more reluctant to seek help (Real, 1997; Royal College of Psychiatrists, 1998; Rogers and Pilgrim, 2003; Miller, 2004).

- Have higher levels of substance misuse (Singleton *et al*, 2001; Scottish Executive, 2003). Figures for Scotland suggest that 33% of adult males, compared with 15% of adult females exceed the recommended weekly alcohol consumption (Scottish Executive, 2003e). Men also comprised 66% of new patients/clients recorded on the Scottish Drug Misuse Database in the financial year to March 2004 (www.drugmisuse.isdscotland.org accessed 29 September 2004).

- May be over-represented in groups at risk of post-traumatic stress disorder (www.mind.org.uk/Information/Factsheets/Men accessed 27 September 2004).

Men and Mental Health: Risk Factors

Socio-economic disadvantage

As the figures in Chapter 3 indicate, socio-economic risk factors impact differently on men and women, and also on different groups of men. For example, although proportionately more women than men are in poverty (EOC, 2003), more men than women are unemployed (Scottish Executive, 2002c). Rates of unemployment are particularly high among men aged under 25 years, compared with young women. Homelessness and rooflessness are also higher among men than women (Scottish Executive, 2004l; Scottish Executive, 2002c).

Further, how men experience or respond to poverty or unemployment, may be different from the response of women in similar economic circumstances (Yeandle *et al*, 2003). Fathers and older men on low incomes, for example, may have less daily contact with friends or family than women (Gordon *et al*, 2000, in EOC, 2003). Unemployment in particular has been implicated as a risk factor for men. Research cited by the Royal College of Psychiatrists (1998) suggests that up to one in seven men who become unemployed will develop a depressive illness in the following six months. Reflecting this, a preliminary analysis of the characteristics of men who used the Camelon Well Man clinic in Falkirk over a sixteen-month period found that those who were unemployed were less likely to describe themselves as content, and more likely to feel anxious/stressed or depressed than men who were employed or retired (Camelon Well Man Clinics, unpub paper).

Physical health

As the figures in Chapter 3 indicate, men have a shorter life expectancy, and fewer years of healthy life expectancy than women. Men, for example, have higher mortality rates in relation to cancer, heart disease and stroke (Scottish Executive, 2002c). Prevalence rates for heart disease are higher for men than for women, at all ages (ISD, http://www.isdscotland.org/isd/). Men may also be more susceptible to some infectious diseases such as tuberculosis (Wizemann and Pardue, 2001 in Doyal *et al*, 2003). Men's poorer physical health takes on particularly salience, given the relationship between poor physical and mental health described in Chapter 4.

Crime and violence: men as victims; men as perpetrators

Men are more likely to commit criminal offences, and to engage in violent behaviour. Men are also the victims of abuse and violence, frequently (though not exclusively) perpetrated by other men (Scottish Executive, 2002c; Gadd *et al*, 2002; Miller, 2004; Scottish Executive, 2004j). For Miller (2004) this means that accounts of men's mental health, and service responses, have to acknowledge men who may be damaged by the experience of sexual abuse and violence and those with the 'capacity to harm'.

Social roles

Issues of gender roles/masculinities may also be implicated as a risk factor. On the one hand, notions of masculinity and of appropriate male behaviour may act as a barrier to men feeling able to express their feelings, or to admit to experiencing emotional/ psychological difficulties (Men's Health Forum, 2004; Miller, 2004). It has been suggested, for example, that the higher rates of suicide in young men may in part be due to their reluctance to express distress (Rogers and Pilgrim, 2003). On the other hand, it has been suggested that the perceived breakdown in traditional gender roles has left men uncertain of what is expected of them in terms of significant relationships (www.mind.org.uk/Information/Factsheets/Men/ accessed 27 September 2004).

A study of depressed and suicidal young men draws attention to the ways in which different risk factors may interact: reactions to worry or upset, and the experience of violence or bullying could result in the men smashing something up, or picking fights. The depressed and suicidal groups in the study were also more likely to have been in trouble with the police than those who were not depressed. At the same time the suicidal group were significantly more likely to keep concerns to themselves – particularly where fathers were believed to want the men 'to fight their own battles' (Buchanan and McCoy, 1999).

Multiple identities; multiple disadvantage

Just as women are not a homogeneous group, so among men there are different 'masculinities' that is, differences between men based on, for example, class, age, disability, ethnicity and sexual orientation. These are also potential sources of multiple disadvantage and discrimination for some groups such as men from black and minority ethnic communities (see Chapter 6) and gay, bisexual and transgender men (see Chapter 7).

Men and Mental Health: Preventing and Responding to Risk

To begin to raise the profile of men's health, Men's Health Forum for England and Wales has published its policy programme for men's health. This argues that national and local policies and services need to recognise and address men's health issues, defined as ones arising from *'physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men and/or where particular interventions are required for boys or men in order to achieve improvements in health and well-being at either individual or the population level'* (Men's Health Forum, 2004). This is clearly intended to encompass mental health and well-being.

In Scotland the Scottish Executive is funding men's health pilot projects – 'Well Man Clinics' – across Scotland. Over two years £4m will be distributed with the aim of encouraging men to take a greater interest in their health and well-being.

The National Programme for Mental Health and Well Being is funding a telephone advice line – *Breathing Space* – targeted at (but not exclusively for) young men suffering from low mood and depression.

Implicit in the Men's Health Forum proposals, and the men's health pilots is the need to consider the way services, including mental health services are delivered to reach and be accessible to men. Miller (2004), for example suggests that since men have a poor record as users of psychological therapy, it is important to consider creative ways of facilitating access. The Equal Minds conference workshop looking specifically at men and mental health identified five service design features for enhancing the accessibility of initiatives targeted at men's mental health and well-being:

- Accessibility and flexibility of services in terms of time, location and ethos. For example, in places with which men were familiar, providing 'Men Only' sessions with male staff, linking in with other activities, such as physical activity programmes.

- Holistic in approach, focusing not just on 'mental health', but on the whole person.

- Early intervention to engage men as anxieties and concerns build up, including the availability of, for example, stress and anger management at an earlier stage.

- Avoiding stereotyping men as unresponsive and lacking in emotional intelligence and supporting men to express their feelings and aspirations.

- Building up trust and confidence to be able to work on issues of identity and role that can underlay men's anxieties and self-perceptions or lack of self-esteem.

Gender and Mental Health Implications

Implications for policy

A number of current policy strands provide the basis upon which to further develop gender-sensitive approaches to mental health and well-being.

- Although not specifically referring to gender, Improving Health in Scotland – the Challenge, the most recent Scottish Executive health improvement strategy (Scottish Executive, 2003a) aims both to improve health for all and reduce health inequalities. The strategy focuses on four priority areas, each of which have different implications for women and for men: early years, teenage transition, the workplace and communities.

- The Framework for Mental Health (Scottish Office, 1997), which has provided the basis for service design in Scotland, includes under service principles and values reference to 'addressing the special needs of women' as one of a number of means for promoting individual self-determination. Although the gendered implications are not followed through into the service elements, policies or guidance have been developed subsequently which are either solely aimed at women's needs, for example, guidance on perinatal mental illness/postnatal (SIGN, 2002; Scottish Executive, 2004m), or where the impact will be felt to a larger extent on women, such as guidelines on eating disorders, or the Doing Well by People with Depression initiative. Proposals have also been put forward for developing forensic psychiatry services for women (FMHSMCN, 2004).

- The principles of non-discrimination, equality and respect for diversity, enshrined in the Mental Health (Care and Treatment) (Scotland) Act 2003, clearly have implications for acknowledging specific experiences and needs relating to gender as well as other dimensions of people's social identities. Within the Act one gender specific requirement is for Health Boards to provide, under certain defined circumstances for any woman who is the mother, or adoptive mother of a child under one year, who has been admitted to hospital for treatment for post-natal depression.

One analysis of gender and health argues that although sex and gender both impact on health and health care, most NHS modernisation policies (as they apply to England and Wales) have been gender blind – to the detriment of both women and men (Doyal *et al*, 2003).

In England and Wales the response, in relation to mental health, has been to take a gendered, but women focused, approach. The strategy 'Into the Mainstream' (DH, 2002) and implementation guide (DH, 2003a) aim to help those 'planning and delivering services to understand better what is meant by being sensitive to the needs of women and ensure that women feel better served by the mental health care system in terms of their individual experience' (Department of Health press release, 23 September 2003). The principles on which the strategy is based are:

- Mainstreaming gender and the specific needs of women.

- Involving women.

- Taking a whole systems approach.

- Partnership and multi-agency working.

- Endorsing the role of the voluntary sector.

These principles are felt to be relevant to all age groups and to men as well as women.

Any approach taken in Scotland to further ensure gender sensitive mental health promotion and improvement and mental health service delivery might want to consider the two dimensions set out in Chapter 1 above:

- How to embed mental health within broader social policies aimed at redressing the social and economic inequalities differentially experienced by women and men.

- How to embed gender sensitivity into mental health services and programmes.

Embedding consideration of the differential mental health impacts on women and on men into other policy domains

Given the social and economic inequalities experienced by women global policies including those relating to low pay, benefits, childcare, access to employment, and community regeneration will differentially impact on women, and those social and economic factors which put at risk women's mental health and well-being (SEU, 2004; Scottish Executive, 2003f).

In addition are those social policies which largely, if not exclusively address aspects of women's or men's experience, which may impact on their mental health and well-being for example, domestic abuse initiatives (Scottish Executive, 2000b; Scottish Executive 2003g; Scottish Executive, 2004n); initiatives for women offenders (Scottish Executive, 2002d) or young male offenders; or prostitution and trafficking (for example, the expert group on prostitution in Scotland, established in 2003).

Embedding considerations of gender within the mental health service system

This has two further elements:

i. Ensuring that programmes and initiatives for improving mental health and well-being are gender sensitive.

Issues to consider might be:

- What does mental health/illness mean for women and for men? What is well-being?

- Given the different employment patterns of men and women, what are the implications for mental health at work?

- To what extent are initiatives for tackling suicide and self harm gender sensitive?

- What does building community capacity mean for men and women?

- How can initiatives improve the mental health of younger men and women, and older men and women?

- How gender sensitive are mental health improvement programmes for children and young people?

- How do measures for improving infant mental health impact on mothers or on fathers?

- How is stigma and discrimination experienced by men and by women with mental health problems?

- What does recovery mean for women and for men with mental health problems?

ii. Ensuring mental health services are gender sensitive

This may include consideration of:

- The need for women-only or men-only services.

- Workforce development to ensure gender sensitivity.

- Issues of equality of access to responsive gender sensitive services including in terms of the times as which clinics are held, availability of child care or care for dependants, enabling people, as far as practicable/appropriate to have a clinician or carer of the same gender.

- The needs of specific groups of men and women with mental health problems such as:

  Women from different black and minority ethnic communities

  Men from different black and minority ethnic communities

  Women with children or other caring responsibilities

  Women who have experienced violence or sexual abuse

  Men who have experienced violence or sexual abuse

  Gay, bisexual and transgender men

  Lesbian, bisexual and transgender women

  Older men

  Older women

Chapter Six
Ethnicity and Mental Health

Introduction

> *'The extent of social exclusion among [black and minority ethnic] communities, the levels of racism and racial discrimination experienced by them in public life and, more pertinently, when they come into contact with institutional agencies are key determinants of psychiatric morbidity within black and minority ethnic groups.'*
> (Sashidharan, 2003, p.11)

Understanding the implications of ethnicity means acknowledging first, the impact on mental health and well-being of people from black and minority ethnic communities of discrimination and victimisation and, secondly, the potential or actual institutional racism of services and systems, including mental health service systems.

What is also important to understand is the heterogeneity of those encompassed within the category 'black and minority ethnic communities'. The census analysis for Scotland includes as 'minority ethnic population': Indian, Pakistani, Bangladeshi, Chinese, other South Asian, Caribbean, African, Black Scottish or any other Black Background, Any Mixed Background and Any Other Background. In addition, are those who experience discrimination and disadvantage not just on the basis of ethnicity, but because of their status as refugees or asylum seekers, or who are gypsies or travellers. Another distinction is between identities based on 'visible' characteristics such as skin colour or 'invisible' dimensions such as religion or nationality, white Irish or European migrants, for example.

Within in each group there will be further divisions based, for example, on whether individuals were born in the UK or Scotland, or experienced migration; between the experiences of women and men within different groups; between the experiences of older people and younger people.

In addition to the social justice imperative of eliminating discrimination and racism, the likely increase in inward migration as a result of employment policies such as Fresh Talent, together with the legal responsibilities placed on public authorities by the Race Relations (Amendment) Act 2000 (see Chapter 2) together reinforce the necessity to identify and address the mental health inequalities stemming from lived experience and service responses.

Ethnicity and Mental Health: Some Indicators

Population profiles

- On the basis of the 2001 census, the minority ethnic population comprised just over 100,000 or 2% of the Scottish population.

- Pakistanis, were the largest minority ethnic group followed by Chinese, Indians and those of mixed ethnic backgrounds.

- Men comprise over one-half of the populations from African, Bangladeshi and Indian communities.

- For both males and females ethnic minority groups have a younger age distribution than white groups – with the exception of the Caribbean group more than 20% of the population is under 16 years of age.

- White Irish comprise just under 1% of the Scottish population.

- There are an estimated 10,000 refugees and asylum seekers in Scotland (Scottish Refugee Council figures, quoted on MEWS website accessed 23 June 2004), the majority living in Glasgow. These include around 70 different nationalities.

- The Scottish Executive twice-yearly count of gypsies/travellers estimates that there are around 1400–1900 gypsies/travellers on sites/in encampments in winter and 2000–2500 in summer. These figures do not include people permanently settled in housing (MEWS website accessed 23 June 2004).

Indicators of prevalence

Information on the pattern of mental health problems among minority ethnic groups is complex and contested. As in relation to gender these are bound up with conceptual issues. In the context of ethnicity these relate to the universality and applicability of western psychiatric concepts and associated assessment/measuring tools. Sample populations on which estimates of prevalence are based i.e. community/population samples or hospital based will also generate different patterns. The latter reflects not just different levels of need, but different (and potentially discriminatory) pathways to care.

Apart from a study undertaken in the late 1980s of psychological distress among South Asians living in Glasgow (cited in Shah, 2004), no Scotland-specific studies appear to have been undertaken to indicate the prevalence of mental health problems among people from black and minority ethnic communities in Scotland.

'National' population based studies (for example, Nazroo, 1997; Singleton *et al*, 2001) reveal differences within and between different groups, but the findings can be inconsistent between studies: underlining the difficulties of being sure that the identified differences are valid, reliable or, in small samples, statistically significant (Nazroo, 1997).

A consistent finding (based on British data) is the higher rate of psychotic disorders among the African-Caribbean samples. The degree of difference is not the same between studies. Nazroo (1997), for example, points out that in his population based study the difference is not as great as in studies based on hospital admission rates. Further, Nazroo found that the differences within his sample were largely accounted for by the higher rates among African-Caribbean women compared with white women.

From a review of seven population based studies of 'common mental disorders' (anxiety and depression) Shah (2004) concludes that that the prevalence of these disorders among minority ethnic groups is equivalent to, or may be higher than among the general population.

Nazroo (1997) found that African-Caribbean people had a 60% higher rate of depression than white people; and the rate for African-Caribbean men was twice that of white men.

The design of instruments for measuring prevalence, different patterns of interpreting and presenting symptoms, different patterns of help-seeking behaviour, and mis- or underestimates of diagnosis are felt to account for the apparently lower levels of mental health problems among South Asian and Chinese populations. Nazroo (1997), for example, refers to the difficulties of translating the term 'depression' into South Asian languages.

Studies have, however, indicated high levels of un-reported psychological distress among Asian communities in general, and among Asian women in particular (Wilson, 2001). The rate of attempted suicide among young South Asian women is particularly high. Figures quoted in a recent Mentality report suggest that women born in India and East Africa have a 40% higher suicide rate than women born in England and Wales, and is particularly high in the age group 15–24 years (Tidyman, 2004; Gilbert *et al*, 2004). Rates of self-harm and eating disorders are also believed to be higher among adolescent South-Asian girls.

Research on mental health needs of asylum seekers/refugees suggests that many asylum seekers are likely to arrive with mental health needs as a result of their experiences (King's Fund, 2000, in Ferguson and Barclay, 2002). Work undertaken in Edinburgh in 2000 argues that it is the refugees and asylum seekers who are the most likely among Lothian's black and minority ethnic communities to experience mental health problems as a result of their life experiences (Munday and Oswald, 2000).

Although the discrimination experienced by Gypsy/Travellers has been documented, the anxiety and distress experienced by women in particular noted, and the difficulties people have in accessing services acknowledged, it was not possible to find studies in Scotland of the prevalence of mental health problems among this group of people.

Other groups are also known to have specific mental health needs. With the caveat that it was based on a small (and heterogeneous) sample, Nazroo (1997) found the highest rates of mental illness among the white minority group (people who said they had Irish family origins or were white but had family origins outside Britain).

Service usage

Scotland-specific information is not routinely/centrally collected to indicate usage of psychiatric services, diagnosis, patterns of compulsory detention, treatments/interventions and outcomes for people from black and minority ethnic communities. Where available, measures of service use by people from black and minority ethnic communities are ambiguous as indicators of need or accessibility. As noted above, over-representation and under-representation at different stages may both reflect in different ways discriminatory practices. However, without data it is not even possible to know what the questions are let alone to begin to identify possible explanations.

Where available the data suggest differential patterns of usage. For example:

- Data from a (British) population-wide sample suggests that compared with other groups, people from African Caribbean communities with mental health problems were just as likely as other ethnic groups to consult their GP, but were less likely to receive medication or other forms of treatment (Nazroo, 1997). Shah (2004) in his review of seven studies, found that people from minority ethnic groups with common mental disorders tend to have lower rates of treatment and received fewer anti-depressants and minor tranquillisers. The Caribbean and African group also appeared to use therapists, social workers and 'alternative' healers less frequently than white and south Asian groups.

- Analysis of the 2001 census by the Commission for Racial Equality (CRE) revealed that, at the time of the census:

  Forty-five people from a black or minority ethnic community were detained under the Mental Health (Scotland) Act 1984

  1.2% of psychiatric patients were from ethnic minority communities, of whom:

  33% were African

  13% Pakistani

  13% Indian

  4% Chinese

  4% Caribbean.

Given that African's comprise just over 5% of the minority ethnic population in Scotland this suggests that they may be disproportionately represented among the hospital population.

- Focusing specifically on high secure care, a review of admissions and discharges to the State Hospital over the period 1991–1998 revealed that of the 463 admissions over this period 2.0% were non-white (and all were male). Of the total of admissions 0.3% were Black-African, 1.0% Black-Caribbean, 0.3% Chinese and 0.3% Pakistani (Thomson *et al*, 2000). The 2001 census figures indicate that people who defined themselves as Caribbean and African comprised 0.04% and 0.10% of the Scottish population respectively. Although based on a slightly different time period the data may again tentatively suggest an over-representation of people from Black-African and Black-Caribbean backgrounds.

- Although not Scotland-specific, data from studies in England and Wales indicate that people of Irish origin are over-represented among users of psychiatric services (Bracken *et al*, 1998).

Ethnicity and Mental Health: Risk Factors

Risk factors

From a review of seven studies Shah identifies 17 risk factors for common mental disorders in ethnic minority groups (Shah, 2004). As Shah points out, many of these factors are the same as for the general population, including unemployment, absence of a full-time worker in the family, low standard of living and social isolation. Others are more specific to people from black and ethnic minority communities including victimisation, racial discrimination and discrimination in housing and employment. Although not referred to by Shah there are, additionally, within-group risk factors based on, for example, gender, age or sexual orientation.

Socio-economic disadvantage

Although, as Shah points out, some of the risk factors, particular those related to socio-economic disadvantage are the same as for the general population, data on the position of people from black and minority ethnic communities indicate that greater proportions are at risk of poverty and social exclusion. The significance of this is highlighted by Nazroo (1997) who found that, with the possible exception of people from Pakistan/Bangladesh, social class was inversely related to mental health outcomes: and households with no full-time worker had particularly poor mental health.

Some sense of the implications for people in Scotland can be obtained from an analysis of data from the 2001 census by the CRE that reveals that people from black and minority ethnic communities experience:

- Higher rates of unemployment than the white population.

- Lower levels of economic activity with a much greater reliance on one wage earner.

- Higher levels of self-employment and segregated employment.

There are differences within and between communities, both along these variables and in relation to variables such as education where there is evidence for both higher and lower attainment levels. Nonetheless even educational attainment is not an indicator of advantage: African communities have the highest levels of academic attainment and also the highest unemployment rate.

A study of the mental health needs of asylum seekers in Glasgow highlighted the impact of the voucher system. On the one hand the vouchers were seen as responsible for the poverty experienced by asylum seekers, and on the other, were felt to be a source of shame, humiliation and stigma (Ferguson and Barclay, 2002).

In terms of housing, the census data indicate that people from black and minority ethnic communities:

- Have a higher reliance on private rented accommodation.

- Higher levels of overcrowding.

- Have fewer household amenities such as central heating.

A recent study of homelessness among black and minority ethnic communities found that the incidence of recorded homelessness among these groups is significantly higher than across the population as a whole (Netto *et al*, 2004). The over-representation of people from these groups in overcrowded conditions or in Below Tolerable Standard housing, also suggests high levels of hidden homelessness. The report also notes that refugees, gypsies/travellers and women from black and minority ethnic communities escaping domestic abuse are particularly vulnerable to homelessness.

Racism, discrimination, victimization and violence

There is a large body of evidence that indicates the pervasive nature of racism, racist victimization and discrimination for people from black and minority ethnic communities. In addition studies indicate the impact of these experiences on mental health and well being (for example, Chakraborty and McKenzie, 2002; Janseen *et al*, 2003), though the precise nature of the relationship has been the subject of debate (see for example, Freeman, 2002). These experiences have two dimensions: the experience of racism in everyday life; and the potential racism experienced through contact with services including mental health services.

- According to one study undertaken in four British cities, including Glasgow, 'the experience of racism had become part of the everyday experience of black and minority ethnic people contacted. Being made to feel different in a variety of social situations and locations was largely seen as routine, and in some instances expected. Racist abuse was the most common form of everyday racism' (Chahal and Julienne, 1999).

- Recent Scottish data collected as part of a study of the policing of racist incidents in Strathclyde found that in the previous 12 months over three-fifths of visible minority individuals and over one-half of minority white participants (for example from Eastern Europe, England or Ireland) had experienced property damage, physical assault or offensive remarks or threats in a public place compared with around two-fifths of white Scots participants. The worst affected were women in non-white categories, of whom four-fifths had experienced offensive remarks or threats (University of Glasgow, c2004).

- The 2000 Scottish Crime Survey found that ethnic minority respondents had a higher risk of household victimisation; and 25% of incidents were considered by the victims to have been racially motivated. Ethnic minority victims were more likely than whites to be affected emotionally, anger being the most commonly cited emotion. Respondents from ethnic minority communities were five times more likely than white respondents to be concerned about racial attacks (Clark and Leven, 2002).

- In a 1999 survey of Gypsy/Travellers 62% of respondents interviewed reported experiencing prejudice or harassment during the previous year (MEWS accessed 23 June 2004).

- Data cited on the UK Disability Forum – Women's Committee website (www.edfwomen.org.uk, accessed 10 May 2004) states that refugee women in the UK are suffering widespread mental distress because of fear of attack. One in two feel so depressed and anxious that they are unable to sleep at night, and many lock themselves indoors throughout the daytime in a self-imposed curfew.

- A study of asylum seekers in Glasgow found that verbal and physical racist harassment was an almost daily occurrence for asylum seekers and their children (Ferguson and Barclay, 2002). They saw this experience as seen as having a negative impact on their mental health.

According to a recent Mentality report 'Racism contributes to mental distress and leads to feelings of isolation, fear, intimidation, low self-esteem and anger, and an increase in negative life events which are considered unfair and lead to stress' (Tidyman, 2004). As a result individuals can be left feeling powerless. Chahal and Julienne (1999) describe as 'profound' the effects of racist victimisation on the health and well being of the people in their study: respondents referred to feelings of anger, stress, depression and sleepless nights.

Studies involving people with mental health problems from black and minority ethnic communities illustrate not only the day to day experiences of racism but also how this is seen as contributing to their mental distress (Wilson and Francis, 1997; Essien, 2003).

Studies undertaken in England suggest that this experience of racism extends to health services, including mental health services.

In addition to the high profile cases, such as the David Bennett inquiry (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) a number of studies suggest the barriers people from black and ethnic minorities face to obtaining appropriate, responsive and effective mental health services. One study, for example, describes the 'circles of fear', that stop black people from engaging with mainstream mental health services which are experienced as inhumane, unhelpful and inappropriate (Sainsbury Centre, 2002). Another study of African and African-Caribbean mental health service users in England found that a number of the sample felt misunderstood within the mental health system because they are feared, stereotyped or ignored (Wilson and Francis, 1997).

Although a number of small scale, local studies have been undertaken (Netto, *et al*, 2001) the experiences of people from black and minority ethnic communities in contact with mental health services in Scotland does not appear to have been researched in-depth.

Stigma

The stigma and discrimination experienced by white people with mental health problems are replicated for people from black and minority ethnic communities. A recent Mentality report (Tidyman, 2004) suggests that the stigma and taboo associated with mental illness can lead to discrimination and harassment from with these communities. Some of the black women interviewed by Essien (2003) felt that having a psychiatric diagnosis was a sign of losing their self-respect in their communities A Mind factsheet on the mental heath of Chinese and Vietnamese people in Britain (www.mind.org.uk, accessed 18 July 2004) for example, draws attention to the stigma that can attach to mental health problems within these communities. As a result people may be reluctant to seek help. Similarly, a study by Gilbert *et al* (2004) describes how the concept of *izzat* – the shame and dishonour that can be brought to others by one's own behaviour – may deter South Asian women from using mental health services.

Potentially at least, people with mental health problems from black and minority communities are at risk of experiencing double or triple jeopardy: discrimination based on ethnicity; and stigmatisation on the part of the majority and minority communities based on having a mental illness.

Life events/experiences

- Studies in England suggest that there are higher levels of contact with criminal justice systems among people from African Caribbean communities (Mallet, 2004); higher admissions to psychiatric hospitals via the courts; and greater involvement of the police in hospital admission (Sainsbury Centre, 2002).

- For asylum seekers and refugees there is both the impact of the past and the experience of the present to cope with. As summarised by Munday and Oswald (2000) 'the trauma of having to leave one's homeland, the insecurity of one's status in the UK, the constant worrying about relatives and friends left behind, survivors guilt, Post Traumatic Stress Disorder, the experience of war, rape or torture are well documented triggers for the development of mental health problems'. In addition, Ferguson and Barclay (2002) describe the impact of the voucher system and dispersal policies on asylum seekers in Glasgow, and the daily experience of racial harassment. Some people saw the pressures of living as an asylum seeker in Glasgow, rather than their experiences in their own country as affecting their mental health.

- For Gypsy/Travellers the life experiences may include 'feeling trapped in a site where no-one would want to live' (Scottish Executive, 2001b) or of being forcibly moved on (Save the Children, 2000).

- Social isolation and limited social networks are known to impact on mental health and well-being (see Chapter 4). For people from black and minority ethnic communities, differences in language, employment patterns, fear of actual or potential racist abuse or violence and lack of appropriate social supports may contribute to social isolation. For the asylum seekers interviewed by Ferguson and Barclay (2002), for example, isolation from the host community was compounded by isolation from their own community. Women with young children were particularly isolated.

Multiple identities: Multiple disadvantage

- The different experiences of men and women across the total population (see Chapter 5) are replicated within different black and ethnic minorities groups. In terms of socio-economic conditions and social exclusion, role expectations, expression or presentation of distress, access, use and responsiveness of services, studies suggest different patterns for men and for women within and across black and minority ethnic communities (Nazroo, 1997; Fatunmbi and Lee; 1999; Bhardwaj 2001; Wilson, 2001; Essien, 2003; Mirza and Sheridan (2003); Zappone, 2003; Gilbert *et al*, 2004). Several studies for example, describe how, as people from black and minority ethnic communities women experienced not just 'racialisation of health' in the sense that others' perceptions of their health needs were informed by racial presumptions, but *gendered* racialisation.

- Age too may impact on both risk factors and outcomes. In addition to socio-economic factors that may impact on different age groups, within-group expectations, and the attitudes of the majority culture may both affect mental health and well being in different ways and with different outcomes.

Ethnicity and Mental Health: Resilience Factors

Netto *et al* (2001) identified two studies illustrating how women from black and minority ethnic communities, rather than presenting themselves as passive victims of a discriminatory or racist society, undertook a number of strategies to prevent deterioration of their own psychological health.

Several other studies describe the strategies women in particular from black and minority ethnic communities draw upon. These include;

- Developing social networks, resources and support: drawing on their cultural capital to find solutions or develop strategies based on their transnational networks (Zappone, 2003); establishing self-help groups (Wilson, 2001; Essien, 2003).

- 'Cultural strategies: constructing identities as survivors and 'challengers for injustice' in opposition to others' negative constructions (Zappone, 2003).

- Developing 'self-healing strategies' or coping mechanisms (Essien, 2003).

- Obtaining support and comfort from spiritual beliefs and practices (Wilson, 2001).

Ethnicity and Mental Health: Preventing and Responding to Risk

Mental health improvement and promotion

The Cares of Life project, in Southwark, South London aims to build community capacity to assist early intervention and build partnerships between the black community and statutory and non-statutory agencies (Olajide, 2004). No other studies, were identified in the course of the review looking specifically at the experience of people from black and minority ethnic communities of programmes aimed at improving/promoting mental health and well-being.

In Scotland the National Programme for Improving Mental Health and Well Being has funded a development post within the National Resource Centre for Ethnic Minority Health (NRCEMH), to develop capacity within Scotland. Activities to date include a Scotland-wide assessment exercise of mental health and well-being policy and practice as it relates to people from black and minority ethnic communities. A series of seminars has also been held across Scotland exploring different models for responding to the mental health needs of people from black and minority ethnic communities. The National Programme is also supporting the development of a transcultural mental health network.

Responding to mental health problems

A common theme across much of the documentation consulted was of the barriers to access appropriate and timely services. Barriers include:

- Language.

- Stereotyping.

- Lack of awareness of different understandings of mental illness.

- Cultural insensitivity including toward religious or cultural beliefs.

- 'Colour-blind' approach.

- Direct or indirect racism – individual and institutional.

These barriers are experienced at each stage from primary to secondary and tertiary care. People may, for example, have difficulty accessing appropriate primary prevention services such as counselling. One Scottish study of counselling services among Asian people, for example, found that most mainstream services provided counselling only in English, in the context of a limited number of black-led organisations (Netto *et al*, 2001). People may be reluctant to access services because of lack of confidence or trust. As a result they may only come to the attention of services in a crisis. On the other hand, patients from black and minority ethnic communities may be less likely to have their mental health problems recognised by a GP or may be mis-diagnosed (Tidyman, 2004; Bhui, 1997, in Wilson, 2001). They may not be offered the same range of treatment options (Nazroo, 1997; Shah, 2004), or be referred early enough for specialist mental health services (Netto *et al*, 2001; Sainsbury Centre, 2002). Advocacy services may also be underdeveloped. One study found that where mainstream advocacy existed for mental health users they were inaccessible and often inappropriate to the specific needs of black service users and carers (Joseph Rowntree Foundation, 2002).

Work undertaken preparatory to the development of guidance on the treatment of black and minority ethnic community detained patients (Patel *et al*, 2003) reveals the pre-admission and after-care issues that affected care. These included:

- Stigma towards mental health in some communities.

- Language difficulties.

- Unfamiliarity among people from black and minority ethnic communities of mental health services and systems.

- Different concepts of mental health.

- Concerns about the ability of services to meet expectations of safety, privacy and dignity.

- The quality of referral information, especially in relation to emergency admissions.

- The shortage of crisis resolution and community treatment services as alternatives to hospitalisation.

The potential outcomes of this apparent lack of cultural competence throughout the mental health service system is summarised in the report *Inside Outside* (Sashidharan, 2003) which addresses mental health services for people from black and minority ethnic communities in England and Wales. Drawing on findings from a number of studies the report suggest that patients from all minority ethnic groups are more likely than white majority patients:

- To follow aversive pathways into specialist mental health care.

- To be admitted compulsorily (with significant differences also between ethnic groups at all ages).

- To be mis-diagnosed.

- To be prescribed drugs and ECT rather than talking therapies.

- To have higher re-admission rates and spend longer periods of time in hospital.

- To be assessed as requiring greater degrees of supervision, control and security.

- To be admitted to secure care/forensic environments.

- Are less likely to have their social care and psychological needs addressed within the care planning process.

- To have worse outcomes.

Beyond acute care, people from black and minority communities may be hampered by inappropriate resources to assist recovery. A study of housing and mental health care needs of Asian people in two London boroughs found that people had been placed in unsuitable high rise blocks or temporary accommodation, with insufficient support from services that were mot culturally sensitive to their needs (Radia, 1996).

There are no equivalent studies for Scotland, however, the assessment of mental health services undertaken by Grant (2004) identifies 13 areas where care for people from black and minority ethnic communities could be improved. A further illustration is provided by the report of the enquiry into the care and treatment of Mr J, a Punjabi-speaker, by the Mental Welfare Commission (MWC) in 2002. Among other issues, the report highlights failures in communication (including inappropriate use of interpreting services), a lack of effort to identify his social or cultural needs and no consideration given to advocacy or befriending services.

Ethnicity and Mental Health: Implications

Policy drivers

There are a number of drivers for change in Scotland that extend beyond, but include the mental health service system. As indicated in Chapter 2, in addition to the Scotland-specific Equalities Strategy, the UK-wide Race Relations (Amendment) Act 2000 places a general statutory duty on a wide range of public authorities, including health boards, to promote racial equality and prevent discrimination.

In response to the legislation the Scottish Executive Health Department published 'Fair for All: Working Together Towards Culturally Competent Services' (Scottish Executive, 2002a). This provides guidance to NHS Boards and Trusts on their responsibilities to deliver a culturally competent service, that is, a 'service which recognises and meets the diverse needs of people of different cultural backgrounds … ensuring that discrimination on the basis of culture, belief, race, nationality or colour has no role in the delivery of services' (Scottish Executive, 2002a). The guidance focuses on five strands of policy including: access, service delivery and community development.

Although not specific to mental health, the 'Fair for All' framework, and the proposed Diversity and Equality strategy for NHScotland, announced in November 2003, provide important avenues to acknowledge and respond to the specific mental health needs of people from black and ethnic minorities as well as that of other 'equalities' groups.

More specifically the principles of 'equality', 'diversity' and 'non-discrimination', embedded within the Mental Health (Care and Treatment) (Scotland) 2003 may add further momentum.

Developing a strategic approach

Despite these drivers for change there may be scope for a more strategic approach to realising the goal of redressing the mental health inequalities experienced by people from black and minority ethnic communities with the aim of:

- Making visible the issues.

- Providing a coherent statement of objectives.

- Identifying action.

- Confirming responsibility and accountability.

In England and Wales the approach has been to develop a framework for action with the aim of 'delivering race equality' in mental health (DH, 2003b). The framework builds on the earlier Case for Action, Inside-Outside, which concluded that 'there are significant and persisting differences in and inequalities in service experience and outcome between minority groups and the majority white ethnic group' (Sashidharan, 2003, p. 16). The framework focuses on three 'building blocks' which it is proposed are fundamental to improved outcomes and experiences of people from black and minority ethnic communities:

- Better quality and more intelligently used information.

- More appropriate and responsive services.

- Increased community engagement.

Whether Scotland takes a similar approach, or locates ethnicity within a wider equalities and mental health framework, needs to be part of a wider discussion: a discussion which unpicks the commonalities across equalities groups and the specifics of, in this instance, being from a black and minority ethnic community. Two fundamental steps which, however, it is suggested need to be taken are:

• Ensuring the involvement of the different black and minority ethnic communities (including asylum seekers and refugees and Gypsy/Travellers), including people who have experienced mental health problems, in the further development of policy.

• Consideration of whether there is sufficient information on the experiences of people from black and minority ethnic communities within Scotland. Accounts and analysis of this experience draw largely on English material, but how generalisable is this to the Scottish context and are there specific dimensions to living in Scotland that are missed by relying on English experience? The experience of people living in rural and remote parts of Scotland, for example, and the implications for service delivery, may have particular salience in Scotland. Further, how might future demographic change in Scotland affect these experiences?

Elements of a strategic approach

1. Embedding consideration of mental health impacts on people from black and minority ethnic communities into other policy domains

   Although largely outwith the scope of this review, the socio–economic disadvantages experienced by people from black and ethnic communities, together with the experience of racism and discrimination, suggest that policies relating to community planning/regeneration, education and training, employment, housing, criminal justice, transport, rural development etc. will have a significant and differential impact on the mental health and well-being of people from black and minority ethnic communities, including asylum seekers and refugees and gypsy/travellers.

2. Embedding equalities considerations within the mental health service system

   i. Ensuring that the activities initiated under the auspices of the National Programme for Improving Mental Health and Well-Being are culturally competent.

      Issues to consider might be:

      • What does mental health/illness mean in different communities? What is well-being?

      • To what extent do the initiatives within *Choose Life* reflect the patterns of suicide and self-harm among people from different black and minority ethnic communities, including asylum seekers and refugees and Gypsy Travellers?

      • How is stigma and discrimination experienced by people with mental health problems from different black and minority ethnic communities?

      • Given the different employment patterns of men and women from black and minority ethnic communities, what are the implications for mental health at work?

      • What does building community capacity mean in the context of small ethnic minority communities within larger majority communities?

- How is the programme able to improve the mental health of younger men and women, and older men and women from different black and minority ethnic communities?

- How might the delivery of mental health improvement programmes for children and young people need to be tailored to particular groups, for example, if young women are not allowed to attend activities outside of school? How would programmes reach older people?

- What does recovery mean for people from different black and minority ethnic communities? How might this be effected?

(See for example, Tidyman, 2004; the Cares of Life Project, London, Olajide, 2004; The Chinese Mental Health Association Multimedia Mental Health promotion project, www.cmha.org.uk)

ii. Developing further capacity at primary, secondary and tertiary care health care levels to provide appropriate, timely, culturally aware and competent services responsive to meet mental health need. Capacity has a number of dimensions: developing the abilities and competence of mainstream services; developing 'specialist' services; developing the work of the voluntary and independent sector, including self-help groups. Where the appropriate balance lies between specialist and mainstream is, however, a debate that requires further airing.

A bedrock of a culturally competent service is a culturally competent workforce including, for example, social care staff and social workers, GPs and other primary health care professionals, pharmacists, psychiatrists, nurses, including Community Psychiatric Nurses, professionals allied to medicine, administrative/receptionist staff. Work is already being undertaken in this area (see for example, the NRCEMH report on the current status of cultural competency training in NHS Scotland, Pankaj, 2004), but this needs to encompass issues specific to mental health.

Monitoring, audit, inspection and performance management processes to ensure that mental health services used by people from black and minority ethnic communities do promote racial equality and prevent discrimination. This process has already started. The Mental Welfare Commission, for example, has recently completed a Race and Culture visit programme.

iii. Developing culturally competent practice

Including, for example:

- Ensuring the provision and use of appropriate interpretation and translation services. This may include consideration of the need for mental health awareness and support for interpreters.

- Developing an equalities practice, including understanding cultural identity, but also the impact of racism, on mental health and on the articulation or expression of mental distress.

- Developing appropriate assessment and diagnostic tools.

- Ensuring that services respect and respond to dietary and spiritual requirements.

- Ensuring equality of access to responsive and culturally appropriate services including advocacy, counselling, psychotherapy and befriending.

- Addressing recovery for people from black and minority communities, including access to appropriate housing, training and employment, welfare benefits, child-care.

Chapter Seven
Sexual Orientation and Mental Health

Introduction

This chapter is concerned with the risk and resilience factors as they impact differentially on lesbian, gay, bisexual and transgender people (LGBT).

There is consistent evidence of higher/different rates of depression, anxiety, suicidal thoughts, self-harming behaviour, eating disorders and substance misuse among LGBT people. *But*, being lesbian, gay, bisexual or transgender is not *per se* a cause of mental distress, nor is it a mental health problem. Homosexuality was declassified as a mental illness by the American Psychiatric Association in 1973 and the World Health Organization in 1992. The significant factors are the social and economic disadvantages LGBT people experience as a result of homophobia, transphobia and heterosexism.[3] This can result in discrimination, bullying at school or in the workplace, harassment, violence (including domestic violence) and exclusion.

Some people may experience multiple disadvantages based on different aspects of their social identity, for example, LGBT people who have a disability, or come from a black or minority ethnic community or who are older. In these contexts the discrimination and exclusion may be both from the wider social communities of which people are a part, but also from within LGBT communities. For women, in particular, double disadvantages may accrue based both on gender and sexual orientation.

These disadvantages may impact on access to, and experience of, services. People may be reluctant to 'come out' to service providers, or experience negative responses to disclosure of their sexual orientation due to:

- Lack of awareness/sensitivity among providers.

- Perceived homophobia/prejudice among professionals.

- Inappropriate treatment regimes. Although beyond the scope of the current paper, there are therapeutic controversies, between officially condemned 'conversion therapies' aimed at 'curing' homosexuality and 'affirmative therapies' targeted at addressing internalized homophobia.[4]

Given that approximately half a million of Scotland's population are lesbian, gay, bisexual or transgender (Inclusion Project, 2003), this raises significant issues for mental health improvement and mental health service delivery.

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3 The following definitions of these terms are taken from, Inclusion Project (2003), *Towards a Healthier LGBT Scotland,* LGBT Health Scotland, Glasgow.
Homophobia: An irrational fear and dislike of lesbian, gay and bisexual people, which can lead to hatred resulting in verbal and physical attacks and abuse;
Transphobia: an irrational fear and dislike of Transgender people, which can lead to hatred resulting in verbal and physical attacks and abuse;
Heterosexism: The belief that heterosexuality is naturally superior to homosexuality or bisexuality. This belief justifies domination and the imposition of values and beliefs.
4 Internalized homophobia: the ways in which lesbians and gay men incorporate learned negative attitudes and beliefs about homosexuality in the process of growing up (Cochran, 2001).

Sexual Orientation and Mental Health: Some Indicators

Data from the US, Australia, New Zealand, Europe, Northern Ireland, England and Wales, as well as Scotland-specific studies all point to higher levels of depression and anxiety, self-harming and suicidal thoughts, eating disorders and substance misuse among LGBT people. Younger people and bisexual and transgender people may be particularly vulnerable groups.

Depression and anxiety

International studies have found gay men to have a rate of depression as much as eight times higher than the general population, and as high as two-thirds of lesbians have been found to have suffered depression (McNair *et al*, 2001). In one English study one-quarter of men, and over one-third of women in a sample of LGBT people had been diagnosed with clinical depression or other kinds of depression (Healthy Gay Life, Birmingham, nd). In Glasgow two-thirds of a sample of lesbians and gay men stated that they had experienced depression (John and Patrick, 1999). Reviews of studies have indicated a greater lifetime risk for major depression among LGBT people (Cochran, 2001).

Young LGBT people may be particularly vulnerable to depression and anxiety. A health needs assessment of young lesbian, gay and bisexual people in Glasgow, for example, found that 41% of the women and 31% of the men had symptoms of depression. Comparison with data from a study of 'mainstream' young people of a similar age, indicates a rate of almost seven times higher for lesbian or bisexual young women, and eight times higher for gay or bisexual young men (Coia *et al*, 2002).

People who are bisexual or transgender may also be at particular risk of depression. One Australian study found that people who were bisexual had the highest rates of anxiety and depression compared with homosexual and heterosexual groups (Jorm *et al*, 2002), while a study in England and Wales found that bisexual men reported more psychological distress than their gay counterparts (King and McKeown in Pointon, 2003). One American study of transgender people found 62% of male-to-female, and 55% of female-to-male transgender people were depressed. Data from a study of young LGBT people in Northern Ireland also indicates the vulnerability of this group of people: around one-half of the young transgender people in the sample had been medicated for depression, compared with around one-quarter of young lesbian and gay young people (Carolan and Redmond, 2003).

Suicide and Self-harm

Studies also consistently indicate the high proportions of LGBT people who have attempted or seriously considered suicide, or who have engaged in self-harming behaviour (the number of successful suicides among this group of people is less easily quantifiable).

Younger people

In addition to international studies (e.g. Vincke and van Herrigen, 1998, in Lumsdaine, 2002) studies in Glasgow, Edinburgh and Northern Ireland, all point to high rates of suicidal thoughts and attempted suicide among young LGBT people. The Glasgow study of young lesbian, gay and bisexual people, for example, found that 50% of the men and 80% of the women thought about suicide at one time: 32% of the women and 19% of the men had actually made an attempt. Comparison with a 'mainstream' group of young people of similar age suggested that young lesbian, gay and bisexual people were between 6–11 times more likely to attempt suicide (Coia *et al*, 2002). Focusing

specifically on young gay and bisexual men in Edinburgh research by Gay Men's Health similarly found that young gay and bisexual men were 6.7 times more likely to have attempted suicide than the general population (Hutchison *et al*, 2003). This study found that young men aged 14–17 years were especially vulnerable.

In Northern Ireland a study of young LGBT people found that while across the sample 29% had attempted suicide this included almost one-half of those who identified as transgender (Carolan and Redmond, 2003).

The prevalence of self-harm among young LGBT people is also high, especially among young women. The Glasgow needs assessment found that just under 40% of the sample of young lesbian, gay and bisexual people had self-harmed: this included just under two-thirds of the sample of women, and 29% of the young men (Coia *et al*, 2002). The authors suggest that LGB young people are between 5–11 times more at risk of self-harming than other groups of young people. The Edinburgh study of gay and bisexual men also found that rates of self harming without suicidal intent were 5.6 higher than among young men in the general population (Hutchison *et al*, 2003).

The Northern Ireland study of young LGBT people again found that while 26% of the sample indicated they had self-harmed (33% of the women and 22% of the men), of those who identified as transgender, 50% admitted to self-harming (Carolan and Redmond, 2003).

Adults

Although the risk declines with age (Cochran, 2001), a Glasgow study of adult lesbians and gay men nonetheless found that nearly one-quarter had attempted suicide (41% of whom were women, 59% men) (John and Patrick, 1999).

Among people who are transgender one study found that 32% of the sample studied had attempted suicide (Clements-Nolle *et al*, 2001).

Self-harming behaviour is also prevalent among adults. The Glasgow study of adult lesbians and gay men found that just over one-quarter of the sample had self-harmed (John and Patrick, 1999). In both this and a study in Birmingham of adult LGBT people, between 32–36% of women had indicated that they had self-harmed, compared with 21–23% of men (Healthy Gay Life, Birmingham, nd; John and Patrick, 1999).

Eating disorders and substance misuse

Eating disorders

The Inclusion Project Report (2003), draws attention to the significance of eating disorders among LGBT people. Summarising the findings of a study comparing food-related attitudes and behaviours of heterosexual men and women with those of lesbians and gay men, the report highlights that gay men and heterosexual women were similar in disordered eating patterns, compared with lesbians and heterosexual men. Differences have also been found between gay and heterosexual male recurrent binge eating and purging. Gay men also report higher levels of body image disturbance compared to heterosexual men.

Over one-third of the young lesbian, gay and bisexual people included in the Glasgow needs assessment believed they had a problem with eating (Coia *et al*, 2002). A similar study in Northern Ireland, found 21% of young LGBT in the sample had experienced an eating disorder (Carolan and Redmond, 2003). In both samples the proportion of

women reporting a problem with eating was higher than that for men. Nonetheless, the Northern Ireland study comments that the incidence of eating disorders among the men was higher than among the general population. This study also found that 57% of the sample of transgender people had experienced an eating disorder.

Substance misuse

Although the research is ambiguous (Inclusion Project, 2003), some evidence suggests that lesbian and gay people may have higher levels of substance abuse disorders and are more likely to have used recreational drugs (King and McKeown, in Pointon, 2003). Lesbians may also be more at risk of developing alcohol dependency than other women (Cochran, 2001).

In the Northern Ireland study of young LGBT people, 34% reported alcohol misuse and 23% drug misuse, with little difference between men and women. People who identified as transgender reported higher levels of drugs and alcohol misuse than their lesbian, gay and bisexual peers (Carolan and Redmond, 2003).

Sexual Orientation and Mental Health: Risk Factors

Economic and social discrimination

The prevalence of homophobia within the wider community is evidenced by an analysis of the 2002 Scottish Attitudes Survey which found that discriminatory attitudes were more likely to be expressed in respect of gay men and lesbians and people from minority ethnic groups, than disabled people or [heterosexual] women (Bromley and Curtice, 2003). The Inclusion Project report, citing a Glasgow City survey of sectarianism, notes that the numbers of people who would be 'very concerned' about a lesbian or gay person moving in next door was amongst the highest expressed (Inclusion Project, 2003).

Given these attitudes it is perhaps not surprising that studies have shown that, in comparison with heterosexual men and women, lesbian, gay and bisexual people report more frequent experiences of discrimination, both as discrete events and everyday affronts (Cochran, 2001). Among a sample of lesbians and gay men in Glasgow, for example, 70% of respondents stated that they had experienced discrimination because of their sexuality (John and Patrick, 1999). From the perspective of mental health, it has been found that these experiences are positively associated with psychological distress (Cochran, 2001; McNair *et al*, 2001).

This experience of discrimination can occur at school, in the workplace, in access to services such as health (see below) and housing, and in the community at large.

Studies have revealed, for example, evidence of homophobic discrimination within schools, whether manifested through bullying or abuse (see below) and/or heterosexist sex and relationships education (McNair *et al*, 2001; Inclusion Project, 2003; Loudes, 2003). The immediate impact is perhaps reflected in the finding that, of the sample of young lesbian, gay and bisexual people interviewed by Coia *et al* (2002), 86% believed that their school had not or did not seem a welcoming a place for young lesbian, gay or bisexual people, or were unsure. Given the links made between homophobic discrimination and academic underachievement and higher than average truancy and drop out rates (Coia *et al*, 2002; Lumsdaine, 2002), this may have longer term social and economic impacts on subsequent life chances. Among a sample of lesbian and

gay men in Glasgow, for example, just under 30% felt that their levels of educational achievement were negatively affected by their own feelings or the attitudes of others towards their sexuality (John and Patrick, 1999).

Beyond school, studies suggest the level of discrimination based on sexual orientation experienced by LGBT people in the workplace. Studies of adults in Birmingham (Healthy Gay Life, nd) and Glasgow (John and Patrick, 1999), indicate the proportions of people who feel that their sexual orientation resulted in being refused a job, being treated differently, victimized or being sacked. Among the Glasgow sample, for example, 43% believed they had experienced sexual discrimination or harassment at work; 20% felt they had had to leave their employment or refuse work because of their own or others' attitudes towards their sexuality; and 42% of unemployed respondents related their unemployment to their sexual orientation. Among young people, one study in Northern Ireland found that 20% of the sample felt they had to leave their job because of their experience as a young person who identified as lesbian, gay, bisexual or transgender (Carolan and Redmond, 2003). Other studies report that young LGB people may feel they have to hide some aspect of their identity in the workplace because they feel their sexual orientation will be a factor in their isolation and alienation from colleagues (Coia, *et al*, 2002; Loudes, 2003).

Lumsdaine, (2002) draws attention to the comparatively high levels of homelessness particularly among young LGBT people. This has been linked to negative responses to the person's sexuality, including family reactions to a young person disclosing their sexual orientation. Among a sample of lesbian and gay men in Glasgow, 34% had been homeless: over one-third felt this was related to their own or others' reaction to their sexual orientation (Patrick and John, 1999). Homophobia was also a factor in the decision by 42% of the sample to move home.

Homelessness is a known risk factor for physical and mental health, and may also be implicated in people selling sex as a survival strategy (Noell and Ochs, 2001; Coia *et al*, 2002; Cochrane *et al*, 2002; Lumsdaine, 2002).

Abuse, bullying, harassment and violence

Among young and adult LGBT people studies suggest the pervasive experience of abuse, harassment, bullying and violence related to their sexual orientation. Studies among young LGB people in Northern Ireland and Glasgow reveal the high level of violence to which young people are exposed in school and in the street when they are perceived as being gay. In Coia *et al*'s study of young lesbian, gay and bisexual people in Glasgow, for example, four-fifths of the sample had experienced some form of abuse, harassment or violence, ranging from name calling/verbal abuse, to threats of, or actual physical violence or sexual assault (Coia *et al*, 2002). Studies among adults across Scotland, and in Edinburgh and Glasgow also reveal the level of abuse to which LGBT people are at risk. The Scotland-wide *Beyond Barriers* survey of LGBT people found that 35% of respondents had been verbally abused or threatened in the past year by someone who assumed they were LGBT (Beyond Barriers, 2002). A study of of lesbian and gay men in Glasgow (John and Patrick, 1999) found that as a result of being known, or presumed to be lesbian or gay:

- 85% had experienced verbal insults.

- 60% had been threatened with physical violence.

- 37% had been sexually harassed.

- 16% had been raped.

Among gay men in Edinburgh, 57% of respondents had experienced some form of harassment over the previous year (Morrison and MacKay, 2000). People in both the Glasgow and Edinburgh studies felt that the threat or experience of violence or abuse negatively affected how they acted or behaved, as well as impacting on self-confidence.

Again these negative experiences can occur at school, in the workplace and in the wider community, but also within the home.

A number of studies have drawn attention to young people's experience of homophobic bullying within the school environment. Over one-third of young gay and bisexual men and one-fifth of young lesbian and bisexual women in Birmingham had been bullied at school due to their sexual orientation (Healthy Gay Life, nd). In one Northern Ireland study of young LGBT people the figure is higher: 44% indicating that they had been bullied at school (Carolan and Redmond 2003). In Glasgow too, 41% of young lesbian and bisexual women, and 57% of young gay and bisexual men had experienced harassment or violence at school (Coia *et al*, 2002). In the Northern Ireland studies both fellow pupils and teachers were identified as the source of bullying. Given the negative impact of bullying on self-esteem and self-harm and possibly suicidal thoughts, this has possible implications for anti-bullying strategies within schools, and the extent to which they specifically address homophobic bullying.

In addition to the experience of employment discrimination, described earlier, a study in Edinburgh argues that the workplace is a significant setting for much of the violence and harassment that gay men experience (Morrison and MacKay, 2000).

For both young and adult LGBT people, however, much of the abuse is experienced in the street or other public places. In the Glasgow study of young LGBT people, for example, 38% of women and 51% of men had experienced harassment or violence in the street. The Scotland-wide *Beyond Barriers* (2002) survey of LGBT people found that where people felt least safe was the street, in or near a non-gay pub or venue or on public transport. Potentially this has implications for social connectedness and participation.

For some people, however, the home too, may not be a place of refuge. This has two dimensions. First, as already noted in the context of homelessness, for some LGBT young people, coming out can result in family rejection (Carolan and Redmond, 2003; Lunsdaine, 2002). Second, both young and adult LGBT people in same-sex relationships can be subject to domestic violence, with similar psychological implications as for people in abusive heterosexual partnerships (Inclusion, Project, 2003). Out of a sample of young lesbian, gay and bisexual people Coia *et al* (2002) found that 12% (14% of the young men, and 8% of the young women) had experienced violence or assault from a partner in a same sex relationship In one Glasgow study of lesbians and gay men 35% indicated that they had experienced violence in a same-sex relationship, of whom 60% were women (John and Patrick, 1999).[5]

Social isolation

For young people in particular, the experience of discrimination, abuse and violence has significant implications for coming out,[6] and with it, for identity, self-esteem and mental health and well-being. Summarised by one study of young lesbian, gay and bisexual people in Northern Ireland:

> *'Because of the violence, social disapproval, isolation and discrimination they experience, young LGB people are more subject to depression, anxiety and poor mental health than their heterosexual peers … both the process of coming out in a society which devalues LGB lifestyles or the need to hide one's sexual orientation are factors impacting negatively on the emotional and mental well-being of young LGB people.'* (Loudes, 2003)

For both younger people and adults the impact may be felt in terms both of social isolation or lack of social connectedness, and social and economic exclusion and disadvantage. These sources of exclusion may be compounded for lesbian or bisexual women, and/or LGBT people who have a disability, and/or come from a black or ethnic community, and/or are older.

Multiple identities; Multiple disadvantage

The impact of stress, stigma and homphobia may be compounded for LGBT people who are disabled, come from black or minority ethnic communities, or who are older (Cochran, 2001; McNair *et al*, 2001).

The multiple impacts of sexuality and gender are flagged up by John and Patrick (2003) in Glasgow who found that of the 51% of the sample who had experienced sexism, the great majority were women. The same study reports the comparative lack of social and cultural provision for lesbian respondents. Reflecting this, a Northern Ireland study of young lesbian, gay and bisexual people, refers to the comparative 'invisibility' in research and policy terms of young lesbians and bisexual women. In practice this has resulted in an increased sense of isolation for young women who have few places to meet to discuss their experiences (Loudes, 2003). As the Inclusion Project report (2003) suggests, the social and economic disadvantages which accrue on the basis of gender may have a particular impact on male to female transgender people.

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5 For more information on domestic violence and abuse experienced by LGBT people, see for example, Broken Rainbow conference report, 2002, accessed via www.lgbt-dv.org. For data on number of reported incidencts of same-sex domestic abuse see Gadd *et al*. 2002.

6 Coming out refers to LGBT people's on-going experience of disclosing their sexuality (Inclusion Project Report, 2003).

Two studies point to the potential double or triple jeopardy experienced by LGBT people with physical disabilities. What the studies also highlight is the potential for exclusion: from the disability movement due to their sexual orientation; from the LGBT community because of their physical disability; and from 'mainstream' society both due to their disability and because it was felt hard for society to accept the idea of lesbian and gay sexuality among disabled people (Brothers, 2003; Molloy *et al*, 2003), this has implications for identity and sources of social support and social connectedness.

The potential for compounded disadvantage for LGBT people from black and minority ethnic communities is flagged up in the Inclusion Project report (2003), which suggests that racism within the LGBT community and homophobia and transphobia in some black and ethnic minority communities may act as barriers to inclusion.

A number of studies allude to the experiences of older LGBT people. An Edinburgh study of gay men, found, for example that it was both the oldest and youngest age groups who were most worried about being victims of violence Morrison and MacKay (2000), while older LGBT people in a Glasgow study reported experiences of discrimination in relation to housing (John and Patrick, 1999). The Beyond Barriers (2002) survey found that 45% of respondents had concerns about ageing, including, being alone, being isolated, in poor health and a lack of LGBT friendly services. This has echoes in a study by Manthorpe and Price (2003), which suggests that the onset of dementia in older gay men and lesbians may make their sexual orientation public for the first time, with implications for social care services.

Sexual Orientation and Mental Health: Resilience Factors

Notwithstanding the risk factors, the point is made by Cochran (2001) in her review of a number of studies, that the majority of homosexual or bisexual respondents did not evidence any of the measured mental health disorders.

The importance of family, a sense of social connectedness and social support have been found to contribute to psychological well-being particularly among young LGBT people (Detrie, 2002; Hershberger and D'Augelli, 1995). Exemplifying the importance of support and acceptance, young people in one study described how being part of LGBT youth groups enhanced their self esteem and self-respect (Carolan and Redmond, 2003).

Cochran, however, makes the point that more research is needed to identify the protective and resilience factors upon which LGBT people can draw.

Sexual Orientation and Mental Health: Preventing and Responding to Risk

Mental health improvement

Lumsdaine (2002) argues that there is a need to integrate the health concerns of LGBT people across all areas of health promotion activity, not just in relation to sexual health. This clearly has implications for mental health improvement strategies.

The Inclusion report identifies a number of innovative health projects, including a project focusing on awareness of LGBT people who self-harm; the development in Edinburgh of the LGBT Centre for Health and Well Being and a pilot LGBT youth project focusing on mental health and esteem (Inclusion, 2003). In addition the National Programme has contributed funding towards a transgender needs assessment.

One London-based organisation, PACE, has drawn up a set of good practice guidelines for working with lesbian, gay and bisexual people in mental health services (PACE website, www.pacehealth.org.uk/guidelines.html, accessed 18 January 04). The suggested guidelines for meeting Standard One (mental health promotion) of the National Service Framework for mental health in England and Wales include: referring to LGB people in relevant publicity and promoting positive images; liaison with relevant LGB groups; promoting services and resources specifically for LGB people, including services such counselling and advocacy provided by LGB organisations.

Responding to mental health problems

Two themes emerge from studies looking at access to health services, including mental health services:

- A reluctance by LGBT people to disclose their sexual orientation to health care professionals because of a fear of discrimination or negative response.

- The lived experience of discrimination and negative reaction following disclosure, including breaches of confidentiality.

Reluctance to disclose

Studies have found that between one-third and one-half of LGBT people may not have disclosed their sexual orientation to their GP (John and Patrick, 1999; Healthy Gay Lives, nd; Beyond Barriers, 2002). Among LGBT with physical disabilities the figure may be even higher. Brothers (2003) found a reluctance to come out to health care providers among a sample of lesbian, gay and bisexual people with disabilities because of their fear of being excluded from services or being treated in a negative way.

One study of a sample of 55 lesbian and gay people with experience of using mental health services found that 42% (23 people) would not feel 'safe' disclosing their sexual orientation within a mainstream mental health setting, a further 20 expressed reservations about disclosure (Golding, 1997). The two main reasons for being reluctant to disclose their sexual orientation were the fear of prejudicial treatment or discrimination, and/or that staff would assume that all their mental health problems were related to their sexuality.

Experiences of homophobia and discrimination within health services

For some people concerns about negative reactions have become a reality. King and McKeown found in their survey in England and Wales that up to a third of gay men, a quarter of bisexual men and more than 40% of lesbians had experienced negative or mixed reactions on disclosing their sexual orientation to a mental health practitioner (King and McKeown, 2003, in Pointon, 2003). An earlier survey of mental health service users found that 73% of the sample had experienced some form of prejudice and/or discrimination in connection with their sexual orientation within a mainstream mental health service (Golding, 1997), while a New Zealand survey of lesbians found that 30% of the women who had used mental health services had experienced discriminatory treatment (in, McNair *et al*, 2001).

For LGBT people with disabilities, prejudice may arise because of their sexual orientation, their physical disability, or in response to both aspects (Brothers, 2003).

In terms of treatment or therapy, heterosexism, homophobia, or a lack of understanding have been implicated in people's sexual orientation being given too much emphasis or being pathologised, that is identified as the cause of their mental distress; alternatively, people may find it difficult to explore issues relating to their sexual orientation because of a lack of understanding or awkwardness on the part of practitioners.

As a result of actual or anticipated discrimination and homophobia, people may be reluctant to access services, or may delay seeking help. For people who do seek help discrimination, homophobia, or lack of awareness or sensitivity, may compound rather than ameliorate distress (Cochran, 2001; Carr, 2002; Carolan and Redmond, 2003).

Sexual Orientation and Mental Health: Implications

Although the shorthand term LGBT is used, as the evidence suggests, it is important to be aware that the factors that impact on mental health and well-being, the ways in which these are experienced and expressed may be distinct between the different groups of people the acronym encompasses.

Embedding considerations of mental health impact on lesbian, gay, bisexual and transgender people into other policy domains

There are clearly issues around the experience of discrimination, homophobia and heterosexism which have implications for the implementation of the broader anti-discrimination and equalities agenda. For example, strategies relating to discrimination in employment and education, including sex education, and housing. The scope of community safety initiatives and anti-bullying strategies in the workplace and school also have implications for LGBT people.

Embedding consideration of inequalities within the mental health service system

Mental health improvement

A number of studies reinforce the need for a public health approach to include and address the specific health inequalities that arise from the homophobia, heterosexism and social exclusion to which LGBT people are exposed (McNair *et al*, 2001; Lumsdaine, 2002). According to Lumsdaine, this requires health promotion initiatives to shift attention away from seeing LGBT people as *at risk groups* to recognising the *risk conditions* which generate health inequalities.

In addition to consideration of the structural inequalities which LGBT people may experience, addressing the mental health and well being of LGBT people may raise questions relating to:

- The nature of programmes to improve the mental health and well being of LGBT people, including for younger people and older people.

- Mechanisms for addressing self-harm and suicide among younger and older LGBT people.

- Mechanisms for addressing stigma and discrimination experienced by LGBT people with mental health problems, including among LGBT communities.

- The implications of 'coming out' for the mental health and wellbeing of LGBT people.

Mental health services

In relation to mental health service design and delivery, the evidence suggests the need to:

- Reflect upon the homophobia and heterosexism that LGBT people perceive or experience within mental health services.

- Enhance awareness of the experiences of LGBT people, and the forms of discrimination and social exclusion they may encounter.

- Consider the nature of a 'culturally competent' mental health service for LGBT people.

Chapter 8
Disability and Mental Health

Introduction

According to recently published data just under one in five adults in Scotland have a disability and/or a long-term illness (Scottish Executive, 2004i). Against this background this chapter has a two-fold purpose: to explore the social and economic consequences of having a mental health problem; and to map out the implications for mental health inequalities of physical disabilities, including sensory impairments.

To include people with mental health problems in a section on disability may seem, in some respects, idiosyncratic. The concept of disability is often associated with physical impairments, and people with mental health problems may not see themselves, or may choose not to see themselves as 'disabled' (Beresford *et al*, 2002; McFarlane, c2000; SEU, 2004). However, for the purposes of the Disability Discrimination Act (1995) (DDA) 'A person has a disability if he has a physical or *mental* impairment which has substantial and long-term adverse affect on his ability to carry out normal day to day activities' (emphasis added). Although issues have been raised relating to awareness, interpretation and application of the legislation to people with mental impairments (Durie, nd; Cullen, 2004), it nonetheless provides important protections against discrimination toward people with a 'clinically well-recognised' mental illness, in relation to, for example, employment and access to goods and services. It is within this legislative context that people with mental health problems are included in this section.

In terms of the causes and consequences of mental health inequality the focus therefore needs to be on the experiences of three groups of people:

• People with mental health problems for whom the experience of mental distress may be compounded by the socio-economic disadvantage, stigma and discrimination associated with mental illness;

• People with mental health problems and physical disabilities who may be multiply disadvantaged;

• People with physical disabilities, whose experience of socio-economic disadvantage, discrimination and stigma due to their physical impairment may impact on their mental health and well being.

Reflecting the readily available evidence this chapter focuses largely on the first group: people with mental health problems. A key finding and implication is the need for further research and analysis of the associations between physical disability and mental health inequalities.

People with Mental Health Problems: Some Indicators

Along a number of dimensions people with mental health problems are disadvantaged. For example:

Poverty and employment

- UK-wide only 24% of adults with long-term mental health problems are in work – the lowest employment rate for any of the main groups of disabled people (SEU, 2004).

- In one study, 60% of the sample of people assessed as having a psychotic disorder had a gross weekly household income of less than £300 per week, compared with 37% of people assessed as having a neurotic disorder, and 28% of the sample with no disorder (Melzer *et al*, 2002).

- In the same study, two-thirds of those with a psychotic disorder were on welfare benefits, compared with one-third of those with a neurotic disorder and 10% of those with no disorder (Melzer *et al*, 2002).

- 35% of people coming onto Incapacity Benefit cite mental health problems as their main disability (SEU, 2004).

- People with mental health problems are nearly three times more likely to be in debt; and one in four tenants with mental health problems has serious rent arrears and is at risk of losing their home (Melzer *et al*, 2002).

- Of over 550 people with mental health problems surveyed in one study, 72% of respondents defined themselves as being on a low income and half felt excluded from their local community because of their financial situation (Focus on Mental Health, 2001).

- The same study also found that 66% of respondents had difficulties making their income last all week (Focus on Mental Health, 2001). This sets in context the findings from another study that adults with mental health problems are more likely to cut down on use of the telephone, gas, electricity and water than the general population (Melzer *et al*, 2002).

- Less than 2% of people receiving Direct Payments in Scotland in the financial year 2003 – 2004 were people with mental health problems (Scottish Executive, 2004o; Ridley and Jones, 2002).

Housing and Homelessness

- People with a mental disorder are more likely to be living in rented accommodation (Melzer *et al*, 2002).

- Mental health problems are four times as common among homeless people as within the general population. At least one in five homeless people have severe mental health problems which are likely to have contributed to the person becoming homeless (Dean and Craig, 1999). Young homeless people in particular may be vulnerable to both mental health and physical health problems (Stephens, 2002).

Further and Higher Education

- In 1999–2000 only 4.5% of 1.6 million students in higher education in the UK declared a disability and only 0.12% declared a mental health disability (Royal College of Psychiatrists, 2003)[7]

Physical Health

- People with mental health problems are at increased risk of experiencing a range of physical health problems. People with mental health problems are nearly twice as likely to die from coronary heart disease as the general population and four times as likely to die from respiratory diseases (Friedli and Dardis, 2002).

Suicide

- Figures reproduced by Rogers and Pilgrim suggest that the risk of suicide is 14 times greater for both men and women with a diagnosis of schizophrenia, and 12 times greater for men with a diagnosis of a major affective disorder and 16 times greater for women (Baxter and Appleby, 1999 in Rogers and Pilgrim, 2003).

- The National Inquiry into suicide and homicide by people with a mental illness found that nearly one quarter of suicides or probable suicides in Scotland over the three-year period April 1997–2000 had been in contact with mental health services one year before death. Of this group of mental health service users, 12% were psychiatric in-patients at the time of death (DH, 2001).

Stigma and prejudice

- One study found that almost one half of a sample of people with current or past experience of mental distress had been abused or harassed in public. One-quarter felt at risk of attack inside their own homes (Read and Baker, 1996, in Mind 2004)

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7 As the authors' note, this may underestimate the extent of mental health problems among the student population because it relies on self-report.

People with Mental Health Problems: Risk Factors

Socio-economic disadvantage

Clearly, people with mental health problems are at risk of experiencing serious socio-economic disadvantage and social exclusion. Mental health problems and exclusion can become mutually reinforcing: mental health problems can lead to unemployment, debt, homelessness, and a breakdown in social relationships, which can contribute to worsening mental and physical health (SEU, 2004).

Studies such as that by Payne (1999) and Focus on Mental Health (2001), illustrate the compounding effects of socio-economic disadvantage and the perceived 'degrading experience' of being on a very low income.

Discrimination and stigma

For people with mental health problems, a fundamental source of socio-economic disadvantage, inequality and social isolation is the stigma and associated discrimination with which they have to deal on a day to day basis. The personal impact is illustrated by the findings from a recent Mind survey of people with mental health problems and a complementary NOP study of the general population. The Mind study found that 84% of people with mental health problems have felt isolated compared to 29% of the general population (Mind, 2004). In the same survey nearly 60% of people with mental health problems felt that isolation was linked to discrimination on the grounds of mental health. People in rural and remote areas can be even more isolated (Mind, 2004; Philo, Parr and Burns, 2003).

Taking as a framework two of the areas covered by the Disability Discrimination Act: employment and the provision of goods, facilities, services and premises and education, helps to understand just how pervasive the impact of this discrimination and stigma can be.

Employment

The Disability Discrimination Act prohibits discrimination against disabled people in relation both to recruitment and in the course of employment, yet the picture that emerges consistently from the research is of the barriers experienced by people with mental health problems in retaining and/or gaining access to employment (Robbie and Pressland, 2003). The inter-related barriers identified include:

- Individual: for example people may lack the confidence or skills to seek employment; or are concerned about the impact of employment on their mental health. In one study, for example, nearly three-quarters of respondents felt that their mental health had affected their work prospects, some even felt it made obtaining employment virtually impossible (De Ponte, 2000; Focus on Mental Health, 2001).

- Attitudinal: Consistently people with mental health problems report being turned down for jobs because of their mental health problem (De Ponte, 2000; Warner, 2002; Read and Baker 1996, in Dunn, 1999; SEU, 2004); have experienced discrimination, stigma and prejudice on the part of employers and colleagues within the workplace, including being passed over for promotion, or bullying, isolation and derision (De Ponte, 2000; Warner, 2002; Robbie and Pressland, 2003; Cullen, 2004) or have been dismissed or forced to resign as a result of their mental health status (Mind, 2001). One study of psychiatric patients found that 80% of those employed at the

time of diagnosis had lost their jobs following admission to hospital (Butterworth, 2001, in Thomas, 2002) The disadvantage is compounded by the reduced likelihood of returning to work the longer people are out of employment (BSRM, 2000).

Because of the expected and actual experience of discrimination or stigma whether from employers or colleagues, people are reluctant to disclose their mental health status either at the stage of applying for a job or subsequently. Judgmental attitudes or lack of understanding or insight on the part of employers and colleagues can also make it difficult for employees with mental health problems to approach them if they are experiencing difficulties (McCollam, Mclean and Durie, 2003). People with mental health problems may therefore be on the horns of a dilemma. On the one hand, if they reveal that they have experienced a mental health problem, a lack of awareness among employers of the legal requirements of the Disability Discrimination Act may mean that they may not get a job, may be overlooked for promotion, experience negative attitudes within the workplace, or be asked to resign. On the other hand, if they do not disclose their mental health history to employers they may not receive the help and support that would enable them to retain their job. More specifically, those who would qualify would lose out on the protections of the Disability Discrimination Act. Under the legislation an employer has no duty to make reasonable adjustments until the disclosure is made.

- Structural: Both the financial disincentives built into the operation of the welfare benefits system and a lack of support services to enable people to remain in, or re-enter employment act as further barriers (Durie, 1999; Robbie and Pressland, 2003; Cullen, 2004; SEU, 2004).

Provision of goods and services

Across a range of goods and services studies have found people with mental health problems to be disadvantaged. For example:

- Difficulties in accessing insurance (Read and Baker, 1996 in Dunn, 1999; Cullen, 2004; SEU, 2004; www.mind.org.uk/Information/Factsheets/Insurance.htm accessed 27 September 2004).

- Difficulties in accessing welfare benefits such as housing benefit, increasing the risk of rent arrears and eviction (Cullen, 2004).

- 'Residential sorting' with people with mental health problems being located in the same few local neighbourhoods and estates (SEU, 2004).

- Barriers to access to education (Learning and Skills Council, 2002; SEU, 2004). According to the Learning and Skills Council 'the main barrier to learning for people with mental ill health is the widespread ignorance and prejudice about mental health' (Learning and Skills Council, 2002).

- Difficulties paying for the costs of transport (Focus on Mental Health, 2001; SEU, 2004).

- Experiencing discrimination from GPs or other health care providers (Dunn, 1999; De Ponte, 2000; www.mhe-sme.org/en/projects_harrassment.htm). In one study, 44% of respondents reported discrimination from GPs, 32% from other health services (De Ponte, 2000). In both cases the reported discrimination took the form of physical illnesses not being taken seriously or attributed to mental distress.

Physical ill-health

The reported discrimination by health care providers takes on particular significance given the very real physical health risks faced by people with mental health problems.

Reasons for the poor physical health of people with mental health problems include the impact on physical health of deprivation and poverty, but also associated lifestyle behaviours. Friedli and Dardis (2002) refer to data indicating that poor nutrition, obesity, higher levels of smoking, heavy alcohol use and lack of exercise contribute to higher rates of morbidity and life expectancy among people with mental health problems. This is reflected in the findings from a recent study comparing health perceptions in Gloucester. This found that people with severe mental illness had poorer self-reported health, undertook less physical activity, had poorer diets, higher body mass index and higher levels of smoking compared with the general population (Crone *et al*, 2004).

Mental health service users in one study in London reported that they were rarely provided with health promotion information and given little information about or offered physical health checks in a primary care setting. Further, health promotion information and services were not seen as open to people with mental health problems. Specifically in relation to smoking cessation, respondents reported little in the way of support to help them quit. The study concludes that, from the point of view of users, a key barrier to more equitable access to health promotion information, services and support was the perceived attitude of primary health care staff toward people with mental health problems (Friedli and Dardis, 2002).

Multiple identities: Multiple disadvantage

As has been described in a number of earlier chapters, the stigma and discrimination that attaches to mental illness compounds, or is compounded by other sources of disadvantage. For example,

- Women with mental health problems (see Chapter 5)

- People from black and minority ethnic communities (See Chapter 6)

- People who are lesbian, gay, bisexual or transgender (See Chapter 7)

- Older people (See for example: Wood and Bain, 2001; Scottish Executive, 2002e; NHSHealth Scotland, 2003; Joint inquiry led by Age Concern and the Mental Health Foundation into Mental Health and Well-Being in Later Life www.mhilli.org.org/inquiry/)

- Children and young people (See for example: Kay, 1999; Melzer *et al*, 2000; Scottish Executive, 2001c; PHIS, 2003 Melzer *et al*, 2004; Mind, 2004)

- Men and women with mental health problems in prison or secure in-patient accommodation (Singleton, N. *et al*, 1998; DH, 2002)

- People with mental health problems in rural and remote areas (Philo, Parr and Burns (2003); (RARARI/NHS Scotland, 2003).

- People with mental health and learning disabilities (See for example: Scottish Executive, 2000c; Foundation for People with Learning Disabilities, 2002; Scottish Executive, 2002f; NHSHealth Scotland, 2004).

People with Mental Health Problems: Resilience Factors

The resilience factors that enable people to recover from mental distress and to resist the disabling effects of discrimination and stigma are the same as for everyone else (see Chapter 4): self-determination, hope, confiding relationships, access to social networks, having meaningful activity and roles, financial security and feeling safe. This implies, however, not just individual reserves, but also support services which enable individual recovery, socially inclusive 'accepting communities' (Dunn, 1999) and a legal infrastructure which enables people to participate fully as citizens.

Participants at a Scottish workshop on Recovery talked about the sorts of things that facilitated their own development including support, relationships, being enabled to make informed choices and finding a new life (SDC, 2002).

People with Mental Health Problems: Preventing and Responding to Risk

Tackling stigma and discrimination, supporting inclusion

The Disability Discrimination Act 1995 provides the legal framework for tackling discrimination experienced by people who meet the criteria of the Act, that is, someone who has 'a physical or mental impairment which has a substantial or long-term adverse effect on his or her ability to carry out normal day-to day activities'. As noted earlier, criticisms have been made of the application and interpretation of the legislation (Cullen, 2004; Durie, nd). In December 2003 the UK Government published a Disability Discrimination Bill which includes a duty for public bodies to promote equality of opportunity for disabled people. In responding to the Draft Bill the Disability Rights Commission and the Joint Scrutiny Committee have made recommendations for changes to the legislation relating to mental health (SEU, 2004).

Strategically, in Scotland the National Programme for Improving Mental Health and Well-Being, encompasses, but extends beyond, people with mental health problems. Among the initiatives it supports are Choose Life, the suicide prevention strategy and See me… the anti-stigma campaign. The programme is also supporting the development of a National Recovery Network. In addition, its broader based initiatives, for example in support of community well-being have the potential to impact on the social inclusion of people with mental health problems.

Another dimension to this 'mainstreaming' approach is the inclusion within other policy areas of initiatives targeted at people with mental health problems. For example, the Healthy Working Lives Action Plan (Scottish Executive, 2004b), which aims both to improve workplace physical and mental health, and enhance individual employability. The Action Plan includes proposals for pilot job retention projects for people with mental health problems. The National Programme will fund the pilot projects.

A project to provide money advice for people with mental health problems is in development in North Lanarkshire with a view to becoming operational in 2005. This is one of a number of pilot projects supported as part of the Scottish Executive's financial inclusion strategy (http://www.scotland.gov.uk/about/DD/SI/00017413/page82906061.aspx).

In England, the Social Exclusion Unit has published its report on Mental Health and Social Exclusion. This includes a 27-point Action Plan aimed at tackling stigma and discrimination, supporting the role of health and social care in addressing social exclusion, overcoming barriers to employment, supporting families and community participation, and ensuring access to goods and services such as housing, financial advice and transport (SEU, 2004). A sister paper, *From Here to Equality*, has been produced by the National Institute for Mental Health in England (NIMHE) setting out a five-year strategic plan to tackle stigma and discrimination on mental health grounds (NIMHE, 2004).

Although the Social Exclusion Report remit covers only England, a number of its recommendations could have implications for Scotland including, for example, raising awareness among individuals and employers of the rights of people with mental health problems under the Disability Discrimination Act (Action 3); promoting best practice in the public sector in readiness for the proposed new public sector duty to promote equality of opportunity for all disabled people (Action 4); improving access to employment programmes (Action 12); easing the transition from benefits to work (Action 13). In other areas there may be opportunities for shared learning, for example, support on employment and social issues for people with severe mental illness (Action 5); models for vocational and social support in or linked to primary care (Action 7); strengthening training on vocational and social issues for health and social care professionals (Action 8); tackling inequalities in access to health services (Action 9); effective interventions for young people (action 19); and access to services such as adult learning, housing, transport and financial and legal advice (Actions, 17, 21, 22, 23).

The role of mental health services

The Social Exclusion Report describes the role of health and social care services in tackling social exclusion. In particular it states that 'Effective mental health services will view rehabilitation and support for reintegration into the community as an integral part of their work' (SEU, 2004, p. 97, para 9). NIMHE has published a social inclusion resource pack for people working in mental health to enable the identification of positive practice in social inclusion in different 'life domains' (NIMHE, 2003a).

In Scotland, there are a number of different drivers encouraging health and social care services to contribute, with others, to tackling the inequalities and exclusion to which people who experience mental illness are at risk. For example, one of the objectives of the National Programme is to improve the ability of public services to act in support of the promotion of mental health and the prevention of mental illness. Specifically in relation to health services, in 2003 the Minister for Health announced the extension of Fair for All, the Scottish Executive Health Department guidance on developing culturally competent health services, to other groups, including people with disabilities. The Scottish Executive is currently developing an Equality and Diversity Strategy: Fair for All – the Wider Challenge as part of the Patient Focus and Public Involvement Agenda (Scottish Executive, 2004a).

Another potential lever is the principle of reciprocity embedded within the Mental Health (Care and Treatment) (Scotland) Act 2003. This is the requirement to provide appropriate services to people who may be detained under the legislation as well as providing continuing care when an order is no longer in place. The Act also places a duty on local authorities to provide for people who are not in hospital services designed to promote their well being and social development. This includes assistance to people to obtain and undertake employment.

For people in in-patient care, particularly women (see Chapter 5) the Scottish Executive policy of abolishing single-sex wards may have a particular impact on psychiatric services. At present a significant proportion of the remaining 21 mixed sex wards in Scotland are located in one psychiatric hospital.

Beyond the in-patient setting is the contribution of Community Planning and Community Health Partnerships (CHPs) to population health improvement. It is anticipated that CHPs, for example, will contribute with local authority partners to improving the 'health of local communities, tackling inequalities and promoting policies that address poverty and deprivation' (Scottish Executive, 2004d). Specifically in relation to mental health, recent guidance on CHPs and integrated mental health services, anticipates that local Mental Health Partnerships, to which CHPs will belong will 'give attention to and allocate resources to health promotion and social inclusion priorities'.

People with Mental Health Problems: Implications

Embedding mental health considerations into other policy domains

Clearly, to redress the inequalities to which people who have experienced mental illness are at risk extends beyond the domains of health and mental health, into the heart of the social justice agenda.

Closing the opportunity gap for this group of people implies, for example, consideration of the impact of community regeneration or development on the economic inclusion or exclusion of people who experience mental distress.

Specifically in relation to access to, and retention in, employment a number of reviews have looked at 'what works' (Crowther *et al*, 2001; NIMHE, 2003; Robbie and Pressland, 2003). Individual Placement and Support (IPS) models of supported employment, developed in the USA, have been found to be more effective than traditional vocational services in obtaining employment. The key features are the use of open employment, integration with mental health care, responsiveness to user preferences, continuous and comprehensive assessment and time-unlimited support (NIMHE, 2003b). A number of different models of practice are described in the Social Exclusion Unit's report (SEU, 2004). Guidance to promote employment and other occupational activity for people with mental health problems is also due to be published by NIMHE.

Within the workplace, employees with mental health problems interviewed in a study by McCollam *et al* (2003) described the importance of sensitive and approachable managers and support for structuring and managing workloads to accommodate individual needs.

Whether through specific projects or programmes, or adjustments within the workplace, enabling people with mental health problems to return to or remain in employment has implications individually and jointly, for mental health service providers, primary health care providers, local authorities, other agencies and professionals as well as public, voluntary and private sector employers.

Meeting the learning and skills needs of people with mental health problem requires similarly flexible, supportive and responsive approaches (Learning and Skills Council, 2002; James, 2002; National Bureau for Students with Disabilities, 2004). This applies to young adults (www.niace.org.uk/information/Briefing_sheets/Young_Adults_MHD.htm) (accessed 23 September 2004; www.lookingforward.org.uk) (accessed 23 September 2004) and people returning to education (James, 2002). One survey of learning provision for young adults aged 16–25 years with mental health problems found that there was a lack of targeted provision for this group of learners and potential learners, with insufficient knowledge and information among providers identified as one of the main barriers (www.lookingforward.org.uk). Again, this has implications for higher and further/continuing education providers, and for partnership working between education providers and other agencies or services, including mental health services.

Across the board there needs to be greater awareness not just of the needs, but also the rights of people with mental illness who come within the criteria of the DDA, in terms of employment, access to premises and access to goods and services. This includes public services such as housing, transport, education, welfare benefits and advice/financial/debt advice. It also extends to the health service, both as an employer, and as a service provider, including a provider of physical health care and health promotion. Awareness that the provisions cover people with mental health problems may also need to be reinforced among private sector employers, including, since October 2004, those with 15 or fewer employees.

Fundamentally too, there is a need to 'empower' people with mental illness who come within the scope of the Act to ensure that they are aware of their rights under the legislation, and the scope for ensuring that these rights are honoured.

Embedding considerations of inequality within the mental health service system

Although perhaps a difficult concept to grasp, there is a role for mental health improvement in the lives of people who also have a mental illness (Herron and Trent, 2000). The National Programme is supporting a number of initiatives, which directly or indirectly impact on the mental health and well-being of people with mental illness.

The other side of the coin is the role of mental health services in redressing inequalities. Rogers and Pilgrim (2003) draw attention to the 'inequalities created by service provision'. This has at least three dimensions: equality of access to services; negative or stigmatising experience of mental health service provision; and the longer term impacts for individuals.

The first two dimensions have been touched upon in earlier chapters. As also discussed earlier, there are possible levers for change from a focus on an individual's symptoms to supporting personal recovery. However, if at a basic level, Mental Health Officer, ward staff, primary care staff, do not, for example, ask questions about a person's employment, then the individual may struggle for years to get back to work. Mental health services (in partnership with other agencies) therefore have a key role in closing the opportunity gap for people who experience mental illness. To take on this mantle requires not just the appropriate skills and resources, but for a social justice culture to be part of the warp and weft of the service system.

Mental Health of People with Physical Disabilities

It was suggested at the beginning of this chapter that, in addition to people with mental health problems, consideration has to be given to the mental health inequalities experienced by people with physical disabilities, including people who may have both a mental illness and physical disability.

It is not possible within the scope of this review to address the mental health impact of the socio-economic disadvantage, discrimination and stigma that can be experienced by people with physical disabilities. The need to consider this is, however, underlined by evidence of the poverty and social exclusion faced by this group of people. For example, data reproduced in the Scottish Executive publication *Social Focus on Disabilities*[8] (2004i) indicate that people with disabilities:

- Have much lower rates of economic activity than people without disabilities.

- Are more likely to live in households with an income below £10,000.

- Comprise 65% of claimants of at least one key benefit (this includes people who have a long-term illness).

- Are more aware of anti-social behaviour where they live and more likely to consider their neighbourhoods unsafe. This is reflected in the findings from one study in Scotland in which nearly one-half of respondents reported having experienced a hate crime because of their disability (DRC/Capability Scotland, 2004).

A number of studies also illustrate the multiple sources of discrimination and disadvantage experienced by disabled people (see for example, Molloy, Knight and Woodfield, 2003; Pierce, 2003; Breslin, 2003).

As summarised by Burchardt (2003), 'someone who is socially excluded is at greater risk of becoming disabled, and someone who becomes disabled is at greater risk of being socially excluded'.

The few studies identified suggest the potential multiple exclusions people with physical and mental health problems may experience. One example is a study in England and Wales (Morris, 2004) exploring how people with physical impairments and mental health support needs experience mental health and physical disability services. This found that the majority of respondents had difficulty accessing mental health services because of their physical impairments, and difficulty using physical disability services because of the inadequate recognition of their mental health needs and negative attitudes amongst staff towards mental health issues. This, together with a lack of communication between the two types of service, resulted in the fragmentation of people's needs. As described by one study respondent 'I have to go to one town for my mind, another for my body'.

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8 Data included in the report may include people with mental health problems.

Specifically in relation to sensory impairment, a Mind factsheet on deafness and mental health cites studies that have found that 38% of people with hearing impairments in the community were experiencing some form of mental distress. People with hearing impairments experience higher rates of depression or anxiety than hearing people, but similar rates of schizophrenia. In terms of risk factors, studies have found that 37% of people with hearing impairments report that they have been sexually abused before the age of 16 years, while one-third of deaf people in touch with mental health services had experienced significant negative attitudes towards deafness from members of their own family (Ridgeway, 1997 in www.mind.org.uk/Information/Factsheets/Sensory+ impairment/Deafness+and+Mental+Health.htm, accessed 27 September 2004). The Mind factsheet also cites findings that suggest that hearing impaired people with mental health problems find difficulty accessing services, and that when they do, can experience problems around assessment and diagnosis. It is believed, as a result that that deaf people are over-represented among people in psychiatric hospitals (Timmermans, (1989) in www.mind.org.uk/Information/Factsheets/Sensory+impairment/ Deafness+and+Mental+Health.htm). It is suggested that misdiagnosis arises because assessment is undertaken by people with inappropriate communication skills. This may be particularly compounded for people from black and minority ethnic communities.

A further Mind factsheet describes the emotional and psychological impact of developing sight problems (http://www.mind.org.uk/Information/Factsheets/Sensory+ impairment/Visual+Impairment.htm). As at the end of March 2004 there were 37,942 registered blind or partially sighted people in Scotland. Of these 536 (1.4%) registered blind and 242 (0.6%) partially sighted people indicated that they also had a mental health problem. The majority of these people were aged 65 years and over (Scottish Executive, 2004r). Studies exploring the implications for mental health service users who are blind or deaf-blind have not been identified.

In early 2004, the Scottish Executive launched its action plan for community care services for adults with a sensory impairment (Scottish Executive, 2004p). The Scottish Executive is also currently working with the Scottish Council for Deafness to look at the needs of people with mental health problems who also have hearing impairments. Options for 'modernising mental health services for people who are deaf' in England/Wales were set out in a Department of Health consultation document issued in 2002 (DH, 2002b).

Mental Health and People with Physical Disabilities: Implications

In terms of mental health inequalities as experienced by people with physical disabilities the main implication is the apparently limited evidence to inform policy and practice. For example, how are mental health services in Scotland able to meet the needs of people with both physical and mental health problems, in an holistic way; what are the risk and resilience factors that have the most impact on the mental health and well-being of people with physical disabilities; and fundamentally, what does mental health improvement and promotion mean for people with physical disabilities?

Chapter 9
Discussion

Introduction

Inequality in mental health is a dimension of social justice that has tended to be overlooked, not least because of the complex patterns and trends involved and the multiple forces that impact on mental health. Drawing on a wide range of source material from research literature and reports of practice the working paper has aimed to make more visible the nature of mental health inequalities in Scotland and reveal how social identity can impact on mental health and well-being. The analysis not only adds to our collective understanding of how differences in mental health may be implicated in other sources of difference and disadvantage, it also illustrates and reinforces why mental health has to be a key component of both social justice and health improvement policies and strategies.

It is important to remember what we share: that is our common humanity, we are all human beings, and therefore 'are born free and equal in dignity and rights' (UN Resolution, 1948). But, living in a social context we are distinguished by our class and socio-economic status and aspects of our social identities. What Chapters 4–8 demonstrate is the association between socio-economic disadvantage and discrimination and poorer mental health and well-being. What is also revealed is the impact of our social identities on the ways in which these sources of disadvantage and inequality are distributed, mediated, experienced and expressed, including the responsiveness and experience of services and health outcomes.

A lot is already being done in different ways to redress health inequalities, including mental health inequalities: through the social justice/Closing the Opportunity Gap agenda and associated equalities strategy, and through policies targeted specifically at health improvement/reducing health inequalities. This policy climate provides an important opportunity to speed up the momentum to address the causes and consequences of mental health inequalities, both across the population and as they impact on different groups. In addition, the legislative measures in place (see Chapter 2) provide a framework within which to tackle discrimination.

Social Justice, Equality and Diversity

The Scottish Executive Equality Strategy (2000a) draws attention to the different ways in which equalities is approached in policy terms including equal opportunities, social justice and diversity models.

It is not intended here to compare these different ways of thinking, but to consider how these models can contribute to identifying and tackling mental health inequality at different levels.

Level 1: At a population level a Social Justice approach identifies and targets the structural causes of poverty and injustice. Programmes targeted at child poverty, or educational attainment for example, can help to improve economic and social life chances with implications for improved mental health and well-being across generations. It also implies a role for services, including mental health services, in helping to address and redress mental health inequality.

Level 2: At the level of social identities, an equalities perspective recognises the differential impacts on specific groups of social and economic inequalities. For policies, services and practices this implies acknowledging that these structural inequalities may impact differently on the mental health and well-being of, for example, women, men, people from black and minority ethnic communities, people who are lesbian, gay, bisexual or transgender and people with disabilities. In addition, it implies consideration of the appropriateness, accessibility and cultural competence of services for different groups of people.

Level 3: At an individual level, a diversity perspective recognises and values difference. A pamphlet produced to promote *Fair for All*, the Scottish Executive/NHSScotland strategy for eliminating discrimination and promoting equality of opportunity (Scottish Executive 2002a; Scottish Executive, 2004a) describes diversity as being about 'the recognition and valuing of difference … creating a culture and practices that recognise, respect, value and harness difference for the benefit of the patients, carers, members of the public and members of staff'. This implies developing practices that include, for example, an understanding of the importance for the individual of their sexual orientation and/or their cultural identity, but also the impact of racism, or homophobia on mental health and on the articulation or expression of mental distress.

Areas for Consideration

It is beyond the scope of this work to identify in any detail the implications for policy and practice that arise from the analysis. The following areas are highlighted as possible starting points to assist mapping out what needs to be done to address and redress mental health inequalities.

Understanding issues of identity

- Understanding differences and recognising areas of commonality across and within different social groups as they relate to mental heath inequality.

- Understanding the implications of multiple identity/multiple disadvantage on mental health and well-being.

Principles and policies

- Developing a set of core values and principles for addressing mental health inequalities.

- Identifying the priorities to tackle inequalities in mental health in Scotland over the coming five to 10 years, drawing on what we already know, collectively, about the key risk (and resilience) factors for mental health, about the nature of inequalities in mental health and about mainstreaming.

- Making more explicit the interconnections between policies to promote social justice and closing the opportunity gap and policies to promote mental health and well-being, to achieve common policy objectives.

- Using the social justice framework as an opportunity to extend the range of vision for mental health policy: considering the impact of priorities and interventions on the structural factors such as economic disadvantage that can be both cause and consequence of mental health inequalities.

- Ensuring that policies foster a practice environment that respects difference within a framework of common values.

Creating a supportive environment for practice

- Identifying the core competencies in service management and delivery required for inclusive practice that recognises and values diversity.

- Building partnerships and alliances, to be able to tap into and share expertise and learning across different groups and communities.

- Ensuring that commitment to evidence-based practice is allied with a commitment to values-based practice.

A theme throughout the report has been that responsibility for reducing mental health inequality includes, but extends beyond, mental health specific policies and practices to encompass the breadth of policies aimed at achieving social justice. As set out in Chapter 1, this implies a two-pronged approach:

- Mainstreaming mental health improvement goals in policies and practices aimed at achieving social justice/closing the opportunity gap, and in ways that reflect the unequal distribution of risk factors between social groups.

- Mainstreaming social justice and equalities objectives within mental health policies and services.

To achieve this requires action: at policy level across policy domains, as well as within mental health policy; operationally, across domains and within mental health specific initiatives; and at the level of practice. It requires both a population based social justice approach; an equalities perspective that recognises the different impacts for different social groups; and a diversity mind-set that recognises and respects individual difference and human rights. This is both the challenge and the imperative.

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