Attempting to mainstream ethnicity in a multi-country EU mental health and social inclusion project: lessons for social work

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Attempting to mainstream ethnicity in a multi-country EU mental health and social inclusion project: lessons for social work

Poskus uveljavljanja načela enakosti etničnih manjšin v večkulturnem evropskem projektu na področju duševnega zdravja in socialne vključenosti: naloga socialnega dela

Shulamit Ramon, Peter Ryan & Mojca Urek

The article will outline the logic, parameters, and methodology of an attempt at mainstreaming ethnicity within EMILIA, an EU 6th FP multi-sites project focused on mental health and social inclusion over two years. Led by two social work researchers within a large multi-disciplinary group consisting of eight sites spread across Southern, Central and Northern Europe, alongside mainstreaming gender, we will look at the findings of the baseline audit, the ensuing action plans and the changes which followed. Examining the process and its outcomes for mainstreaming across the different sites and the services they provide for people experiencing mental health problems highlights the impact of country-specific policies on disclosure of information pertaining to ethnicity as well as country and site policies and practices pertaining to recognising the existence of ethnic inequality and tackling it. Issues underlying formal mainstreaming staff and users’ training will be explored. The role of social work within a multi-disciplinary group will also be looked at, and the lessons for European social work will be outlined.
The lessons pertain in part to the impact of the wide ranging variation in background, scope and focus on the role social work values, knowledge and skills can play in the intersection between mental health, parameters of social inclusion and mainstreaming ethnicity.

Keywords: Social Inclusion; Mainstreaming Ethnicity; Mental Health; Social Work

Introduction

Today’s Europe is a multi-ethnic, multi-cultural and multi-faith global society, with a considerable number of recently arrived immigrants either from within Europe or outside it. This composition and the tensions it creates have important implications for both mental health and for social work (Watters, 2002; Lorenz, 2006; Husband, 2007; Levin, 2007). Existing evidence of discrimination by ethnicity within European mental health systems requires concern and action (Fernando, 2003, pp. 11–45; Veling et al., 2007). Roma people offer an example of an ethnic group with its own values and lifestyle, persecuted for many years in most European countries, often living in poverty and discrimination (Plafker, 2002), accentuated by the introduction of neo-liberalism (Zavirsek, 2007, pp. 11–12). Poor physical and mental health are in evidence among Roma people, as are lower level of use of services and lack of attention to their needs among mainstream service providers (Kolarcik et al., 2009).
Ethnicity and ‘race’ in Europe: concepts and terminology

As Williams, Soydan and Johnson (1998, p. 3) stated, the issue of terminology is one of the key considerations in the development of perspectives on social work with minorities in Europe. Identifying a shared language for use in these debates is difficult given that specific terms may carry a variety of meanings across different contexts. The concepts of ‘race’, culture and ethnicity tend to get mixed up in our discourse and in our thinking, but they have different emphasis. Although race is a scientific myth, it persists as a social entity for historical, social and psychological reasons—in fact for all the reasons that result in racism. Within social work in Britain, the language of ‘race’ has been a powerful locus of political mobilisation for change, defining and operationalising the anti-racist project within social work (Williams, Soydan, & Johnson, 1998).

Considerable variations exist in Western and Eastern Europe in the way ethnicity, ‘culture’ and ‘race’ are used (Fernando, 2009, pp. 17–18). Thus whilst the terms ‘race’, racism, or anti-racism characterise the debates about ethnic minorities in the British context, wider European writing takes a distinctly more critical approach to their use. In countries such as France, Germany, the Netherlands and the Scandinavian countries, the powerful negative connotation of the term ‘race’ has ensured its omission from popular and official discourse. In post-communist Eastern Europe the ideology of equality and sameness came to a brutal end, as ethnic wars divided people and changed multi-ethnic societies into mono-ethnic countries with minorities struggling for their formal and everyday rights.

Racism is seen as the discourse and practice of discriminating against ethnic minorities whatever its basis (Williams et al., 1998, p. 9). Dominelli (2007, p. 25) introduced the term ‘racialising others’, emphasising that ‘white’ people act as if ‘race’ only involves others. Similarly, ‘ethnicity’ is often externalised as relevant only to others, to minorities and rarely or never to members of majority ethnic groups. For this reason, many social workers view ethnicity as pathology per se, a socio-biological attribute which in and of itself contains and causes violence, poverty and illnesses (Zavirsek, 2007, pp. 12–13).

Although we used ethnicity mostly in this article, we are aware that the denial of the explicit use of the salient language of ‘race’ in social work and more generally in public policy making has not served to prevent racism from permeating institutional and professional practice. The tendency to avoid this terminology in favour of ethnicity may serve to mask systematic inequalities associated with differences based on colour, religion or culture in a celebration of the benign pluralism of multiculturalism (Williams et al., 1998, p. 9). Using all terms contextually, we sometimes use both terms while putting the term race in quotation marks when referring to Britain. Referring to the experiences of other European countries we used ethnicity, as this is the term which is predominantly used in their context.

The aim of the article is to outline the logic, parameters and methodology of an attempt at mainstreaming ethnicity within EU multi-sites project EMILIA as well as
to look at the findings of the baseline audit, ensuing action plans and implemented changes.

**Project background**

The project ‘Empowerment of Mental Illness Service Users Through Lifelong Learning Integration and Action’ (EMILIA), uses lifelong learning as a means of achieving improved social inclusion for people with long-term mental health distress in learning organisations. Social inclusion is fostered by enabling mental health service users to access education and employment opportunities. An EU Research Framework 6 Integrated Project of 54 months duration, it began in September 2005, and includes 17 partners from Northern and Southern Europe, Western and Eastern European states. Eight countries are demonstration sites: Bosnia & Herzegovina, Denmark, England, France, Greece, Norway, Poland and Spain. Support partners are located in Denmark, Finland, Greece, Lithuania, Slovenia, Sweden and the UK. Most partners are providing mental health services (hospitals, community based services, non-governmental organisations, a user group), with one university and one research centre. In total, 206 service users have been recruited to take part in the project; Table 1 shows their distribution across sites.

Social exclusion, inclusion and recovery (Repper & Perkins, 2003) and lifelong learning (Gould & Baldwin, 2004) are the key concepts underlying this project. The complex problem of social exclusion is intensified for individuals belonging to multiple excluded groups, and EU data highlight that people experiencing severe and long-term mental distress are among the poorest and most socially excluded of all European citizens, whether judged by the criteria of long-term unemployment, low income, low quality employment, homelessness, poor general health or immigration, low qualification or early school-leaving. According to Sayce (2001, p. 122), this list could be augmented by factors such as lack of status, lack of opportunities to establish one’s own family, small or non-existent social networks, compounded by discrimination, repeated rejection and consequently restriction of hope and expectations. Only a low level of solidarity has been given to people experiencing mental ill health in most EU member states (Prior, 2001), for reasons related to the

<table>
<thead>
<tr>
<th>Site</th>
<th>Participants numbers at baseline, by site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnia:</td>
<td>33</td>
</tr>
<tr>
<td>Denmark:</td>
<td>25</td>
</tr>
<tr>
<td>France:</td>
<td>30</td>
</tr>
<tr>
<td>Greece:</td>
<td>11</td>
</tr>
<tr>
<td>Norway:</td>
<td>13</td>
</tr>
<tr>
<td>Poland:</td>
<td>45</td>
</tr>
<tr>
<td>Spain:</td>
<td>27</td>
</tr>
<tr>
<td>UK:</td>
<td>22</td>
</tr>
</tbody>
</table>
discomfort and fear of the potential harm users of mental health services may do to others and to themselves (Thornicroft, 2006).

The lifelong learning philosophy is driven by the belief that everyone should have equal and open access to high quality learning opportunities (Gould & Baldwin, 2004). The starting point of the EMILIA project is that the lifelong learning process stimulates and supports recovery and social inclusion of people with long-term mental health distress. This involves a fundamental transformation of learning systems with a view to enabling high quality learning opportunities to staff and users in mental health services on an ongoing basis, inclusive of the gradual integration of formal academic learning environments. Through the application of lifelong learning it is hoped that mental health service users will acquire the knowledge and skills necessary to enter the labour market.

Social work and mental health

The core values of social work focus on social care and social justice, and thus by definition oppose discrimination due to differences in ethnicity (Graham, 2007). Most national associations of social workers and national quality assurance organisations responsible for social work education have developed a code for good practice in this area. However, the question of the degree of the implementation of such a code in practice, in education and in research continues to be raised, given the apparent instances in which poor practice has been observed (Williams & Soydan, 2005).

The role of mental health social workers in European societies is usually narrowly defined within the multi-disciplinary teams in which they are working, preventing and disabling them from using their potential contribution to psychosocial interventions to the full (e.g. Ramon, 2006). Often it includes responsibility for psychosocial assessment, risk assessment, assessment and a degree of gatekeeping to financial benefits and housing, and at times therapeutic work with individuals and their families, and/or community project work (Campanini & Frost, 2004). The introduction of the European Convention on Human Rights added a new dimension for mental health social work (Johns, 2004).

More specifically, in most European countries mental health social workers have been at the forefront in supporting desegregation, deinstitutionalisation, community living and social inclusion (Ramon & Williams, 2005; Herrmann & Sapouna, 2006) in addition to upholding the principle of non-discriminatory practice in relation to ethnicity and gender (Ravinder, 2008). Their position on these central issues has preceded that of all other mental health professions, and on occasions has led to them being branded as ‘traitors’ by other mental health professionals who objected to deinstitutionalisation (Ramon, 1992). It is on these occasions that the degree of commitment to inclusionary, non-discriminatory, practice has been tested. While the move to deinstitutionalisation and community living and services is widespread in EU countries, there are considerable variations as to the degree that these policies
have been implemented. Furthermore, this commitment continues to be tested in each European country today too, as the reality of post-institutional living and mental health services continues to contain elements of segregation, ‘mini’ institutionalisation, and expressions of discrimination related to ethnicity and gender. For example, while the UK has been at the forefront of hospital closure and deinstitutionalisation in Europe, testimonies and statistical evidence repeatedly highlight that people from black ethnic minorities are detained under the Mental Health Act more often, while being offered fewer opportunities for psychotherapy of any type, than white people (Rogers & Pilgrim, 2003; Fernando, 2003). Working well with diversity issues continues to be a challenge to all members of the multidisciplinary mental health teams, including social workers, especially because the challenge is implicit rather than explicit in nature (Antebi et al., 2008).

Social workers do not set out to discriminate against clients who are members of ethnic minorities, but the lack of understanding of cultural nuances, coupled with the unintentional application of stereotypes and of lack of acceptance of diversity in everyday living, inevitably lead to misunderstanding, difficulty in establishing trusting relationships, and misinterpretation by both social workers and clients from an ethnic minority. However, the continued adherence to a colour blind approach represents a powerful and tenacious paradigm within social work and medicine (Dominelli, 2006; McKenzie & Bhui, 2007), resonating with the wider ambitions for assimilation of ethnic minorities held by many Western liberal welfare regimes (Williams & Soydan, 2005).

The subtleties called for in mental health work, in which people’s subjective experiences and relationships are so central, and the common (yet largely unsubstantiated) fear of widespread unpredictable behaviour by users of mental health services, compound the complexity of attending to diversity issues in this context. Furthermore, most mental health social workers are aware of the mental health consequences of discrimination, including those due to ethnicity (Brown et al., 2000).

**Ethnicity as a potential reason for discrimination and social exclusion in mental health organisations**

Across Europe ethnic minorities are poorer than the majority populations, impacting on their general health state (Karlsen, 2008, p. 59). Difficulties in access to, and insensitivity within, mental health services have been identified as an important potential source of inequality in the mental health experience of different ethnic groups, likely to influence both the quality and outcomes of care (Fernando, 2003; Carta et al., 2005; McKenzie & Bhui, 2007; Veling et al., 2007). It has been acknowledged that there are major variations in service delivery and treatment outcomes which relate to ethnicity. The UK experience has demonstrated that people from black and minority ethnic communities and newly arrived asylum seekers are more likely to have negative experiences when using mental health services (Thomas &
Bracken, 2006; Watters, 2007). These may be explained by a number of factors, including poverty, social exclusion and racism, lack of power, but also because mainstream mental health services at times fail to understand and/or meet the needs of minority ethnic communities.

In the cultural sensitivity audit conducted by The Sainsbury Centre for Mental Health in 2001, 34% of users of Inner London City and Hackney Community services thought their treatment and diagnosis would have been different if they had been in contact with staff who understood their experiences as a person belonging to a minority ethnic group (Sathyamoorthy et al., 2001). More than half indicated that spiritual and religious issues were important to them. Of these, more than half felt they could not talk to staff about it for fear their beliefs would be perceived as psychiatric symptoms. A number of studies have found that members of ethnic minorities had a higher rate of mental illness, and have under-utilised psychiatric services. Further clarification indicated that this was true for some ethnic minorities, but not for others, and that the dividing line is not always colour or ‘race’. The impact of socio-economic deprivation already highlighted above means that poorer people in ethnic minority communities are more likely to experience mental ill health than those who are not, as do groups whose members feel that their expectations of migrating to the host country have not been met (e.g. Irish people and South Asian women in the UK) (Nazroo, 2003; Ravinder, 2008).

Ethnicity mainstreaming within EMILIA

One of the key objectives of the EMILIA project is to improve the mainstreaming of both ethnicity and gender within the sites, as the lack of such mainstreaming adds to the already existing barriers of social inclusion. This paper focuses only on mainstreaming ethnicity; cultural sensitivity was treated as an element of this process (Sathyamoorthy et al., 2001). We understand mainstreaming equality as concerned with the implementation of equal opportunities principles, policies, strategies and practices into everyday work of mental health and related services. It is a long-term strategy to frame policies in the realities of users’ and staff members’ daily lives, and to change organisational cultures and structures of mental health services accordingly (Urek & Ramon, 2008, p. 179).

The main objectives of mainstreaming within the project are to:

- reduce ethnicity inequality in the demonstration sites;
- encourage sites to be more sensitive to core social inclusion issues, such as ethnicity;
- ensure that each site will collect comparable data as to the prevalence of equality and inequality in terms of ethnicity among its staff and service users;
- enable each site to have a constructive evidence-based action plan focused on improving its ethnicity record, based on reliable information which is applicable in everyday practice, and one which is implemented; and
last but not least, ensure that members of ethnic minorities are getting mental health services which attend to their needs.

In the first phase we went about achieving these objectives by developing audit tools focused on ethnicity issues which require action for staff and service users, as well as staff responses to them. We piloted the staff audit tools in the first year of the project in two sites (one West and one East European site) and then re-formulated the audit tools. Only staff members were audited at the pilot stage, as users in all demonstration sites have been recruited later. The audit enables each respondent to select the issues related to mainstreaming ethnicity, as well as asking them to respond to issues we viewed as central to this aspect.

Background information pertaining to ethnicity was collected from all sites during the first year, followed by an in-depth EU policy review on ethnicity issues which provided all sites with an overview on these issues. In the first half of the second year of the project non-pilot sites conducted the staff audit of ethnicity. This was followed by sites constructing their specific action plans focused on the objectives they wish to improve within the coming two years in terms of increased ethnicity and gender equality. By now all demonstration sites have administered the users’ audit and have revised their ethnicity action plans. Tables 2 and 3 provide some demographic information on both groups. The re-drafting offered each site a natural review point of the value of the actions undertaken following the first draft.

The rationale for opting for this process of mainstreaming was to move beyond factual data in order to find out and understand how staff and users are making sense of ethnicity issues and how they are responding to them. The ethnicity audit tools developed within our project were aimed at helping the demonstration sites to audit these aspects of their practice on the basis of the experiences and viewpoints of the people working and using these services. In the staff ethnicity questionnaire staff members were asked first about the basic characteristics of ethnic minority service users, for example what proportion are they of their caseload; from which ethnic minorities are they coming; or are there any language barriers. These items were followed by questions concerning communication, for example who is translating when necessary; do they have any written information in different languages; and the availability of staff of different cultural and ethnic origins to work with users. Knowledge and views about anti-discrimination principles concerning ethnic and cultural issues followed (e.g. items related to the existence of written anti-discrimination policy and to the ethnic profile of the staff vs. that of the local general population). Another important set of questions concerns the availability of services meeting users’ religious requirements. Instances of discrimination committed either by users or staff members came next. Finally we asked if the staff/user group already had any training concerning different ethnic minority groups and what do they see as their future training needs. In the first part of the users’ ethnicity audit we focused on language and interpreters, for example how much do users understand of what staff say to them if their first language is different from the local dominant language. We inquired also
<table>
<thead>
<tr>
<th>Site</th>
<th>Number of participants</th>
<th>Profession</th>
<th>Work place</th>
<th>Ethnic/cultural background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnia and Herzegovina</td>
<td>7</td>
<td>Three nurses, one social worker, one psychiatrist and two defectologists</td>
<td>Day hospital</td>
<td>All staff members are of Bosnian origin, though some define themselves as Bosnian Catholics</td>
</tr>
<tr>
<td>Denmark</td>
<td>13</td>
<td>Educators, researchers and managers</td>
<td>A centre for health education and research in Storstrom</td>
<td>The staff group is Danish in origin and identity, with some regional variations</td>
</tr>
<tr>
<td>France</td>
<td>13</td>
<td>11 ward nurses and community psychiatric nurses and two orderlies</td>
<td>Bar one, all of them are currently working in inpatient services</td>
<td></td>
</tr>
<tr>
<td>Greece</td>
<td>72</td>
<td>36 nurses, eight unqualified care staff, seven psychologists, eight administrators, four social workers, one occupational therapist, eight other (cooks, cleaning staff)</td>
<td>Staff members working in seven residential psychosocial rehabilitation facilities in different parts of Greece and of one day centre in Athens participated</td>
<td>Almost all staff members stated their nationality was Greek</td>
</tr>
<tr>
<td>Norway</td>
<td>45</td>
<td>Counsellor and nurses</td>
<td>Staff from mental health rehabilitation team which functions as an Assertive Outreach Team and 30% randomly selected staff of the more generic district psychiatric centre</td>
<td>All but one are Norwegians</td>
</tr>
<tr>
<td>Poland</td>
<td>33</td>
<td>12 nurses, eight doctors, eight orderlies (auxiliaries, who have no nursing training), four psychologists, one occupational therapist, and one social worker</td>
<td>Hospital</td>
<td>All respondents see themselves as Polish, all are Christians, and apart from four all are practising Catholics. All but two were born in Poland and the two who were not came from a part of Poland which belonged to Ukraine</td>
</tr>
<tr>
<td>Site</td>
<td>Number of participants</td>
<td>Profession</td>
<td>Work place</td>
<td>Ethnic/cultural background</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------</td>
<td>------------</td>
<td>------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Spain</td>
<td>29</td>
<td>The majority were nurses or clinical auxiliary</td>
<td>All of them work in a psychiatric hospital; two work also in an outpatient clinic. A quarter of their patients are from a variety of ethnic minorities</td>
<td>The majority define themselves as Catalan, and the minority as Spanish. Their usual languages are Catalan and Spanish</td>
</tr>
<tr>
<td>UK</td>
<td>9</td>
<td>All are university lecturers, six come from social work, two from nursing, and one is described as a researcher</td>
<td>Mental Health and Social Work Academic Group in Middlesex University</td>
<td>All white bar one who is of ‘mixed race’ (likely to be perceived as black by others), but with cultural variations (e.g. White Irish), likely to be perceived by others</td>
</tr>
<tr>
<td>Total:</td>
<td>221</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 (Continued)
## Table 3 User sample

<table>
<thead>
<tr>
<th>Site</th>
<th>Number of participants</th>
<th>Have used mental health services</th>
<th>Ethnic/ cultural background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bosnia and Herzegovina</td>
<td>7</td>
<td>At least three years</td>
<td>All define themselves as Bosnians, some as Bosnian Muslims and some as Bosnian Catholics</td>
</tr>
<tr>
<td>Denmark</td>
<td>7</td>
<td>There was diversity of experience with the mental health system, though all participants had had some contact with the system and most still did</td>
<td>Danish ethnic origin</td>
</tr>
<tr>
<td>France</td>
<td>5</td>
<td>Two of them had been users of psychiatric services for over 10 years. The three others had been using mental health services for between three and eight years</td>
<td>Four users defined themselves as Parisian and two described themselves as Tunisian. Two of them said they had a religion: Muslim and Jewish. French is the only language quoted for all five</td>
</tr>
<tr>
<td>Greece</td>
<td>4</td>
<td>Three users less than three years and one uses services for between three and five years</td>
<td>All four living in Athens. One was born in Kalamata and one in Crete</td>
</tr>
<tr>
<td>Norway</td>
<td>4</td>
<td>No data</td>
<td>Norwegians</td>
</tr>
<tr>
<td>Poland</td>
<td>31</td>
<td>For more than five years</td>
<td>They invariably see themselves as Polish, and/or from Warsaw</td>
</tr>
<tr>
<td>Spain</td>
<td>12</td>
<td>For more than three years</td>
<td>55% of the users defined themselves as Catalan, 12% as Spanish and 11% as immigrant origin; 11% described themselves as a world citizen and the other 11% defined themselves as European</td>
</tr>
<tr>
<td>UK</td>
<td>6</td>
<td>Length of being a student in the university: all six under one year</td>
<td>All of the respondents were white and British born, in an area of London</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>76</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
about how interpreters were experienced, for example how they felt about having to communicate with the staff in this way and if they preferred to speak with staff members who understood their language, rather than use an interpreter. The availability of a mental health worker who is from the same ethnic and cultural minority background as the users was explored next, and the availability of services provided specifically for ethnic minority users [e.g. the provision of personal care products (hair and skin care) or services (barber, hairdresser)] which specifically meet the needs of an ethnic minority group, special dietary requirements users may have due to religious preferences, and access to different ministers of religion were also looked at. In the last part of the questionnaire we focused on instances of discrimination experienced by staff or users within the mental health service due to ethnic minority status.

The ethnicity aspect of the action plans

The audit findings indicated the baseline of successes and gaps in reducing ethnicity inequality and in enhancing equality and mainstreaming. The action plan included a process of consultation and reaching consensus decisions about targets to be applied over the next 18 months towards improving mainstreaming ethnicity in each site. To be able to complete the task, sites were advised to prepare a strategy leading to the formation of the action plan which included the planning and consultation process by which the action plan will be decided. The rationale for this process was to enable a wide ranging discussion, participation and representation of all relevant groups. Sites were asked to opt for wide ranging consultation with staff, users and representatives of relevant local organisations. The second draft of the action plan was drawn up when the responses to the users’ audit tools had been collected.

Main findings

The findings presented here are taken from the reports provided by local researchers. The overall interpretation has been added by the central researchers of EMILIA, and made available to the local researchers as an integral part of the project. In keeping to the value of confidentiality, we are unable to name sites when identifying uncomfortable issues.

Difficulties encountered in carrying out ethnicity audits

Several difficulties were encountered, depending mainly on the historical background of the country. In two sites it is illegal to ask people about their ethnic affiliation, on the grounds that this militates against treating everyone equally under the law. In four of the sites only some ethnic minorities are defined as such, while others are not. For example, in Bosnia, Bosniaks (the Moslem majority), Serbs (with whom the first group had a violent political conflict in the 1990s) and Croats are not defined as ethnic groups, while Gypsies and Albanians are defined as such.
In Poland people have learned to state that they are only Polish, even if they come from a minority group, as belonging to an ethnic, national or religious minority carries with it negative connotations. That also meant that staff and users were not sensitive to ethnic diversity, and hence claimed not to know anyone from a minority background who is using mental health services. In yet other sites, staff and users claimed not to have ethnic minorities in their town, though staff members told us of the existence of specialised services for refugees from other continents, available nearby, and in one case even of a homicide committed by a user of a mental health service who is a refugee from an ethnic minority.

In all sites, a typical response by users who do not see themselves as belonging to an ethnic minority, although living in areas where the presence of ethnic minorities is visible and where they amount to a sizable component of the population, has been to state that this is irrelevant to them, thus implying that ethnicity does not exist as an issue. It is only when a user has difficulties communicating in the local main language spoken that s/he counts as a member of an ethnic minority, an immigrant or a refugee. Thus it is the high visibility of not speaking the language which leads to the identification of ethnic diversity. This finding implies that ethnic diversity does not receive recognition as an aspect which calls for further focus and investigation for the members of ethnic minorities who use mental health services yet speak the majority’s language. The underlying reasons for these difficulties will be looked at in the discussion section.

**Relevance of ethnicity audit to staff and users and identified needs for further action**

Unlike findings related to gender, the majority of staff and users who responded to our ethnicity audit in seven of the eight sites perceived the audit to be irrelevant to them. Thus in most cases even if they met people from an ethnic minority in their encounters within mental health services, this would not have registered as relevant. Consequently the majority of the respondents did not identify needs arising which require further action, such as staff and user training, working on increasing public awareness, reducing discrimination, attending to special needs related to religious food regulations, and the availability of non-Christian religious services. In fact, only the majority Christian church service (e.g. either Catholic or Protestant, but not both) of a country is likely to be available in most sites.

Yet both staff and users in all but one site were satisfied that the issues of discrimination due to minority ethnicity membership were focused upon in the EMILIA project and have agreed it is important to try to improve the current situation, while remaining unclear what it is possible to do, and how. Nevertheless, most sites did identify generic needs for more knowledge of the culture of ethnic minorities, more staff from ethnic minorities, the availability of interpreters, and of written information in the languages spoken by local ethnic minority groups. The recognition of these needs for improvement of existing services seems to relate to a general notion of wishing to achieve equity of access and use for all service users.
The request for more knowledge about cultural differences without specification came across almost like a tourist’s wish for information about far away countries. The failure to identify further specific action pertains also to sites with a recognised presence of sizable ethnically and culturally different groups. These groups usually live in considerably socio-economically deprived areas, with older people who do not speak the language of the majority, and younger people who are involved in periodical riots against discrimination in the job market.

Typical targets of sites’ action plans include improving anti-discrimination and equity policy, communication with service users, making links with local services and community groups and introducing training on ethnicity. Thus half of the sites decided to raise staff awareness about existing policies, improving available information about the rights and obligations concerning equity issues in accessing services. Two sites focused on improving translation services, translating information leaflets about their services into several languages, identifying relevant local services, research groups, human rights groups, and conducting outreach work to network with them. One site has already made use of innovative services in relation to ethnicity (e.g. the cultural mediation service in Barcelona).

The more positive and specific actions included:

1. In one site where two languages are spoken daily on the street, and the minority language in the country is spoken by the majority of the population in the city and region and has the status of a recognised culture, there was a wish to have information and education delivered in the languages spoken by the recently arrived minority ethnic groups. Furthermore, organisations working with ethnic minorities were invited to participate in the network that the mental health services were creating to enhance EMILIA’s work.

2. When encouraged in one site to think about instances in which service users met people from another ethnic minority even when they themselves belong to the majority, they were able to identify one such instance, and to demonstrate considerable concern and empathy with the plight of the person unable to communicate with staff and other patients, including the observation that that person was unable to identify whether the meat served was/was not of the type they could eat or not for religious reasons.

3. The arrival of a new group of refugees to a small town and the referral of a few of them to mental health services has led to establishing the case for a training course for staff to enable them to work with this newly emergent population. The site staff and users have not identified any such need prior to this development, even though there have been refugees living in the area; this was explained by the existence of a refugees generic centre, unqualified to provide mental health support.

4. As part of a generic training to staff members on discrimination, a day was set aside for training on ethnicity at a site based in an EU member state where it is illegal to ask people about their ethnic background.
However, the process of implementing decisions made in the action plan seems to be delayed in most sites, even when dates and specific programmes were agreed, for reasons looked at in the discussion section.

**Discussion**

A number of difficulties were encountered in implementing both the audit tool and the action plans, as outlined above. These indicate that the concept of an ethnic minority is reserved for groups held in low, if not negative, esteem by the majority. The connotations between minority ethnicity and recent migration perhaps accentuates the negativity, even though all of the countries involved have a long history of having ethnic minorities in their midst, which have often made a notable contribution to society. In the case of mental illness the fear of unpredictability and risk is much more likely to apply to people from an ethnic minority who are experienced as strangers.

Furthermore, the assumption is that if the respondent is not from an ethnic minority then the issue is of no relevance to them, implying that social equity, as well as sensitive understanding and solidarity with members of ethnic minorities, do not matter. With only 6% of the 206 service users in EMILIA identified as being from ethnic minorities (mainly in France, England and Spain), and even a smaller percentage among the staff group within the demonstration sites, perhaps we could have predicted the difficulties outlined above.

However, these findings may also relate to more fundamental issues within psychiatry. One user, referring to the psychiatric system in the country s/he lives, has been quoted as saying: ‘The survival of psychiatry is based on secularity so there will inevitably be some exclusion of cultural differences. People get on well with people with whom they have common cultural and moral values’. If s/he is right, then the issue is not secularity *per se*, but the lack of positive space within the shared values of European psychiatry for sensitivity pertaining to ethnic, cultural and religious differences. It is as though the assumed universality of psychiatry is in conflict with paying sufficient attention to diversity issues both theoretically and in everyday practice. Colour blindness is perceived as signifying equality.

However, the evidence demonstrates otherwise. The Rocky Bennett Enquiry in England (Blofeld, 2003, p. 11) found that ‘Africans and Afro-Caribbeans were over-represented in the mental health services, received a more coercive spectrum of care, were more likely to be regarded as dangerous, and were more likely to be overmedicated’. This finding demonstrates well the connections between risk perception, generalised stigma and discrimination due to minority ethnic status. The report concluded that mental health services *per se* were inherently institutionally racist, described in the report as a ‘disgrace’ and a ‘festering abscess which is at present a blot upon the good name of the NHS’ (Blofeld, 2003, p. 33).

This does not necessarily mean that everybody working in a given institution is racist but rather that processes, structures and values can operate at the institutional
level to disadvantage black and other ethnic minority service users and staff. In the UK, for example, the evidence suggests that ethnic minority staff, who form nearly one third of the workforce of the English NHS, are disadvantaged too when they apply for jobs at both junior and senior levels, and are more likely to be suspended if concerns are raised about their performance (Esmail & Everington, 1993). They are paid less, are disadvantaged in the allocation of discretionary payments, are more likely to face bullying and harassment from both patients and staff, and are overwhelmingly over-represented in the more junior ranks of staff in the NHS (Lemos & Crane, 2001; Esmail et al., 2003).

Training on anti-discriminatory practice and in cultural competence is often offered within social work and mental health systems, but as Bennett and Keating (2008) assert, such training should focus specifically on areas of inequality in mental health services within a specific context, on strategies to improve professional practice rather than be generically focused on culture and ‘race’ of ‘the other’ (p. 58). Cultural competence training has been criticised for being ineffective in reducing inequality and leading to further stereotyping, but it is an effective awareness tool (p. 54).

However, lack of training per se does not seem to be the reason why the problem continues. The UK police, for example, held over 130,000 days of anti-racism training over a four year period, but that did not prevent racist misconduct (Woodcock & Barrett, 2005). For the caring professions the problem is one of acceptance and recognition of this type of discrimination at a structural system-wide level. It is perfectly possible to have many individuals who are not racist embedded within an organisational system which patently is. Examples of good practice (e.g. Antebi et al., 2008) exist, and need to be well understood in terms of what enables these instances to succeed.

Conclusions

We have attempted to mainstream ethnicity within the EMILIA project by enabling sites to collect relevant local evidence for the purpose of constructing their own action plans aimed at enhancing equality instead of discrimination, as against background information of EU activities in this field. Two thirds of the way through the life of the project, we are working towards establishing greater sensitivity and equality for members of ethnic minority groups through the implementation of these action plans.

While positive—and at times innovative—action has been taken by different sites, ethnicity has not been perceived as a major issue for either the staff or the users of the project. This is explained by the insignificance attached to having ethnic minority clients and staff members within mental health services, and the negative connotations attached to minority ethnicity and immigration.

Most mental health service providers, especially social workers, are aware of the existence of discrimination and its social reasons, but feel that they have neither caused it nor can they do anything significant about it. This is half a truth, but one
which is cherished because it keeps at bay responsibility, guilt and/or shame, the sense of helplessness and hopelessness. This type of disempowerment has also been found among other health professionals (Kai et al., 2007). Being socialised as ordinary members of our diverse European societies to have prejudices and stereotypes about ethnic minority groups inevitably affects the way we work with clients coming from these groups. Training to become a mental health professional, and in particular a social worker, includes an element of understanding discrimination and oppression in the context of ethnicity, as well as what social inclusion and equality are about. However, if we want people with lived mental ill health experience to give up living in the chronicity mode to which they have been assigned for many years and to move to education and employment, we need to begin by demonstrating hope and respect in our contacts with them, including taking on board the user’s painful experiences of ethnic and gender discrimination. Yet genuine empathy with the pain of the users is painful for the staff to take in, as we live in societies which do not want to focus on pain in everyday life, and often engage instead in ways of masking it. Furthermore, as professionals we are keen not to admit to mistakes or appear to be ‘too emotional’.

Hence, one of the challenges for the EMILIA project, for mental health social work and for other mental health professions, is to facilitate training which would enable staff to listen, live with the pain which habitually accompanies discrimination instead of running away from it, and to find positive means of addressing it by treating people as equals and by giving them opportunities for growth and equality. Williams (1998) proposes that emancipatory pedagogy is called for in the context of social work education for a multi-cultural Europe. This would also apply to a recovery-oriented mental health practice, such as the one fostered by EMILIA, and in which taking control by the service user over their reality is a core component. At the same time we need to remember that training and attitudinal change cannot come instead of the structural changes necessary to eradicate the connection between poverty, discrimination by ethnicity and health (McLeod & Bywaters, 2000).

Service providers who combine compassion, good therapeutic skills, wish for social change and social justice, with the ability to act as a change agent, are much in need. In terms of values and knowledge, social workers are at a more advanced position than other mental health professionals in relation to tackling discrimination due to ethnicity and social exclusion. To make use of this potential they need to be ready to lead the struggle for mainstreaming ethnicity and gender and for recovery from mental illness, and not to be taken aback by their own minority position within current European mental health systems or the narrow definitions of their role within it.

References


