# ESSENTIALS OF MENTAL HEALTH NURSING

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# ESSENTIALS OF MENTAL HEALTH NURSING

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# 6

# CHAMPIONING EQUALITIES AND ADDRESSING VULNERABILITY IN MENTAL HEALTH CARE

Peggy Mulongo and John Wainwright

**Content Warning**

This chapter includes examples of female genital mutilation and child trafficking, which you may find troubling or distressing.

## This Chapter Covers

- The concepts of race, ethnicity, equality and cultural competency in the UK health care system
- The importance of understanding Black, Asian and other ethnic minoritised migrant women, their specific mental health needs, and the challenge they may face when they navigate the UK health care system
- Gender-Based Violence (GBV) and health beliefs: caring for ethnic minoritised migrant women, particularly those from Black and South-Asian heritage affected by GBV
- The value of 'decolonising' treatment provision in mainstream mental health care settings and developing knowledge on transcultural therapeutic interventions to support Black, Asian and other ethnic minoritised migrant women.
- Health professionals' barriers to meeting the mental health care needs of Black young men in Criminal Justice Settings (CJS).

'Ethnic minoritised migrant women who have been affected by Gender-Based Violence or Modern Slavery, particularly those from Black African and South-Asian heritages, need a safe space to freely talk about their experiences and ventilate their emotions. A space where they can be empowered and learn about Human and Women's Rights. A space where they have freedom of choice for the type of support and therapeutic interventions that meet their psychosocial needs. A multi-purpose space, which is safe from any form of injustice, discrimination, exploitation, where culture, race and diversity are valued. This is the space I promote.'

**Sarah Malik, Transcultural Psychotherapist and FGM Specialist**

'I need help. I'm sinking and I'm not being able to help myself anymore. The loneliness and isolation still kicking in. My body is now free, but my mind and soul are left prisoners. I called the GP; he referred me to the counsellor. I could not see him. I wanted a woman counsellor; I explained to the GP. One nurse said, there is no woman counsellor here, you can go home, and we will call when there is one. They don't understand, no one ask me why, but the GP knows. They never called me again, and the GP asked me to wait, and I waited one year, then I met these doctors who work in communities, they came to my local community centre. I did not want to see them; they are all the same. But my friend talked to them about me, they took me to another place, like another Centre. There, other community doctors helped me because they know the problem very well, I met someone else I know, she is like me. She told me she was receiving lots of support. But many doctors here are not understanding. They should still do more, and they should tell people to speak up. Because we are dying in silence with abuse, because we are scared, we need emotional support. Because out of the violence, it's like frying pan to fire, the insecurity, the many other problems, the anxiety, the fear. So, to face all this we need proper support, but not many doctors understand.'

**Anonymous voice of a survivor of domestic slavery**

from the narrative above, it is clear that communication was one of the main barriers here; cultural needs were not explored to understand the patient's choice for a female counsellor, leading to mistrust of health professionals. For the patient, having disclosed her story to the GP and justified the need to be seen by a female counsellor was sufficient. A pivotal turning point for the patient was meeting the 'doctor in the community' and meeting someone she knew helped decrease her anxiety, although she remained reticent about trusting health services. This experience created a barrier in addressing the needs of the patient, while demonstrating the importance of communication, to develop a rapport of trust with the patient, and the need to become culturally competent.

## INTRODUCTION

The Nursing and Midwifery Council (2021) states clearly that:

> there is no room for any kind of discrimination in the healthcare sector, and we're committed to working with partners to do everything in our power to tackle inequality and promote diversity and inclusion.

Moreover, the law safeguards individuals possessing various protected characteristics from discrimination and specific duties are placed upon public services. Despite such institutional aspirations and protections, mental health care workers, services and wider society are beset with prejudicial actions and anomalous circumstances. Notably, people from ethnic minorities suffer a range of differential treatment and outcomes which are hard to account for on a rational basis. Moreover, ethnically diverse staff often find themselves discriminated against in the workplace and are overrepresented in NMC professional conduct hearings.

Such matters can be considered through a lens of 'race' equality, but it is important to highlight the complexity of terminology in this context. The notion of race itself is a contested and controversial term, freighted with the unpalatable baggage of colonial distinctions made to justify inhumane treatment of peoples under slavery. Such representations and stereotypes play into ongoing social inequalities that have resulted in systematic discrimination against minoritised populations. However, while considerations of **race** and **ethnicity** are an important aspect of thinking about equalities, it is not the only one, and it is equally important for nurses to appreciate the potential for inequalities around gender identity, sexual orientation, religion, disability, amongst others, and intersections between these.

In this chapter we mainly focus on ethnicity and gender, exploring factors that contribute to mental health disparities, including social determinants of health such as poverty, discrimination and lack of access to health care. Additionally, cultural factors may also influence ethnic minoritised individuals' experience of handling mental health issues and these can often collide with institutionally discriminatory practices.

In an era where mental health nurses' identity is constantly fluctuating, the invisibility of transcultural mental health nursing is evident, struggling to fit in this contemporary debate, and questioning its significance in a society that rhetorically promotes equality and diversity. Mental health nurses have the responsibility to understand and learn to address the distinct mental health issues experienced by individuals from ethnic minority communities in the varied settings they work, including the criminal justice system.

By reading this chapter, student nurses will understand some of the salient issues related to discrimination, cultural sensitivity and health inequality, and how these may impact on the care needs of individuals. They will also learn about the significance of developing cultural competency and ensure they provide appropriate health care support free of any form of discrimination and prejudice, to ethnic minoritised migrant women, particularly those from Black and South-Asian heritage affected by GBV, and to Black young men in CJS. The benefits

of this chapter go beyond nursing students, further informing other health and social care students, as well as qualified health professionals, and those working in the Criminal Justice System (CJS).

## RACE, ETHNICITY, HEALTH INEQUALITY AND DISCRIMINATION

Despite noted misgivings about race as a social category, the term has salience in relevant legislation. Race is a protected characteristic under contemporary equality law (Equality Act 2010) and is key to the relevant measures which forbid discrimination. Despite these legislative efforts, such discrimination remains present in society and key institutions, impacting health (Alvarez-Galvez & Salvador-Carulla, 2013; Hackett et al., 2020), particularly relating to health and mental health (Equality and Human Rights Commission, 2016).

Racism remains widespread, according to 64% of adults in Europe (Eurobarometer, 2015) and 26% in the UK (Kelley et al., 2017). Besides, hate crime incidents (Home Office, 2018) or 'Brexit' (the withdrawal of the United Kingdom from the European Union) can be cited as examples that awakened hostility towards migrants, along with the growth in right-wing nationalist movements (Bhui et al., 2018) and amplification from the current government committed to a hostile environment immigration policy (McKeown & Dropkin, 2020).

Within the health system, racism is also recognised as a **social determinant** of both physical and mental health (Paradies et al., 2015; Yearby, 2020), and a driver of ethnic health inequalities (Kapadia et al., 2022; Zambrana & Williams, 2022). This can be interpreted as a complex, organised system embedded in socio-political and historical contexts, where ethnic groups are classified into social hierarchies. Ideologically, ethnicity can be boxed into different categories and differential values, which drive disparities in access to power, resources and opportunities, at both structural and individual levels (Krieger, 2021). Zambrana and Williams (2022) indicated that key reports on health inequalities in the contemporary world are mainly produced by statutory health agencies, citing the World Health Organisation as an example.

While these conventional reports help in developing health equality policies, they are slow in incorporating evolving academic studies on racial discrimination as a root cause of health, retarding the process of tackling health inequality. Moreover, studies exploring the discriminatory experience of people of colour, particularly Black women and Black men when accessing public services, such as the NHS Marmot review (Marmot et al., 2010, 2020), the mental health system (Carr, 2017; Lammy, 2017), education (HMIP, 2021), or immigration and health (Hanley, 2022), are scarce in the UK. Investigating racism in UK health research, Powell et al. (2022) explored several aspects of medical research that inform treatment decisions for ethno-racial groups and reported poor investigations that led to harmful implications. The authors provide several examples of poor diagnoses and treatments for racialised minority patients leading to medical errors, thus increasing health inequalities. Powell et al. (2022) suggest that academic research should be more inclusive in planning and prioritising the health needs of racially minoritised groups.

It is, however, comforting to observe positive initiatives such as the 'racism in medicine' (Adebowale and Rao, 2020) , which led to the launch of the NHS Race and Health Observatory (Kmietowicz, 2020). Nonetheless, while such positive intentions should be embraced and encouraged, their effectiveness can only be validated when actively addressed, linking words to actions, particularly when applied in health care settings, where racially minoritised populations may be vulnerable and believed to benefit from established rules.

### Critical Thinking Stop Point 6.1

Reflect on a particular situation where you may be confronted, as a student nurse or a health professional, to assess the health of a person of colour who presents in your health setting. The patient shares with you her view that all nurses are discriminatory, based on past experience when she was admitted in hospital.

- Think about what information you would like to gather from the patient that may help you conduct health assessment effectively or allay her anxieties.
- Examine your own feelings and any prejudice that may affect your judgement.
- Think about the Nursing and Midwifery Council (NMC) Code requirements in tackling discriminatory behaviour:

What NMC platforms would help you successfully explore potential equalities issues that may be present? Is there any framework that you could use in this circumstance?

The documents below will help you respond to these questions:

- Code for professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018) The Code (nmc.org.uk)
- www.england.nhs.uk/long-read/combatting-racial-discrimination-against-minority-ethnic-nurses-midwives-and-nursing-associates/
- Developing anti-racist practice to support black and other racially recognised nurses and midwives within the NHS: A rapid qualitative evidence synthesis (Jieman et al., 2022).

Constantly challenging structural determinants of health inequalities should be a goal pursued at all levels, by all health professionals, working in different health settings, to ensure fairness, inclusivity and a powerful anti-discriminatory message in the UK health workforce.

## BLACK AFRICAN AND SOUTH-ASIAN MIGRANT WOMEN: THE CHALLENGE OF NAVIGATING THE UK HEALTH CARE SYSTEM

It is important to note that certain disadvantaged migrant groups residing in the UK, such as asylum seeker families or migrants with no recourse to public funds (NRPF) continually face an

uphill battle to settling in the UK. Often portrayed negatively by the media, refugees and asylum seekers are regularly confronted with racism, isolation, poverty and destitution. Seeking sanctuary on the grounds of asylum and being granted refugee status is a fundamental right, universally recognised by the UN (1951) Convention (UNHR, 2015). A huge solidarity for Ukrainian families seeking sanctuary from the outbreak of war was recorded in many European countries including the UK, with British people hosting and providing support to newly arrived asylum seekers. While individuals may have subjective interpretations of immigration policies related to asylum and different views of what can be classed as discriminatory (Auer & Ruedin, 2019), we must promote a positive, universal non-discriminatory message that conveys trust.

For example, gender vulnerability of Black African and South-Asian women is often globally associated with several socio-cultural issues alongside environmental, economic, immigration and pre-conceived discriminatory factors. These root causes can be silently assimilated in health problems, broadly experienced by migrant women in general, potentially resulting in health inequality due to lack of cultural competence, or unconscious bias on the part of workers. Although a growing number of studies have explored varied perspectives that link race and health inequality (Flanagin et al., 2021; Hackett et al., 2020; Hamed et al., 2022), there are still areas where more research is required, particularly in the UK (Hackett et al., 2020), where there is a paucity of literature about gender-based race inequalities in health, specifically for Black and South-Asian migrant women. Associated mental health impacts were highlighted in the UK Race Disparity Audit (Cabinet Office, 2017).

## Critical Thinking Stop Point 6.2

Consider how would you define a migrant. Look for other terms referring to a migrant and to someone with NRPF.

- Try to define these terms, linking them with health-related policies for service provisions
- Think about the types of race inequalities Black African women may experience in the UK health care system.

As a student nurse or health professional, how would you address identified health inequality relating to Black women asylum seekers or those with no recourse to public funds?

The documents below will help you respond to these questions:

- Health disparities and health inequalities: www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-healthHealth and mental health statistics - Institute of Race Relations (irr.org.uk)
- Racial inequalities and ethnic disparities in healthcare: www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/race-equality-in-medicine/race-inequalities-and-ethnic-disparities-in-healthcare
- UNCHR – Asylum and Migration: www.unhcr.org/what-we-do/protect-human-rights/asylum-and-migration#:~:text=UNHCR%20therefore%20strives%20to%20engage%20with%20

migration%20issues,its%20expertise%20to%20processes%20that%20relate%20to%20migration.

- Who counts as a migrant?: https://migrationobservatory.ox.ac.uk/resources/briefings/who-counts-as-a-migrant-definitions-and-their-consequences/
- Health and mental health statistics: https://irr.org.uk/research/statistics/health/

## DEVELOPING CULTURAL AWARENESS, SENSITIVITY AND COMPETENCY WHEN CARING FOR BLACK AFRICAN AND SOUTH-ASIAN MIGRANT WOMEN

In recent decades, socio-cultural determinants such as Gender-Based Violence (GBV), Modern Slavery, unsettled immigration status, discrimination or institutional racism encountered by ethnically minoritised women have become increasingly known and denounced in the UK (Olabanji, 2022; Siddiqui, 2018). This rise of awareness was further amplified by the COVID-19 pandemic (Hisham et al., 2022; Mulongo et al., 2022).

The United Nations Refugee Agency (UNHCR, 2020) describes GBV as a serious violation of human rights, harmful acts to demonstrate power towards a person based on gender, and as a life-threatening health and protection issue. UNHCR's (2020) statistics reveal that approximately one in three women are affected by sexual or physical violence in their lifetime, worsened by factors such as migration. Similarly, cumulative evidence highlights the rise of Modern Slavery in the UK, an umbrella term encompassing all forms of slavery, human trafficking and exploitation, with statistics revealing 5,144 modern slavery offences have been recorded by the police in England and Wales in 2019, an increase of 51% from the previous year (ONS, 2020).

While this is not a thorough list of predicaments that afflict migrant women and those with unsettled immigration status, they are used in this chapter to illustrate root causes of race and health inequalities. Indeed, this group of women are often uncomfortable seeking medical support or to develop a therapeutic relationship with health professionals for fear of being misunderstood. A person's cultural beliefs or health literacy may impact on their perception of wellbeing and understanding of their own health issues, particularly when interacting with health professionals from a different culture. Additionally, spirituality, culture and customs may influence how one could seek health care, when to seek this, and who to trust when making decisions about the right treatment (Gov.UK, 2017).

Nutbeam and Kickbusch (1998) described health literacy (HL) as more than the capacity to read leaflets about health topics and more about individuals' capacity to obtain health information, understand, evaluate and utilise this information to promote and sustain good health for themselves and people in their network. However, Rudd (2015) stresses the shared responsibility lying with government and health systems, to ensure equity and access of accurate and suitable information to varied populations. Considering cultural-related factors such as language, spirituality, beliefs, or poor educational background, to cite only a few,

assessing the health literacy of African migrant women becomes essential in tackling health inequality and achieving healthy physical and mental wellbeing, and this is not without challenges (Medina et al., 2022). Additionally, distress caused by **stigma** and discrimination in recognising and accessing mental health services within African and South-Asian communities is evident (Fauk et al., 2022).

The dilemmas described below provide a foundation for health care professionals in developing cultural competency, encouraging them to reflect on problems and avoid assumptions and unconscious bias. Table 6.1 provides some real (pseudonymised) examples of cultural *incompetence*. We present these, to reflect on what can go wrong, and ask that you consider what could have been done instead.

**Table 6.1** Case examples of problems affecting the mental health of Black African and South-Asian migrant women

| | |
|---|---|
| **Gender-Based Violence: FGM** | Marika is a 31-year-old African asylum seeker woman who has been through a severe type of FGM when she was 7 years old. She is invited for the first time to attend a cervical cancer screening at her local GP surgery. Although the young woman agreed to be examined by the nurse practitioner, she appeared tense and kept her eyes closed. After a brief examination, the nurse called the GP for a second opinion. She was told that in her situation, she would need an evaluation of her cervix, and was referred to the colposcopy clinic. An information leaflet 'About your colposcopy' was also given to her. She became anxious and asked for an explanation of what was wrong with her, what '*situation*' she was in, and became hysteric. She shouted, 'I was brave this time, because you are doctors, I trusted you. I can't do this again. It was painful, I can't do this again'. She refused to consent to any further examination procedures. No further appointment was arranged for her. |
| **Modern Slavery: Domestic Servitude/ Child trafficking** | A triage nurse is trying to assess Amina, a 16-year-old Nigerian pregnant young woman who stated she was abandoned at the casualty department by her auntie. She was very distrustful and sickly suspicious, however she managed to communicate with the nurse. Amina stated she was brought into the UK to help her uncle and auntie and study, but she was used as a servant, had not been to school, and had never been out unaccompanied in two years. Her uncle recently died, and her auntie left her in front of the casualty department because she was pregnant and useless. She was told she would receive all the help she needs at the hospital. Amina was ignorant of her rights, and feared everybody; however, she did confide to the nurse. The nurse contacted the Police. Amina's age was disputed and she was assessed as an adult, which affected the health and social care package she could be entitled to. |
| **Unsettled immigration status: NRPF** | You have received a referral in respect of Aisha, who is suffering from post- traumatic stress disorder. The GP's referral states that she was listed to see a Clinical Psychologist, but it was cancelled when she became ineligible for free secondary care, as she is fully dependent on her husband. During your consultation, she discloses having been a victim of civil war, torture and rape in Iraq two years ago. She entered the UK last year with a spouse visa to join her husband who was already residing in England. She has struggled to have sexual intercourse since she was raped, and this is causing problems in her marriage. She left her husband as he was emotionally, sexually and physically abusing her. She has no recourse to public funds and is unsure of what support is available to her. All these events pre- and post-migration caused her a lot of mental distress, and she continues to have nightmares about it. You are allowed to see her as an emergency only with no follow-up. |

These case examples clearly demonstrate some health professionals' lack of cultural competency, and the need to develop cultural awareness to enhance quality of care provided to Black migrant women. Health professionals do have a significant role to play when caring for women affected by GBV and other forms of abuse, as they may advocate for them in case of disclosure, becoming their life-savers and the main link for multi-agency referral support (WHO, 2021).

There is a need to reflect upon basic skills needed (Table 6.2) when caring for a person who may require culturally sensitive therapeutic interventions to ensure you meet legislative, professional and ethical principles of non-discrimination, equal treatment, beneficence, justice and non-maleficence.

**Table 6.2** Suggested culturally sensitive advice

| | |
|---|---|
| Be the Change Agent for your mental health team | • Migrant women affected by Gender-Based Violence (GBV) and Modern Slavery are often vulnerable and may have no recourse to public funds and/or unsettled immigration status in the UK.<br>• Patients like Marika, Amina or Aisha have the rights to be registered with a GP practice, regardless of their immigration status (Doctors of the World, Research Briefing 2019), unless the surgery is not taking any new clients. |
| Promote self-education | • Ensure relevant policy documents related to health care provision for refugees, asylum seekers and those with NRPF are available to staff in your workplace.<br>• Learn about relevant GBV and immigration legislations, and how they affect health care service provisions.<br><br>In the case of Marika, lessons learnt involve the need to initiate a cervical screening awareness campaign for women affected by FGM:<br><br>• Planning with your team the design of the awareness package, including a leaflet in key main languages, widely promoted in the community you serve.<br>• Share responsibilities with colleagues, discuss the delivery approach.<br>• Consider involving ethnically diverse staff in your team (if any) who can facilitate in non-English languages.<br><br>Multi-agency approach: collaborate with local third sector women organisations and faith venues, refugee community organisations and those with NRPF. |
| Create a safe, welcoming and inclusive environment that considers your patient's needs | • Promote, initiate and sustain a reliable cross-cultural approach to care that fosters trust.<br>• Show your patient any facility/amenities she may need (i.e. prayer room, special dietary access, etc.)<br>• Promote any other relevant service in your setting she may need (childcare, interpreters, etc.)<br><br>Growing understanding of trauma-informed care tells us that building an environment where people feel safe enables them to build trust and is therapeutic. |
| Work in building a cross-cultural therapeutic relationship with your patient | • Ensure you understand your patient's cultural needs and health beliefs, which are often barriers to accessing mental health services (Fauk et al., 2022).<br>• Consider psychoeducation for your patient and how you will deliver this.<br>• Evaluate health literacy.<br>• Demystify mental health diagnosis, treatment and access to mental health services in your area.<br>• Openly respond to questions related to health beliefs and traditional medicine.<br>• Actively listen, support and clarify any cultural health beliefs you do not understand.<br>• Be non-judgemental and impartial.<br>• Use interpreters when necessary (BMA, 2022), as patients who use NHS services have the right to use the language support. |

Discussions around adapting standard assessment processes gradually progress, but this is still limited. Indeed, researchers continuously stress the need to include appraised transcultural tools to lessen misdiagnosis and increase treatment outcomes for ethnically diverse populations (Andrews & Boyles, 2019; Jongen et al., 2018; Lachal et al., 2020; Larsen et al., 2021). Considering the variety of determinants of health and ethnic sub-groups, it is essential to continue investigations that identify, evaluate, integrate and standardise cross-cultural therapeutic interventions (Chae et al., 2020; Mishu et al., 2023; Mirza et al., 2019), particularly within UK mainstream health services.

### Critical Thinking Stop Point 6.3

- What unique mental health challenges might Black and South-Asian migrant women who have experienced Gender-Based Abuse face, and how might these challenges differ from those faced by other populations?
- How might systemic racism impact the mental health of Black and South-Asian migrant women who have experienced Gender-Based Abuse?

#### Tasks

- Case study analysis: look at the above case examples and analyse the psychological and emotional impact of their experiences. Consider discussing suitable interventions or treatment approaches for survivors.
- Understanding the asylum process: research the UK legal and policy frameworks related to asylum seekers in general, and to women asylum seekers with no recourse to public funds in particular. Understand and discuss the impact of your findings, potential stressors and trauma that women asylum seekers may experience during this process. How can a mental health nurse help address these?
- Group discussion and reflection: choose one of the case examples presented and consider your personal reactions and reflections on the subject (i.e. impact of GBV, Modern Slavery, NRPF) on Black and South-Asian migrant women. Share your thoughts and discuss as a group. This could be a valuable opportunity for you to share your own experiences or biases, and explore how you can be more culturally sensitive and responsive when you are in practice.

## DECOLONISING MAINSTREAM MENTAL HEALTH CARE SERVICE PROVISIONS

Scholars and critics of psychiatry and its intersection with race point to the obduracy of stereotypical thinking and discriminatory practices that have their roots in colonialism but continue to be negatively influential in the present (Bracken et al., 2021). As such, a politics of decolonisation can also be applied to thinking about reforms to mental health care or

even framed in terms of abolition (Burstow, 2017). Frantz Fanon was the black psychiatrist and intellectual giant who pioneered such critique alongside innovative practice, and latterly there have been calls to revisit his writings for contemporary relevance (Eromosele, 2020).

Fanon is better known for his revolutionary critique of racism and advancement of a politics for the emancipation of the developing world (Zeilig, 2016) but he was also a prolific commentator on psychiatry. Identifying a number of failings of so-called transcultural psychiatry, Kobena Mercer (1986) noted Fanon's stress on matters of power and domination, rather than cultural differences between patients and doctors. For him, these were the key issues in the genesis of mental distress for individuals, with psychiatric care mirroring the oppression of colonial subjects. Fanon went on to forge novel ideas for psychiatric practice aligned with his politics (Khalfa, 2018; Robertson & Walter, 2009). For example, Fanon saw that matters of racial disadvantage were enmeshed with place and space, so he endeavoured to innovate practices that meaningfully attended to the character of the place within which help and support was to be transacted. He was thus involved in pioneering work that we would now recognise as a democratisation of care in place and space, innovating day hospitals as opposed to asylums and pointing the way to community owned and led alternative mental health centres, that offered culturally aligned care.

In reaction to the aforementioned discriminatory character of mainstream mental health services and emboldened by various policy turns and increasingly confident local community activism, a number of alternative black mental health initiatives were created in the UK in the 1980s and 1990s. For example, the Black Spaces Project grew out of advocacy for better meeting Black service users' needs and facilitating their voices and the voice of their communities to be heard (BME Voices, 2018; Christie & Hill, 2003; Wright & Hutnik, 2004). Other similar developments included the Bradford transcultural psychiatry centre, and alternative providers in Hackney, Brixton, Manchester and Liverpool (Christie & Hill, 2003; Fernando, 2005; Francis, 1991). Around this time, the national mental health charity MIND published *Diverse Minds* magazine, highlighting inadequacies within the mainstream and celebrating alternatives. Not all of these initiatives have survived, and many have struggled to maintain a clear alternative identity in dealing reciprocally with the mainstream and in competition for funding. The UK government Delivering Race Equality policy responded to the various identified anomalies in the system with a programme of community development and key race equality development workers (Department of Health, 2005; NIMHE, 2003). Many of the latter were able to pivot their practice on established alternative provision whilst attempting to raise awareness and standards in the NHS. Despite this, critics say that on the whole, a focus on trying to change attitudes and practice within core services represented a missed opportunity to galvanise or expand independent alternative provision in the community (Bhui et al., 2012; Fernando, 2010).

Mary Seacole House (MSH) was established in Liverpool by dedicated community activism, against a backdrop of wider race equality struggles in the city (GCMHG, 2018; Gifford et al., 1989). This service has survived to the present day, successfully offering a range of creative and participatory forms of support to local people and hosting one of the first Black mental health advocacy projects. The location of MSH, at the epicentre of where the 1981 riots took place, has significant psycho-geographical resonance for the

community (Boland, 2010; Christian, 2008) and Black mental health system survivors (Torkington, 2009). This reverberation with broader struggles against racism in the city and oppressions within the mental health system, and the attention given to establishing a nurturing, inclusive space in the heart of the community, reconnects with the spirit of Fanon interests in culture and place and his burning desire for a more equitable care system and society (McKeown & Wainwright, 2019).

## CULTURAL COMPETENCY IN PRACTICE

Strategies for mental health nurses to develop cultural competency when supporting ethnic minoritised patients include:

1 Increasing awareness and education on the cultural and social factors that may impact the diagnosis and treatment of mental illnesses in ethnic minoritised populations, including awareness of how systemic racism and cultural stigma may impact diagnoses and treatments' outcomes.
2 Providing culturally sensitive care that recognises and values the cultural, social and spiritual backgrounds and experiences of your patients from ethnic minoritised communities.
3 Considering using culturally appropriate language and interpreters when necessary, and include suitable cultural health beliefs and practices in the care plans.
4 Becoming familiar with specialist agencies to signpost your patients when necessary, for example, financial support, immigration legal advisors.
5 Being flexible and offering mental health support online, via a mental health helpline, as these may be convenient for some of the patients who may have barriers to access face-to-face support, especially survivors of abuse or prisoners.
6 Advocating for systemic changes that address the root causes of mental health disparities, such as systemic racism and economic inequality.

## TRANSCULTURAL MODELS OF MENTAL HEALTH NURSING

Transcultural models of mental health nursing aim to provide culturally competent and responsive high-quality care to patients from diverse cultural populations, considering their unique cultural backgrounds, beliefs and values (Ludwig-Beymer, 2022).

By using the frameworks shown in Table 6.3, mental health nurses should be able to provide culturally competent care that is respectful, responsive and effective.

It should be noted that the above list is not exhaustive, and another example of a transcultural model of mental health care that mental health nurses could have also used in case studies included in this chapter is the Cultural Formulation Interview (CFI) (APA, 2013), a structured interview that can be used to gather information about a patient's cultural background, beliefs and values to inform diagnosis and treatment (Jarvis et al., 2020). It is designed

**Table 6.3** Transcultural models of mental health nursing

| Model | Author(s) | Year | Benefits in Practice |
|---|---|---|---|
| Campinha-Bacote's Process of Cultural Competence in the Delivery of Healthcare Services Model | Campinha-Bacote, J. | 2003 | Provides a framework for developing cultural competence amongst health care providers, which can help improve the quality of care provided to patients from diverse cultural backgrounds. |
| Leininger's Theory of Culture Care Diversity and Universality | Leininger, M. | 1991 | Highlights the importance of understanding cultural differences in health care and providing care that is tailored to each patient's unique cultural needs, which can help improve patient satisfaction and outcomes. |
| Purnell's Model for Cultural Competence | Purnell, L.D. | 2014 | Provides a comprehensive framework for developing cultural competence amongst health care providers, which includes 12 domains of culture and can help improve the quality of care provided to patients from diverse backgrounds. |
| Giger and Davidhizar's Transcultural Assessment Model | Giger, J.N., & Davidhizar, R. | 1991 | Provides a systematic approach to assessing the cultural needs and preferences of patients, which can help improve the quality of care provided to patients from diverse backgrounds. |
| Kleinman's Explanatory Model of Illness | Kleinman, A. | 1988 | Highlights the importance of understanding a patient's cultural beliefs and experiences of illness, which can help health care providers develop more effective treatment plans and improve patient outcomes. |

to be used as part of a comprehensive psychiatric evaluation and can help mental health nurses understand how cultural factors, such as race, ethnicity, religion and immigration status, may influence patients' mental health and wellbeing.

The CFI consists of five domains (Lewis-Fernández, 2016): (1) cultural identity of the individual, (2) cultural explanations of the individual's illness, (3) cultural factors related to psychosocial environment and levels of functioning, (4) cultural elements of the relationship between the individual and the clinician, and (5) overall cultural assessment.

By using the CFI, mental health nurses can gain insight into Ruff's cultural backgrounds and beliefs (see Case Study 6.1). Mental health nurses will also be able to identify their cultural strengths and resources that can be incorporated into their care plans. For example, if their cultures value community support, mental health nurses can explore opportunities for him to participate in support groups or peer networks.

It is important to note that CFI is not prescriptive and that mental health nurses should continue to learn about other models (see Table 6.4) and self-reflect to provide culturally competent care that meets the unique needs of each patient.

Overall, these models can provide a range of benefits in practice when used effectively to develop cultural competency amongst mental health nurses and other health professionals, providing an adapted approach to care that puts each patient at the centre and improve health outcomes.

**Table 6.4** Transcultural models of nursing for Gender-Based Violence (GBV) and Modern Slavery (MS)

| Models | Author(s) | Year | Benefits in Practice |
|---|---|---|---|
| Trauma-Informed Care Model (GBV) | Substance Abuse and Mental Health Services Administration (SAMHSA) | 2014 | Creates a safe and supportive environment, builds trust, and empowers patients to make their own choices about their care, which can help women who have experienced Gender-Based Violence feel more comfortable seeking and receiving care. |
| Duluth Model (GBV) | Domestic Abuse Intervention Programme | 1981 | Encourages collaboration between various stakeholders to prevent and respond to domestic violence, which can help improve the safety and wellbeing of victims. |
| Survivors of Slavery Empowerment (SSE) Model (MS) | International Organization for Migration (IOM) | 2012 | Focuses on empowering survivors to make their own choices about their recovery and rehabilitation, providing comprehensive support services, and addressing systemic issues that contribute to modern slavery, which can help survivors regain their independence. |
| Human Trafficking Intervention Model (HTIM) (MS) | University of Pennsylvania School of Nursing | 2014 | Highlights a victim-centred approach, providing a safe and supportive environment. Collaborating with other organisations to address the broader systemic issues related to human trafficking. |

## BLACK LIVES MATTERS (BLM) – CHANGING THE LENS

The brutal killing of George Floyd, and Eric Garner before him, by New York and Minneapolis police officers, respectively, through strangulation with both gasping for breath uttering the heart rending words 'I can't breathe', has become a watershed moment for Black people in both the US and UK, and elsewhere in Europe. This is the moment when Black people made a stand against the everyday and many manifestations of racism to assert that Black Lives (actually) do matter (Wainwright, 2021; Wainwright & Larkins, 2020). The BLM movement has spread like a wave of liberation across both countries and wider Western population. The BLM has shone a bright light on the experience of being Black or Brown, being of African heritage. It was, and is, a protest against everyday racism that Black and Brown people experience.

While the BLM movement has brought global attention to the issues of police brutality, systemic racism and the unequal treatment of Black people in the criminal justice system, there is still a scarcity of academic literature exploring the philosophy underpinning this movement, especially in investigating its complexity in the Criminal Justice System in the UK, and its impact on the mental health of young Black men. Such impacts appear to be complicated and multifaceted when looking at the literature.

It is evident that the BLM movement has empowered many Black young men to speak out against racism, providing an opportunity to put pressure on law enforcement agencies

to address issues of racial bias and excessive use of force, while asking for adjustments in the criminal justice system. As such the BLM movement played an important role by empowering them, positively impacting on their mental health (Bartholomew et al., 2018; Lu et al., 2021).

Adversely, the BLM movement may have provoked stress and trauma to some individuals in Black communities due to the continuous exposure to images and videos of police brutality and racial injustice, potentially causing anxiety, depression and post-traumatic stress disorder (PTSD) (Alexander et al., 2022).

However, the BLM movement's critiques include a backlash against police officers when the movement is used as an excuse to attack law enforcement and results in negative impacts for public safety. Hodgkinson et al. (2019) discussed Britain's BLM movement based on four core themes, mainly (1) critical race theory and British social science; (2) the policing of Black people in Britain; (3) the omission of social class from the analyses of BLM scholars and activists in Britain and, (4) the aims of Britain's BLM movement. The authors critique inconsistencies in understanding racism related to the BLM movement within the CJS, as well as the use of the terms 'White privilege' and 'Whiteness'.

Bartholomew et al. (2018) stress the importance of promoting a space of vulnerability to increase critical consciousness and discuss historical and contemporary trauma still experienced by Black people in the USA. The authors developed a BLM framework of healing justice that employs an anti-racist, intersectional, holistic, and culturally and politically appropriate informed therapeutic approach to help address the wellbeing of Black people.

Overall, the impact of the BLM movement on the mental health of Black young men and implications for mental health services, criminal justice system, or their intersections, is complex and nuanced. On the one hand, this could represent an empowerment tool for change that improves individuals' mental wellbeing and confidence in dealing with services, or conversely be seen as a source of stress and trauma for some individuals, undermining their mental wellbeing.

It is important for mental health professionals to be self-aware of their own preconceived ideas around racism when caring for ethnic minoritised individuals, especially Black men, to ensure inclusivity and avoid falling into a culturally blind practice that does not consider patients socio-cultural needs and treatment choices.

## Case Study 6.1

Ruff is a 23-year-old Black young man who was arrested and charged with assault after being falsely accused of attacking a police officer during a demonstration in support of the Black Lives Matter movement. Ruff is known in his community as an activist for human rights, always advocating for inter-racial peace and cohesion, and his active participation in the BLM protest was peaceful, according to his friends and family. Being accused and arrested had a detrimental impact on his mental health, as he reported feeling overwhelmed, anxious and traumatised by this experience, while expressing his anger and frustration towards the criminal justice system and the ongoing systemic injustices faced by Black individuals.

*(Continued)*

Research has demonstrated that Ruff's arrest experience was not exceptional, considering the disproportionate number of Black young men arrested and imprisoned during protest, leading to mental health issues and trauma. Ruff's experience shows that false allegations and unfair arrests can have a significant impact on mental health and wellbeing, highlighting further the need to increase access to mental health services and support for Black men in the criminal justice system.

Mental health nurses involved in supporting Ruff should consider the following:

- Build a trusting and supportive therapeutic relationship, which can help him feel heard and understood.
- Create a safe space for Ruff to express his thoughts and feelings to help him process his trauma and work towards healing.
- Provide a tailored and culturally sensitive trauma-informed care that considers the effects of his experiences on his mental health, hence empowering Ruff to feel in control and lead on his treatment.
- Help Ruff to develop and use coping mechanisms such as relaxation techniques and mindfulness, to help him manage his symptoms and build resilience.
- Use a collaborative approach and consult with all relevant professionals such as psychiatrists, social workers and community organisations, to put Ruff at the centre of care and ensure he is well equipped with all the necessary support he needs to address his mental health needs and navigate the criminal justice system.

## Critical Thinking Stop Point 6.4

- What unique mental health challenges might Black young men in the health and criminal justice system face, and how might these challenges differ from those faced by other populations?
- How might systemic racism impact the mental health of Black young men in the criminal justice system?
- What are some potential strategies that mental health nurses and other health care providers can use to support the mental health of Black young men in the criminal justice system?
- How can mental health nurses help address the stigma surrounding mental illness in the Black community, particularly amongst young men?
- What role can mental health nurses play in advocating for changes to the criminal justice system that may impact the mental health outcomes of Black young men?
- How can mental health nurses work collaboratively with other professionals (such as social workers, psychologists and lawyers) to address the mental health needs of Black young men in the criminal justice system?
- What ethical considerations should mental health nurses keep in mind when providing care to Black young men in the criminal justice system, particularly in light of the historical and ongoing mistreatment of this population by the health care system?
- How might the experiences of Black young men in the criminal justice system impact their families, and what role can mental health nurses play in supporting families who are coping with these experiences?

- What are some potential challenges that mental health nurses might face when working with this population, and how can they address these challenges in a culturally sensitive and effective way?
- How can mental health nurses ensure that they are providing patient-centred care that is responsive to the unique needs and experiences of Black young men in the criminal justice system?

## CONCLUSION

This chapter has explored racial inequality in mental health, highlighting the experiences of Black African and South-Asian migrant women, as well as anomalies in the mental health system and approaches to provide alternatives.

Overall, the evidence base clearly shows the existence of health inequalities for people of colour, influenced by diverse issues such as social determinants of health and cultural factors. Similarly, various institutional factors work to disadvantage people of colour within the mental health and connected systems. It is evident that addressing these disparities will require a multi-faceted approach that includes improving access to mental health care, including in criminal justice settings, addressing social determinants of health, promoting cultural competency amongst mental health professionals, and respecting and supporting provision of alternative services. Mental health nurses play a crucial role in promoting health equality and diversity for individuals from racial and ethnic minority groups.

### Chapter Summary

This chapter has covered:

- The promotion of race, ethnicity, equality and cultural competency in the UK health care and the criminal justice systems.
- The value of respecting and understanding the mental health needs of Black, Asian and other ethnic minoritised migrant women.
- Gender-Based Violence (GBV), Modern Slavery and their impacts on survivors' mental health.
- Understanding community anger and protest as exemplified in the Black Lives Matter and other social movements, and implications for mental health support across settings.
- Cultural competency and mental health nurses.

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### Weblinks

FURTHER READING: WEBLINKS

- Institute of Race Relations (IRR): https://irr.org.uk/research/statistics/health/ – provides UK health and mental health statistics
- NHS Race and Health Observatory: www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf – a review of ethnic inequalities in health care and within the NHS workforce
- Royal College of Nursing (RCN): www.rcn.org.uk/magazines/People/2022/Jan/Mental-health-care-must-be-culturally-sensitive-140122 – a report that highlights how ethnic minority groups are at a greater risk of compulsory detention than white majority groups.

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