

Research paper

Accounting for difference: analysis of nine murder inquiry reports involving black people with mental health problems

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ABSTRACT

Using textual and critical discourse analysis this article examines the complexities of racism and racial stereotyping within murder inquiries where the perpetrator of the violence was from a black minority ethnic background. Nine inquiry reports are examined and the issues highlighted show how certain stereotypes and misconceived notions about black people's lived experiences are incorporated into professional practice, such as risk assessment

and management, care planning and therapeutic interventions. The article examines both the process of carrying out murder inquiries and the care and treatment given to patients with mental health problems.

Keywords: black minority patients, mental health, murder inquiries, racial stereotyping

Introduction

Health Service Guidelines issued by the Department of Health (1994) require that an inquiry is held whenever a person who has been receiving care and treatment from a service provider commits a murder. The guidelines stipulate that the inquiry must be set up and conducted independently of the service provider concerned. The report following each inquiry sets out its terms of reference that usually include aspects such as exploring the care the individual was receiving at the time; the suitability of the care that was given; the extent to which the care given corresponded with statutory obligations, departmental guidance and local and operational policies; the exercise of any professional judgement; and the adequacy of the care plan and its monitoring by the key worker.

Lingham and Murphy (1996, cited in Eldergill, 1999) state that the aims of an independent inquiry should be:

- to establish the circumstances and events leading up to a serious incident
- to examine whether any change in operational methods, professional practice or management arrangements would prevent a recurrence of the incident

- to identify any concerns over professional standards, practice or conduct which may need to be examined in other forums
- and importantly to provide explanations and insight for patients, victims, relatives and the wider community.

The Department of Health has stated for the past six years its intention to review the guidelines for murder inquiries (Winchester, 2000). It still remains the case that the functions of such inquiries are not clear, particularly with regard to issues of race and ethnicity. To illustrate this point, the inquiry team often includes a psychiatrist, a representative from social services, usually a senior social worker, and a nurse manager. The chair is always a lawyer. However, the ethnicity of the panel members and the relevant expertise that each brings to the inquiry are never made explicit, nor are factors relevant to race and ethnicity in the examination of the evidence. In some inquiry reports it is claimed that race and ethnicity issues were not significant factors in the final findings (see for example reports on the inquiries into the care and treatment of Winston Williams, July 2002; NG, April 1996; and Christopher Clunis, February 1994 (Box 1)). There is

Box 1 Murder inquiries examined in this report

- 1 *Report of the Inquiry into the Care and Treatment of Christopher Clunis*, North East Thames and South East Thames Regional Health Authorities, February 1994
- 2 *Report of the Independent Inquiry Team into the Care and Treatment of NG*, Ealing, Hammersmith and Hounslow Health Authority and the London Borough of Hounslow, April 1996
- 3 *Report of the Inquiry into the Care and Treatment of Naresh Bavabhai*, Wigan and Bolton Health Authority, 1999
- 4 *Report of the Inquiry into the Death of Mr David Phillips*, Kensington and Chelsea and Westminster Health Authority and Westminster City Council, April 2000
- 5 *Report of the Inquiry into the Care and Treatment of Wayne Matthew Hutchinson*, Lambeth, Southwark and Lewisham Health Authority, November 2001
- 6 *Report of an Independent Inquiry into the Care and Treatment of SH*, North East London Health Authority, July 2002
- 7 *Report of the Independent Inquiry Team into the Care and Treatment of DN*, North East London Health Authority, September 2002
- 8 *Independent Inquiry into the Care and Treatment of Winston Williams*, Thames Valley Health Authority, July 2002
- 9 *Report of an Independent Inquiry into the Care and Treatment of Daksha Emson MBBS, MRCPsych, MSc and her Daughter Freya*, North East London Strategic Health Authority, October 2003

no explicit recognition of the need to identify and highlight overt and racist practices, or the failure by institutions to recognise that the person who has committed the murder may be subject to institutional racism in their care and treatment (see Box 2).

Box 2 Institutional racism

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people. (Home Office, 1999, para. 6.34)

Outline of the review

This article challenges this lack of attention to race and ethnicity. It presents an examination of nine murder inquiries involving black perpetrators who had mental health problems, demonstrating that institutional practices did affect the care and treatment given to such people. Textual analysis, together with critical discourse analysis, are used to identify assumptions, by both the inquiry teams and service providers, about the ways in which black minority ethnic communities live their daily lives within British society. Hall and Hall (2004, p. 167) identify the importance of ensuring that text construction should not be 'taken for

granted', and that issues of concern should not only include the writer's own part within the text and the style of discourse that is used, but also how evidence is treated. 'Why do some items get included and some excluded?' In examining the inquiry reports the analysis draws upon four basic assumptions identified within emancipatory and feminist research. These are that all knowledge is socially constructed; the dominant ideology is that of the white indigenous population and group; that there is no such thing as a value-free text; and that the perspectives of black and white people differ because people's perspectives vary systematically with their position in society (drawn from Stanley and Wise, 1990, p. 38).

The nine reports were examined with a view to observing the different ways in which race issues were addressed or omitted within the inquiries (see Box 1). The analysis surrounding racism and mental health from the reports fell into broad themes (see Box 3).

Background

Analyses of murder inquiries have tended to ignore or minimise issues relating to black perpetrators. Parker and McCulloch (1999, p. 6), for example, identify the strengths of murder inquiries as:

- focusing in detail on specific incidents
- gathering a considerable range of evidence – little is overlooked
- representing multidisciplinary and senior professional expertise.

Box 3 Main themes identified from the analysis

- Acceptance by professionals that black minority ethnic men were more violent and that this was the norm for them
- A perception that there is more stigma in black minority ethnic communities resulting in professional workers having less involvement with them
- Belief that black minority ethnic groups 'look after their own', resulting in professionals having less involvement with them in relation to care planning and a care programme approach
- Assumption that black minority ethnic communities prefer medication to counselling, resulting in fewer referrals to such services
- Assumption that members of black minority ethnic communities, particularly African-Caribbean men, are more likely to be substance misusers. Hence professional workers gave this aspect of their behaviour less prominence when making risk assessments
- A misconception that some professionals from black minority ethnic communities would automatically understand the nature of multiple oppression and how this affects other members of black minority ethnic groups

Yet, by their own admission, in the analysis of 14 major murder inquiries, ethnic minority issues are summarised as:

These do not come up in reports as much as might be expected. Some, however, observe that staff may have been too ready to make incorrect and stereotypical assumptions about black services users. (Parker and McCulloch (1999, p. 4)

Of the seven reports that Parker and McCulloch looked at involving black people it was only the Woodley Team report (Woodley *et al*, 1995) that concluded that mental health agencies had failed to recognise and respond to the cultural dynamics of care. Similarly, the Zito Trust report *Learning the Lessons* (Sheppard, 1996), when examining race and culture issues in murder inquiries, highlights only the case of Sharon Campbell, an African-Caribbean woman, stating that staff in community mental health centres ought to take account of the needs of ethnic minority communities, adding that training is essential in enabling them to do this. The absence of a critical focus on race and ethnicity issues suggests that the agenda for murder inquiries is different from that of other inquiries. For example, when a black person dies in the care of service providers as in the recent inquiry into the death of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) the response is quite different. In this case, how racial abuse was handled between David Bennett and another patient held a prominent position in the analysis of the circumstances surrounding his death, although it was not a direct consequence of it. The issue of racial practices and shortcomings is highlighted very confidently in this inquiry and is included in the terms of reference; indeed the findings of this inquiry have contributed to the Department of Health's (2005) delivery of race equality in mental

health. Such outcomes do not follow from murder inquiries.

To illustrate the difference, in murder inquiries, issues relating to race and ethnicity include comments such as:

We have asked witnesses for direct and indirect examples of racial discrimination which could have affected his care and treatment. We record that no example of such prejudice or discrimination has become apparent to us, save for the possibility of too great a willingness to accept that he had abused drugs. (*Care and Treatment of Christopher Clunis*, 1994, p. 4)

NG is a Kenyan Asian; the victim was also Asian ... We did not find any evidence or suggestion of racial prejudice or discrimination in the provision of services to NG. (*Care and Treatment of NG*, 1996, p. 26)

It would be good practice for patients from ethnic minority cultures to be offered periodic support from a care worker from their own culture. (It was not felt, however, that issues of race were central to the case under review, nor is there any suggestion of staff insensitivity to these issues.) (*Care and Treatment of Winston Williams*, 2002, p. 132)

These comments place a responsibility on the provider services to identify institutionalised racist practices within their own organisations – an aspect that they might be unwilling to admit openly or may not even recognise as a problem. Such unwillingness to explore issues relating to race and ethnicity, and indeed dismissing them categorically in some instances, raises questions as to whose priorities the inquiries really serve. If the aim is to investigate the care and treatment received by the perpetrator, then the inquiry team must examine all aspects of race and ethnicity issues that arise in that care, including taken-for-granted assumptions about black people. Muijen (1997) suggests that inquiries address incidents at three levels that include not only relatives' concerns but also

highlight the implications for local management and a wider political agenda. The political agenda in relation to inquiries where the perpetrator of the violence is a black person, unfortunately, do not generally account for race and ethnicity issues. Here the political agenda is generally to play down such issues.

It is hardly surprising that race and ethnicity issues are marginalised when the Health Service Guidelines (Department of Health, 1994) do not themselves articulate explicitly the need for the inquiry team to include at least one member from the same ethnic community as the person who has committed the murder, or identify consultant(s) or witnesses who are not only able to identify issues relating to culture but also have an understanding of the processes of institutional racism and how this operates both overtly and covertly through, for example, non-intervention strategies. Such marginalisation of race and ethnicity issues is indicative of the institutional processes involved in the conduct of murder inquiries themselves.

Racism and ethnicity

Discourses represent ideologies that are seen as evidence of the ways in which certain groups or individuals interpret the world. Racist discourses are used to include and exclude people's experiences, a feature that is evident in murder inquiries in which the origins and ethnicity of both the perpetrator of the violence and the inquiry team members are not stated. Murder inquiry reports have to be read in depth before the ethnicity of the perpetrator becomes apparent, and even then this has to be surmised from comments such as:

Wayne Hutchinson's father, who came from Jamaica ... His mother was also born in Jamaica. (*Care and Treatment of Wayne Hutchinson*, 2001, p. 7)

Or, as was identified in the inquiry following the death of David Phillips:

Andre, a refugee from Angola ... (*Inquiry into Death of David Phillips*, 2000, p. 1)

There is nothing to suggest that either of these two men is black. Having parents who were born in Jamaica or being a refugee from Angola does not in itself constitute such an identity. It has been a requirement since 1995 for NHS trusts to record the ethnicity of all patients admitted to hospital. However, in a survey for the Mental Health Act Commission undertaken by the Sainsbury Centre for Mental Health and the University of Central Lancashire, only half of the 104 mental health and learning disability units visited had a clear policy on recording ethnicity (Warner *et al*, 2000). Furthermore, the survey report states that:

without ethnic monitoring, it is difficult to establish the nature and extent of inequality, the areas where action is

most needed, and whether measures aimed at reducing inequality are succeeding. (Warner *et al*, 2000, p. 23)

It is not easy to evaluate whether black people are over-represented within murder inquiries, and neither is it possible to differentiate the ethnic representations between various ethnic minority groups. There is no central point, within the Department of Health, where inquiry reports are held together with statistics on the race, sex and ethnicity of the perpetrator of the violence or the victim; this makes quantifying race and ethnicity issues difficult. Where race and ethnicity issues are accounted for, as in the case of SH (*Care and Treatment of SH*, 2002), careful consideration was given by the panel to the involvement of a spiritual healer in the care of those people who have mental health problems. Interestingly, this was one of the few inquiry reports that stated explicitly that one of its members had knowledge of the cultural practices of Bengali communities. A study by Bhui *et al* (2002) shows that Asian men complained that their religious beliefs were not always considered as part of their mental health treatment, and that this, in their opinion, distracted from the care that they received. In SH's case, his spiritual needs were never taken into account when assessing his mental health problems by either health or social services. Consequently, when he became more spiritual as he became more ill, this was not picked up as a signal that things were not going well in his life despite the emphasis on a holistic approach to mental health in both social work and healthcare practice (Dutt and Ferns, 1998). In SH's case, neither the spiritual healer nor his wife recognised that his religious beliefs were no longer a coping mechanism for him but were taking over his life. A clear recognition and understanding of how religion played such a central part in SH's care and treatment could have enabled service provider agencies, particularly those of clinical and social care, to intervene much more assertively and support his wife, whom he very likely physically abused before he went on to kill her.

Racial discourse and stereotyping

Racist practices are not always evident in the omission of black ethnic minority people's identities, because racial discourses are expressed in terms of *common sense* thinking and ideology. *Common sense* is a challenging term. If it is derived from research and evidence it can be a helpful process in practice. However, *common sense* based on unquestioned beliefs and assumptions can be used to limit the scope of inquiries rather than open them up (Thompson, 1995). The myth of increased stigmatisation of mental health

problems in black communities is often used as a means for not intervening with carers and relatives. This myth, coupled with another myth that black people *look after their own*, further diminishes the need to intervene. While there may be some evidence to suggest that black communities are less likely to be interested in mental health issues (Walls and Sashidharan, 2003), there is no connection between this and any increase in stigma. In the analysis reported here, professional workers' misconceived perceptions were evident in the lack of contact between them and carers, which resulted in poor and dangerous practice. In all the reports, aftercare was either never instigated or very poorly managed. There was no instance in which close relatives or carers were involved in any care planning or aftercare, resulting in serious consequences for two of the carers: DN who killed his paternal grandmother, and SH who killed his wife.

Carers and family members are clearly at risk and have a vital role to play in preventing the escalation of abnormal behaviour, with the possible exception of Andre da Conceicao, a refugee who killed David Phillips (*Report of the Inquiry into the Death of David Phillips*, 2000). In the cases of Christopher Clunis, NG and Naresh Bavabhai, family members made attempts to meet with workers and their advice was ignored, resulting in the family of Naresh Bavabhai making a formal complaint to their social services department for a Gujarati-speaking link worker to support his mother who was his primary carer. Walls and Sashidharan (2003) reported that accessing services was 'overwhelmingly regarded as problematic', because services were not culturally sensitive to the needs of ethnic minority groups. All the murder inquiry reports demonstrated the problems that carers and relatives experienced in accessing mental health and social services.

Racialised practices and madness

Violence and aggression

A significant feature of the nine murder inquiry reports was the expectations that health and social care professionals had of black men, and which seemed to be related to racialised practices in their care and treatment. The construction of racialised identities is built upon the expectations that professional workers have of black people and black cultures. The images of black men as being more violent and threatening to society than others was used as a means of providing more punitive forms of psychiatric intervention. This issue has been highlighted significantly in *Inside Outside* (Department of

Health/National Institute for Mental Health in England (NIMHE), 2003, p. 14), which identified the need for a national strategy to improve the care and treatment of ethnic minority communities because:

Within psychiatric settings, black and minority patients are more likely than white people to be assessed as requiring greater degrees of supervision, control and security and, partly as a result, more likely than majority white people to be admitted to secure care environments. There is a very strong association between ethnicity and transfer/admission to secure units, particularly medium secure facilities. Over-representation of black people in high secure settings has been an enduring feature of British psychiatric care.

This stereotyping of black men as being more aggressive and violent was evident in the inquiry reports demonstrating that staff in psychiatric, social, housing and police services held such expectations of black men. However, even if their response to these men did not always lead to a more punitive intervention, aggressive behaviour was not assessed as a risk factor but was taken for granted. It was assumed that black men would behave in this way; that this was a norm for them even though a history of violent behaviour has been identified as a clear risk factor in the prediction of future violence (University of Manchester and Department of Health, 1996). Out of eight murder inquiry reports in which there was evidence of previous violence, six identified the use of knives (*Care and Treatment of Christopher Clunis*, 1994; *Care and Treatment of NG*, 1996; *Care and Treatment of Naresh Bavabhai*, 1999; *Care and Treatment of SH*, 2000; *Care and Treatment of Winston Williams*, 2002 and *Care and Treatment of DN*, 2002). Aggressive behaviour, together with non-compliance or the erratic use of medication and other factors such as high levels of anger and hostility, and a clinical diagnosis should have alerted professionals to intervene much more assertively and much earlier on. In the case of black men and mental health, interventions are either too coercive or forceful, as in the case of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003), or minimised because their behaviour is seen as part of the norm.

Substance abuse

Substance abuse seemed to be regarded in the same way. For example, Winston Williams (2002) tested positive for substance misuse but this was regarded as a 'one-off' event. Random urine tests were abandoned because he refused to co-operate with the procedure. Despite the positive test result, he constantly denied taking drugs, and no referral was made to other agencies that might have helped him. This inquiry demonstrates the complexities of stereotyping,

and highlights that even when there was clear evidence of drug abuse, the matter was not diligently pursued. To give another example, in two cases, Christopher Clunis (1994) and Andre da Conciecao (*Inquiry into the Death of David Phillips*, 2000) both claimed that they abused drugs, and the service provider agencies believed them, even though there was no corroborative evidence to support the men's claims.

While substance abuse featured as an issue in all the cases relating to African-Caribbean men this was not so much the case with South Asian men. Indeed, when the matter was raised, as in the case of Naresh Bavabhai, service providers recognised that he had an amphetamine addiction and that he had been assessed by a substance misuse team. For a short time he also attended Narcotics Anonymous. Evidence therefore suggests that substance misuse is seen as a fact of life for African-Caribbean men but not for South Asians. The consequences of this are that, for African-Caribbean men, substance abuse is discounted as an important factor in their care and treatment.

Black professionals/white professionals: implications for practitioners

Previous analyses of murder inquiry reports (Sheppard, 1996; Parker and McCulloch, 1999; Stanley and Manthorpe, 2001) have not examined the effectiveness of responses to *race* and *ethnicity* issues when black professionals are involved in the care of black service users. There has been a naïve assumption that because various health professionals, such as consultant psychiatrists or GPs, are also from black ethnic minority communities, this in itself will lead to antiracist practice from such practitioners. The link between racism and western psychiatry has been well established (Fernando, 1991; Watters, 1996; Desai, 2003). Professional training in mental health for health and social care workers, however, is slow in accounting for this link, still promoting the idea that psychiatry is a scientific activity which is not reliant upon understanding people's lived experiences, how these experiences prove to be a strength to them, and where they are a constraint.

Two cases highlight the issues of the awareness of black professionals and the impact that this awareness can make. In the first case, *Care and Treatment of SH* (2002), the ethnicity of SH's responsible medical officer (RMO) and his GP are assumed to be non-white from their names, although the inquiry report does not specifically state this. SH eventually killed his wife AK after she had probably experienced violence from him prior to the murder. Neither the RMO nor

GP placed any value upon AK's role in the care of SH. The inquiry team stated that:

... No doubt both relied in large measure upon AK to notify the mental health services of any further deterioration in SH's mental state, but this was a heavy burden to place upon AK. She was never offered any formal advice or assistance in this role, or asked whether she would value the involvement of the CMHT [community mental health team] in the care of SH ... (*Care and Treatment of SH*, 2002, p. 38).

Such poor practice may, and most likely would, have been framed by critics within the context of racist and sexist intervention had the RMO and GP been white and male, with the main criticism being that they had not taken account of SH's culture in their assessment of his mental health and the impact that this had on those caring for him. Such criticism would have suggested that the GP and RMO had been racist in their approach in the care and treatment of SH. However, as neither were white practitioners, the inquiry team noted this as evidence of poor practice, not taking the opportunity to explore how cultural and institutionalised practices are marginalised or ignored by all practitioners. This criticism of the care and treatment given to SH would have remained whether the practitioner was white or black. The National Institute for Mental Health in England (NIMHE) has recommended that all GPs should have training in cultural awareness and that this together with mental health should become part of GP training (Department of Health/NIMHE, 2003). NIMHE also recommends that the initial training of GPs should incorporate cultural competency (Department of Health/NIMHE, 2003). While these recommendations may be seen as a positive step forward, they also have limitations and it is important to remember that while cultural awareness is an important factor in understanding racism, it is not ostensibly the only one necessary for anti-racist practice: the self also requires attention. Thompson (1995) highlights the importance of reflecting on one's own practice at personal, cultural and structural levels when analysing anti-oppressive interventions. The recommendations for GP training therefore need to go further in enabling all practitioners, irrespective of whether they are black or white, to understand how their personal values inform their understanding of cultural values, and how knowledge can be institutionalised into oppressive practices, including sexist as well as racist practices.

The second case, *Care and Treatment of Winston Williams* (2002), demonstrates the impact a practitioner who has an awareness and understanding of racism and its negative effects can bring to a scenario. Winston Williams had a history of irregular and infrequent contact with both his medical and social supervisors. His RMO took a liberal approach to his

care, and did not enforce urine tests to check if he was remaining drug free which was a condition of his discharge under section 37/41 of the Mental Health Act 1983. The RMO gave his reason for this as not wanting to adversely affect his relationship with his patient. At one time, Williams was allocated a black social worker, whom the panel commented had a positive and commendable approach to supervising Williams. The social worker laid down clear boundaries for Williams and took a much more proactive approach in his care. However, Williams did not like this approach and threatened to kill him. He also stated that he did not like having a black social worker, possibly because the black social worker was not afraid to challenge him. This case illustrates the need to understand that working anti-oppressively with black service users is not just about acquiescing to the wants and desires of such service users, but is also about building trust and a good working relationship based on openness. Where workers are prepared to do this with difficult-to-manage service users, the institutional response should be to support them. Unfortunately, in this scenario the threats to kill his black social worker were ignored by the social services department and the social worker withdrew from the case.

Providing a different framework

It may appear as if the current prevailing discourses will always remain as the dominant feature in mental health, and that other discourses will only ever remain as marginalised entities, perhaps helpful in highlighting and critiquing only certain aspects of concern. However, the case of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003) offers a different perspective. David Bennett did not commit a murder. He died in psychiatric care while being pinned to the floor and placed in a prone position during control and restraint. Following a prolonged struggle he collapsed and died. The subsequent inquiry report does not overtly state the ethnicity of the inquiry team, but the terms of reference clearly highlight ethnicity as a relevant factor to be examined in his care and treatment alongside incidents of racial abuse. The introduction to the report states very clearly that:

Mr David Bennett was an African Caribbean who suffered from schizophrenia. (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003, p. 6)

Moreover, the inquiry's terms of reference were formulated after gaining the views of David Bennett's sister and following tireless campaigning by the family. It could be argued that David Bennett was the victim, that is to say that the incident resulted in his death as

opposed to him killing someone else, and hence the purpose and nature of the inquiry are different. However, drawing on the earlier definition of institutional racism, it is also arguable that those mental health service users who commit murder are victims of a system of care that has failed them. In the case of David Bennett, the inquiry team did not fudge the issue that he had violently attacked a female nurse, causing her very serious harm before he was placed in the prone position. The inquiry report made assertive recommendations for dealing with racial abuse, even though David Bennett did not die as a direct consequence of this. The findings and recommendations set out in the report have also led to the consideration of wider implications for change in the care given to black and ethnic minority communities within mental health.

Conclusion

Adopting a critical discourse analysis has highlighted various areas that the inquiry teams investigating murder committed by people with mental health problems could have explored in more detail. The complexities of institutionally racist practices require an awareness, knowledge and understanding of how racism operates both covertly and overtly, as well as responses to black ethnic minority people through over-reaction or non-/poor-intervention practices. In examining the suitability of care given to black ethnic minority people, inquiry teams need to account for the ways in which black people are perceived in society. Inquiry teams, therefore, should adopt a critical reflective process in their analysis of evidence that allows for questioning of taken-for-granted assumptions formed by service providers, rather than reliance on service providers to produce such evidence themselves. The Race Relations (Amendment) Act 2000 makes clear that racist practices are evident through prejudice, ignorance and stereotyping, and hence there is legislative support and requirement to examine these issues in practice.

Racism and racist practices are socially and discursively produced and hence, exist as entities in all areas where care is given. The fundamental challenge is to not ignore or minimise their impact, but to explore their consequences in hindering effective care and treatment in mental health. Any professional, whether they are black or white, will give credence to the epistemological status of things because this represents reality. Therefore, the fact that a South Asian GP was administering drugs to SH (*Care and Treatment of SH*, 2002), in the earlier example, may have been seen as both the most important and the only aspect of his interaction with SH's wife. The fact that she would have been caring for someone who may

potentially have been aggressive and had a severe mental health problem would not have entered his reality as a medical practitioner. He would have operated within a narrow medical discourse focused only on SH's wellbeing through the administration of drugs, anything else being irrelevant. Burr (1995, p. 90) argues that change is possible 'because human agents are capable (given the right circumstances) of critically analysing the discourses which frame their lives'. Change is also possible by engaging with other, more marginalised discourses, such as racial discourses that enable us to see the complex and contradictory ways in which black people's realities are constructed in mental health systems.

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CONFLICTS OF INTEREST

The views expressed in this article are the author's own.

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