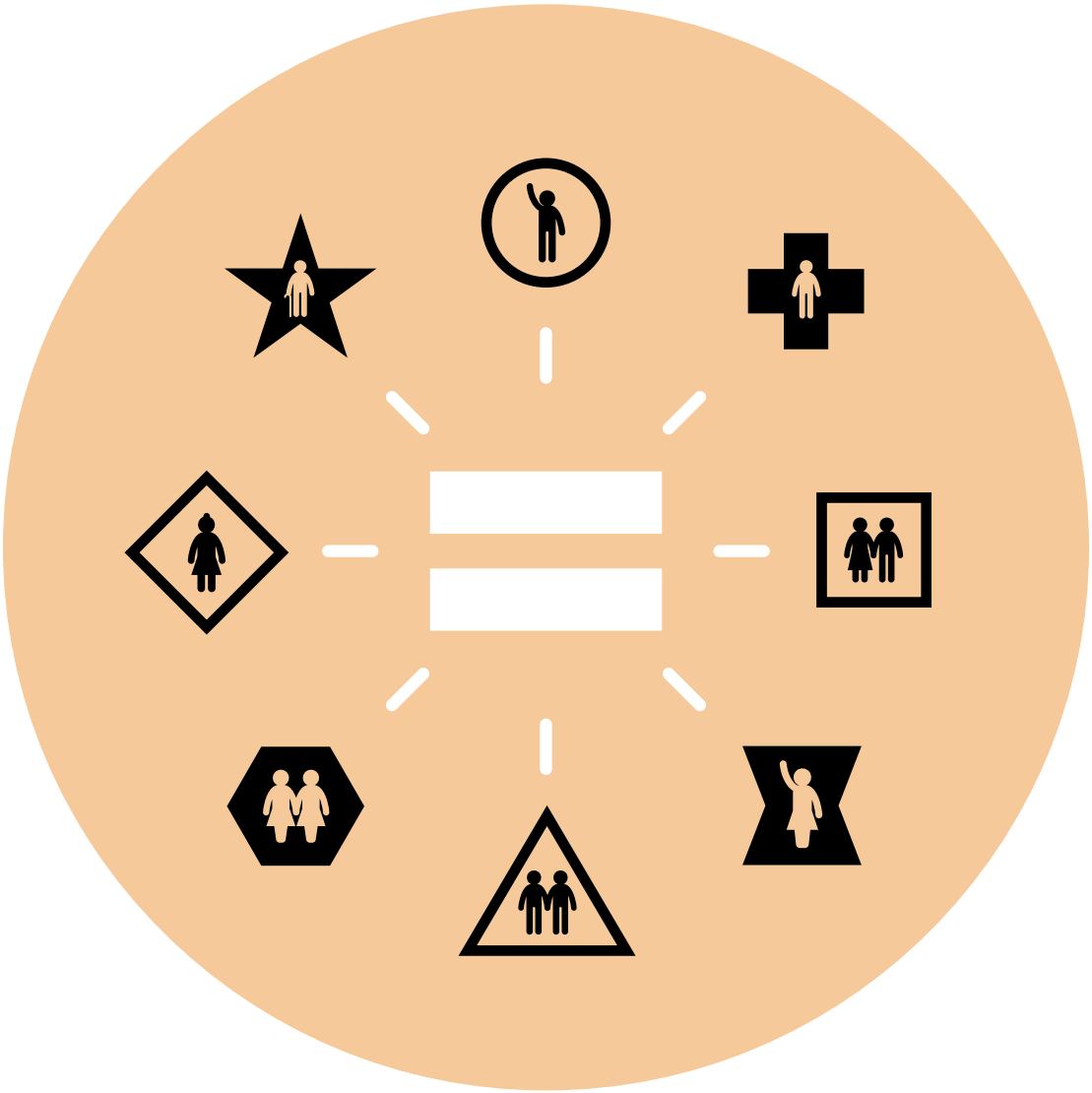
Equality and diversity:

Findings from the Mental Health Fellowships



Mental Health Foundation

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The Winston Churchill Memorial Trust runs the Churchill Fellowships, which support UK citizens to travel the world in search of innovative solutions for today's most pressing problems. Any UK adult citizen can apply, regardless of qualifications, age or background. They are chosen not for their past achievements, but for the power of their ideas and their potential to be change-makers. Applications can be made annually from May-September at www.wcmt.org.uk.

The vision of the Mental Health Foundation is good mental health for all. We work to prevent mental health problems, to drive change towards a mentally healthy society for all, and to support communities, families and individuals to live mentally healthier lives, with a particular focus on those at greatest risk. The Foundation is the home of Mental Health Awareness Week.

To find the full body of research produced by all 59 Churchill Fellows, or to listen to the corresponding podcasts for **Equality and diversity**, please visit the Mental Health Foundation and Winston Churchill Memorial Trust websites.

To get in touch with a Fellow included in this briefing, or for more details on any of the case studies featured, please contact the Winston Churchill Memorial Trust at office@wcmt.org.uk

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Introduction

From 2016 to 2019 the Winston Churchill Memorial Trust ran the Mental Health Fellowships programme, funding individuals to travel abroad to learn more about how community-based solutions are being created in response to some of today's most pressing mental health challenges.

The Mental Health Foundation was the expert partner in this programme, helping to shape its aims, select the successful candidates from hundreds of applicants and provide mentoring to the successful Churchill Fellows. In total, 59 Fellows were chosen to investigate best practice in 17 countries and bring back new evidence and ideas to create positive change in their profession, practice and communities in the UK.

This is one of four briefings that distil the key findings from this rich body of learning, and make recommendations for policy and practice in the UK. Each briefing focuses on an aspect of the Mental Health Fellowships' overarching theme **'community-based solutions'**, and an overview of the learning from this Fellowship can be found in the programme's summative briefing.

Scope

This briefing on Equality and Diversity brings together learning from five Fellows' research in Australia, Canada and the USA, demonstrating how approaches in other countries are being used to help reduce mental health inequalities and protect the rights of vulnerable groups.

Section 1: Reducing mental health inequalities for minority groups focuses on some of the mental health problems experienced by minority groups, provides a number of case studies and findings from three Fellows' research, and details good practice examples of culturally competent support.

Section 2: Protecting the human rights of vulnerable groups introduces the relationship between human rights law and mental health, provides a number of case studies and findings from two Fellows' research, and details good practice examples of human rights legislation being used to protect the mental health of vulnerable groups.

Fellows' recommendations

Reducing mental health inequalities for minority groups

The UK Government and governments in the devolved nations of the UK should:

- Support the development and implementation of standardised LGBT+* training for health and social care providers, adopting a similar approach to the Australian Government and the National LGBTI Alliance through their Silver Rainbow training.

Public sector providers and commissioners should:

- Be proactive in meeting their duties under the Equality Act 2010. This should include regularly monitoring data on the needs of local minority groups and developing tailored health care plans in partnership with communities.
- Understand that LGBT+ people and other minority groups are disproportionately affected by mental health problems, and adopt the use of the Minority Stress model to inform their practice.
- Provide programmes that are culturally competent and incorporate an appropriate level of awareness and understanding of the issues affecting minority groups.

Protecting the human rights of vulnerable groups

The Department of Justice (Northern Ireland) and its equivalent in other UK nations should:

- Continue to implement problem-solving courts in the UK and extend the department's problem-solving portfolio to include a mental health problem-solving court.

The UK Government and governments in the devolved nations should:

- Ensure that the design and implementation of supported decision-making policies involve people with decision-making difficulties and their supporters.
- Pilot collaborative education and support programmes for non-professional guardians and attorneys on how to implement the principles within mental health capacity law.

** The abbreviation 'LGBT+' refers to the lesbian, gay, bi and transgender community as a whole. LGBTI is the preferred abbreviation in Australia, with 'I' standing for 'intersex'.*

Why equality and diversity?

Mental health is something that we all have, and mental health problems are something we can all experience, whatever our background and walk of life. The risks of developing mental ill-health, however, are not equally distributed, with some groups of people being more likely to develop mental health problems than others.

People living in financial hardship, for example, are at increased risk of developing mental health problems and lower mental wellbeing.[1] Similarly, people from minority groups who are exposed to discrimination and social exclusion based on race, gender and sexual orientation are also at greater risk. There is consistent evidence of a higher incidence of psychosis among immigrants, particularly among ethnic minority populations,[2] and across England, Scotland and Wales, 52% of LGBT+ people have experienced depression in the last year.[3] This is far higher than the national average, with 19.7% of people in the UK aged 16 and over experiencing symptoms of anxiety and depression.[4]

Everyone should have an equal opportunity to live well and experience good mental health; it is unjust that some people in society should be at greater risk of developing mental health problems than others. In recent years, much has been done to combat this problem. The combined efforts of researchers, policy makers and the general public (to name a few), along with the introduction and adaptation of equality and human rights-based legislation, have led to major advances in creating a more tolerant, accepting and equal society that protects and supports the rights of all citizens and their mental health.

There remains however, a long way to go, and the Fellows' research is a welcome and timely contribution, as we continue to look for new ways to help reduce mental health inequalities and create a fully inclusive, more mentally healthy society. As the radical revolution of mental health services progresses - with a community-based care model largely replacing the acute and long-term care provided in in-patient settings - the Fellows offer innovative ideas for how we as individuals, families and communities can work together to support each other in respectful, inclusive and culturally appropriate ways, valuing our rights and enabling us all to feel appreciated for who we are, in all our diversity.

Section 1: Reducing mental health inequalities for minority groups

Context

What do we mean by 'minority groups'?

The United Nations Minorities Declaration (Article 1) refers to minority groups as groups of people who are culturally, racially, religiously or linguistically distinct in some way to the majority of people living within a country or society.[5] This includes distinctions related to their ethnicity, sexual orientation and/or population group.

According to the UK's most recent Census (2011),[6] the main ethnic group represented in England and Wales was White British (80%). Other ethnic groups, such as Asian British (6.8%) and Black/African/African-Caribbean (3.4%), are often described as black and minority ethnic (BAME) communities.

Similarly, people in the UK identifying as LGBT+ are a minority group. An estimated 1.1 million people aged 16 years and over identify as LGB. This is out of a UK population of approximately 53 million people aged 16 years and over.[7]

What challenges do minority groups face?

Minority groups often experience exposure to discrimination and social exclusion based on their race, gender, sexual orientation and other protected characteristics. A study by Nuffield College at the University of Oxford, for example, found that black and south Asian ethnic minorities face 'shocking' discrimination in the employment market, at levels unchanged since the 1960s.[8]

This is despite movements in the UK towards greater equality and the prohibition of discrimination, harassment and victimisation of individuals who have one or more of the 'protected characteristics' defined by the Equality Act (2010), including age, race, sexual orientation and disability. Under the Act, it is the legal duty of organisations to make reasonable adjustments for people who fit into one of these categories.

How does this impact on the mental health of minority groups?

The emotional and psychological effects of racism have been described as consistent with traumatic stress[9] and its negative effects are cumulative.[10]

Racism and a lack of cultural awareness may also contribute to the discrimination experienced by people from BAME communities in mental health services,[11] with evidence showing a persistent greater use of compulsory detention and coercion involving the police and criminal justice system among BAME communities,

particularly people from Black, African and Caribbean communities.[12] [13]

Minority groups are also at risk of developing mental health problems linked to their greater vulnerability to experiences such as bullying, hate crime, domestic violence and abuse, or other types of trauma. Experiences of bullying and violence, for example, place LGBT+ people at substantial risk of poor mental health outcomes, especially through their link to suicide attempts and substance use.[14]

Good practice from abroad

Three Churchill Fellows visited a number of international programmes providing good practice examples of approaches for reducing mental health inequalities in minority groups through inclusive and culturally competent support. The Fellows were:

Dr Erica Mapule McInnis

Report title: How Can We Inspire More 'African-Centred Healing' in the UK?

In 2016, Erica, a chartered clinical psychologist, travelled to the USA to investigate African-centered psychological services for wellbeing.

Jacqui Jobson

Report title: LGBTQ Mental Health: Exploring Advocacy Approaches to Health Inequalities

In 2017, Jacqui, former Director of Advocacy at Connected Voice and now freelance consultant, travelled to Australia and Canada to explore advocacy approaches addressing mental health among LGBT+ communities.

Allison O'Kelly

Report title: Improving Dementia Services for People who are LGBT+

In 2018, Allison, a mental health nurse, travelled to Australia to investigate support for LGBT+ people with dementia.

Key findings

Understanding mental health inequalities: minority stress

The term minority stress (MS) from Meyer's minority stress model,[15] describes the high levels of stress experienced by minority groups, such as LGBT+, as a result of living in Western societies that can often, despite progress being made, still have homophobic, biphobic and transphobic attitudes and behaviours.

The model recognises that mental health inequalities for minority groups are partly a consequence of the ongoing stress caused by accumulated stigma, prejudice and discrimination to which minority and marginalised people are often exposed. It acknowledges that persistent and ongoing stress can lead to individuals experiencing trauma and developing a range of mental health problems.

In relation to the LGBT+ community, the minority stress model holds that there are three instances of particular stress:

1. External and objective stressful events and conditions, such as bullying or discrimination in the workplace.

2. Expectations of such events and the vigilance this expectation requires.

3. Internalisation of negative social attitudes.

What is happening abroad

Jacqui visited a number of community mental health initiatives based in Australia and Canada that are using an awareness and understanding of the MS model as a foundation upon which to develop trauma-informed programmes for the LGBT+ community. Trauma-informed care is focused on creating conditions within services and/or organisations that reduce harm and promote healing, especially for individuals who have already experienced trauma.[16] More detail on this emerging approach can be found in our Trauma and Adversity briefing.

At The 519 - Space for Change project in Canada, Jacqui was introduced to the MS model and gained insights into how it is being used to support the development of trauma-informed approaches that recognise the impact of minority stress, and the lasting effects of trauma on LGBT+ communities. The 519 aims to create a trauma-informed environment that helps avoid re-traumatisation and supports recovery - something they have found to be particularly helpful for LGBT+ refugees.

Similarly, Sherbourne Health, a multidisciplinary health provider in Canada, include MS and trauma-informed approaches in their counselling

programmes and ensure that staff and volunteers have an awareness of the model and an understanding of the impact of trauma on the LGBT+ community.

Potential for the UK

Trauma-informed care is an emerging field that has not yet been widely adopted by public services and organisations in the UK and, to date, it is most commonly found in drug, alcohol and homelessness services. This is perhaps unsurprising if we consider the close links that often exist between people experiencing homelessness, and traumatic life experience.[17]

Less consideration has been given to trauma-informed care in the context of LGBT+ communities, and the need for public services and organisations to adapt their approaches to ensure that their practice is informed by an awareness of the accumulated prejudice and discrimination often experienced by this group of people.

With this in mind, there is scope for the MS model to play a more central role in informing practice with the LBGT+ community in the UK, giving careful consideration to how organisations can be effectively supported to ensure this emerging theory is adopted in a systematic way and informs the basis of practice with minority groups.

The importance of cultural competence

A key finding from all three Fellows' research is the need for community mental health support to be culturally competent. Cultural competence, as defined by the Health Policy Institute at Georgetown University, is the "ability of providers and organisations to effectively deliver healthcare services that meet the social, cultural, and linguistic needs of patients."[18] In essence it means creating healthcare systems that are appropriately sensitive, responsive and tailored to meet the varying needs of different cultural and ethnicity groups within a society.

The term cultural competence did not appear consistently in healthcare literature until the 1990s[19] and came about in response to the increasing ethnic diversity of global nations, and the need for healthcare providers, healthcare systems and policy-makers to deliver culturally-competent support.

Despite this, people in the UK often receive care that neither respects nor takes account of their culture, and there is often confusion between providers about what cultural competence means in practice.[20] This can often lead to people disengaging with available support and experiencing poorer mental health outcomes as a result.[21]

The Fellows identified a number of international approaches providing good practice examples of cultural competence through appropriate training for healthcare professionals and targeted community programmes for specific minority groups.

Ensuring staff receive appropriate training

One of the key recommendations of the Mental Health Taskforce report, The Five Year Forward View for Mental Health (2016), was to strengthen the

knowledge, understanding and capacity of the mental health workforce, to ensure that all individuals are treated with respect, irrespective of their cultural or ethnic background.[22]

Currently, UK-based health professionals are not always trained in cultural competence, which can - often inadvertently - lead to culturally inappropriate, offensive or discriminatory practice. This can result in individuals choosing to avoid engaging with support at all. One study found that 14% of LGBT+ people in England, Scotland and Wales avoid seeking healthcare for fear of discrimination from staff.[23]

Both Jacqui Jobson and Allison O'Kelly travelled to Australia to investigate international approaches to training healthcare professionals in working effectively with the LGBT+ community, with a particular focus on people in later life who are living with dementia.

Silver Rainbow LGBTI training

In 2012, the Australian government funded and helped to develop Silver Rainbow LGBTI training in consultation with respected LGBT+ community groups. It is the gold standard for LGBT+ training in Australia and has been rolled out in each state to a wide range of organisations providing care to different age groups.

Once accredited in the training, providers are certified with a Rainbow Tick. Rainbow Tick accreditation means that organisations have successfully demonstrated their commitment to LGBT+ inclusive practice and service delivery, including their:

- Organisational capability.
- Workforce development.
- Consumer participation.
- Being a welcoming and accessible organisation.
- Disclosure and documentation.
- Culturally safe and acceptable services.

CASE STUDY

Enabling Confidence at Home, North Adelaide, Australia

Since its creation in 1964, Enabling Confidence at Home (ECH) has established itself as a respected provider of ageing-care programmes in South Australia. Today, they are one of the largest not-for-profit providers of integrated retirement-living accommodation enabling people to continue to live independently at home as they age.

ECH was the first South Australian ageing care provider to receive Rainbow Tick accreditation, which recognised the organisation's commitment to celebrating diversity and its ability to provide a wide range of initiatives for the LGBT+ community. The LGBTI Connect programme, for example, was co-created with members of the lesbian, gay, bisexual and transgender communities and provides culturally safe access, navigation, advocacy and connection to ageing-care services for and from LGBT+ community members in South Australia.

In addition, EHC's LGBT+ diversity statement is included in all job adverts and their commitment to diversity and inclusivity is covered in all staff inductions. A staff survey also found that approximately 15% of EHC employees identify as LGBT+.

Potential for the UK

The Women and Equalities Committee (2019) found that the UK's health professionals are often untrained in LGBT+ inclusive practice and, for those who are, the training can often be "extremely prescriptive and light touch."[24] The same inquiry found that every witness providing evidence emphasised the need for frontline staff to better understand the lives and needs of LGBT+ people under their care.[25]

In funding the development and delivery of the Silver Rainbow training, the Australian government delivered a strong message and enabled organisations such as Enabling Confidence at Home to deliver a range of appropriate programmes for people identifying as LGBT+. In the UK, there is clearly a need for healthcare professionals to receive more appropriate training in relation to the LGBT+ community, and an opportunity for the UK government and its devolved equivalents to lead in supporting its development and delivery.

Community programmes for ethnic minorities

A number of Fellows visited international programmes targeted at reducing mental health inequalities for minority ethnic groups.

Dr Erica Mapule McInnis, for example, visited a number of community services providing evidence based African-centred psychological interventions and healings. African-centred psychology is a modality of healing that can benefit a range of communities and focuses on those of African origin, recognising their lived experience and considering their unique history of multi-generational trauma from nearly 400 years of enslavement, slave trading and colonisation.

Erica visited African-centred services (including psychotherapy programmes) in suburbs of Washington, DC, with high populations of socially and economically disadvantaged Black-African Americans. In Washington the demand for high quality African-centred support meant that several programmes existed in close proximity, each meeting a different aspect of the community's diverse needs.

CASE STUDY

Ascensions Psychological & Community Services Inc, Washington, DC, USA

Ascensions work with their local community (which is predominantly African-American) to support their mental health, using a range of therapeutic programmes and social initiatives.

The psychological interventions are provided by a team of therapists and clinical psychologists and, following an initial assessment, provide individuals with tailored support that aims to help them to improve their self-concept and interpersonal relationships, and enables them to make positive contributions to their communities. Individual and group interventions combine psychological theories and research with Black-African culture, history, and spirituality, in order to provide each client with an individualised plan.

Ascensions is located in a homely house in Washington. To help reduce stigma and enable people to feel at home, both the waiting and therapy rooms are decorated with African symbols and paintings, and African stones with traditional African symbols are used during therapeutic sessions.

Applying the learning in the UK

Dr Erica Mapule McInnis

Since returning to the UK, Erica has published several papers in academic journals and collaborated with a number of universities in order to incorporate the findings from her Fellowship into doctorate-level clinical psychology training courses. These include the University of Oxford (2018), the University of Hertfordshire (2018) and the University College London (2019).

Inspired by her Fellowship, Erica founded an organisation, Nubia Wellness and Healing, and has developed and implemented a number of African-centred approaches aimed at supporting the wellbeing of both adults and young people. These include emotional emancipation circles for healing and resilience-building, training courses in African-centred counselling and psychotherapy, and workshops to support practitioners in implementing African-centred psychology.

Erica gained post Fellowship funding to develop "Know Thy Self Adinkra Cards" (see image below). This a deck of 50 cards featuring Adinkra symbols which originate from West Africa and convey traditional African wisdom that is important to the lives of people with African heritage. Adinkra symbols represent concepts, sayings and wisdom originally used in fabrics and pottery by the Ashanti and Akan people in the old kingdoms in West Africa, particularly Ghana.

Erica first became aware of Adinkra symbols from the Association of Black Psychologists (ABPsi), a USA-based international organisation she visited on her Fellowship. She uses Adinkra cards in therapy work with clients and found them helpful in drawing out important values that can be missed in traditional Western methods. An interview in which Erica provides further information about the Adinkra cards is available on BBC Sounds and our Equality and Diversity podcast.

Section 2: Protecting the human rights of vulnerable groups

Context

What are human rights?

Human rights are the basic rights and freedoms that belong to everyone. In the UK, they are legally enforceable under The Human Rights Act (1998) which incorporates into domestic law the rights enshrined in the European Convention on Human Rights (1953). Under the law, all public authorities are legally obliged to respect an individual's rights and do whatever is in their power to protect them.

Some human rights covered by The Human Rights Act include:

- The right to life.
- The right to a fair trial.
- Freedom of expression.
- Freedom of thought, belief and religion.
- Freedom from slavery and forced labour.

How do they help protect people with mental health problems?

The Human Rights Act 1998 adds a layer of protection for certain individual freedoms to which all citizens are entitled under UK law, including legislation related to mental health. It has played an important role in improving the way that people with mental health problems are treated, allowing them greater access to justice and shifting the power balance from providers, commissioners and the state, to individuals and their families.

There have been a number of changes to mental health law as a result of The Human Rights Act, such as the Mental Health Act (1983) being amended in 2007 in order to be human rights compliant. The rights contained in the European Convention have also affected carer practice in the mental health sector, and professionals working in community mental health services have a duty to treat people with dignity and to respect their human rights in everything they do.

Whilst not having a status in UK law, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) is a body of independent experts that monitors implementation of the Convention by the States Parties. The UK signed up to the convention in 2009 and has moral responsibilities to accord with its Articles. By following the CRPD, the UK agrees to protect and promote the human rights of all its citizens by eliminating disability discrimination, ensuring an inclusive education system and ensuring disabled people are protected from all forms of exploitation, violence and abuse (amongst much else).

Are their human rights always respected?

Most people in the UK have their core human rights protected, but there are still many cases of human rights abuses in relation to people's mental health. Examples include people from minority groups, such as LGBT+ individuals, who have experienced discrimination, or those in later life who are abused and mistreated in care homes.

As a mature democracy with a well-developed legal system, the UK is in a good position to provide legal protection for the human rights of its citizens, and is obliged to do so by virtue of its legislation, and the relevant UN Conventions to which it is a signatory. It is vitally important that public services and institutions use their powers to protect the rights of people with mental health problems, who are often some of the most vulnerable in our society.

Good practice from abroad

Two Churchill Fellows visited a number of international programmes detailing good practice examples of human rights legislation being used to protect the mental health of vulnerable groups. The Fellows were:

Geraldine O'Hare

Report title: Investing In Treatment To Reduce Re-offending

Geraldine, Head of Psychology Services and Interventions for the Probation Board for Northern Ireland, travelled to the USA to research models of diversion and treatment for offenders with mental health problems.

Jan Killeen

Report title: Supported Decision-making: Learning from Australia.

Jan was the Director of Public Policy for Alzheimer Scotland before her retirement in 2012. She travelled to Australia to research best practice in supported decision-making for adults with incapacity.

Key findings

Investing in support to prevent re-offending: problem-solving courts

Around one in four people will experience a mental health problem in their lifetime,[26] although this proportion is much higher for those involved in the criminal justice system. NICE guidelines suggest that, at any one time, approximately 90% of the prison population experience mental health problems.[27]

There is a growing concern, both in the UK and abroad, that offenders with mental health problems enter into a justice system that does not recognise their mental health needs. Partly as a result of this, they often move in and out of jail terms, and may serve a significant period of time in prison.

The neglect and maltreatment of offenders with mental health problems raises important human rights concerns. A 2017 report found that individuals entering the criminal justice system need to be clearly identified and supported, and that a failure to do so raises concerns about whether their fundamental right to a fair trial is jeopardised.[28]

Geraldine O'Hare travelled to the USA to research problem-solving courts as an alternative to custody, for individuals with mental health problems who find themselves in the criminal justice system.

What are problem-solving courts?

Problem-solving courts are part of a judicial process that attempts to address the underlying root problems that contribute to criminal behaviour. They are based on the concept of therapeutic justice, whereby the offender is encouraged to engage in treatment interventions, rather than time in prison, in order to reduce their risk of reoffending.

Originating in the late 1980s, there are now approximately 2,800 problem-solving courts in the USA, comprising adult drug courts, juvenile drug courts, domestic violence courts and mental health courts, to name a few. Problem-solving courts, and in particular mental health courts, provide criminal courts with more appropriate sentencing options for responding to offenders with mental health problems, though it is important to avoid unnecessary coercion in the operation of such courts.

How do they work?

It is recognised that judges and court staff do not always have the specialist knowledge of problems affecting offenders or victims, such as drug addiction, mental health or domestic violence. To facilitate individualised justice, problem-solving initiatives invite community providers to share the court

room, in order to create a centralised and collaborative joined-up approach, making it easier for the offender to access the appropriate help that they need.

The enhanced information and guidance provided by specialist staff can help to improve the decision-making process among judges, legal teams and other justice officials. It can also help practitioners to make decisions about treatment needs and the risk posed to public safety, by ensuring that offenders are receiving appropriate levels of supervision.

CASE STUDY

The Brooklyn Mental Health Court, New York, USA

The Brooklyn Mental Health Court was the first in the state of New York, and aims to address both the treatment needs of those who appear before it with a mental health need, and public safety and community concerns. It does so by using the authority of the court to link defendants who have persistent mental health problems with long-term treatment as an alternative to custody.

The Brooklyn Court works to four main principles:

Better information: The court has an onsite clinical team, including a psychiatrist, psychologist and social worker. A psychological and social assessment is directed, for each defendant referred to the mental health court, which allows the judge to make an informed decision about the individual's mental health problems and any risks to public safety. It also allows for individualised treatment plans to be developed.

Judicial monitoring: Each participant in the court must return regularly to meet with case managers and to have an assessment and progress review with the judge. This ensures that the judge is engaged with the defendant and that the defendant is aware of the seriousness and the validity of the process.

Accountability: The court uses a broad range of rewards and sanctions to mark progress and setbacks in treatment. The aim is to motivate participants to continue to engage with treatment and to make positive long-lasting changes in their lives. Those who comply with all the treatment mandates have their criminal charges dismissed or reduced at the end of their court treatment programme.

Co-ordinated services: The court works with a broad network of state

and not-for-profit service providers to address inter-related issues of homelessness, unemployment, substance misuse, mental and physical health problems in relation to their own conditions and offending behaviour.

Evaluation

An evaluation of the mental health court found that participants are significantly less likely to re-offend, as compared to similar people with mental health problems who experience normal court proceedings.

Potential for the UK

The research and evidence around problem-solving courts supports the idea that this approach is effective, helps reduced repeat offending and enhances treatment engagement.[29]

Following the Ministry of Justice's review of problem-solving courts in England and Wales (2015), a small number of problem-solving courts have emerged across the UK, most notably in the areas of drug addiction and family. There is not, however, a problem-solving court for mental health, and there is scope for the Ministry of Justice to support the implementation of problem-solving courts in this area.

In Northern Ireland, the Department of Justice is the lead government body responsible for the problem-solving portfolio. Since returning to the UK, Geraldine has been working with the department to support the introduction of the first substance misuse problem-solving court in Northern Ireland. Planning for the first mental health problem-solving court in Northern Ireland and the UK is also presently underway.

Protecting the human rights of adults with incapacity

The UK has a number of legal protections in place to support adults with cognitive disabilities and mental capacity issues to make decisions, as far as is possible. There is, however, concern that the implementation of incapacity laws falls short of compliance with human rights principles, particularly in relation to supported decision-making.[1]

Jan Killeen travelled to Australia to research best practice in supported decision-making (SDM) for adults with incapacity and explored learning from pilot programmes in Australia designed to support the fundamental right of adults with cognitive disabilities to make their own decisions.

What is supported decision-making?

The decisions we have to make in life are sometimes complex and we often turn to experts for advice on important decisions about our health care, finances, relationships or where to live. People with cognitive disabilities may face additional challenges in making decisions about their own lives and may benefit from additional support. A person's decision-making ability may be

affected by the nature of their condition, their ability to communicate, their previous decision-making experience and/or the complexity of the decision being made.

SDM is the term generally used to describe the process of assisting a person with cognitive disability to build their capacity for making decisions for themselves.

What is happening abroad?

Australia was one of the first countries to endorse the United Nations Convention on the Rights of Persons with Disabilities (2008), which the UK government signed shortly afterwards in 2009.

Article 12 (3) and (4) of the Convention requires states to provide access to support for people with decision-making difficulties and protection from abuse of their rights. Australia has become a world leader in developing research programmes to find effective ways of supporting people with decision-making difficulties. A critical review of evaluations of six Australian decision-making support pilots, operating between 2010 and 2015, offers a wide range of empirical evidence of what constitutes effective practice for both the decision-maker and the supporter.

Jan visited members of the research teams responsible for operating the pilots in South Australia, including the Australian Capital Territory, New South Wales, Victoria, and Western Australia, observing practice in four of them.

CASE STUDY

Uniting Jaanimili, New South Wales, Australia.

Jaanimili is a Gumbaynggirr (an Australian Aboriginal group) word from the mid-north coast of New South Wales meaning "gathering together."

The initiative is run by Jaanimili, the Aboriginal Services and Development Unit, and works closely with members of the Aboriginal community who are living with a cognitive disability. It aims to build their confidence and provide assistance with decision-making when transitioning onto the National Disability Insurance Scheme.

The Australian Aboriginal community has specific cultural approaches to individual decision-making, and the project is the first of its kind in the world to use a cultural lens when providing supported decision-making in a community setting.

The project is in its second phase of development, having been evaluated by the Department for Ageing, Disability and Home Care in New South Wales. In supporting people to build confidence and engage in their community, the project has demonstrated positive outcomes for people

living with cognitive disabilities and has since been implemented in two new localities in the state.

A community development approach to SDM

Jan met with project co-ordinator Kerin Carpenter at its centre in Campbelltown, which has the highest percentage of people from the Aboriginal population living with a disability within New South Wales. Kerin explained how the project found creative ways to engage with the community, such as setting up a "kids club" with parents, to help make the initial contact and build trust.

The club integrated the idea of supported decision-making for both children and adult participants, by providing a range of opportunities for SDM, including one-to-one work as well as group work. The club became a focal point to build decision-making capacity for parents and children, helping parents to overcome their anxieties about giving their children choice and building the confidence of children, who learnt to negotiate with each other and make decisions about activities.

The project runs a carers' support group which uses experiential learning focused on "How do you make decisions?" This helps parents to understand how important it is to give their child, from when they are a baby, the opportunity to make simple choices and to build their own decision-making skills.

Applying the learning in the UK

Jan Killeen

Since returning to Scotland, Jan has worked part-time as a consultant for the Scottish Government with the aim of creating a National Overarching Supported Decision-Making Framework, to support future work in relation to the Scottish Government's commitment to develop an overarching mechanism to support the autonomy of adults with disabilities and to combat the discrimination they often experience.

Jan led an expert advisory group consisting of key agencies such as the Scottish Independent Advocacy Alliance, The Mental Welfare Commission, the Scottish Human Rights Commission and other organisations supporting people with lived experience. The work of this group directly informed the Scottish Government's consultation on incapacity.

Jan presented her report to the Scottish Government in July 2018, after which it was sent to the Health Secretary and the Minister for Mental Health. In May 2019, the Minister for Mental Health announced a Review of the Mental Health and Incapacity Act in Scotland, which endorsed continuing work to progress supported decision-making practice.

Conclusion

Through investigating international good practice for reducing the mental health inequalities of minority and vulnerable groups, the Churchill Fellows' findings have made one thing clear: as our UK population grows and becomes increasingly diverse, so too our health and social care system must adapt if it is to effectively meet the wide range of cultural needs that exist within our communities.

The Fellows' research draws attention to a rich variety of approaches being used abroad that are taking a lead in this area. This includes public services in Australia and Canada using Meyer's minority stress model (2003) to inform trauma-informed practice for the LGBT+ community, and also examples of culturally competent care in Australia and the USA that is appropriately sensitive and responsive, tailored and delivered by healthcare professionals who have the necessary knowledge and understanding to ensure that all individuals are treated with respect, irrespective of their cultural or ethnic background. The Australian Government's decision to fund the development and delivery of the Silver Rainbow training is a strong international example of leadership in this area.

The Fellows' research also drew attention to international programmes providing good practice examples of human rights legislation being used to protect the mental health of vulnerable groups, including new models of therapeutic justice in offenders' rehabilitation that places greater importance on the role of community provision, rather than prisons. This, along with a number of other programmes visited by the Fellows, is a good example of how it is possible to integrate a mental health perspective into other settings, such as judicial courts, recognising the benefits of a whole-systems approach to mental health.

In considering the UK's movement towards creating a more tolerant, accepting and equal society that protects people's mental health, it is sometimes easy to forget how far we have come. There is, however, still a long way to go before everyone has an equal opportunity to live well and experience good mental health. In providing examples of good

practice, detailing innovative approaches and identifying challenges for successful integration in the UK context, the Fellows' research makes a valuable contribution to this important area of work.

To find the full body of research produced by all 59 Churchill Fellows, or to listen to the corresponding podcasts for **Equality and diversity**, please visit the Mental Health Foundation and Winston Churchill Memorial Trust websites.

To get in touch with a Fellow included in this briefing, or for more details on any of the case studies featured, please contact the Winston Churchill Memorial Trust at office@wcmt.org.uk.

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