ESSENTIALS OF MENTAL HEALTH NURSING

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6 DIVERSITY ISSUES WITHIN MENTAL HEALTH CARE

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THIS CHAPTER COVERS

- The importance of recognising the specific mental health needs of disabled people and individuals from a diverse range of cultures, religions, genders and sexualities
- The ways in which patients may vary in their beliefs about the health care system and their attitudes about seeking appropriate care, especially mental health care
- The importance of reflecting on your values and attitudes towards disabled people and individuals from different cultures, religions, genders and sexualities
- Solution-focused interventions to enhance the experience of patients who may be disabled or from a diverse range of cultures, religions, genders and sexualities.

> "It is pertinent that people from all cultures, religions, genders, sexualities and minority ethnic groups are involved in decision making about the kinds of services they need, and how we make services accessible and appropriate to meet their individual needs, so that their priorities and values inform the process.
>
> **Ramsey Quilliam, retired mental health nurse**"

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> I was off work a lot when [she] was ill, and what they do then is they make you see Staff Health. And I had this wonderful doctor, and she actually gave me this form to fill in, 'Do you think you're depressed?'
>
> Yes, yes, yes, all the way down.
>
> And she looked at me, she said, 'My goodness, you've ticked a lot! Come in!' And she said, 'Why do you think you're depressed?'
>
> And I immediately came out with it – 'My girlfriend's dying.'
>
> And she was so lovely – she came out and hugged me. Oh, she was so lovely. And she said, 'Tell me all about it.'
>
> And of course, I was crying my eyes out. And she said, 'Right, you're not to go back to work; I'm signing you off now, with reactive depression. And you're not to go back to work at all, you go home and look after her.'
>
> And that was lovely, then. What a wonderful woman.
>
> And eventually, she [her girlfriend] just got worse and worse and worse [...] she was crying out with pain [...] And then she said, 'I think I need to go to hospital.' [...] she was lying on the stretcher, and she said, 'I am going for the angels.' Oh, it was awful. It was just terrible. And the Sister was lovely, because she said, 'Well, who are you?' and I said, 'I'm her relationship, we're a gay couple'. And she put her arm round me, she was a lovely Sister, lovely, put her arm round me and everything, and took her up to the ward. She died a few hours later.
>
> Paaie Clague (cited in Traies, 2014)

Commentary: There are two moments in this story at which Paaie felt she had to 'come out' – first to the occupational health doctor and then to the ward sister. Paaie's life had been lived 'in the closet'; her experience in the Army had made her extremely secretive about her sexual orientation. She was never out at work; her social circle consisted entirely of other lesbians. It was only in these two moments of extreme need that she let her guard down, and on both occasions, as you have seen, she met with the unconditional compassion she desperately needed.

INTRODUCTION

Mental health nursing has a chequered history in dealing with diversity (Dickinson, 2015; McFarland-Icke, 1999). However, characteristics such as racial and cultural backgrounds, disabilities, genders, religious beliefs and sexual **orientations** open up complementary ways of perceiving, thinking and acting that enrich our understanding of mental health and **recovery**. In the diverse society that we live in today, mental health nurses are expected to recognise diversity in their practice and actively tackle oppression. Indeed, respect for diversity is a well-established tenet of mental health nursing practice. People can be situated in ways that invite multiple oppressions, and these can interact to magnify detriment and discrimination. The notion of intersectionality helps to make sense of this and is a key strand of critical thinking represented in the emergent field of **Mad Studies** (LeFrançois et al., 2013).

In this chapter, you will identify the components of disability, sexuality, gender, **ethnicity**, **culture** and religion that can **affect** the **therapeutic relationship**; and learn how you can incorporate this knowledge to promote an inclusive **environment** and provide culturally competent care.

EQUALITY AND DIVERSITY

Whilst the terms ‘equality’ and ‘diversity’ are sometimes used interchangeably, they are not the same. Equality is about ‘creating a fairer society, where everyone can participate and has the opportunity to fulfil their potential’ (DH, 2004). By striving to eliminate prejudice and discrimination within mental health care, services can deliver personal, fair and diverse care, thus making it more accountable to the patients it serves and tackling discrimination in the workplace (Hunt, 2004).

In short, diversity literally means difference. Diversity aims to recognise, respect and **value** people’s differences to contribute and realise their full potential by promoting an inclusive culture for all staff and patients. It is about acknowledging individual as well as group differences, treating people as individuals and placing positive value on diversity in the community and in the workforce. It is paramount that group and individual diversity needs are met and considered in order for mental health services to create an inclusive culture for all staff and patients. Indeed, if mental health nurses are to take a holistic approach, they need to make a commitment to equality through the recognition of diversity.

EQUALITY LEGISLATION

Legislation governing equality in England, Wales and Scotland was streamlined into a single piece of law, known as the Equality Act 2010, in an effort to simplify and strengthen existing law. This Act prohibits discrimination, to help achieve equal opportunities across all aspects of society and does so by specifying ‘protected characteristics’. The nine protected characteristics are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; **race**; religion and belief; sex; and sexual orientation. Under the Equality Act, individuals are afforded protection against discrimination, harassment and victimisation. However, in addition to its protective function, the Equality Act endeavours to promote equality to groups of people who may be disadvantaged or under-represented, or have particular needs, but must be applied in a way that is proportionate to the aim.

Comparatively, the existing equality protection in Northern Ireland remains unconsolidated and, as a result, provides less comprehensive and enforceable rights with uneven and diverse application (Northern Ireland Assembly, 2011). As such, Northern Ireland continues to retain the Equal Pay Act 1970; Sex Discrimination Act 1976; Disability Discrimination Act 1998; Race Relations Order 1997; Northern Ireland Act 1998; Fair Employment Treatment Order 1998; Employment Equality (Sexual Orientation) Regulations 2003; and Employment (Age) Regulations 2006.

Whilst the UK’s Equality Act 2010 seeks to address previous deficiencies in equality law, these remain pervasive in Northern Ireland’s law. Primarily, the complexity of the equality law in Northern Ireland has led to difficulties for those seeking to exercise their rights, as well as those endeavouring to comply with its provisions and poor consistency in its application. Moreover, the arguably outdated legislation of Northern Ireland fails to keep abreast of new forms of discrimination, therefore offering little or no protection, and may ultimately breach standards within international human rights conventions (Equality Commission for Northern Ireland, 2014).

BLACK AND MINORITY ETHNIC GROUPS

In recent times, England and Wales ethnic makeup has become increasingly diverse, with rising numbers identifying with minority ethnic groups (Office for National Statistics, 2012). Whilst the majority ethnic group remained White British, the 2011 Census showed the UK’s population comprised 2.2% mixed/multiple ethnic groups; 7.5% Asian/Asian British; 3.3% Black/African/Caribbean/Black British

and 1% other ethnic groups. A similar pattern emerged from the data of the Scottish census, with the African, Caribbean or Black groups representing 1%; Asian groups 3%; mixed or multiple ethnic groups 0.4%; and the White population holding the largest percentage at 96% (Scottish Government, 2011). In Northern Ireland, additional ethnic groups were identified, however the White population remained the greatest at 98.21%; Chinese 0.35%; Irish Traveller 0.07%; Indian 0.34%; Pakistani 0.06%; Bangledeshi 0.03%; other Asian 0.28%; Black Caribbean 0.02%; Black African 0.13%; Black other 0.05%; Mixed 0.335; and other populations represent 0.13% (Northern Ireland Statistics & Research Agency, 2011). This diversity enriches our society but also brings with it challenges for health care providers, health care systems and policymakers, to ensure that mental health services are appropriate for and relevant to a multicultural society.

Table 6.1 Culture, race and ethnicity

Concept	Characterised by	Perceived as	Assumed to be	In reality
Culture	Behaviour, attitudes, etc.	Social, changeable	Passed down by parents, parent substitutes	Variable and changeable blueprint for living
Race	Physical appearance	Physical, permanent	Genetically determined	Socially constructed
Ethnicity	Sense of belonging	Psychosocial, partially changeable	How people see themselves in terms of background and parentage	Culture-race, mixture

Source: adapted from Fernando, 2010

CULTURAL COMPETENCE

An individual's values, beliefs and behaviours are influenced by factors including race, ethnicity, language, age, socio-economic status and occupation (Kramer et al., 2002). It is imperative that a health care system integrates these factors into the delivery of its services, to ensure it meets its legal, moral and ethical obligation, to provide care that is both person-centred and culturally competent (Belfast Trust, 2014). On an individual level, mental health nurses have had a legal and professional duty to promote equality in accordance with the Race Relations (Amendment) Act 2000 (now subsumed under the new Equalities Act). A culturally competent service helps to improve health outcomes and quality of care and reduces racial and ethnic disparities; and a culturally competent professional provides care which is safe, effective, timely, equitable and individual (Betancourt et al., 2005).

Cultural competence is considered an ongoing process which is developed over time (Campinha-Bacote, 2002). The model in Figure 6.1 highlights the stages by which cultural competence is acquired, allowing mental health nurses to work effectively with black and minority ethnic (BME) groups.

BLACK AND MINORITY ETHNIC ISSUES IN MENTAL HEALTH

It is widely documented that health disparities exist between black and minority ethnic (BME) groups and the majority white population, with BME people suffering from increased morbidity and reduced life expectancy, and experiencing greater difficulty accessing health care. This disparity also extends to mental health, with increased rates of mental ill health and poorer experience within mental health services and treatment outcomes (Owen & Khalil, 2007).

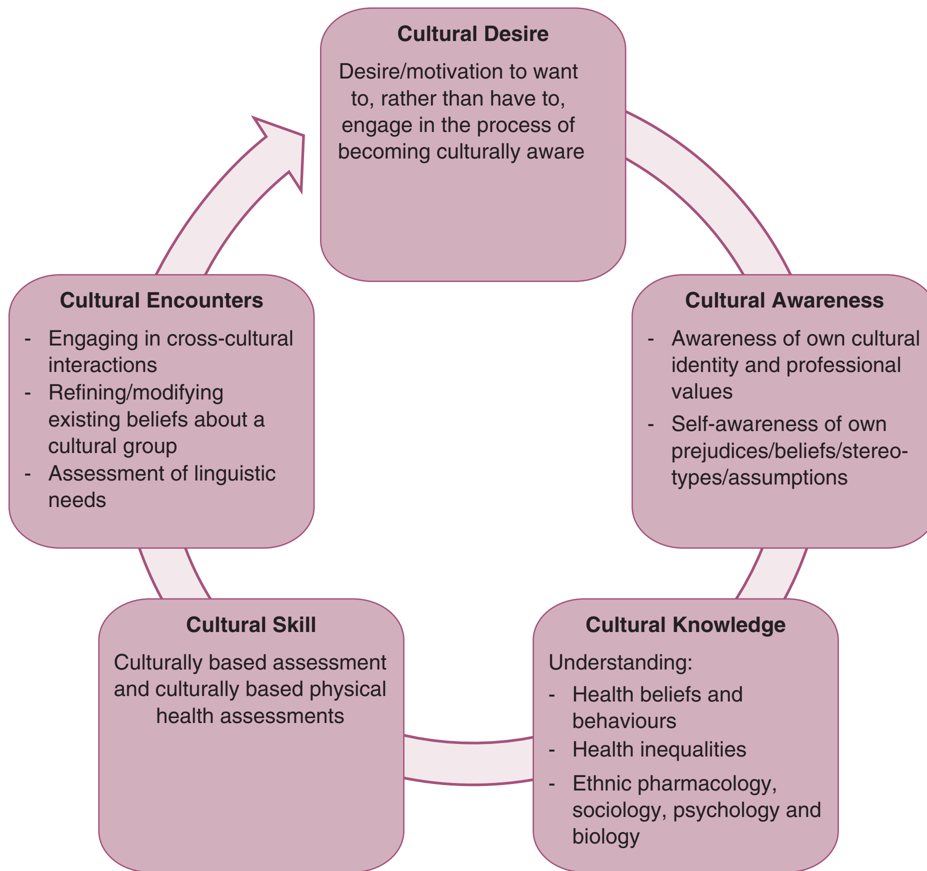

Figure 6.1 Culturally based physical and mental health assessments

Source: adapted from Campinha-Bacote, 2002

Rates and routes of admission

Although there is an impetus to reduce hospital admissions, it is important to consider the routes of admission into mental health services as these may vary among societies and may be reflective of the cultural appropriateness, attractiveness, attitudes towards services and an individual's previous experience (Goldberg, 1999).

In England, it is well documented that African-Caribbean men are 3–13 times more likely to be admitted to mental health hospitals than their White counterparts (Davies et al., 1996; Van Os et al., 1996). This has resulted in a disproportionate representation of those from black communities in the mental health system. However, focus has moved away from their over-representation to the pathway in which they arrive there. It has been found that Black people, in comparison to White people, are more likely to experience 'an aversive pathway into mental health services', with a greater number of compulsory detentions under the Mental Health Act 1983 [as amended] in England and Wales, greater involvement in legal and forensic settings, and increased rates of transfer to medium- and high-security settings (National Association for the Care and Resettlement of Offenders, 2007: 3). These patterns are also reflected amongst Black women who are three times more likely to be admitted to a forensic unit than White women (Maden et al., 1992).

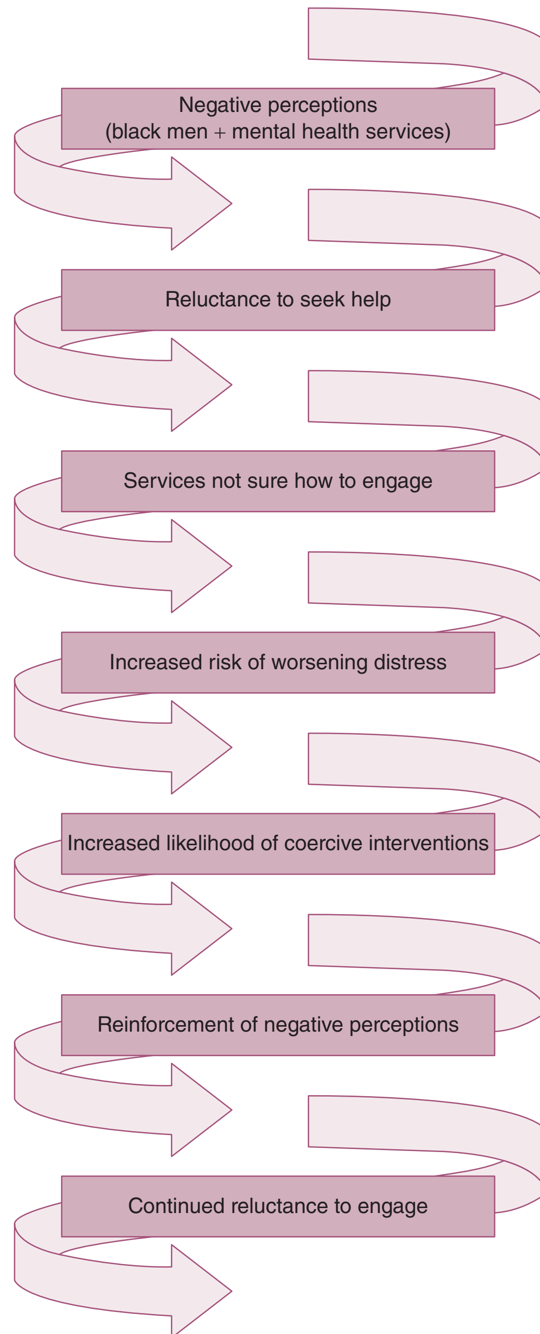

Figure 6.2 Spiral of oppression

Source: Trivedi, 2002

Issues faced by BME groups in mental health do not stand alone but have a close relationship to one another. Although perceptions of Black patients will be discussed in more detail later, the association of increased risk and fear of danger amongst Black people has led to an increased likelihood that these

patients will be detained by the police under Section 136 of the Mental Health Act 1983 [as amended] in England and Wales and be taken to a **place of safety** (Braine, 1997).

The disproportionate rates of compulsory detention amongst Black people has been found to be independent of psychiatric diagnosis, total number of admissions a year, marital status, employment, sex, age and type of accommodation (Davies et al., 1996). Possible explanations for Black people entering services involuntarily have included mental health services being inaccessible or inappropriate to this community (Davies et al., 1996). Arguably, the way Black people have contact with mental health services creates an aversive experience of them, leading to services being viewed as anti-therapeutic, thereby creating a delay in seeking help, which ultimately leads to an increased likelihood of compulsory admission (Moodley & Perkins, 1991). Figure 6.2 demonstrates Trivedi's (2002) 'spiral of oppression', whereby Black people do not trust mental health services, and those who work within them hold a sense of fear towards these patients, which leads to poor engagement on both sides.

CASE STUDY: PARANOID SCHIZOPHRENIA

DIAGNOSIS OF SCHIZOPHRENIA

Research shows that people from BME groups are more likely to be diagnosed with mental health problems, despite differing opinion about whether the prevalence of mental health problems in these groups is any higher than the majority White population (DH, 2005; CQC, 2009). More specifically, it is widely documented that African-Caribbean patients are more likely to be diagnosed with severe mental **illness**, in particular **schizophrenia** (Coid et al., 2000; Davies et al., 1996). Additionally, the inquiry into the death of David 'Rocky' Bennett, along with other issues, highlighted that African-Caribbeans are more likely than other ethnic groups to be diagnosed with drug-induced **psychosis**. In this way, Black people are considered to suffer 'double jeopardy' (Fernando, 2002). These findings contrast with lower rates of psychosis among the majority White population and conflicting results in Asian populations.

American psychiatrists document that the disparities in the diagnosis of schizophrenia between racial groups is explained by the White psychiatrists' lack of understanding and subsequent inability to properly evaluate the feelings and behaviour of Black people as a result of mutual mistrust and hostility (St Clair, 1951). Inevitably this will lead to diagnostic difficulties including atypical **syndromes** being misdiagnosed as schizophrenia (Littlewood & Lipsedge, 1981). These findings are not unique to the USA, but are also reflected in the results of UK studies. Specifically, Bhugra et al. (1997) concluded, the incidence of schizophrenia is higher in males of all ages but only in females under the age of 30. Research appears to focus heavily on African-Caribbeans, however King et al. (1994) argue that this is misleading as all BME groups are vulnerable.

'BIG, BLACK AND DANGEROUS'

The death of David 'Rocky' Bennett, who died following prolonged restraint and the earlier deaths of Orville Blackwood, Michael Martin and Joseph Watts in Broadmoor Hospital, brought about discussion regarding institutional racism in UK health care (McKeown & Stowell-Smith, 2001). In both inquiries it was found that professionals drew on stereotypes of black patients as 'aggressive,' which was further heightened by a diagnosis of schizophrenia and subsequently generated a fear of violence amongst staff. These perceptions are supported by research and extend to other ethnic minority groups, with clinicians over-predicting violence amongst members of these communities and under-predicting violence in White majority groups (Hicks, 2004). Yet research shows no correlation between race and actual assaultive behaviour (Hoptman et al., 1999).

Institutional racism in this respect manifests itself not in direct racism but what is termed the colour blind and culture blind approach (Fernando, 2002). Here, mental health practitioners are unaware of their own bias and ignore the existence of racism in the wider society, resulting in patients' race being unrecognised and their self-perception, social opportunities, rights and life experiences invalidated (Fernando, 2002). This leads to culturally blind practice where health related behaviours, variations in beliefs associated with illness and treatment preferences are misinterpreted or not considered (Engebretson et al., 2008). Although superficially this may be perceived as an attempt to avoid discrimination, it assumes homogeneity amongst patients and subsequently leads to a failure to provide individualised care.

An over-prediction of dangerousness, cultural ignorance and stereotypical views coupled with the **stigma** and **anxiety** associated with mental illness, influences the delivery of mental health care, in particular towards African-Caribbean patients. The perception of heightened risk translates to an increased likelihood of African-Caribbean patients receiving more coercive treatments including the use of manual restraint, seclusion and rapid tranquilisation (Hicks, 2004). This is further supported by the David Bennett inquiry, which found that nurses more easily initiated restrictive practice as a result of perceptions held about this group of patients. It is therefore unsurprising that Black and ethnic minorities are less likely to receive psychotherapy in comparison to their White counterparts. The increased use of coercive treatment towards Black patients has been found to remain on discharge from detention, where the use of restrictive community orders is more likely to be enforced (CQC, 2009).

MEDICATION

As mentioned earlier, psychological therapies are less available to BME groups, with perceptions held that members of these groups are unable to articulate their feelings as effectively as their White majority counterparts (Royal College of Nursing, 2004). This discriminatory practice severely disadvantages BME groups and leads to these communities receiving medication as the primary form of treatment (Fernando, 2002; McKenzie et al., 2001). As a result, there is an increased likelihood of BME patients receiving **antipsychotic** medication, higher doses and more frequently depot formulations, of which this disparity is even more pronounced amongst Black patients (Kuno & Rothbard, 2002). This finding is partly supported by Lloyd and Moodley (1992), who concluded, whilst there was no significant difference in doses of antipsychotic medication between Black and White patients, Black patients were more likely to receive depot antipsychotic and at markedly higher doses. Additionally, the David Bennett inquiry suspected the prescription of poly-medication was more likely amongst members of Black communities when compared to White patients, as they were perceived to be more dangerous and a nuisance (DH, 2005).

CULTURAL COMPETENCY IN PRACTICE

If a patient's cultural, social, and religious needs are not considered in the delivery of care, this may affect their reactions and exacerbate symptoms. It is therefore crucial that patient care is delivered in accordance with their needs. Although not an exhaustive list, Table 6.2 contains some of the barriers BME groups may encounter when accessing mental health services and the steps that can be taken to overcome these in clinical practice.

Table 6.2 Overcoming barriers to services in clinical practice

Barrier(s)	In practice
Language	Ask about your patient's proficiency of English and consider the use of an interpreter Find out the correct pronunciation of their name and how they prefer to be addressed Avoid the use of jargon or complex clinical language
Lack of information regarding available services	Provide information leaflets in your patient's native language, if appropriate
Stigma and fear of mental ill-health and social rejection	Promote mental health for all, working with individuals and communities to overcome discrimination and promote social inclusion (National Institute for Mental Health in England, 2003)
Not registered with a GP	Be aware of the different sources of support and help-seeking patterns
Reluctance to accept western medication	Be aware that health beliefs about psychiatry may be different across cultures. Therefore, it is important to find out how your patient perceives their mental illness. Always remain aware that you are nursing someone from a different culture. Therefore, they may put different interpretations on events and feelings
Isolation and lack of social/ family support	Signpost individuals to appropriate BME groups
Misunderstanding leading to misdiagnosis	Allocate longer periods of time for assessments where an interpreter is being used. Summarise frequently throughout assessments to check your understanding
Generalisations and assumptions	Ensure your care plans detail each patient's ethnic origin and cultural needs

Source: adapted from Belfast Trust, 2014

CRITICAL THINKING STOP POINT 6.1

- Write a 'cultural biography' that reflects how your own culture has influenced and shaped your beliefs about mental health and mental illness.
- Discuss your cultural biography with your mentor and record your discussion and reflections for your portfolio.

CASE STUDY 6.1

Adina is an 18-year-old female and is admitted under Section 2 of the Mental Health Act 1983 [as amended] (England and Wales), to an acute mental health, mixed-sex ward and has a longstanding history of anxiety. As part of the admission process, information is gathered regarding Adina's religious and cultural needs. Adina informs staff that she is a strict Orthodox Jew, she speaks limited

(Continued)

English and her preferred language is Hebrew, maintains a Kosher diet and on the Sabbath she observes the rule that she will not 'work'. The admitting nurse is unsure of what this entails and asks Adina to explain what it means. Adina informs the nurse that from sunset on Friday to sunset on Saturday this religious injunction prohibits engaging in tasks which initiate the flow of electricity, such as turning on a light switch, writing, and carrying items. The nurse needs to develop a care plan to ensure other members of the nursing team are aware of and know how to meet this need.

Questions

- What aspects of care should be considered in the initial care plan to meet Adina's religious needs and how could these be addressed in clinical practice?
- How would you develop this care plan during Adina's admission and are there any other considerations you may need to take into account?

> **"As a nurse with experience in a variety of clinical settings, I have found that person centred planning and understanding diversity should never be underestimated when trying to engage individuals to participate in occupational activity. When working on a forensic unit, the weekends were always quiet and patients were often at a loose end, which was not always beneficial to their wellbeing or recovery. I suggested having a 'world day' every Sunday in which the patients were encouraged to select a country. Once they had selected a country, they would be given a variety of different tasks that related to that country; whether that was to plan a menu, impart some knowledge about the country (e.g. fun facts, a phrase, history) or play music originating from the selected country, etc. It turned out to be quite successful in that both patients and staff were equally enthusiastic about taking part. It also created an opportunity to learn about different cultures in a fun and informal manner, as all individuals were freely contributing or learning information without feeling they were being 'assessed' or 'judged' by their peers or clinicians.**
>
> **Donna Taylor, learning disability nurse"**

WOMEN'S MENTAL HEALTH

Women's experience of mental health differs from men's for both biological and social reasons. The area of women's mental health is relatively new and considerably more research is required to develop better understanding of and treatments for many of the mental illnesses experienced by women (Castle et al., 2006). Women's health is inextricably linked to their status in society; it benefits from equality and suffers from discrimination. Various feminist inspired critics have highlighted and challenged inequities for women within psychiatric services (Chesler, 1972; Millett, 1990; Ussher 1991). Today, the status and wellbeing of countless millions of women worldwide remain tragically low (WHO, 1998).

Approximately twice the proportion of women as men are diagnosed as having mental health problems (Green et al., 2002). Women are more likely than men to experience abuse, be in poverty and be lone parents, to **self-harm** and suffer from anxiety and/or **depression**, and to attempt suicide.

However, they are more likely to seek talking therapies and benefit from self-help (Kermode et al., 2007). Eating **disorders** and **body image** are issues with great relevance to women's lives (Hudson et al., 2007). While it seems that eating disorders are more prevalent amongst women, it may be that help seeking and openness about these disorders is lower amongst men.

Women are more likely than men to be in a caregiving role and the sedation caused by many psychiatric drugs makes looking after children/dependent adults difficult. Side-effects in general may be experienced as worse by women than men. Possible reasons for women experiencing a greater side-effect profile, as a result of antipsychotic medication, include the length of time such medication is stored in adipose tissue, more comorbid illnesses which increase the likelihood of drug interactions, and a higher prevalence of immune reactions (Castle et al., 2006).

PERINATAL MENTAL HEALTH

Women's mental health may have a consequential effect on their reproductive health – for example, oestrogen and progesterone influence **mood** and emotions. Phases of women's lives, including puberty, childbirth and menopause, are factors that may increase their risk of developing mental illness. More specifically, so too are miscarriage and termination, the phase of menstrual cycle, use of hormonal contraception, pregnancy, the postpartum period, breastfeeding or weaning, infertility treatment, hysterectomy and perimenopause.

The majority of women with severe mental illness (SMI) are mothers (Diaz-Caneja and Johnson, 2004). Women with SMI are substantially more likely to have child caring responsibilities than their male peers and women with bipolar disorder are at significantly greater risk of developing puerperal psychosis (Frisch & Frisch, 2009). Fear of losing custody of children colours interaction with mental health services. Women with SMI feel they are assumed to be inherently poor parents. Mothers receive little continuing support with parenting; instead, help may arrive only at times of crisis and is not always what the mothers would want. Custody loss is frequent – only 20% of mothers with SMI still have full custody of their children (Joseph et al., 1999). Women talk about the fulfilling aspects of motherhood and its role as an incentive to stay or get well (Antai-Otong, 2008). However, having children makes it difficult for mothers to adhere to medication and use mental health services, which may be perceived as non-concordance. Furthermore, the need to wake up during the night to attend to their children's needs may decrease the mother's ability to adhere to a medication regime.

MEETING WOMEN'S NEEDS

Short and Donna (2007) argue that current mental health service provision fails to adequately address the specific needs of women and can re-traumatise the women in its care. Women with mental ill health need treatment that is, first, tailored to women and, second, individualised. Women need to feel safe on wards and in the community, that staff respect them for who they are and that services are meeting their specific needs. Some women may benefit from women-only spaces and culturally appropriate staff/staff attitudes.

Women should have access to psychological therapies, as it has been shown that they do well with talking therapies, group therapy and self-help. Complementary therapies such as aromatherapy and reflexology are also often highly valued by women, although the evidence base for these is sparse (Short & Donna, 2007). Psychological treatments can also help women to cope with the emotional numbing which may be experienced as a result of taking antipsychotic medication. Finally, mental health services rarely, if ever, provide crèches so mothers may miss appointments. Those interviewed

in a study by Caneja & Johnson (2004) said they would like respite for children of mothers with a mental illness, family support workers and support groups. The Drayton Park Crisis House (Killaspy et al., 2000) was seen by three of Caneja's research participants as a positive alternative to inpatient care. Children were able to stay with their mother in residential care for up to four weeks rather than being separated from them and placed with family or foster **carers**.

MAKING A DIFFERENCE 6.1

Being sexually abused by my uncle for most of my childhood I was naturally very scared of men. When I self-harmed on the acute ward sometimes I was restrained, invariably by men. This brought my traumatic history to the fore and cumulated in a vicious cycle of me wanting to harm myself further. It was only when I was moved into a specialist women's unit, which had a high proportion of female staff, that I began to feel more secure. I worked with my Named Nurse to develop a care plan around my advance directive that if my self-harming became so severe that for my safety I needed to be restrained, it would only be female staff that restrained me. As a result of this my desire to self-harm reduced and I was eventually discharged. I now have a female community psychiatric nurse visit me at home. In my opinion, having accessed the specialist women's service was paramount to my journey to recovery.

Eunys Vorgel Kelly, mental health survivor

CRITICAL THINKING STOP POINT 6.2

The nurse should be aware of certain cultural considerations specifically relevant to women. For example, some older South Asian women can be softly spoken and reluctant to express direct opinions; and some Asian women avoid shaking hands with one another or with men.

DISABLED PEOPLE'S MENTAL HEALTH

Disabled people are much more likely to experience poverty and social isolation than their non-disabled counterparts. These factors are positively correlated to mental health problems and, as such, it is likely that disabled people are disproportionately represented within the client base of mental health services. This may be particularly the case for learning impaired people (Cooper et al., 2007) and people who have recently acquired an impairment.

Table 6.3 shows two competing models of disability – the medical model and the social model. An example to demonstrate the difference between the two models would be the case of a wheelchair user who is unable to access a building because the building has steps. The medical model places the disabling factor in the fact that the person cannot walk up steps. The social model places the disabling factor in the lack of level access. The social model was first developed by Oliver (1990) and has since become the preferred model of disabled people's organisations in the UK on the pragmatic basis that reducing barriers to access has a greater potential to improve the lives of disabled people than seeking

Table 6.3 The medical versus the social model of disability

Model	Understanding of disability	Language used to address patient
Medical	Sees disability as a medical problem which resides within the individual	'Person with a disability'
Social	Sees disability as a social problem which resides in the barriers (physical, social, attitudinal) which prevent disabled people from being included in all aspects of life	'Disabled person'

Source: adapted from Goodley, 2011

out individual cures or fixes. When dealing with disabled patients, it is best practice to identify any barriers to accessing the service and seek to reduce them.

There can be many barriers for disabled people accessing treatment within a mental health setting, which vary depending on impairment. Giving the patient time in advance to prepare for the meeting with as much information as possible (the length, venue and topics covered), and asking what you can do to help meet their access needs in advance, are useful. You should also make sure you look at any relevant files, such as speech and language reports, in advance. Meeting people's access needs might involve 'physical' things like changing venues to a place that might better meet their needs, or rearranging furniture so that wheelchairs or other equipment can fit. It might mean allocating more time to the meeting if you need to discuss extra issues around accessibility or if the patient might need more time to absorb any information. It could involve providing written material in another format, or inviting an interpreter, family member, friend or personal assistant (carer) along to support them. Remember that if another person is coming in to support the patient, questions should be directed at the patient alone. It could also mean changing how you interact with the patient, using plain English if communication might be an issue, or asking more follow-up questions to check understanding.

Many people with learning impairments may exhibit behaviours such as echoing what others have said, overactivity or a very active imagination, which can be completely normal for them but pathologised as echolalia, **hypomania**, or **hallucinations** or **delusions** within a mental health context (Hardy et al., 2010). As such, it is important to build a picture of what constitutes 'normal' behaviour on a case-by-case basis. This should take into account that neurodivergent people (those displaying atypical patterns of thought) have different normalities to neurotypical people, that many people may have undiagnosed learning impairments, and that, conversely, behaviour that seems normal for a neurotypical person may be a signifier of distress in a neurodivergent person. The Royal College of Nursing has produced best practice guidance on working with patients with learning impairments in a mental health setting (see Hardy et al., 2010).

CRITICAL THINKING STOP POINT 6.3

Values and beliefs

A values and beliefs exercise is a versatile and meaningful way of exploring your values and beliefs. It can be used to help you create an individual and shared purpose for practice or care. Answer the following questions individually and then share your responses with your fellow nursing students:

(Continued)

- Recall times when you have been so absorbed in what you were doing that you hardly noticed the time. What were you doing?
- Think about the things that you find meaningful. What do you think of? Include ideals, feelings and activities.
- What are the five most important to you? Prioritise them.
- What is important to you as a future registered nurse?
- What do you feel is most important to accomplish with your patients?
- What matters most to you when you are NOT nursing?

LESBIAN, GAY, BISEXUAL AND TRANS MENTAL HEALTH

The **lesbian**, gay, **bisexual** and **trans** (LGBT) community is diverse (see Table 6.4 for a description of common LGBT identities). Whilst the L, G, B and T are often grouped together as an acronym that suggests homogeneity, each letter represents a wide range of people of different races, ages, socio-economic status, ethnicities and identities. Nevertheless, what binds them together as social and gender minorities are their shared experiences of discrimination and stigma, the challenge of living at the intersection of many cultural backgrounds and trying to be part of each, and, particularly with respect to health care, a long history of discrimination and lack of awareness of health needs by health professionals (see Fenway Health, http://fenwayhealth.org/). For example, between the 1930s and the 1970s some members of the LGBT community received aversion therapy: chemical and electrical treatment within psychiatric hospitals, in an attempt to 'cure' them of their 'sexual deviations'. Chemical aversion therapy involved using emetics to produce nausea and vomiting in the patient while showing him pictures of naked men, in the hope that he would come to associate the two. In electrical aversion therapy, the patient would be asked to watch pictures of men in various states of undress, whereupon electrical shocks would be administered if he got an erection above a certain size. Men convicted of homosexual offences[1] were given a choice of going to prison or undergoing treatment. Thinking it would be an easier option, many made the calamitous decision to undergo the treatment (Dickinson, 2015).

FENWAY HEALTH

This has resulted in LGBT people sharing a common set of challenges in accessing culturally competent health services and achieving the highest possible level of health. Indeed, LGBT people have higher incidences of mental health problems than their heterosexual counterparts as a result of living in a homophobic society, which can lead individuals to experience 'minority stress' (Almeida et al., 2009). Minority stress is the psychological consequences of harassment and stigmatisation that members of minority groups may face. It is important to note that minority stress is a significant factor in mental health and wellbeing. Being LGBT places one outside of societal norms around gender and sexuality, thus positioning one as 'different from the norm'; an inevitably stressful experience which can be an influential contributing factor in becoming mentally distressed (Mayer, 2003).

Indeed, LGBT people have higher rates of self-harm (King et al., 2008), suicide/suicidal ideation (Haas et al., 2010; Mayock et al., 2008) and substance use (Buffin et al., 2012) than their heterosexual/ **cisgender** counterparts. Moreover, 49% of lesbian and bisexual women and 34% of gay and bisexual men do not feel able to be 'out' to any health care providers (Guasp & Taylor, 2012). This means that health care providers often miss out on important contextual factors, which may impact on a patient's care.

[1]Sex between men was illegal in England and Wales until the Sexual Offences Act became law in 1967, decriminalising sex between two consenting male adults over the age of 21 in private. Men in Scotland, Northern Ireland, Guernsey, Jersey and the Isle of Man had to wait until 1980, 1982, 1983, 1990 and 1993 respectively.

Table 6.4 Common LGBT identities

Bisexual: A person who is sexually and/or romantically attracted to women and men. You may see this shortened to bi.

Cis/cisgender: A cis person is someone who does identify with the gender that they were assigned at birth, i.e. a person who is not trans.

Gay man: A man who is sexually and/or romantically attracted to other men.

Intersexed person: An intersexed person (old word = hermaphrodite) is someone who has physical characteristics that differ from the typical male or female arrangements. They are most likely to be intermediate between the sexes, having some male and some female characteristics, or to have under-developed sex characteristics. Around 1 in 2000 people is identified as intersexed at birth. They may have chromosomal or hormonal differences – if an intersexed person is identified at birth, doctors usually test chromosomes and hormones to help them advise parents which gender to bring their baby up as. The notion of intersex complicates the legal insistence on a two-option (male/female) model. The system does not allow for sex or gender expressions other than male or female, although, for many people, their sex is not so clear-cut.

Lesbian: A woman who is sexually and/or romantically attracted to other women.

Non-binary: A person who identifies outside the gender binary, i.e. a person who identifies as neither a man nor a woman. Genderqueer, androgyne and gender fluid are non-binary gender identities you might hear used.

Pansexual: A person who has the capability of attraction to others, regardless of their gender identity or biological sex. A pansexual could be sexually and/or romantically attracted to someone who is male, female, transgender, intersex or genderqueer.

Trans: A trans person is someone who does not identify with the gender that they were assigned at birth. Trans (sometimes written trans*) is an umbrella term to describe a wide range of identities. Some trans people suffer from gender dysphoria, a sense of intense discomfort caused by the mismatch between their physical sex and their gender identity. This may cause them to seek out medical interventions such as hormones or surgery.

Transgender: Usually this refers to a trans person who socially and/or medically transitions from one binary gender to another. You may also hear the term transsexual used which implies a greater focus on medical transition which some consider to be pathologising.

Transitioning: The process of changing the way one's gender is lived publicly. Transitioning may involve changes in clothing and grooming, a name change, change of gender on identity documents, hormonal treatment and surgery.

As such, it is imperative to create an environment where LGBT patients feel comfortable discussing their sexuality and identity within a clinical environment.

There are several ways in which to make LGBT patients feel more comfortable in a clinical environment. LGBT patients often search for subtle cues in the environment to determine acceptance. This can include 'physical' cues, such as displaying a non-discrimination statement addressing equality issues such as homophobia, transphobia and biphobia where it can be seen publically, and providing LGBT-specific health promotion literature within waiting rooms and on notice boards (Eliason & Schope, 2001).

In consultations, it is important to stress that discussions of sexuality with clinical staff remain confidential and will be dealt with sensitively. This means that clinicians should not assume that patients are heterosexual or cisgendered, or that their relationships take a particular form (i.e. marriage), and same-sex partners should be treated as any other close family member.

When patients disclose their sexual orientation, clinicians should be mindful of adopting an appropriate response. This may include briefly thanking the patient for disclosing the information, confirming that it will be kept confidential and signposting them to any relevant LGBT-specific services, if appropriate.

If you are the first person that the patient has told, you may wish to talk more in depth about the issue and what support they may need, always letting the patient take the lead. Clinicians should be mindful not to ignore this information – the patient will have disclosed their sexuality because they either feel it is relevant to their care or because it is an important part of their identity.

Clinicians should also be mindful in attributing patients' mental health problems as being 'caused by' their sexuality or identity. Whilst the LGBT community has higher prevalence rates for mental health problems than the cisgender and heterosexual community, it is not an innate part of being LGBT (Dalloway & Dickinson, 2014). Rather, it is often a symptom of living in a homophobic, transphobic and biphobic society. The patient may also feel that their sexuality is irrelevant to their mental health, and this should be respected.

Finally, it is important to create a safe environment for LGBT people. Staff in inpatient settings should be mindful of the safety and security of LGBT individuals, who may be subjected to negative comments or behaviour related to their LGBT identity from other patients. It is pertinent to challenge homophobia, transphobia and biphobia on the ward and in the wider clinical environment. It is important to do this without 'outing' the patient as LGBT, i.e. by saying, 'this behaviour is inappropriate' or 'you are disturbing other patients'.

TRANS MENTAL HEALTH

Whilst on placement with an A&E liaison team we undertook a risk assessment on a trans woman who had taken an overdose. The Registered Nurse who was supervising me explained that the patient was trans, however he referred to her using the incorrect pronoun. The patient was clearly uncomfortable with this and she later explained to me that similar attitudes in her local area had caused her to become isolated and low in mood. When writing up her notes, the nurse asked why I referred to her as female rather than male, explaining that in his opinion, she was physically male and, therefore, would use a different pronoun. I stressed the importance that she identified as a female and, therefore, I would be referring to her using the pronoun that she preferred. I later spoke to my mentor about the situation, stressing the importance that we recognise people's individual choice (NMC Code, 2015), which I did not feel the other nurse was doing with this patient. It is important in situations like this to speak with your mentor to help resolve the issue and prevent future harm to patients.

Rachel Lyon, mental health nursing student

According to the Trans Mental Health Study (N = 991), 66% of trans people use mental health services for reasons other than to access gender transition treatments (McNeil et al., 2012). When undergoing transition-related treatment, many trans people feel that being open about any mental health problems can complicate their access to treatment, with some trans individuals having their gender treatment delayed or even denied on grounds that they have accessed mental health services (Webb et al., 2014). Moreover, trans people are often denied access to mental health treatment as they can be seen as 'too complicated', or their mental health problems are viewed as related to their trans status. As such, trans people are less likely to access help with mental health problems and are disproportionately represented in crisis services (McNeil et al., 2012).

WHAT'S THE EVIDENCE? 6.1

WHAT'S THE EVIDENCE? 6.1 ARTICLES

Read the following articles (available at https://study.sagepub.com/ essential mental health):

Dickinson, T., Cook, M., Hallett, C. & Playle, J. (2014)
Dickinson, T., Cook, M., Playle, J. & Hallett, C. (2012)
Simpson, P., Horne, M., Brown Wilson, C., Brown, L., Dickinson, T. & Torkington, K. (2017)
Simpson, P., Horne, M., Brown, L.E., Dickinson, T. & Brown Wilson, C. (2016)

Now consider the questions below:

1. For LGBT people, who may remember that homosexuality and cross-gender transvestism were classified as mental illnesses and routinely (and largely unsuccessfully) 'treated' with barbaric aversion therapy until the 1980s, how do you think this may affect their perception of mental health services?
2. If you were instructed by a senior nurse or medical officer to undertake a clinical intervention that you did not agree with, for whatever reason, what would you do and why?
3. You are working in a nursing home and one of the residents, with mental capacity, wants to continue having a sexual/intimate relationship with his same-sex partner. What are your thoughts on this?
4. What factors may impede on his ability to maintain a sexual/intimate relationship with his partner within a nursing home environment?
5. How could you work around some of these environmental factors?

CASE STUDY 6.2

Onnee, aged 57, is a trans woman with a diagnosis of posterior cortical atrophy (PCA), also known as Benson's syndrome. This is a rare degenerative condition in which damage occurs at the back (posterior region) of the brain. Onnee was admitted to a specialist nursing home that provides nursing intervention for younger people with dementia. On admission, the team was unsure which gender unit to place her on, so they placed her on the male unit. This has caused great distress to Onnee and some of the male patients have been noted to mock her. Staff on the unit are also struggling with this and are addressing her with incorrect pronouns, which is very upsetting for Onnee. She wants to use the female bathroom, but other female patients are complaining about this. Therefore, she is currently using the disabled toilet.

Questions

- How would you deal with the transphobic behaviour on the unit?
- Which gender unit do you think Onnee should be on?

CRITICAL DEBATE 6.1

Now that you have worked through this chapter and considered some of the issues, why not deliberate the following questions with your fellow nursing students:

1. How would valuing diversity enhance mental health nursing practice?
2. If someone from another culture, religion or sexuality, or a person who identifies outside the gender binary, is admitted to your mental health setting, is it not up to that person to adjust?
3. What specific actions could you take in a mental health setting that would show that you acknowledge and appreciate diversity?

CONCLUSION

This chapter has explored the components of disability, sexuality, gender, ethnicity, culture and religion that can affect the therapeutic relationship. It is paramount that mental health nurses recognise that these unique characteristics within their patients open up complementary ways of perceiving, thinking and acting that enrich our understanding of mental health. Mental health nurses are generally striving to provide patient-centred and high quality care in often challenging, stressful and frustrating environments. Patients should receive a holistic assessment that endeavours to promote health and considers the unique characteristics among those with a mental illness to foster a state of mental, social and emotional wellbeing for all. Creating an environment or displaying an attitude that does not value and embrace these characteristics may curtail patients' recovery. If mental health nurses are to provide culturally competent care, they must recognise and respect diversity and actively tackle oppression.

CHAPTER SUMMARY

This chapter has covered the following ideas:

- Respect for diversity is a well-established tenet of mental health nursing practice and helps to promote recovery.
- Mental health nurses must recognise and respect diversity and actively tackle oppression.
- Unhelpful practices and pejorative attitudes towards diversity can obstruct recovery.
- Each patient is unique, with different social, biological and psychological factors that may influence their response to stress and ill health.
- Knowledge of various cultural patterns and variances helps the nurse begin to relate to patients of different ethnic and cultural backgrounds.
- To provide competent nursing care, nurses must be alert to, and knowledgeable regarding, factors that may impact on the care of patients. This includes issues related to gender, disability, sexuality, culture and ethnicity.

BUILD YOUR BIBLIOGRAPHY

Books

- Dickinson, T. (2015) *'Curing queers': Mental nurses and their patients, 1935–1974*. Manchester: Manchester University Press. 'This book should be read by everyone with an interest in mental

health care and by all who recognise their democratic responsibility to ensure that those in need are assisted and neither deceived nor abused.' *Peter Nolan, Professor of Mental Health Nursing (Emeritus), Staffordshire University*

- Leininger, M.M. & McFarland, M.R. (2006) *Culture care diversity and universality: A worldwide nursing theory*. Boston, MA: Jones and Bartlett Publishers. This book aims to support nurses who would like to develop their skills in providing culturally competent practice.
- Zeeman, L., Aranda, K. & Grant, A. (2014) *Queering health: Critical challenges to normative health and healthcare*. Monmouth: PCCS Books. For those looking to provide insight into equality and diversity in their nursing practice, then this book does just that in a way that will inspire.

SAGE journal articles

Go to https://study.sagepub.com/essentialmentalhealth for further free online journal articles related to this chapter. If you are using the interactive ebook, simply click on the book icon in the margin to go straight to the resource.

FURTHER READING: JOURNAL ARTICLES

- Bains, J. (2005) Race, culture and psychiatry: a history of transcultural psychiatry. *History of Psychiatry*, *16*(2), 139–154.
- Jimenez, M.A. (1997) Gender and psychiatry: psychiatric conceptions of mental disorders in women, 1960–1994. *Affilia*, *12*(2), 154–175.
- Mildenberger, F. (2007) Kraepelin and the 'urnings': male homosexuality in psychiatric discourse. *History of Psychiatry*, *18*(3), 321–335.

Weblinks

Go to https://study.sagepub.com/essentialmentalhealth for further weblinks related to this chapter. If you are using the interactive ebook, simply click on the book icon in the margin to go straight to the resource.

FURTHER READING: WEBLINKS

- The Royal College of Nursing (RCN) has produced suicide prevention guidance for trans young people. See, e.g., Dockerty, C. & Guerra, L. (2015) Preventing suicide among trans young people: A toolkit for nurses. Available at: www.suicideinfo.Ca/wp-content/uploads/2015/09/Preventing-Suicide-among-Trans-Young-People_oa.pdf
- The RCN has also produced a suicide prevention kit for lesbian, gay and bisexual young people. See, e.g., Guerra, L. (2015) Preventing suicide among lesbian, gay, and bisexual young people: A toolkit for nurses. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/412427/LGB_Suicide_Prevention_Toolkit_FINAL.pdf
- Transcultural C.A.R.E. Associates have produced some online resources regarding transcultural health care practice. Available at: http://transculturalcare.net/

ACE YOUR ASSESSMENT

Revise what you have learned by visiting https://study.sagepub.com/essentialmentalhealth. If you are using the interactive ebook, simply click on the tick icon to go straight to the resource.

ONLINE QUIZZES & ACTIVITY ANSWERS

- Test yourself with multiple-choice and short-answer questions and flashcards.

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