Module 5
Equality and diversity: respecting difference

Welcome to Module 5

Every person, whatever his or her background, should expect to receive a high standard of care from mental health services. Delivery of high-quality mental health services is to a large extent dependent upon staff understanding and putting into practice some key issues.

This module will support your understanding of what equality and diversity mean and how practice can be developed to tackle inequalities. It relates to all of the ESCs, but especially to:

- ESC 2 - Respecting Diversity;
- ESC 4 - Challenging Inequality.

Learning outcomes

After completing this module, you will be able to:

- reflect on what equality and diversity mean to you;
- describe current issues in inequalities in Scotland that impact on mental health;
- examine equality and diversity issues in relation to mental health services in Scotland;
- discuss broader issues in relation to health inequalities in Scotland that are relevant to mental health;
- reflect on your own experiences and practice in relation to equality and diversity issues.
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### Estimated time to complete learning activities

- 4 hours
- SCQF level 8
Module 5

1. What do we mean by diversity, equality and discrimination?

We are all different as individuals. Even so-called ‘identical twins’ exhibit differences and unique characteristics. We also have different experiences of health and well-being, and of mental health services. We can talk about all this as representing the ‘diversity’ of individuals and communities in Scotland.

‘Diversity’ is a word that is now used frequently. It is considered an important factor in a wide range of public services across, for example, health, social services, education and justice sectors.

The springboard for diversity and equality work in NHSScotland is Fair for All – the Wider Challenge (SEHD, 2004), which aims to ensure that services work to eliminate discrimination and promote equality of opportunity for everyone.

Within mental health services, the principles of equality, respect for diversity and non-discrimination also underpin the Mental Health (Care and Treatment) (Scotland) Act 2003, and are reflected in other mental health-specific policies.

According to Fair for All, diversity is about:

‘…the recognition and valuing of difference’.

In other words, it is about respecting and valuing the things that make us unique as individuals. These could include our physical appearance and size, our habits, preferences, beliefs, customs and traditions, our family background and upbringing, our dialect or language and so on. These variations also reflect in the way individuals and communities think about mental health.

But respecting and valuing diversity stands for little unless we also respect and value everyone’s right to the same life opportunities and the same standards of services.

This takes us further into the area of equalities and the need to tackle inequalities in Scotland.

Let’s start by considering some examples of the inequalities that exist. Take a look at the following issues drawn from the report Equal Minds (SDCMH, 2005):

- people with mental health problems are two times more likely to die from coronary heart disease and four times more likely to die from respiratory disease than the general population in Scotland;
- mental health problems affect more women than men, and a relatively greater number of women experience depression and anxiety – women, however, may be more prepared to acknowledge difficulties and may seek help more readily than men, who tend to under-report depression and anxiety;
- alcohol and drug misuse levels are higher in men, although rates of alcohol misuse among women are rising;
- the suicide rate among men is nearly three times that for women, and suicide is one of the leading causes of death among young men;
- the rate of depression among gay men is as much as eight times that found in the general population;
up to two-thirds of lesbian women have been found to suffer from depression; bi-sexual and transgender people are also at particular risk of depression;
young people who are gay, lesbian or bisexual are 6–11 times more likely to attempt to take their lives than their heterosexual peers.

There are limited numbers of Scotland-specific studies and statistics on black and minority ethnic people’s experience of mental health and services. The issues below, however, mainly drawn from information gathered in England, may reflect similar trends here:

- disproportionately high numbers of people from minority ethnic communities are subject to compulsory treatment and admission to mental health hospital in-patient units;
- Afro-Caribbean people have a 60% higher rate of depression than white people, with Afro-Caribbean men at twice the rate for white men;
- the incidence of attempted suicide and self harm among young Asian women is higher than it is among their English counterparts;
- black and minority ethnic people who declare their mental health problems speak of experiencing racism and discrimination on a recurrent basis;
- Pakistani and Bangladeshi women have higher rates of common mental health disorders (anxiety and depression) than white women.

Activity 5.1

What does the word ‘equality’ mean to you?

Do you feel you experience any inequalities in your life? Why?

It would be true to say that in our present society, differences among people are not always valued and respected. Individuals, communities and services are all culpable in failing to respect difference and promote equality. Righting these wrongs, making the playing field level and creating the same opportunities for everyone is what tackling inequalities is all about.

*Here’s an important point for us to keep in mind as we move through the module and beyond. Tackling inequalities isn’t about making everyone the same or treating everyone in the same way. An individual’s uniqueness becomes irrelevant in that kind of scenario, which serves to perpetuate a lack of respect for difference.*
The real task in tackling inequalities (and creating equality) is to make sure all people have the *same* opportunities to shape their lives the way *they* want to, and have the *same* access to high-quality services when they need them.

Let’s take a closer look at inequalities.

**Exploring inequalities**
Differences in health status among individuals and communities are real, present and widespread. The lower life expectancy and higher levels of mental health problems people in disadvantaged communities in Scotland face are about the complex cultural, social and economic inequalities they experience every day, compared to their ‘better off’ fellow citizens.

Once established within a community, inequalities become stubborn and difficult to wipe out. Think of access to health services, for instance. There may be a wide range of reasons why people might not access services, which might include services not being in the right place at the right time. People may feel services do not meet their needs, or may be put off by (or even *fear*) some health or social care services based on previous contacts with authority. The result is that people fail to get the services they need, and inequalities widen.

**Activity 5.2**

From your experience, give some examples of the inequalities people with mental health problems can face in life.

What issues do you think cause people with mental health problems to experience these inequalities?

Inequalities in people’s health, including their mental health, have been linked to:

- **socio-economic status** – living in poverty, for example, and/or living in a socio-economically disadvantaged community;
- **life circumstances** – being homeless, in care or in prison, for example;
- **social identity** – being a woman, being a man, coming from a black or minority ethnic community, being lesbian or gay, or being old or young;
- **health status** – being physically disabled.
Work undertaken to tackle inequalities and discrimination has identified six particular inequality strands related to people’s identity:

- gender, including those who are transgender;
- race or ethnicity, including refugees, asylum seekers and gypsy or travelling people;
- religion or spiritual beliefs;
- sexual orientation – being lesbian, gay or bisexual;
- disabilities, including mental health problems;
- age.

Inequalities can arise from the discrimination, prejudice and stigma people may face on the basis of some aspect of their identity. Prejudice and stigma reflect negative attitudes and views attributed to those differences of identity. Assumptions that underpin prejudices influence not only perceptions of individual people, but also of the social groups to which they belong, be they ‘gays’, ‘blacks’, or people with mental health problems.

The National Programme for Improving Mental Health and Well-Being in Scotland has led the establishment of ‘See Me’, Scotland’s national anti-stigma campaign. For more information, links and resources, see: www.seemescotland.org

**Activity 5.3**

Think of a time when you felt others made judgements about you or discriminated against you.

What form did this take?

Why do you think the people involved behaved in this way towards you? What was influencing them?

*Discrimination, reflecting actions or behaviours based on prejudice and stigma, can be personal or institutional, but always results in people being treated less favourably.*
Discrimination sometimes arises as a result of inaccurate stereotypical images people hold of others – people believing, for example, that a particular gay man must be sexually promiscuous because of their perception that ‘all gay men are sexually promiscuous’, or that a woman from a minority ethnic community has poor command of English because their previous experience of people from a similar community suggested this would be the case.

Holding stereotypical images such as these demonstrates how people can fail to recognise and respect the differences between individuals, even among those who seem to belong to the same social group.

So far, we have talked about the impact of discrimination and stereotyping in society, but this also takes place within mental health services and can influence how we behave towards people who have been given a particular diagnosis or ‘label’.

Activity 5.4

Read the following account carefully and then complete the associated activity.

Mila’s account

Basically, I’ve had a crap life. I had a hell of a childhood with abuse, racism and foster care. I came into services when I was 12 years old. I think it must have been because I was harming myself pretty badly by then.

Being part of child mental health services wasn’t too bad – they pissed me off sometimes, but I generally got the feeling they wanted to help me. It was just so difficult. But when I was 18 years old, they moved me into adult services and I had my first admission to an adult ward. My god, what a shock – they looked at me as if I was a criminal. I felt they hated me and saw me as a time waster stopping all the people who were really ill from getting help.

I know I was difficult; I was just all over the place, my moods seemed so extreme. I felt wretched all the time and nobody seemed to understand. They kept telling me to stop being so attention-seeking and take some responsibility for myself. But I just felt like exploding all the time. The more they didn’t like me and ignored me, the more I wanted to hurt myself, and the more they said I was attention seeking.

No one told me I had been diagnosed as having a personality disorder – I don’t know if they treated me the way they did because of how I behaved or because they had been told my diagnosis. I just know it was a shit time and no one seemed happy – me or them.
2. Mental health inequalities in Scotland – implications for mental health services and practice

Service users representing different equalities issues (or ‘inequality strands’, as we defined them in Section 1) and the local and national organisations that focus on their areas of concern (such as the Lesbian, Gay, Bi-sexual and Transgender (LGBT) Centre for Health & Well-being and the National Resource Centre for Ethnic Minority Health) highlight several issues that are common to all, and which negatively affect people’s access to and experience of services. These are:

- discrimination and prejudice;
- lack of trust;
- inappropriate services;
- services’ lack of cultural competence – in other words, their inability to understand individuals’ backgrounds and the inequalities and discrimination they face;
- the need for services to give greater importance to service users’ experiences;
- people’s desire for more person-centred, holistic services.

We’ll now look at mental health inequalities in Scotland in relation to each of the defined inequality strands and the implications for mental health services and your practice.
Gender issues and mental health

We know that gender influences mental health. For example, look at some of the issues we presented in Section 1, and see the report Equal Minds (http://www.wellontheweb.org/well/files/EM-Report.pdf).

The reality of men and women’s lives is different. It’s different in terms of their life experiences and the socio-economic and environmental factors that affect mental health. For instance, we have to understand women’s mental health issues in the context of the discrimination they face in society, which includes issues associated with sexism, living in poverty and being victims of domestic violence.

Gender influences perceptions of mental health and well-being, what people need from mental health services, and how they experience health services.

**Activity 5.5**

Think of the service or team in which you work or with which you are most familiar.

Would the team or service meet what you feel are mental health needs specific to your gender?

In what ways are they currently meeting these needs?

What things need to change to meet these needs more consistently?

We need more gender-sensitive services and responses to mental health problems which are based on recognition that the context of men and women’s lives is different. People want services that acknowledge the gender-based issues underlying their mental health difficulties, not just the symptoms.
Looking at issues impacting on men’s mental health:

- rates of unemployment are particularly high among men, and men respond more negatively to unemployment;
- men have poorer physical health;
- issues of masculinity may negatively impact on men’s mental health; it has been suggested, for example, that higher rates of suicide among men have been linked to their reluctance to express distress.

**Activity 5.6**

Mental health services often consider men as being ‘hard to reach’. What could you do to make the project or service in which you work more accessible to men?

We need to make sure that mental health services for men:

- are flexible;
- focus on the whole person;
- avoid stereotyping men as being unfeeling or uncommunicative;
- build up trust, particularly through modelling values and behaviours around positive well-being.

The *Breathing Space* service, for example, ticks many of these boxes. It is a confidential phone service targeting young men who are experiencing difficulties and unhappiness in their lives. You can find out more about Breathing Space at: [www.breathingspacescotland.co.uk](http://www.breathingspacescotland.co.uk).

Now let’s consider the issues for women. Since women often carry the bulk of caring responsibilities within families, there are fundamental issues around access to services which must be taken into account.

*Equal Minds* sets out the following key factors that may impact on women’s mental health:

- women are more likely to be living in poverty;
- there is a higher proportion of women in lower grades in all professions in Scotland;
- women are at much greater risk of experiencing domestic abuse;
- estimates suggest 20–25% of women have experienced childhood sexual abuse, compared to 6–7% of men.
Activity 5.7

Consider the last two bullet points above in particular, and think about the service you work in. To what extent are these issues acknowledged and attended to?

What more do you think could be done?

Ethnicity and mental health inequalities

Understandings of ‘mental health’ and mental health problems varies between cultures and individuals, as we all have different concepts of mental health and illness.

Minority ethnic disadvantage cuts across all aspects of deprivation. Taken as a whole, minority ethnic groups are more likely than the rest of the population to live in disadvantaged areas, be unemployed, have low incomes, live in poor housing, have poor health and be victims of crime. As a document from the Department of Health in England, *Inside Outside* (DoH, 2003), puts it:

“There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority.”
Activity 5.8

What are your views on the following statement?

‘We don’t have any black and minority ethnic community people around here, so it’s not a problem.’

Because the black and minority ethnic community in Scotland may be not be as large as in other parts of the UK, there is a real risk that we do not see issues of ethnicity and mental health as a priority for us.

There is an assumption that racism exists only when people from black and minority ethnic communities are present in significant numbers – this is not true. Racism may be an even bigger problem when numbers of black and minority ethnic people are few.

This is compounded by the rural nature of much of Scotland. Isolation and the lack of their own community support systems mean racism and racial tensions can have a deeper impact on the health and mental well-being of black and minority ethnic people in rural communities.

*Fair for All* (SEHD, 2001) acknowledges this general issue when it states:

> “It has to be recognised that numbers alone are not the only determinants of priorities. Everyone is entitled to fair access to health care and the right to opportunities for better health – this is the founding principle of the NHS.”

It is crucial to accurately identify communities and their needs to deliver appropriate and competent services. Let’s take a better look at what we know, or don’t know, about Scotland’s minority ethnic population.

First, it is not large compared to that of England. The 2001 census provides the only national statistics on the black and minority ethnic population, but these are now out of date; for instance, there are recognised increases in the numbers of at least two groups, the refugee and migrant communities. Still, the census tells us that in 2001, minority ethnic people comprised just over 2% of the total population of Scotland, with a range of 0.5%-4.5% between areas, the highest percentage being in Glasgow.

Second, the National Resource Centre for Ethnic Minority Health (NRCEMH) has identified that there are no substantial data collected on the use of mental health services by minority ethnic people. Their *Equal Services* report (Grant and Jackson, 2005) (available at [www.nrcemh.nhsscotland.com/men_health_wellbeing.html](http://www.nrcemh.nhsscotland.com/men_health_wellbeing.html)) recommends active monitoring of ethnicity by NHS boards at local and national levels.
To help boards and NHS staff engage in this vital component to improving mental health and well-being, NRCEMH has worked with ISD Scotland to create an Ethnic Monitoring Toolkit which can be seen at: www.isdscotland.org/isd/files/ETHNIC%20MONITORING%20TOOL.pdf.

Activity 5.9

Find out what information your service holds about the minority ethnic populations in your area and how local services are responding to meet the needs of these populations.

Third, there is a lack of Scotland-specific data on the prevalence of mental health problems among people from minority ethnic communities, and national (UK) data have been described as ‘patchy’. Other than the issues listed in Section 1, however, we do know that:

- studies indicate a relatively high level of under-reporting of psychological distress from some minority ethnic communities, such as Asian communities;
- asylum seekers face particular mental health issues related to their experiences prior to arriving in the UK and also while living in the UK as asylum seekers; research has shown their levels of psychological distress while in the UK may be higher than those experienced while imprisoned and tortured in their country of origin;
- there are lower rates of treatment for people from minority ethnic backgrounds who have some of the more common mental health problems;
- minority ethnic communities fare worse than people from the majority community in terms of experience of services and outcomes of service interventions;
- gypsy and travelling people are also subject to discrimination; women from these communities consequently report experiences of anxiety and distress.

Activity 5.10

What are your views on the following statement?
‘It doesn’t matter to me what background people are from – I treat everybody the same.’
The ‘equality and diversity-blind’ position assumes that equality is about ‘treating everybody the same’. But as we have pointed out, we are all different, with different experiences of life, society and family, and have very different needs. We all struggle to have these differences heard, recognised and valued. We all want to be appreciated just for who we are. Being treated the same as everyone else somehow misses the point!

Equality is about equal respect, but not necessarily about having the same treatment. An individual’s ‘differences’ are important aspects of his or her identity and life experience; denying their existence devalues the person’s life experience.

**Activity 5.11**

Reflect on Mila’s story again (Activity 5.4). Consider the impact abuse, racism and foster care might have had on Mila’s self-identity while progressing through her teenage years. What might it have been like to have been in her shoes? How might this have influenced what others thought of her?

People from minority ethnic backgrounds also have to contend with a range of culturally specific factors. To better attend to their needs, services and their staff need to increase their awareness of what minority ‘culture’ is, its possible impact on people’s lives, on their health in general and mental health in particular, and on their understanding of what mental health is.

*Customs, ethical values and attitudes, hierarchical roles, family systems and loyalties are important foundations in the lives of minority ethnic people. They are elements of culture: the learned behaviour of a group of people in perceiving, interpreting, expressing and responding to the social realities about them.*

Services and staff must try to better appreciate the effect of communities’ cultures on people’s needs and what they perceive to be socially acceptable. In other words, services need to become more culturally competent and to support their staff to deliver culturally competent care.

*Cultural competence relates to a set of practices, attitudes and approaches within an organisation that enables the organisation to work effectively with people from a diversity of ethnic backgrounds.*
There is some evidence to suggest that the ‘shame’ and ‘stigma’ associated with mental health problems may be felt even more intensely among some minority ethnic communities. This makes it less likely that people from these communities will present to mental health services, particularly if they are worried about issues around confidentiality.

We have already explored general issues around confidentiality in Module 3. Confidentiality for minority ethnic service users has additional angles. The ‘comings and goings’ of individuals in small communities are easily spotted and can provoke gossip. For instance, seen through the lens of stigma, an individual’s appearance at a location known for its work with sensitive issues (such as mental health, HIV/AIDS, violence or abuse) can create many difficulties for that person, regardless of the purpose of the visit. So to gain the trust and respect of people wary of them, services must take the unique characteristics of life within a minority community into consideration.

Research (see: [www.jrf.org.uk/knowledge/findings/socialcare/341.asp](http://www.jrf.org.uk/knowledge/findings/socialcare/341.asp)) with young women in Edinburgh using the counselling service at Saheliya found that confidentiality was a vital issue, not just because ‘news travels quickly’, but also because the young woman’s difficulties might be reported back to her family under some pretext or even at the request of the family. Subsequent hesitation delays the much-needed process of ‘healing’ or recovery for the service user; worthwhile outcomes will only accrue with the slow development of trust in the counsellor, worker and organisation.

There are particular issues around confidentiality when someone’s first language is not English, or if the person chooses to express him or herself in another language. Fulfilling the statutory obligation to provide a translator has its implications.

**Activity 5.12**

What might some of the practical difficulties of working with translators/interpreters be (a), for yourself and (b), for the service user? Where possible, draw on practical experience in your answer.

(a)

(b)
Awareness of and willingness to understand the complex family systems of minority ethnic communities is crucial in developing working relationships with individuals and their families. The management of language is a primary challenge within this priority.

Helpful guidance on working with interpreters has been produced by the Mental Welfare Commission for Scotland. It can be accessed at: www.mwscot.org.uk/web/FILES/Publications/MWCInterpreter_highres.pdf

Providing accessible services that meet the needs of minority ethnic communities continues to be a challenge. Experience of racism in (or as a result of) services is widely reported. The Bennett Inquiry in England in 2002 investigated the death of a black man in a secure unit in Norwich and presented 22 recommendations, mainly on racial issues. This has resulted in significant measures being implemented in England that, while not mandatory in Scotland, are relevant to us. The Inquiry concluded:

“Institutional racism is present throughout the NHS and greater effort is needed to combat it. Until that problem is addressed, people from black and minority ethnic communities will not be treated fairly. The cultural, spiritual and social needs of patients must be taken into account.”


Some practical (if not definitive) points to facilitate supporting race equality in mental health care are raised in a new initiative launched by the Department of Health in England in February 2007 called Positive Steps (see: http://www.actiondre.org.uk/positivesteps/welcome.html). It also lists some useful resources and contacts.

Saheliya, the mental health and well-being support organisation mentioned above, is unique in Scotland. It works in a holistic way with women, girls and their families from all minority backgrounds, including asylum seeker and refugee communities. It has recently begun a programme that aims to increase the capacity of workers (minority or majority ethnic) to engage with minority issues and work with the mental health care of black and minority ethnic people. For more information, see www.saheliya.org.uk

It is important to be aware that mental health workers also experience discrimination, prejudice and stigma. The MacPherson Report (Home Office, 1999) and Equal Services (Grant and Jackson, 2005) recommend that:

- all staff should receive training in cultural competency, awareness and sensitivity;
- services should have a written policy for dealing with racist abuse against staff members;
- the workforce should be ethnically diverse.

It is also crucial to remember that people have a duty in law to act on racism.
Activity 5.13

Read the scenario and below and consider it by putting yourself in the position of a team leader.

Morna
One of the valued members of your team is Morna, who came to work in Scotland from Zimbabwe three years ago. Recently, Morna has been subject to racial abuse from Billy, a service user your team supports. The abuse has taken the form of serious verbal abuse, which Morna has experienced over the past week. It has caused her great distress. Billy is also refusing to have Morna involved in his care.

As a team leader, how would you respond to the situation set out in the scenario:

to work with Billy to address the issues?

to work with Morna to address the issues?

What policies relevant to your team or organisation can help you resolve this, and in what ways do they assist?

Is there any further action your team, department or organisation needs to take to achieve a satisfactory outcome all round?
Spirituality, religion and mental health inequalities
Scotland is a religiously and culturally diverse country. We need to recognise this to address the spiritual and religious needs of people we support in mental health services.

The Scottish Executive has stated that spiritual care, which includes but is not limited to religious care, must be provided in an equal and fair way for those of all faith communities or none. To enable this, all NHS boards have produced a spiritual care policy and work is underway to develop culturally competent standards for spiritual and religious care. Most NHS boards now have a Department of Spiritual and Religious Care staffed by a chaplaincy team, who are a good source of knowledge and experience on how to serve the needs of a multi-faith population.

Sometimes a person’s mental health problem is expressed in a religious way or through religious terms. Having a sense of spirituality or belonging to a faith or belief system or a faith community can be a major help in supporting people through the recovery process.

You can resolve many of the issues arising from caring for people from a faith community or culture unfamiliar to you by simply asking the person, or his or her family and friends, how he or she wishes to be looked after and addressed.

NHS Education for Scotland produced an online multi-faith resource for NHS staff in 2006. It includes links to a wealth of other learning and support materials. You can access this at: http://www.nes.scot.nhs.uk/documents/publications/classa/multifaith/Interactive%20master.pdf

Sexual orientation and mental health inequalities
We noted in Section 1 that the rate of depression among gay men is as much as eight times higher than that found in the general population. Up to two-thirds of lesbian women have been found to suffer from depression, and bi-sexual and transgender people are also at particular risk.

Some research also suggests that lesbian and gay people may have higher levels of substance misuse, a higher incidence of eating disorders and be more likely to use recreational drugs.

Factors that may be causing higher rates of mental health problems among lesbian, gay, bisexual and transgender (LGBT) people include the following, which are highlighted in Equal Minds.

- Experience of stigma, discrimination and homophobia. This can occur throughout an individual’s life – in school, in the workplace, when accessing services and in local communities.
- LGBT people may be subject to abuse, bullying, violence and harassment because of their sexual orientation. Fifty-seven percent of respondents in a study of gay men in Edinburgh said they’d experienced some form of harassment over the previous year. A study of lesbian women and gay men in Glasgow revealed 85% had experienced verbal abuse and 60% had been threatened with violence.
- Negative attitudes, discrimination and abuse have made it difficult for people to feel included and connected and have made it more difficult for people to disclose their sexuality, or ‘come out’.
Activity 5.14

In what way do you feel the issues outlined above might impact on people’s experiences in mental health services?

What does your service do to meet the specific needs of LGBT people?

There is a very definite fear of stigma/discrimination which acts to deter people from the LGBT community from accessing services. This fear may lead people to be less than open with health professionals about their sexuality due to concerns about discrimination and negative responses. Research suggests that these fears are not unfounded: for example, a survey in 2003 found that a third of gay men, a quarter of bisexual men and more than 40% of lesbian women had experienced negative or mixed reactions on disclosing their sexual orientation to a mental health practitioner (SDCMH, 2005)

Disability and mental health inequalities
Inequalities in this area can be considered in different ways as impacting on:

- people who experience mental health problems;
- people who experience mental health problems and physical disabilities;
- people for whom having a physical disability has negatively impacted on their mental health.

Although the concept of disability is often associated with ‘physical impairments’, the Disability Discrimination Act 1995 encompasses people with physical or mental impairments with substantial and long-term adverse affects. The legislation therefore provides important protections against discrimination toward people with a ‘clinically well-recognised’ mental illness.

People with mental health problems can experience:

- social deprivation and poverty;
- poor nutrition, obesity, higher levels of smoking, heavy alcohol use and lack of physical activity;
- discrimination from health care providers; people with mental health problems report that their physical illnesses are not taken seriously, or that an assumption is made that physical problems are linked to their mental health problems.
All of this means that some people with mental health problems are at risk of poorer physical health with a lower life expectancy than the rest of the population. Yet studies have shown that mental health service users are rarely provided with health promotion information or offered physical health care checks in primary care settings.

**Activity 5.15**

Think of one person you support with mental health problems.

What health promotion advice, support and health screening is he or she currently being offered?

What role could you play in increasing his or her access to this?

People with mental health and physical health problems may experience multiple inequalities. For example, people might have difficulty accessing mental health services because of their physical impairments, but also have problems using physical disability services because of inadequate recognition of their mental health needs and negative attitudes among staff towards mental health issues. In addition, recognition and understanding of people’s needs may be lost due to lack of communication between different services.

People with hearing impairment face specific issues in relation to mental health. Studies have found that 38% of people with hearing impairment living in the community experience some form of mental distress. People with hearing impairment also experience higher rates of depression and anxiety than hearing people, although rates of diagnosed schizophrenia are similar across the groups.

There are suggestions that hearing-impaired people with mental health problems find difficulty accessing services; when they do, they can experience problems around poor assessment and misdiagnosis. This may help to explain why deaf people are over-represented among psychiatric hospital populations. It is suggested that misdiagnosis arises because assessments are being undertaken by people with inappropriate communication skills. This problem may be compounded among people from black and minority ethnic communities: see www.mind.org.uk/Information/Factsheets/Sensory+impairment/
Activity 5.16

Think of someone you work with who has a physical impairment. Which services/programmes/supports does he or she use in addition to the one in which you work?

How are the person’s holistic needs met within your service?

How could you improve the links between the services involved?

Age and mental health inequalities

Health issues impact most at the extremes of the age range. Children and older people are more likely to experience poor health and health inequalities.

Population trends in the UK and in Scotland show that the challenges are set to grow as our population ages. The black and minority ethnic people who migrated to the UK in the 1950s from Caribbean and South Asian countries are now becoming part of Scotland’s growing older population. The importance of this is that while there are likely to be improvements in the future in the health and well-being of older people, the likelihood of poor health increases with age.
Here are some issues for you to consider:

- older people are more likely to live in poverty and isolation;
- their ability to access services, in particular preventative services, is lower in comparison with other members of the population;
- issue-aware and culturally competent services for black and minority ethnic older people are severely limited, and the lack of language support may create serious risks in service delivery;
- depression affects 10–15% of people aged 65 years and above in the UK; it is also a major cause of suicide among older adults in Europe;
- there are more new cases of Alzheimer’s disease in Europe each year than there are of stroke, diabetes or breast cancer;
- in some long-stay hospital settings, residents have no access to primary care services to meet their physical health needs and have to rely on mental health practitioners who have limited physical health training and expertise;
- the adverse effects of some mental health medications contribute to poor physical health among older people.

Older people experience ageism, discrimination and social isolation. Mental health problems may make older people more vulnerable to abuse in society, the community and in mental health services. Such abuse can take several forms, including psychological abuse, physical abuse, financial abuse, sexual abuse and neglect. For more information, see the Age Concern website at: [http://www.helptheaged.org.uk/en-gb/Campaigns/ElderAbuse/](http://www.helptheaged.org.uk/en-gb/Campaigns/ElderAbuse/)

**Activity 5.17**

Consider the scenario below:

Mary

Mary, an older woman, has personal care workers calling three times a day to get her up, give her lunch and put her to bed. She talks to you about one of the care workers. She says the care worker ‘jokes’ to her constantly that Mary is a ‘lazy lump’ who could do a lot more for herself if she really tried. Mary says she thinks the care worker generally ‘means well’, but the comments are really getting her down. She is frightened to complain in case the worker gets into trouble or the care is withdrawn.
To what sort of abuse is Mary being subjected?

How would you respond to this situation?

*Action on Elder Abuse (AEA)* run the UK and Ireland’s only national freephone helpline for anyone concerned in any way about the abuse of older people.

The helpline is confidential and provides information and assistance for anyone – including older people, their friends and relatives – and also takes calls from practitioners seeking advice on handling difficult situations and looking to identify ways in which they can work more positively to prevent abuse. You can find out more at: [http://www.elderabuse.org.uk/Mainpages/Helpline.htm](http://www.elderabuse.org.uk/Mainpages/Helpline.htm)

Similar to adult mental health, the mental health of *children and young people* is also affected by the circumstances in which they live.

Many children and young people are more vulnerable to mental health problems due to their birth/life circumstances, including those who are looked after or ‘accommodated’, those who have learning and/or physical disability, those who have been, or are at risk of, abuse, and those who have experienced living with racism, domestic abuse or homelessness.

The Scottish Executive published *The Mental Health of Children and Young People – A Framework for Promotion, Prevention and Cure* in 2005 (SEHD, 2005). This framework was developed to assist all agencies with planning and delivering integrated approaches to children and young people’s mental health. It includes advice on tackling mental health inequalities among children and young people. You can access the framework at: [http://www.scotland.gov.uk/Publications/2005/10/2191333/13337](http://www.scotland.gov.uk/Publications/2005/10/2191333/13337)

In this section, we have explored diversity, equality and mental health inequalities in relation to the different inequality strands that inform our policy and practice in Scotland – ‘gender’, ‘race and ethnicity’, ‘religion and spiritual beliefs’, ‘sexual orientation’, ‘disability’ and ‘age’. But this is a bit of a false division; all these strands are inter-related, with issues like racism crossing all of them in what are known as multiple inequalities.

**Multiple inequalities**

People with mental health problems can face stigma and discrimination, which can negatively impact on social inclusion, employment and opportunities for social development. But mental health problems can be compounded by other inequalities, such as poorer physical health.
People may experience double or multiple disadvantages, which exist in many guises. In fact, inequalities can sometimes proverbially be seen as being like an onion, with multiple layers of ‘disadvantage’ covering and containing the human being inside.

Black and minority ethnic people, especially those who are non-white, may be subjected to discrimination based on ‘race’, as described above. But other layers of disadvantage made up of some or all of the other inequality strands can also co-exist.

Let’s explore this more by looking at the example below.

**Multiple inequalities – example**

A young woman in Scotland may:

- be born into a family of low socio-economic status;
- have parents who have had limited educational opportunities;
- have had no role models in her life to direct her through her teenage years and the transition into adulthood and employment;
- have experienced physical and emotional abuse;
- have a learning difficulty or physical impairment;
- have a long-term health condition such asthma or diabetes;
- be from a black and minority ethnic community that faces racism and discrimination;
- have recognised that she is sexually attracted to other women.

The cultural values and expectations predominating how she had been brought up may serve to protect her in many ways; others, however, might not be helpful in a Western, Scottish society and may only serve to further isolate her.

As you can see, it is possible for multiple inequalities to accrue. The potential multiple disadvantages of this woman’s life could cause her to be alienated from the lesbian community, from the rest of her female peers, from the majority community, from her own minority community, and from her family.

So what does all we have explored in this section mean for your practice?

We started the module by exploring what the terms ‘diversity’ and ‘equality’ mean. We also asked you to reflect about times you might have been treated in a way that made you feel you were being discriminated against, or had experienced inequalities.

Valuing difference starts with *valuing ourselves* and using this as a ‘touchstone’ to help us reflect on the way we would like to be valued and treated in society, in our communities and in mental health services. Taking this stance helps us to *value others*.
3. Conclusions

Legislation and policy
Tackling inequalities is not optional – it is statutory due to separate pieces of legislation:

- The Race Relations (Amendment) Act 2000, which strengthens the earlier Race Relations Act 1976;
- The Disability Discrimination Act 2005, which strengthens the Disability Discrimination Act 1995;

All these pieces of legislation have identified duties with which organisations such as the NHS and local authorities must comply as providers of services and as employers. General Duties require public bodies to have due regard to the need to eliminate unlawful discrimination AND to promote equality of opportunity.

The Mental Health (Care and Treatment) (Scotland) Act 2003 also requires that anyone acting or considering acting within the Act has regard to the principles of equality and non-discrimination.

We looked in Section 1 at how people can be discriminated against directly because of their social identity. We also have to recognise that people can face indirect discrimination. Lack of access to childcare, for example, can mean some people, especially women who are mothers, may be unable to attend certain programmes and services; this is a case of indirect discrimination against women users of mental health services.

Activity 5.18

You are working with Nadia, a service user, who asks your advice as she feels she is being discriminated against in a local community centre she attends. She asks you what she should do about this.

What can you do to support Nadia?

*Discrimination contravenes the law.* If you are working with service users who have been discriminated against, your service should be able to provide information and support to enable them to obtain legal advice to make a challenge. This could involve, as a first step, supporting and helping them to get in touch with an independent advocacy worker or solicitor.
We hope this module has increased your knowledge of what diversity and inequality mean, and why it is important to acknowledge them.

Understanding that inequalities exist, that they are unjust and that it is everyone’s responsibility to mitigate their effects and work to ensure access to appropriate health care, is a starting point for future progress.

**Activity 5.19**

Why is it important to talk about issues of inequality and diversity within the workplace?

What ‘safe spaces’ are there within your work where you can talk about issues of inequality, such as incidents of racism, and discuss the ideas you have outlined in the above questions? Who can you talk to, when, and how often?
Resources to support further learning

Action on Elder Abuse http://www.elderabuse.org.uk/Mainpages/Helpline.htm
Disability Rights Commission http://www.drc-gb.org/
LGBT Health Scotland http://www.lgbthealthscotland.org.uk/home.htm
LGBT Centre for Health and Well Being http://www.lgbthealth.org.uk/tandc/nhs.php
MEOPP: Supporting Minority Ethnic Carers http://www.mecopp.org.uk/
MIND Fact Sheets on Black and ethnic minority mental health
http://www.mind.org.uk/Information/Factsheets/Diversity/MHSACB.htm#ftnS3
MIND Fact Sheets Mental Health and Sensory Impairment
www.mind.org.uk/Information/Factsheets/Sensory+impairment/
Multi faith resources for NHS Scotland staff
National Resource Centre for Ethnic Minority Health
http://www.nrcemh.nhsscotland.com/aboutus.html
Positive steps online – supporting race equality in mental health care
http://www.actiondre.org.uk/positivesteps/welcome.html
Saheliya - a service that supports the mental health and well-being of black and minority ethnic women in Edinburgh
www.saheliya.org.uk
SEHD/NHS Scotland Fair for All diversity booklet.
SEHD Equalities and Diversity Impact Assessment Toolkit
http://www.scotland.gov.uk/Publications/2005/02/20687/52429
See Me – Scotland’s national anti-stigma campaign
www.seemescotland.org.
The Equality Network.
www.equality-network.org
References


