

Model values?

Race, values and models
in mental health

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Foreword

Our implicit models of mental disorder and other key values and beliefs determine how we understand and respond to mental distress and disorder, as well as impacting at organisational and national levels on policy and practice in mental health and social care. Yet there has been relatively little research on these models and such research as there has been has had little direct relevance to the issues of race, ethnicity and culture that are of crucial significance to many service users and service providers at the front-line of care. This study is ambitious and ground breaking because it attempts to look both at models of mental disorder and people's assumptions about race and ethnicity and it begins to show how these might interact.

Although a pilot study, the findings provide a number of new insights and raise key questions for further research. The report is also significant in being the Mental Health Foundation's first major online study. The size of the response, and more particularly the extent of the contributions from service users, shows the power of this approach as one method among others for exploring key questions in this area.

The Mental Health Foundation has taken a strong lead in developing service user-led research that directly addresses current priorities in health and social care. The research on which this report is based was led by Dr Colin King, who has experience both as a service user and as a social care professional, and the richness of the findings directly reflects the wealth of insight and experience that he has brought to the study.

We hope that our findings will stimulate further research on models and beliefs and their key place in developing services that are fully responsive to the needs of all groups in our widely diverse society because we are acutely aware that inequity in provision and outcomes damages us all.



Dr Andrew McCulloch
Chief Executive
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Executive Summary

- 1.** This report describes the results of a web-based pilot study of the explanations (“models”) of mental distress and disorder that are used by people who receive mental health services, carers, and people who work in mental health services. It was carried out by a principal researcher with previous personal experience both as a service user and as a provider of services (as an Approved Social Worker).
- 2.** The study brings together: 1) the Mental Health Foundation’s experience of service user-led research, with 2) Warwick Medical School’s programme on values-based practice, in particular an earlier study of models.
- 3.** An earlier study of models used face-to-face interviews and a standardised case vignette to explore the values and beliefs about mental disorder (i.e. ‘models’ of disorder) of respondents. The main aims of the present study were thus to: 1) test the continuities and differences generally that might emerge from a web-based approach to understanding models as compared with the original study; 2) test the extent to which areas relevant to understanding mental disorder not covered by the original study, in particular aspects of religion and spirituality, might emerge where the principal researcher (in contrast with the original study) had previous personal experience of services, and 3) test the extent to which aspects of culture, race, ethnicity and racism, might emerge where, again in contrast to the original study, the case vignettes employed included relevant ‘trigger’ elements.
- 4.** Although there are methodological problems with web-based survey methods, the study proved highly effective in reaching a large number of respondents from minority or otherwise disempowered groups, whose ‘voice’ might not otherwise have been heard.
- 5.** Despite the very different methods adopted, the study produced results that were in many respects consistent with those in the original study. However, a number of important differences also emerged: 1) the web-based methodology revealed, i) a wider spread of models and, ii) a greater sensitivity of models to context, 2) the different vignettes evoked many responses covering aspects of race and racism, 3) these responses, although in some respect following expected ethnic and cultural lines, were in certain respects surprising (for example a polarised response within a given ethnic subgroup), and 4) evidence was found for models distinct from those in the original study relating in particular to aspects of culture and ethnicity, and religion/spirituality.

- 6.** As a pilot study, and given the methodological limitations of an online survey, these findings are provisional. Nonetheless they show the potential value of further research on: 1) the diversity of models, including the diversity of values and beliefs held in relation to aspects of race and racism, 2) the sensitivity to context of models, and 3) the existence of 'new' models, i.e. models not previously well recognised, in particular relating to aspects of culture and ethnicity, and religion/spirituality.
- 7.** If borne out by further research, our findings have a number of implications for policy, training and front-line services in mental health. In particular, they show the need for: 1) policy to be based on robust 'evidence of values' rather than pre-suppositions, 2) training to include training in the skills for values-based practice, and 3) a greater focus in the commissioning and delivery of services on how a mental health issue is understood, i.e. on assessment rather than merely on management. Existing resources to support each of these in the current policy context of increasing personalisation of services, are briefly indicated.
- 8.** We offer a brief final reflection on the methodological implications of our experiences – both positive and negative – of working together over an extended period and bringing together our very different backgrounds, values, skills and experiences, in this challenging area of research.

1. Background

1.1 Assessing and explaining mental health problems

Most people probably believe that there is as much agreement as to what defines a mental health problem as there is in defining a physical health problem, and therefore what should be done if someone is experiencing such a problem. We all understand the terms “pain” and “distress” and if we were experiencing them we would want help to get rid of them. Yet recent research has shown what many people with mental health problems, their families, and the professionals who look after them have long known about; that there are very different perspectives and understandings of mental health problems. Opinions vary significantly even when different people are presented with the same situation involving someone apparently experiencing mental distress (Colombo et al., 2003a and b). Research also shows that people from some Black and minority ethnic groups in this country are more likely to be diagnosed with mental health problems even though views differ widely about whether the prevalence of mental health problems among these groups is any higher (Department of Health, 2005; Care Quality Commission, 2009).

Understanding and assessing mental health problems is therefore a very complicated business. Because mental health and mental health problems involve our thoughts, feelings, beliefs and values in a way that physical health does not, these same factors also come into play when mental health problems are being assessed. And this becomes even more complicated when it involves people from different ethnic groups. Getting a diagnosis or assessment wrong can have devastating consequences for individuals because it may involve being forcibly detained and treated against one’s will, and being subject to stigma, discrimination and social exclusion. Correspondingly, understanding the different values people may use when assessing or understanding mental health problems could enable people to be much clearer and more honest in these situations, leading to better relationships between people with mental health problems and mental health services, and ultimately better outcomes (Colombo et al., 2003a and b).

1.2 Values and values-based practice in mental health

The importance of differences of values in all areas of mental health and social care is widely recognised and has been the basis of a number of national and international policy, training and service development initiatives (Fulford, 2008). These initiatives were built in part on a training manual in a new skills-based approach to working with values, called values-based practice. The manual, called ‘Whose Values?’, was developed by Kim Woodbridge, Bill Fulford, Toby Williamson and others in a partnership between the Sainsbury Centre for Mental Health and Warwick Medical School, and was launched by the Minister, Rosie Winterton, at a conference in London in 2004 (Woodbridge and Fulford, 2004).

1.3 Values-based practice and assessment in mental health

Values-based approaches have thus far been developed mainly in relation to how mental health issues are managed: for example, the National Institute for Mental Health in England (NIMHE) Values Framework was a framework for values-based practice (this can be found on page 25, Woodbridge & Fulford, 2004); the Ten Essential Shared Capabilities (Department of Health, 2004) build equally on evidence-based and values-based sources; and the training materials for the new Mental Health Act have been developed within a values-based framework (Care Services Improvement Partnership (CSIP), and NIMHE, 2008).

Values-based practice, however, emphasises the importance of values, not only in how mental health issues are managed but also in the models of disorder that we use to understand them in the first place. These models of disorder include medical diagnoses, such as 'schizophrenia', but also social and stress-related, psychological, family and a wide range of other ways of understanding mental distress and disorder. NIMHE and CSIP recently published the results of a consultation involving all stakeholders on a shared vision of best practice in assessment as a crucial aspect of mental health and social care (NIMHE and CSIP 2008).

1.4 Values, culture, ethnicity, race and mental health

Better understanding of the role of values in relation to how mental health issues are understood is likely to be particularly important in the development of more accessible and appropriate service provision for Black and Minority Ethnic (BME) and other minority communities (Fulford, Sallah and Woodbridge, 2007). An example of this is illustrated by at least three decades of empirical evidence of inequalities in experience and outcomes in mental health for BME communities in Britain. Members of the African-Caribbean community have one of the most marked experiences: a number of studies (Sainsbury Centre for Mental Health, 2002; Department of Health, 2003; Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003; and Department of Health, 2005) have shown that, for example, they are:

- three times more likely to be admitted to psychiatric hospitals,
- 44% more likely to be compulsorily detained mental health patients,
- significantly more likely to receive antipsychotic medication and also receive higher doses than others,
- more likely to be restrained,
- less likely to be offered psychological therapies.

Further inequalities in the rates of diagnosis of different mental disorders in BME communities, notably very high rates of diagnosis of schizophrenia in young black men are also well recorded. There has been considerable recent debate about the causes of such inequalities (Singh and Burns, 2006; McKenzie and Bhui, 2007). It seems likely, however, both on theoretical grounds (Fulford, 1989; Fulford et al., 2005), and from the personal experience of service users themselves (King, 2007), that values are important in shaping the ways in which mental distress and disorder are understood (Glasgow Anti-Stigma Partnership, 2007).

1.5 Origins of this study

The pilot study reported here builds on research on models of mental disorder carried out by Anthony Colombo (a social scientist), Bill Fulford and others, at Warwick University and subsequently Warwick Medical School (Colombo et al., 2003a and b; Fulford and Colombo, 2004; and Williamson, 2004).

Colombo et al.'s research drew on a combination of social science and philosophical methods to explore the models of disorder, including the values and beliefs, adopted by different stakeholders involved in the community care of people with a long-term diagnosis of schizophrenia.

The study involved service users and service providers equally and was important in showing for the first time clear differences in the models of disorder adopted by different groups. The models explored in Colombo et al.'s study are summarised in Table 1 below. However, these models did not specifically include aspects relevant to race, culture, ethnicity, religion/spirituality and discrimination or other potential sources of bias and stigmatisation, such as gender, religion and sexuality. Hence, Williamson (2004) suggested that an important extension of this work would be to explore the models that might emerge from other paradigms, specifically from studies that, in contrast to Colombo et al.'s study, were service user led, that explored culture and ethnicity, and religious/spiritual explanations for mental distress, and could incorporate the value systems of BME communities living in Britain.

The pilot survey reported here arose from this suggestion and was devised in a partnership between Dr Colin King, a freelance researcher with personal experience both as an Approved Social Worker and as a user of mental health services, Toby Williamson and others from the Mental Health Foundation, as an organisation that has played a leading role in supporting service user-led research (see for example, Faulkner and Layzell, 2000), and Bill Fulford, representing Warwick Medical School and one of the researchers in Colombo et al.'s original models project.

Table 1: Brief descriptions of the Models of Disorder as defined in Colombo et al's study

Model of Disorder	Description / Key Features
Medical (organic)	Mental illness continuous with bodily illness; causes are primarily bodily (genetic, physiochemical changes in the brain, etc); treatment is primarily medical (especially use of drugs)
Social	Mental health issues on a stress-disorder continuum; causes are primarily social (includes victimisation as well as economic and cultural stresses); treatment is primarily social interventions
Cognitive-behavioural	Mental health issues on a normal-abnormal psychological continuum; causes are primarily psychological (e.g. poor coping skills and inappropriate learned behaviours); treatment is primarily psychological (e.g. brief CBT (cognitive behavioural therapy) particularly aimed at developing self-management skills)
Psychotherapeutic	Mental health issues on a continuum of emotional distress/difficulties with individual personal meanings (may be partly unconscious); causes are primarily unconscious (e.g. arising from early trauma); treatment is one-to-one or group therapy (like psychological, particularly aimed at developing self-management skills)
Family interactions	Mental health issues located within a family 'nexus' rather than any one individual; causes are understood in terms of family dynamics; treatment is interventions with the family as a whole
Conspiratorial	'Mental illness' a myth constructed in various ways (e.g. labelling); arises particularly through unequal power relations to serve the purposes of a dominant group (e.g. political control of dissent); 'treatment' abusive (instead, minority and other vulnerable groups should be empowered)

Note: Some of the summary descriptions given in this Table may appear different from the way in which the models in question are sometimes used in the literature. For example, the term 'social model' is often used particularly in relation to the social model of disability, to describe interventions aimed at changing society to accommodate people with disabilities, rather than, as in this study, focusing on the individual. Similarly, the term 'empowered' is widely used in mental health as a generic term in relation to a wide range of policy and service development initiatives rather than, as here, specifically in relation to the 'conspiratorial model'. The 'conspiratorial model' itself, furthermore, has a range of possible meanings: as used here, it focuses on issues of power but it can have a number of further meanings concerned in one way or another with the need to dismantle altogether what is seen as a faulty social/political system.

In the present study, in order to maintain continuity, we have retained as far as possible the meanings of the different models as defined by Colombo et al.

2. Methodology

2.1 Aim and objectives

The aim of this project was to pilot survey methods for exploring values and models of explaining mental health problems, particularly as these are influenced by race, racism, religion and spirituality, while drawing on the experience of users of mental health services and building on Colombo et al's original study.

The objectives were to:

1. test the continuities and differences generally that might emerge from this approach to understanding models of mental distress as compared with the original study by Colombo et al.
2. test the extent to which areas relevant to understanding mental distress not covered by Colombo et al., in particular aspects of religion and spirituality, might emerge from this approach
3. test the extent to which aspects of culture, race, ethnicity and racism might emerge from a different approach to exploring models of mental distress as developed by Colombo et al.

2.2 Design and procedure

As the Mental Health Foundation has had a long standing commitment to service user involvement in mental health research, and given the focus of this research, it was felt to be important to involve service users from BME communities. Two service user researchers were contacted to invite them to be involved with this project. This led to considerable discussion about the best methodology to be used. One researcher planned to meet various BME voluntary sector mental health organisations to hold some focus group events to discuss perceptions and explanations of mental distress among the people involved with those groups. Sadly, the researcher involved had to withdraw and this aspect of the project was not taken forward.

The other researcher (Dr Colin King) proposed that professionals from a range of different disciplines should be invited to participate in a research process involving completion of a questionnaire about their values in relation to young men and mental distress, where issues of ethnicity were a key factor. Having completed the questionnaire participants would go on to observe an enactment of an assessment being carried out under the Mental Health Act, and then be asked to complete the questionnaire again. This would allow a comparison to be made of the views they expressed before and after watching the Mental Health Act assessment, and to investigate in particular whether there had been any shift in their values or explanations. Because of the limited resources available, the logistics of using this methodology, especially the enactment, and the belief that it might prove difficult to find a range of mental health professionals willing to participate (especially because of the limited time and resources available for the project), it was agreed not to proceed with this methodology.

Working closely with members of the research team at the Mental Health Foundation it was decided instead to use an online survey methodology. This would use tried and tested technology already available to the Mental Health Foundation that would replicate as far as possible what the researcher had proposed. This was much more achievable within the resources available and had the additional advantage of almost certainly attracting a far greater number of respondents. It also had the benefit of being able to use a methodology that was quite similar to the Colombo et al study because it could use case vignettes which participants were then asked questions about, in order to find out what models or explanations of mental distress they were using.

To try and capture respondents' more general, theoretical views of mental distress the survey was divided into two halves. Part 1 covered demographic information and then asked some general questions, using both rating scales and free text, about respondents' views of ethnicity and mental distress. Once this section had been completed and the respondent went on to Part 2 it was no longer possible for them to amend their answers in the first section. Part 2 asked respondents to answer questions on two different case vignettes, involving fictitious individuals where ethnicity, culture and apparent mental distress were explicit elements. The survey was aimed therefore at finding out respondents' explicit views on mental distress, especially in relation to ethnicity (thereby creating the possibility that other models based upon different cultural values might emerge). However the intention was also to explore what differences, if any, there might be between responses to the more general questions in Part 1, and the responses to questions about specific scenarios in Part 2 (see Appendix for the survey questionnaire).

After a number of iterations of the survey including testing it 'blind' with various internal and external individuals, the survey went 'live' from December 2005 until February 2006 (during which time 1,100 entries were made – see below). To attract interest a press release was issued and announcements made via the Foundations website, electronic discussion forums and networks.

Responses to the direct questions in Part 1 of the questionnaire were analysed quantitatively. Responses to Part 2 were analysed qualitatively to extract principal themes.

2.3 Participants

A total of 1,100 responses to the online questionnaire were received over the three month period that the web-site was open. Of these, 345 were not sufficiently complete to be included in the analysis. The sample thus consisted of 755 completed questionnaires.

As Table 2 below indicates, respondents were mainly from the UK, with approximately twice as many female as male respondents.

- race and ethnicity: by far the largest single group of respondents described themselves as 'white English' (76%). However, there were also significant groups of 'black British' (13%), 'Asian' (5%), and 'mixed race' (4%)¹.
- mental health service users/carers and workers: although the largest groups of respondents described themselves either as a 'mental health worker' (57%), or 'other occupation' (22%), there were relatively large groups of respondents who described themselves either as a current service user' or an 'ex-service user' (16%) or as a 'mental health carer' (5%).

Table 2: Sample description n=755

	% response
Gender	
Male	35
Female	65
Ethnicity	
White	76
Black ²	13
Asian ³	5
Mixed heritage	4
Missing data/did not say	2

1. Categories for ethnicity were based upon the categories used in the 2001 census.

2. Includes Black British, Black Caribbean, Black African.

3. Includes Indian, Pakistani – also Chinese of whom there were only 3 respondents.

Table 3 gives the main subdivisions of 'mental health workers'. As this shows, there were relatively large numbers for nursing (22%), social work (16%) and psychology/talking therapies (16%), with the remainder either 'other health professionals' (25%) or non-health staff (10%). There were small percentages only of both psychiatrists and occupational therapists (4% each).

Table 3: Subdivisions of health disciplines/professions

	%
Other health (includes pharmacists, dieticians, physiotherapists,	25
Nursing	22
Social work	16
Other (includes non-health staff e.g. support workers, etc)	13
Psychology	10
Other talking therapies	6
Psychiatry	4
Occupational therapy	4

2.4 Limitations of online surveys

Ethical issues were carefully managed in the pilot study but the online methodology presented distinctive advantages and disadvantages. The negotiation of informed consent, acceptance of confidentiality and data protection management, together with ensuring participants understood their freedom to withdraw and systematic desensitising of difficult emotions that might emerge through taking part in the research were important issues for consideration. The researchers communicated these issues carefully to potential participants and gave clear details of who to contact at the Mental Health Foundation if participants needed to contact someone. In the event, no participants contacted the Foundation.

As an online survey, this pilot study has a number of methodological limitations: there is no control over the way the study sample is made up (we had no way of controlling 'multiple returns', for example); the description of the survey may lead to biases in the study sample (in the present case, for example, the survey notes that it is concerned among other things with issues of ethnicity, and hence is likely to be responded to by people with similar concerns), and the survey is by its very nature limited to those with electronic access: thus, homeless people, despite their high rates of mental distress and disorder, people with chaotic lifestyles, people with substance and alcohol misuse problems, and people on very low incomes, are all less likely to have access to online communication, and hence were likely to have been excluded in the present case. As against these limitations, however, an online methodology also has a number of advantages, particularly in the constituencies

that it is able to reach among service users and carers (Allott et al., 2005; Woodbridge et al., 2005).

A particular limitation of the present study arising from the uncontrolled sample group is that there were inevitably differences in sample groups between Colombo et al., and this study: for example, in Colombo et al., there were equal numbers of professionals groups, service users and carers. In this survey there were many more professionals and other mental health workers than there were users or carers. There were also different relative numbers of respondents within each professional group.

2.5 Limitations of using case vignettes

Using case vignettes in research can present its own challenges as almost by definition, they will not be made up of neutral, objective components but will contain elements that are open to interpretation and will be experienced subjectively by participants in the research. However both vignettes were carefully designed to contain references to the individuals' ethnicity and culture without explicitly stating the person's race or ethnicity. Similarly the vignettes contained several indicators regarding the person's mental health without explicitly stating a mental health problem or diagnosis. The aim of this was precisely to ensure that the case vignettes did not automatically provide leading information or labels that would significantly increase the likelihood of generating responses based on stereotypes or that were deemed to be 'politically correct'.

Case vignettes may also be criticised as not being representative of real life situations or people. However for this study the case vignettes were based upon real people, suitably anonymised. Importantly also, no feedback or criticisms were received from research participants that the vignettes were unrealistic or skewed in such a way as to elicit a specific response from participants.

The use of case vignettes was also important in order that the theoretical answers to the questions in Part 1 could be compared with people's responses to the questions in Part 2 that focused on the vignettes.

2.6 Limitations of a pilot study

There are also limitations arising from the pilot nature of the survey particularly in the degree of sophistication that we could use in defining our variables. In particular, as discussed further below (see below, Findings), beliefs about the two quite distinct concepts of race and racism, should ideally have been explored separately. However, we were concerned to keep the questionnaire short and, as the basis of a pilot study, we opted for treating them together. As we describe in the Results section, this approach produced useful results in its own right and suggests a number of key questions that could be usefully followed up in larger studies using different methodologies (see Conclusions).

3. Findings

The findings set out in this section of the report are presented, first for models of disorder, and then for race, racism and other aspects of discrimination.

3.1 Models: overview of findings

The main findings for models of disorder were:

1. an overall correspondence between our findings and those of Colombo et al.,
2. marked shifts between explicit and implicit models (predicted but not actually shown in Colombo et al.'s study),
3. strong indications of the sensitivity of models to context (again, consistent with but not demonstrated by Colombo et al. in their study), and,
4. evidence of possibly distinct models for religion/spirituality and other aspects of culture, particularly ethnicity and race. This is a finding that significantly extends those of Colombo et al., and that, if repeated in future studies, could prove highly significant for current developments in policy and practice in mental health (see further discussion below, section 3.1.4, and Conclusions).

3.1.1 Causes of mental distress

The first set of findings that were looked at in detail involved the explanations of mental distress given by respondents in the first part of the survey. These are shown in Table 4 below and compared with the corresponding findings from the earlier study by Colombo et al.

The majority of responses in the present study could be quite easily mapped onto the models defined by Colombo et al. in the original study (see Introduction) and as Table 4 illustrates, the findings overall were broadly similar, although for methodological reasons it is not possible to draw definitive like-for-like comparisons. Thus, Table 4 looks at the findings from our study for Question 6 in Part 1 (about “What do you consider to be the main causes of mental distress?”) and compares them with the findings in Colombo et al.’s study for ‘aetiology’. In both studies, there was a good spread of models overall and indeed similar findings were reflected throughout our study. It is interesting to note that in this study only a relatively small number (18%) gave a response that reflected a broad and inclusive biopsychosocial explanation (i.e. a response that included elements of medical, social/family and either cognitive-behavioural or psychotherapeutic models in their response). There were some differences of emphasis, however. Again, these are illustrated by Table 4 which shows that there was less emphasis on medical (39%) as against social (90%) models (of those who gave responses in terms of single models only 1% gave ‘medical’ as the sole cause, while 30% gave ‘social’ as the sole cause).

Table 4: References to models in responses to Question 6, Part 1 – “What do you consider to be the main causes of mental distress?”

Reference given in answers to models	Current study	Colombo et al., study
	% response	% response
Social	90	69
Medical	39	45
Cognitive-behavioural	28	25
Psychotherapeutic	24	28
Family	17	8
Conspiratorial	nil	nil

Note: The percentages in this Table reflect the number of respondents that included a particular model in their answer (this is why the percentages add up to over 100%).

The overall correspondence between the two studies, despite the very different methods and vignettes used, is an important finding in its own right. It suggests that the models defined by Colombo et al. have a good degree of validity and thus provide a helpful framework for thinking about how people understand and respond to mental health issues.

However, as shown above, the present study also extended Colombo et al.'s findings for models in a number of respects. It showed:

- shifts between explicit and implicit models
- the sensitivity of models to context
- evidence of distinct models for both religion/spirituality and other aspects of culture including race and ethnicity
- the importance of racism and other aspects of discrimination (to which we return in section 3.2).

3.1.2 Shifts between explicit and implicit models

A key finding for models that built on Colombo et al.'s study was that, as predicted but was not actually shown, there were wide differences between explicit and implicit models, i.e. between the models that people say/think they hold (as reflected in the direct questions of Part 1 of the survey) and the models that may actually drive the way they respond to mental distress in practice (their implicit models as reflected in their responses to the case vignettes in Part 2 of the study).

Thus, Part 1 of the survey explored people's explicit models in relation to causes particularly through Question 6, "What do you consider to be the main causes of mental distress?" (responses to this question are given above in Table 4). Implicit understandings of causes, by contrast, were explored by looking at the responses to the two case vignettes in Part 2 of the survey particularly through Question 2; "What reasons would you give for the person's behaviour e.g. biological, social, cultural, psychological, etc?"

Comparing responses to these two questions thus gave a direct comparison between explicit and implicit understandings of the causes of mental distress as a key aspect of respondents' models. The differences between the two sets of responses is illustrated by Table 5 below which shows the percentage of people who used the same cause to explain mental distress in Part 1 as they did for the case vignettes in Part 2. Complete consistency would be 100%. However, as Table 5 shows, even taking into account standardised residuals this was not the case, the highest level of consistency being 47% for the social model for Mr A (i.e. 47% of people who responded with a social model in Part 1 also responded with a social model to Mr A in Part 2).

Table 5: Comparison of explicit and implicit understandings of the causes of mental distress

Explicit cause given for mental distress as indicated in answer to Q6, Part 1	% of respondents that answered the same	
	Mr A	Mr B
Medical	34	30
Social	47	15
Cognitive-behavioural	35	32
Psychotherapeutic	9	Not available
Family	15	Not available

The fact that shifts were found between explicit and implicit models (consistent with the predictions of Colombo et al) is a further indication of the potential usefulness of models in relation to theoretical understandings of mental distress. At a practical level this finding is also important in providing further evidence of the importance of context and situation in relation to the models that people use in understanding and responding to episodes of mental distress.

Comparing Tables 6 and 7 below, shows the additional finding that respondents were generally more likely to jettison a cause for mental distress they had cited in Part 1, when looking at the case vignettes (Table 6), than they were to include a “new” cause (Table 7).

Thus, Table 6 shows that relatively large numbers of respondents jettisoned a given model in moving from Part 1 to Part 2 in response to questions about the causes of mental distress. For example, of those who included medical model responses in their answers to Question 6 in Part 1, 23% (Mr A) and 25% (Mr B) did not include medical model elements in their responses to the corresponding Question 2 in Part 2.

Table 6: Percentage of respondents who mentioned a given model in Part 1 and then did not include it in their corresponding answers in Part 2

Variation	% of respondents that changed	
	Mr A	Mr B
Medical -> not medical	23	25
Social -> not social	42	51
Cognitive-behavioural -> not cognitive-behavioural	16	17
Psychotherapeutic -> not psychotherapeutic	20	Not available
Family -> not family	13	Not available

Table 7, by contrast, shows the variation the other way, i.e. the percentages of those who did not mention a given model in their responses to Question 6 in Part 1, but then went on to include it in their responses to the case vignettes for Question 2 in Part 2. Comparing this with Table 6 shows that the percentages this way round are much lower - for the medical model, again, the percentages are 11% (Mr A) and 9% (Mr B).

Table 7: Percentage of respondents who did not mention a given model in Part 1 and then included it in their corresponding answers in Part 2

Variation	% of respondents that changed	
	Mr A	Mr B
Not medical -> medical	11	9
Not social -> social	5	3
Not cognitive-behavioural -> cognitive-behavioural	9	16
Not psychotherapeutic -> psychotherapeutic	3	Not available
Not family -> family	7	Not available

Respondents were therefore more likely to jettison a model and adopt a more pragmatic approach to assess and understand apparent mental distress than to consistently use a theoretical model when faced with a practical scenario.

Shifts between explicit and implicit models are important practically because they reflect, as described earlier, the difference between what we say (our explicit models being the models that we say/think we hold) and what we do (our implicit models being what drives the way we actually respond to mental health issues).

As Colombo et al. pointed out, conflicts between our implicit models and our explicit models could thus well lie behind and explain many of the difficulties of communication and shared decision-making that can arise between service users, carers, and service providers, as well as between different practitioners within multidisciplinary teams. The implicit models described by Colombo et al have subsequently been included in training materials designed to improve communication and shared decision-making (see Woodbridge and Fulford, 2004).

As a topic for possible future research, the greater willingness of respondents to eliminate possible causes (i.e. models) for mental distress from one's vocabulary as opposed to including new causes, would be worth following up (see below, Conclusions).

3.1.3 First and third-person perspectives

An important example of the sensitivity of models to context is illustrated by Tables 8 and 9 below. These two Tables compare responses for both Mr A and Mr B between the question 'What would your response be to Mr A/B?' (Part 2, Question 6) and 'If you were Mr A/B how would you want people to respond?' (Part 2, Question 7, emphasis added). As the two Tables show, despite these being very similar questions, and in some cases eliciting very similar responses, there were some respects in which they produced very different answers.

An example of an important similarity of response is the emphasis given by respondents for both Mr A and Mr B on the importance of such factors as reassurance, empathy and support if the respondent was Mr A or Mr B. Thus, in Table 8 these factors are included right at the top of the ratings and in Table 9 they are included as the second most important rating. This was consistent also with the emphasis for both Mr A and Mr B on the importance of listening and being listened to in Table 8.

Table 8: Topics mentioned in responses to Question 7, Part 2 "If you were Mr A/Mr B how would you want people to respond?"

Preferred intervention to be received	Mr A - % (rating)	Mr B - % (rating)
Reassurance, empathy, caring, calm, compassion	13 (1)	11 (1)
Enable/guide/mentor/ coping strategies/build positives	11 (2)	4 (6)
Respect/valuable/open/accept/take seriously/ etc.	11 (2)	4 (6)
Listen/hear	10 (3)	7.5 (3)
Leave alone	10 (3)	3 (7)
Understand	8.5 (4)	8 (2)
Support	8 (5)	5 (5)
Help (offer, give, obtain), assist	7 (6)	4 (6)
Safe/non-threatening	5 (7)	2 (8)
Non-judgemental, no stigma, tolerance	3.5 (8)	6 (4)
Talk	2.5 (9)	1 (9)
Practical help	2 (10)	-
Trusted person/worker	1 (11)	-
Arrange education/work/training	1 (11)	-
Professional	1 (12)	-
No assumptions	1 (11)	-
Express feelings	1 (11)	-
Black mental health worker	1 (11)	-
Medical	0.5 (12)	-

Table 9: Topics mentioned in response to Question 6, Part 2 “What would your response be?”

Preferred intervention to be provided	Mr A - % (rating)	Mr B - % (rating)
Medical, GP, MH team, medication full assess	25 (1)	25 (1)
Develop rapport, empathy, sympathy	18 (2)	13 (2)
Support, address practicalities	11 (3)	2 (10)
Family therapy/involvement/mother (Mr B)	6 (4)	8 (4)
Counselling, CBT	5 (5)	11 (3)
Talk	4.5 (6)	5 (6)
Monitor/assess/risk assess	4 (7)	4 (7)
Therapy/psychotherapy	4 (7)	7.5 (5)
Social contact, improve social skills, reduce isolation	3.5 (8)	-
Mentor, role model, build positives	3 (9)	-
Listen	3 (9)	3 (8)
Help, obtain help, seek help	3 (9)	2.5 (9)
Gay/Irish support groups	-	11 (3)

However the medical model provides an example of an important difference in responses to the two questions. When respondents were asked how they would want people to react if they were themselves in the situation of Mr A or Mr B (Table 8), a large majority of the responses were non-medical, i.e. answers like ‘leave alone’, ‘support’, ‘listen/hear’, ‘respect/take seriously etc’, ‘understand’, and there were almost no references to the medical model (respectively 0.5% for Mr A and none at all for Mr B). By contrast, when asked how they would actually respond to Mr A or Mr B in practice (Table 9), medical responses came at the top of the ratings with no less than 25% for both Mr A and Mr B.

A second difference between the two questions was that both vignettes elicited much more active interventions in response to the question “What would your response be?” (Table 9, for example practical help, therapy, etc.) than for the question “How would you want people to respond?” (Table 8, for example listening, understanding, respecting, etc).

The consistency of response around the importance of empathy, listening and other aspects of person-centred care is significant in practical terms, given that all too often such aspects are eclipsed by more professionally specific interventions (social, psychological and medical). Clearly these are not exclusive. But the findings in our survey show the importance of keeping a balance here.

The marked contrast between “How would you respond?” and “What response would you want?” can be understood in different ways that would be worth following up in further more detailed research. Again, it may indicate a shift between an ideal, theoretical approach and an approach that is more rooted in what people might do (or expect to be done) in practice. It may also be an indication of the risk averse culture that is so pervasive in mental health services – respondents would like a relatively ‘light touch’ applied to themselves if they were experiencing mental distress but would not want to risk the possible consequences of this if they were looking after someone else. However it is explained, the finding is a particularly striking example of the extent to which models of disorder are sensitive to context and people can shift quite dramatically in their understanding and preferred responses when dealing with mental distress. Certainly not an obvious case of ‘do unto thy neighbour as one would have done unto oneself’.

The sensitivity of models to context shown by this study reflects an important aspect of how people understand and respond to mental distress. It shows that people shift between different models depending upon the context and the presenting problem, and use a model which seems most appropriate to the individual involved. This may indicate that people are able to provide a flexible response rather than trying to fit the individual into a pre-defined paradigm of mental distress. On the other hand it may be an indication that, as was shown in Colombo et al’s research, people are inconsistent, or consciously choose to reject what they believe in theory when faced with what they would do in practice.

3.1.4 Possible distinct models for religion/spirituality and other aspects of culture

A major difference from Colombo et al's study was that a number of the responses in this study were quite explicitly concerned with facets of religion, spirituality and other aspects of culture, particularly in relation to race and ethnicity.

Table 10 illustrates the extent to which respondents emphasised these and other aspects of culture. The percentages given show the topics included in responses to Question 7 in Part 1, "How might your understanding of mental distress be influenced by cultural factors?". 10% of respondents explicitly mentioned religion or spirituality as a factor. 47.5% indicated cultural factors and cultural diversity as being significant (those topics that are shaded). For those that did indicate the importance of cultural factors there is the strong suggestion of possible links with issues of ethnicity and race, thus raising the possibility of underlying culturally-specific models of mental distress.

However it is important not to over interpret here because the wording of the question is somewhat ambiguous as some respondents may have thought it referred to their own culture, while others may have thought it referred to wider cultural forces at play in society.

Table 10: Percentages of topics included in responses to Question 7, Part 1, on the influence of culture on mental distress

Influencing factor	%
Different beliefs, attitudes to dominant culture	21
Service reaction/different professional judgements	11
Religion/spirituality	10
Need for cultural awareness	8
Interpretation based on own culture	8
Increased stigma/shame associated with mental distress	7
Racism/discrimination	7
Family/support systems	7
Perception abnormal/normal	6.5
Eurocentric model used for mental illness	4
Negative/positive media portrayals	3
Alienation/isolation	2
Verbal/non-verbal communication misunderstood	2
Need for education on MH issues for BME	2
BME over-represented in psychiatric units	1
Gender issues	0.5

The possibility of one or more distinct models specifically concerned with aspects of religion and spirituality is also illustrated by the responses to Question 3, Part 2 “In what ways do you think the family influenced these behaviours?” (in relation to the case vignettes), as shown in Table 11 below. This question, being about the influence of the family did not explicitly invite or suggest responses concerned with religion/spirituality. Reflecting the family factors in Mr A’s vignette (see Appendix), many respondents emphasised these in their responses (particularly the threat that Mr A felt his father presented). Responses to Mr B, by contrast, whose vignette included important issues of religion and sexuality, the largest single category of response was concerned with the Catholic family background.

Table 11: Topics included in responses to Mr A and Mr B for Question 3, Part 2, about the influence of the family

Topics included	Mr A (%)	Mr B (%)
Threat from father	60	0.5
Lack support, poor coping	14	17.5
Issues with mother	14	27
Bond with sister	6	-
Lack of father	5.5	27
Catholic family background	-	28

The fact that answers to this question so clearly reflected the content of the two case vignettes is an important finding in its own right. First, it underlines again the extent to which models are sensitive to context. Second, it suggests, as evidence from elsewhere would also indicate (Glasgow Anti-Stigma Partnership, 2007), the possibility that such answers might reflect one or more distinct models concerned specifically with religion and spirituality in addition to other aspects of culture.

The possibility of one or more distinct models for religion and spirituality, in addition to other aspects of culture which may have links with ethnicity and race, is further strengthened by the fact that answers on similar themes were found also in Part 1 of the questionnaire, i.e. even before respondents had sight of the case vignettes in Part 2. Thus, as Table 10 above shows, although involving a general question about the influence of culture on mental distress, 10% of responses were concerned with religion/spirituality.

Again, more detailed studies, using more direct methods of investigation, are required to establish whether there are indeed distinct models of mental disorder reflecting aspects of religion, spirituality and different aspects of culture in relation to race and ethnicity. The preliminary evidence for such models provided here is nonetheless consistent with a growing body of evidence, particularly from service user narratives and service user-led research (Faulkner and Layzell, 2000) of the importance of these factors in how mental distress is understood and responded to.

3.1.5 Conclusions for models

In this Section we have shown that, although an online survey with all the methodological limitations of this approach, our findings build on those of Colombo et al.,

1. in showing the sensitivity of models to context,
2. in providing evidence that, as Colombo et al. predicted, there are marked shifts between explicit and implicit models, and
3. in adding to the data suggesting the existence of distinct models concerned with religion/spirituality and other specific aspects of culture, which could link with cultural differences based on ethnicity and race.

As a pilot study, these findings are given greater weight by the fact that, as noted at the start of this section, there was a strong overall concordance between the models that we elicited and those found in Colombo et al.'s study.

In the next Section we explore the results of our pilot study for race and racism in more detail.

3.2 Race and racism: overview of findings

In this section of the report, we outline our findings for race and racism. Our main findings in this area were:

1. A considerably greater number of responses concerned with race and racism than in the Colombo et al. study of models.
2. Strong and consistent endorsement across all groups of the view that racism affects mental illness.
3. A number of contrasting responses that were along race/ethnic lines: for example, those of black/Asian ethnicity were more likely to agree that white men have better mental health support systems, while those with white ethnicity were more likely to disagree with this.
4. A number of responses that did not follow anticipated race/ethnic lines: for example, a polarised response among those of black ethnicity about whether young black men are more likely to suffer mental illness than young white men.

3.2.1 Issues of racism

Issues of racism figured significantly in response to the direct questions in Part 1 of the questionnaire (see Table 12 below). A key overall finding was the extent of agreement across respondents as a whole that racism affects mental illness – 87% agreed or strongly agreed that racism affects mental illness.

Table 12: Percentages of respondents agreeing/disagreeing to Question 3 in Part 1, about whether racism affects mental illness

Agree/Disagree	% responses
Strongly agree	47
Agree	40
Neither agree nor disagree	7
Disagree	5
Strongly disagree	1
Catholic family background	-

Issues of racism, and the effects of race more generally, also emerged in the responses to the case vignettes in Part 2, especially as one would expect, in the responses to Question 4, “in what ways do you think race or racism contributed to these behaviours?”

Table 13 gives the responses to this question. As anticipated, both Mr A and Mr B elicited many responses around race, racism and other related aspects of discrimination, but the actual content of the responses reflected the very different descriptions of the two case vignettes.

Table 13: Responses to Question 4, Part 2, “In what ways do you think race or racism contributed towards these behaviours?”

Factors mentioned	Mr A (%)	Mr B (%)
School institutional racism	27	-
Issues with white population	21	-
Social exclusion, disadvantage	21	-
Black/Irish stereotypes	9	4.5
Leads to fear/anger/aggression	8	1.5
Diminished self esteem	4	-
Social control vested in white population	4	-
Affects diagnosis/ treatment	3.5	3
Leads to alienation, isolation	3	6
Irish discrimination	-	82
If mixed race	-	4
Catholic religion	-	77.5

Note: The numbers are based on responses to this question by the first 50 respondents (many respondents mentioned more than one factor).

It should be noted that in the study by Colombo et al the case vignette involved someone called 'Tom', who was a construct from the criteria for a diagnosis of schizophrenia as set out in a major psychiatric classification of mental disorders, the American Psychiatric Association's (1994) Diagnostic and Statistical Manual (or DSM). 'Tom' was deliberately made neutral as to race, sexuality and religion. In the present study, by contrast, Mr A and Mr B were described respectively as having Jamaican parents, and as gay/Catholic. Correspondingly, therefore, responses for Mr A included many along the lines of 'school/institutional racism' and issues with the white population, while for Mr B responses were mostly around 'Irish discrimination' and 'Catholic religion'.

Although important, these responses reflect the methodological limitations of a pilot study as noted in the Introduction. Ideally, beliefs about race and racism, as two quite distinct concepts, should have been explored separately. However, as noted in the Introduction, a priority was to keep the questionnaire short in this pilot study, and for this reason we decided to treat them together. We were aware in particular that beliefs about race and racism may often be closely tied together: for example, the belief that black people are more likely to suffer from mental disorder than white people, could be, either a belief about the differential rates of disorder by race, or a reflection of a racist prejudice. It might also reflect the view that racism and other socio-economic disadvantages that many black people experience could be the cause or key factor in mental distress which would not be seen in more socially and economically advantaged ethnic groups. But short of in-depth face-to-face interviewing it may be impossible in a given case to tell these very different beliefs apart. Furthermore, as shown elsewhere, there may also be quite distinct and different understandings of mental distress held by different ethnic groups (Glasgow Anti-Stigma Partnership, 2007). This is a limitation of the online questionnaire methodology, therefore, which, as we discuss further below, has to be weighed against the advantages of this approach (see Conclusions).

3.2.2 Beliefs about the influence of race and racism on mental disorder

As noted in the last section, issues of race and racism figured strongly in response to the direct questions in Part 1 of the questionnaire, a key overall finding being the extent of agreement across respondents as a whole that racism affects mental illness (see Table 12 above). As also noted in the last Section, issues of race and racism were evident in the responses to the case vignettes in Part 2 (see Table 13 above).

It is worth emphasising the extent of the agreement on this key issue, i.e., that despite the wide ethnic spread of respondents, well over 80% either agreed or strongly agreed that racism affects mental illness (Table 12 above).

Cross-tabulating the overall results with ethnicity showed no significant difference between groups on the question of whether racism affects mental illness. This reflected the strong agreement across the sample as a whole on this point.

3.2.3 Ethnicity and mental illness

In contrast to the overall agreement that racism affects mental illness, there was a wide spread of views as to whether young black men are more likely to suffer from mental illness than young white men. This is shown in Table 14 below.

Table 14: Question 1, Part 1 – “Young black men are more likely to suffer mental illness than white young men”

Response	% responses
Strongly agree	10
Agree	27
Neither agree nor disagree	27
Disagree	28
Strongly disagree	8
Catholic family background	-

The response to this question by ethnic sub-group was also rather more complex than for other questions in that the responses of those with black or Asian ethnicity (over 18% of all respondents) showed a marked degree of polarisation as shown in Table 15 below. These groups were significantly more likely than the white group to agree with the view that young black men are more likely to suffer from mental illness than young white men. However, those with black ethnicity were also less likely to select the ‘neither agree/disagree’ option, and this was reflected in the fact that they also showed a high level of disagreement with the question.

Table 15: Question 1, Part 1 – “Young black men are more likely to suffer mental illness than young white men” – analysis by ethnicity of respondents

	Black	White	Asian
Strongly agree/agree	50	33	45
Neither agree or disagree	11	31	27
Strongly disagree/disagree	39	35	27

3.2.4 Support systems

There was a divided response to the statement that white men have better support systems than black men, with overall more agreeing (44.5%) than disagreeing (27.5%) and many undecided (28%). Further, in contrast to the agreement on Question 3 (that racism affects mental illness), as Table 16 below shows, responses to this question were divided broadly along ethnic lines - those with black or Asian ethnicity were significantly more likely to agree that white men have better support systems, whereas those with white ethnicity were more likely to disagree with this view.

Table 16: Question 2 – “White men have better support systems than black men”

	Black	White	Asian
Strongly agree/agree	72	38	64
Neither agree or disagree	9	32	12
Strongly disagree/disagree	19	29	24

3.2.5 Perceptions of resilience when misdiagnosed

Although respondents were broadly split on this question, overall a minority of respondents (44.5%) agreed with the statement that black men show more resilience when misdiagnosed.

As can be seen in Table 17 below, respondents were divided broadly on ethnic lines; those with black or Asian ethnicity agreeing more than those with white ethnicity, and vice versa, in relation to disagreeing with the statement.

Table 17: Question 4 – “Black men are more resilient than white men when misdiagnosed”

	Black	White	Asian
Strongly agree/agree	27	4	24
Neither agree or disagree	38	35	36
Strongly disagree/disagree	34	60	39

3.2.6 Beliefs about willingness to accept help

This question, like the preceding one, elicited a split response, again with a minority (43%) of respondents agreeing with the statement that white men have more problems accepting help than black men. However, perhaps surprisingly, there were no significant differences between ethnic groups on this question.

3.2.7 Conclusions for race and racism

The study elicited overwhelmingly more responses concerned with race and racism than the original research on models by Colombo et al. This in part reflects the fact that the introduction to the survey itself states that it is concerned particularly with ethnicity and mental health; and issues of race and racism were explicitly investigated in the first part of the survey and of course, reflected in the vignette of Mr A used in Part 2. However, this provides a further indication of the extent to which the models we use in understanding mental distress are dependent upon context and situation.

Among specific findings, it is important to note the strong overall agreement with Question 3, that racism affects mental illness, among all groups irrespective of ethnicity. Again, this possibly reflects the interests of people likely to respond to a survey of this kind (see above, section 2.4), but if repeated, provides an important counterbalance to ethnic stereotypes. However it was not possible to tell from the findings as to the ways in which respondents believed it affected mental illness.

Also important in countering stereotypes were a number of findings about the differences between ethnic groups in their responses to particular questions. As noted, those of black ethnicity agreed more strongly than other groups that young black men are more likely to suffer from mental illness than young white men; but it was surprising to find such a large proportion of this group also disagreeing with it. There were, similarly, fewer differences between ethnic groups than we had expected on questions exploring perceptions of support systems, resilience when misdiagnosed, and willingness to accept help.

The findings here should be interpreted with caution given that some of the defined subgroups were relatively small. Nonetheless, all the findings described are statistically significant, and, if supported by further research, they have important implications for the development of positive practice.

4. Conclusions

As we have emphasised, there are well-recognised limitations of the online methodology that we adopted and this study was always intended as a pilot survey. Our conclusions should therefore be read throughout as tentative and subject to further research and indeed evidence from other sources, including service user and carer narratives.

Although a pilot project, however, and subject to all the methodological limitations we have noted, the study produced a surprisingly rich set of results. In this section we indicate some of the headline points from these results. First, we note an important strength of online methods and draw together a number of the directions for future and more definitive research towards which we believe our findings point. We then outline some of the wider implications of our findings for policy, training and front-line service delivery in mental health. Finally, we conclude with a reflection on the methodological aspects of the project particularly as these reflect our experience of working together in this challenging area.

4.1 Voices heard and unheard

As a method for reaching minority voices, the limitations of web-based survey methods outlined above, are also among its strengths. Problems such as bias in the responses obtained and control of the study sample remain. But these problems also allow the method to be more open in the groups that it reaches. The very fact that those planning and running the survey have relatively little control over who responds, opens up the possibility of voices being heard that might otherwise have been neglected.

In the present case, the findings summarised in Table 2 – a 2:1 female to male ratio and relatively high proportions both of 'black/Asian/mixed parentage respondents and of 'service user/carer' respondents (both over 20%) all tend to show the value of a web-based approach in this respect. This welcome result is indeed consistent with earlier work by the Mental Health Foundation using similar methods (Allott et al, 2005; Woodbridge et al., 2005). As already noted, given the limitations of online methods, our findings as such should not be accepted in an unqualified way. But our findings do suggest that online methods, particularly through reaching voices that might otherwise not be heard, have a valuable role to play in their own right alongside other more traditional researcher-controlled methodologies.

4.2 Further research

As just noted, despite being a pilot study, the survey produced a number of statistically significant findings, and we believe that these could form a fruitful basis for further research using more formal methods. We have indicated a number of these areas for further research in earlier sections of the report. Overall, they cover three main areas, the diversity of perspectives on models of disorder, the sensitivity of models to context, and possible new models.

4.2.1 Diversity of perspectives

It is a specific prediction of a values-based approach (see Background) that perceptions of mental health issues will be far more diverse between different groups and between different individuals than would be expected from any particular point of view (Woodbridge and Fulford, 2004, chapter 3). This prediction was clearly fulfilled in the present case by the findings both for models and for race and racism.

First, as to models, the spread of models was even wider than in the original Colombo et al (2003) study (Table 4) and we found greatly increased emphases on both culture and ethnicity (for example, Table 12) and religion/spirituality (for example Table 10). Second, in relation to attitudes to race and racism, while some responses divided up according to ethnicity, for example perceptions respectively of support systems (Tables 16) and of resilience (Table 17), other responses, such as the agreement among all groups that racism affects mental illness (Table 12), did not. In addition, one response (Table 15) clearly polarised within a particular ethnic group.

A first important area for research is thus to explore in more detail the great variety and complexity of this diversity of perspectives both for models of disorder in general and specifically for aspects of race and racism, and to explore the causal factors by which they are driven.

4.2.2 Sensitivity to context

A second area for further research, closely related to the first, is the remarkable sensitivity of models of disorder to context suggested by our pilot study. This sensitivity to context has at least three aspects.

- Marked shifts between explicit and implicit models as shown by differences in responses respectively to the direct questions in Part 1 of the study and the responses to the vignettes in Part 2 (Tables 5, 6, and 7).
- Differences between first and third person perspectives as suggested by differences respectively in how respondents said they themselves would respond to a mental health issue (first person, as in Table 9) and what they believed the person concerned would want (third person, as in Table 8).
- Vignette specific responses, for example the emphases respectively on family background as a factor in Vignette A (Table 11) and on Irish discrimination in Vignette B (Table 13).

The need for further research on these and other factors that shift so dramatically the ways in which people respond to an episode of mental distress and disorder, is thus strongly indicated by our pilot findings.

4.2.3 Evidence of 'new' models

The evidence we found for components of models of disorder not well identified in previous studies, is limited but potentially important, and is thus, we believe, important as a focus for further research in its own right. In particular, the indication of possible models based upon culture and ethnicity and a distinct religious/spiritual model (Table 10) could be significant given the growing recognition of the importance of religious and spiritual beliefs as factors in recovery and other aspects of resilience (Glasgow Anti-Stigma Partnership, 2007).

4.3 Implications for policy, training and front-line services

Assuming that the above findings are born out by further research, they have a number of clear practical implications for mental health in such areas on policy, training and the development and delivery of front-line services. Clearly, in their application to practice, our findings overlap in a number of respects, but we outline their practical implications separately in this section.

4.3.1 Evidence on values

Policy in mental health, and corresponding training and service development initiatives, are often driven by untested perceptions of expected attitudes and beliefs among not only the wider public but also particular ethnic and cultural subgroups. The finding from this pilot study, therefore, that well-established expectations of attitudes around race and racism are often seriously out of line with the actual attitudes adopted by stakeholders in mental health (Tables 12 and 15), is potentially important.

While, again, the results of a survey of this kind have to be treated with caution and invite more research to be undertaken, our finding of the extent of the diversity of views even within particular ethnic groups, underlines the importance of policy being developed on the basis of a balanced and fully evidence-based understanding of the diversity of views in this area. A particular aspect of this diversity, moreover, highlighted by this study is diversity of values. As already noted, a specific prediction of the theory of values-based practice, is that differences of values are likely to be wider than those concerned expect or anticipate. One clear implication of the findings of this pilot study, therefore, is the importance of policy and practice in mental health being based on robust 'evidence of values' rather than presuppositions, however reasonable these may seem.

The difficulties involved here, even in developing valid and reliable methods of searching electronic databases, are only just beginning to be recognised (Petrova et al., 2006). It is worth noting, therefore, that Warwick Medical School, as one of the original partners to this study, is developing methods for such searches and will be publishing its initial findings in the form of a web-based manual later this year.

4.3.2 Values-based training

The marked sensitivity of models of disorder to different aspects of context suggested by this pilot study might be thought to reflect at best a pragmatic and at worst an inconsistent application of models and hence of the values and beliefs underpinning them. This however would be to misunderstand the values-based approach. As Colombo et al. (2003) pointed out, and as they further showed in a subsequent article (Fulford and Colombo, 2004), the diversity of models, of which the sensitivity of models to context is a key aspect, is a reflection of our individuality as particular and unique individuals and groups. A failure to recognise the full diversity of our individuality in this respect is a source of failures of communication and lack of shared decision-making both within multidisciplinary teams and between service users and service providers: whereas by contrast, acknowledging these differences and developing the skills to work with them effectively, is a basis for balanced decision-making that is dynamic and fully responsive to the relevant features of the particular context in which a given decision is being made.

This approach has been adopted for example in developing training materials to support the recently amended Mental Health Act by giving a much enhanced role to the Guiding Principles (Care Services Improvement Partnership and National Institute for Mental Health in England, 2008). Traditionally, such principles have been understood as a check-list of important considerations (i.e. values) underpinning a piece of legislation. As Lord Woolf has argued, however, in relation to the Human Rights Act, they are better understood as a framework of values within which balanced decisions have to be made (Woolf, 2002). In the amended Mental Health Act, correspondingly, the model adopted in the training materials is that, while the law tells us what to do, and the Code of Practice tells us how to do it, the Guiding Principles form a framework of values for balanced decisions on issues of compulsory treatment that are responsive to the particular context on a case-by-case basis (see in particular, the Foundation Module, Care Services Improvement Partnership (CSIP) and the National Institute for Mental Health in England (NIMHE), 2008).

Our findings, then, if repeated in further studies, suggest that this 'framework of values' approach to balanced decision-making could be helpfully employed more widely in mental health. This of course has implications for training. But there are now available a wide range of training resources to support values-based approaches, including the original training manual, *Whose Values?*, noted earlier, and a recently re-released (and further developed) set of materials produced through the 10 ESCs (Ten Essential Shared Capabilities) and related workforce programmes (see, National Health Service University, 2005, and recently updated in a new CD, National Institute for Mental Health in England, 2009).

4.3.3 Assessment and the personalisation of services

The evidence we found of distinct models based upon spirituality and other aspects of culture including race and ethnicity, although of course provisional and preliminary, has particular implications for assessment in mental health.

Traditionally, particularly within a narrow conception of the medical model, it has been assumed that assessment ('diagnosis'), even in an overtly values-based area such as the assessment of risk, is essentially an objective process carried out by experts drawing on generalised knowledge and with little reference to the particular individual concerned. It is important to emphasise that this is a mis-use of the medical model which, like any other approach to mental health care, should be carefully attentive to the particular individual concerned as well as drawing on expert generalised knowledge. However, in a recent consultation on good practice in assessment (National Institute for Mental Health in England and Care Services Improvement Partnership, 2008), all stakeholders, including service users and carers as well as practitioners, noted the extent to which services often still fall short of providing assessments that are genuinely person-centred and reflective of individual perspectives.

The findings of this study, therefore, add an extra edge to the importance of person-centred assessment in the extent to which cultural (including race and ethnicity) and spiritual aspects of mental distress, despite increasing evidence of their significance in recovery (Allott et al., 2002; Coyte et al., 2007), are neglected in most standard approaches to assessment. As with values-based approaches to training, moreover, there are resources available to support this. Taking spirituality as an example, a paradigm for exploring spiritual aspects of an episode of mental distress has been published by the Mental Health Foundation (2007). The NIMHE/CSIP consultation noted above includes a number of powerful examples of innovative practice bringing together mental health professionals with respected religious and spiritual leaders: Sharing Voices, a voluntary sector organisation in Bradford, has run a successful project for clients from Islamic groups, the "Listening Imam" Project (National Institute for Mental Health in England and Care Services Improvement Partnership, 2008).

Particularly with the current emphasis on 'personalisation' of services (Department of Health, 2007 and 2008), therefore, our results show the need for these and similar exemplar service models in spirituality and other aspects of culture including race and ethnicity, to be more widely adopted in assessment in mental health.

4.4 Research methods and our experience of working together

As noted at several points above, an important theme running through the findings from the survey was the extent to which the responses appeared to be highly sensitive to various aspects of the context in which they were elicited. A particularly important aspect of context from the perspective of a values-based approach to research on perceptions of mental distress, is the values and beliefs of those actually carrying out the research. The value-dependence of research has been well-recognised for some time by those working particularly in such areas as the history and philosophy of science (Fulford et al., 2006) and there is a growing recognition of its importance particularly in relation to research that, as in the present instance, is led by someone with experience as a service user (Fulford and Wallcraft, 2009).

In this last section, we reflect on the importance of this in the way the study was undertaken. In the first place, by way of setting the scene, it is important to note that from birth to completion this research project took place over a relatively long period of time (over 4 years). This posed some problems, not least in the turnover of staff involved with the project. Although the three key members of the research team (Dr Colin King (CK), Professor Bill Fulford (BF), and Toby Williamson (TW)) were the same at the beginning as at the end, TW was not involved in the data collection and main analysis period, because he was on secondment to another organisation at the time.

There was also some divergence of aspirations, expectations and values, among the key researchers, although it was also precisely this diversity which brought enormous benefits to the project as well. While the project was part funded and hosted by the Mental Health Foundation, BF also brought funding to the project and CK was employed on a freelance basis for his contribution. This meant that there were different expectations of the research, both in terms of process and outcomes between the three core members of the research team. A shared objective, was to explore the possibility of models of mental distress based upon, or using elements of, ethnicity, race, culture, and spirituality, which had not been evidenced in Colombo et al's research, and which might emerge using a different methodology and in a study led by someone (CK) with previous experience of services. But there was no escaping the fact that the research was attempting to address an area of the mental health system, and the experiences both of people using and/or working in that system, which is perhaps the most sensitive yet also most politically charged – race, ethnicity and mental distress. Combining this with the power dynamics of mental health organisations, professionals, and people with experience of using services trying to collaborate together to undertake the research was not easy. The Mental Health Foundation has studied these issues extensively (Mental Health Foundation, 2001 and 2003) yet the challenges in practice remained very real.

These challenges were at times drawn into even sharper contrast when the key members of the research team reflected upon their own identity, experience and position within the project, as well as being part of the wider mental health system. Two members of the research team (BF and TW), objectively speaking, were in the more powerful positions because of professional status, access to funding, and organisational support. The fact that they are also white men, whereas the ex-service user researcher (CK) is a black man, certainly is a common reflection of power dynamics, roles and position within the mental health system. The members of the research team became more aware of this as the project developed, but this required honest and explicit, and sometimes difficult discussions, for members of the team to understand each other's values, perceptions and experiences.

These power dynamics were factors in discussions about the design, analysis and write up of the research. TW was very committed to completing the project within the resources available, but as far as possible remaining true to the original aim of an honest exploration of the challenging issues that the project was trying to investigate. At times this was not always congruent with the views of BF or CK. TW's perspective was also shaped partly by the corporate objectives and priorities of the Mental Health Foundation (which like some of the other staff involved with the project, had gone through some changes during the lifetime of the project). These did not affect the data collection process but, partly because there was so much data available, meant that a number of compromises had to be made during the analysis and writing up phases of the project. This was a difficult process and TW was aware that this was the source of some frustration, although agreement was reached regarding both the analysis and final report.

Our conclusion, therefore, in the present case is that, as a result of all these factors, although the survey was successful in producing a number of potentially important findings, the traditional framework of theoretical values and beliefs within which it was set, limited the extent to which we were able to access and explore areas relevant to such key issues as the origins of the dramatic inequalities in the rates of diagnosis of mental distress and disorder particularly in black and minority ethnic groups. As we noted in the introduction to this report, despite extensive research into this and other aspects of potential discrimination in the assessment of mental health issues, little progress has been made, with views among traditional researchers themselves becoming increasingly polarised (Singh and Burns, 2006; McKenzie and Bhui, 2007). Our experience suggests that this may well be because the critical issues are and remain, as one of us (CK) has graphically put it, masked by 'the theatre of theoretical indulgence'.

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Appendix: The survey questionnaire

Values in mental health assessments

An online survey

The Mental Health Foundation is supporting a project to find out more about how people understand mental health and mental distress, particularly in relation to men and ethnicity. We would be very grateful if you could help us by participating in this survey.

Your responses will form the basis of a report on these issues, which will be available from the Mental Health Foundation.

The survey is in the form of an online questionnaire, which has been created by someone who has experience of the mental health system. The questionnaire is in two parts. The first part asks about your views concerning mental health, mental distress, men and ethnicity. You will be asked to submit your answers at this point. Please do so. You will then go on to the second part, which invites you to read two fictional case studies and asks you some questions. There is then a brief final section which asks for basic information about yourself. Please answer this as well (it's all tick boxes).

You do not have to supply your name or contact details to complete the survey. All personal information you provide will be kept confidential. However we may use quotes from your responses although these will be anonymised. Your participation is entirely voluntary.

If you have any questions about the survey itself please do not hesitate to contact Toby Williamson at the Mental Health Foundation. If you have any technical problems in completing the questionnaire please contact the Web Team at the Mental Health Foundation.

It is estimated that the questionnaire will take approximately 20-30 minutes to complete.

Your responses are extremely valuable and we would therefore thank you in advance for taking part.

The project is being done in partnership with the University of Warwick.

Part 1

Questions	1.Strongly Agree	2.Agree	3. Neither Agree or Disagree	4.Disagree	5. Strongly Disagree
1. Black young men are more likely to suffer from mental illness than young white men.					
2. White men have better support systems than black men					
3. Racism affects mental illness.					
4. Black men are more resilient than white men when misdiagnosed					
5. White men have more problems accepting help than black men					

6. What do you consider to be the main causes of mental distress?

7. How might your understanding of mental distress be influenced by cultural factors?

Part 2

Mr A

Mr A is seventeen years of age, he lives alone in a council flat, his parents are originally from Jamaica and he visits them once a week. His relationship with his father broke down at the age of 14, as his father was physically threatening towards him. He has just been expelled from school after assaulting a teacher and he was also stabbed in the back after defending his sister at a youth club. He has developed morbid feelings about his mother, and felt life was not worth living. He has not eaten for one week, he stays in doors and can be heard talking to himself, shouting 'white people are evil'. When members of his family come to visit him he has taken a knife to them, chased them from his door, then often sleeps for long periods of time. Despite this he is known as a bright child who has under-achieved, he has no close friends, and often said to be 'in a world of his own'.

Questions	Mr A
1. How did this case make you feel?	
2. What reasons would you give for the person's behaviour e.g. biological, social, cultural, psychological, etc?	
3. In what ways do you think the family influenced these behaviours?	
4. In what ways do you think race or racism contributed towards these behaviours?	
5. How would you describe the mental health problem?	
6. What would your response be to Mr A?	
7. If you were Mr A how would you want people to respond?	
8. What were the factors affecting your decisions about these cases e.g. personal feelings, political beliefs, professional judgements, etc?	
9. Might being accused of racism or homophobia affect you, e.g. your use of language, behaviour, actions etc?	

Mr B

Mr B is a twenty two year old gay man, his mother was born in Ireland and is a Catholic, and his father was born in Brixton, south London. Mr B is a single child, attended the local comprehensive, and presently lives alone in a rented flat; he has a job as an administrator at the local social services. He has had several voluntary psychiatric admissions but often discharges himself within a week, and refuses medication. During the last few weeks he has hit his mother on three separate occasions, claiming that she has created demons in him because of her strict religious background and her negative responses to his sexuality. Mr B refuses to see his GP, he has stopped eating, and is often seen talking to himself whilst walking down the road

Questions	Mr B
1. How did this case make you feel?	
2. What reasons would you give for the person's behaviour e.g. biological, social, cultural, psychological, etc?	
3. In what ways do you think the family influenced these behaviours?	
4. In what ways do you think race or racism contributed towards these behaviours?	
5. How would you describe the mental health problem?	
6. What would your response be to Mr B?	
7. If you were Mr B how would you want people to respond?	
8. What were the factors affecting your decisions about these cases e.g. personal feelings, political beliefs, professional judgements, etc?	
9. Might being accused of racism or homophobia affect you, e.g. your use of language, behaviour, actions etc?	

The final section just asks you for some information about yourself.

Age	Under 18	<input type="checkbox"/>
	18 – 30	<input type="checkbox"/>
	31 – 45	<input type="checkbox"/>
	46 – 60	<input type="checkbox"/>
	61+	<input type="checkbox"/>
Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Race self-declaration.	White English	<input type="checkbox"/>
	White other	<input type="checkbox"/>
	Black British	<input type="checkbox"/>
	Black African	<input type="checkbox"/>
	Black Caribbean	<input type="checkbox"/>
	Asian British	<input type="checkbox"/>
	Asian	<input type="checkbox"/>
	Chinese	<input type="checkbox"/>
	Mixed Parentage	<input type="checkbox"/>
	Other please specify	<input type="checkbox"/>
Do not wish to say	<input type="checkbox"/>	
Sexuality.	Heterosexual	<input type="checkbox"/>
	Gay	<input type="checkbox"/>
	Lesbian	<input type="checkbox"/>
	Bi-sexual	<input type="checkbox"/>
	Do not wish to say	<input type="checkbox"/>
Main Role(s) You can tick more than one box	Mental health worker	<input type="checkbox"/>
	Current service user.	<input type="checkbox"/>
	Ex-service user.	<input type="checkbox"/>
	Mental health carer	<input type="checkbox"/>
	Other	<input type="checkbox"/>
	Do not wish to say	<input type="checkbox"/>

Occupation	Please state Do not wish to say <input type="checkbox"/>
Location	England <input type="checkbox"/> Scotland <input type="checkbox"/> Wales <input type="checkbox"/> Northern Ireland <input type="checkbox"/> Other – please state
Type of area where you live	Urban <input type="checkbox"/> Rural <input type="checkbox"/> Urban-rural mix <input type="checkbox"/>
Religion	Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Sikh <input type="checkbox"/> Muslim <input type="checkbox"/> Buddhist <input type="checkbox"/> Rastafarian <input type="checkbox"/> Jewish <input type="checkbox"/> Other <input type="checkbox"/> None <input type="checkbox"/> Do not wish to say <input type="checkbox"/>

Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. If you would like to make a donation, please call us on 020 7803 1121 .

Visit www.mentalhealth.org.uk for free information on a range of mental health issues for policy, professional and public audiences, and free materials to raise awareness about how people can look after their mental health.

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