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*National Institute for  
Mental Health in England*

## Inside Outside

Improving Mental Health Services for  
Black and Minority Ethnic Communities in England





**Act3b by Glasford Hunter. Glasford experiments with computer manipulation of digital photographs of oil paintings**

Glasford has exhibited at Network Arts Lewisham. Network Arts is an arts project set up for people with mental health support needs. We are a user led project and run along the lines of a small creative business.

We offer the following services:

- Opportunities to be part of the running of a small arts/crafts business (craft production, marketing, IT, retail, accounting etc).
- Offer training in different art techniques e.g. batik, tye-dye, and decoupage.
- Opportunities to work as part of a team on larger art projects e.g. murals, large mosaic pieces.
- Support for members to facilitate art sessions/workshops/projects both within Network Arts and at other centres e.g. Basic leatherwork sessions, mosaic sessions and a music c.d. production project.
- Support and encourage member artists to promote and develop their own work; through organising exhibitions both in our own gallery and outside (Lewisham Library), developing individual portfolios.

For further info visit our website at [www.networkartslewisham.com](http://www.networkartslewisham.com) or email us at [info@networkartslewisham.com](mailto:info@networkartslewisham.com).

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# Inside Outside

Improving Mental Health Services for  
Black and Minority Ethnic Communities in England



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# Ministerial Foreword

The Government is profoundly committed to race equality. One of the core values underpinning the modernisation programme within mental health, the *National Service Framework for Mental Health* and the *NHS Plan* is that mental health services should be appropriate to the needs of those who use them and non-discriminatory. We are determined to ensure that everyone in our society benefits equally from these reforms.

However, the testimony of many service users, carers and members of the black and ethnic minority communities is that this aspiration is not yet a reality. I acknowledge this. Tackling ethnic inequalities within mental health services, in terms of prevention, early detection, access, diagnosis, care and quality of treatment and outcome is one of the greatest challenges facing us. We have an obligation to meet this challenge and tackle racism and institutional discrimination within our mental health services.

I am immensely grateful to Professor Sashidharan and the members of the external reference group who drew up, on behalf of the Mental Health Taskforce, the proposals for the Department of Health outlined in this document. They cover in equal part, statutory service providers, voluntary organisations, users, carers and most importantly, the communities concerned.

I believe that the publication of *Inside Outside* marks the beginning of a historic dialogue. I confirm the commitment of this Government to combat long established patterns of ethnic and other inequalities in service experience and outcome within mental health services.

Jacqui Smith  
Minister of State for Health

# Foreword

When the Mental Health National Service Framework (MHSNF) was launched in September 1999 it recognised that services were not adequately meeting the needs of black and minority ethnic service users and that communities lacked confidence in mental health services. This situation needed to be addressed. There are no more important challenges facing mental health services.

The innovations laid out in the MHNSF and NHS Plan aim to improve the lives of all service users including those from minority ethnic communities, but more can be done.

This report is part of the Department's response to this. Its author, Professor Sashidharan, is a member of the Mental Health Task Force and Medical Director of North Birmingham Mental Health Trust. The report *Inside/Outside* is the result of many months' hard work by him and members of the Ethnicity and Mental Health external reference group. . The Mental Health Task Force has approved it.

Professor Sashidharan is currently consulting with black and minority ethnic communities around the country on the proposals set out in this document. Their comments will help to inform the Department of Health's Black and Minority Ethnic Mental Health Implementation Framework, which will be released for further consultation later this year. The Implementation Framework will provide comprehensive guidance on how services can meet the needs of the communities it serves.

*Inside/Outside* is the first step. The National Institute for Mental Health in England will be taking forward the Implementation Framework and will actively support services in making changes on the ground.

Louis Appleby  
National Director for Mental Health

# Introduction

Britain is a multicultural society. Nearly 6.4 million people in England belong to ethnic minority communities<sup>1</sup>. This figure represents about 1 in 8 of England's population. The ethnic minority communities<sup>2</sup> in England share a number of features. Disadvantage and discrimination characterise their experiences in this country in almost all walks of life. This is particularly true in the area of health and health care. People from black and minority ethnic groups suffer from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority white population. Over the years, there have been several policy and service initiatives within the National Health Service aimed at reducing ethnic variations in disease incidence, access to care and service experience.

Mental health is an area of particular concern for the minority communities in this country. For decades the disparities and inequalities between black and minority ethnic groups and the majority white population in the rates of mental ill health, service experience and service outcome have been the focus of concern, debate and much research. However, there is little evidence that such concerns have led to significant progress, either in terms of improvement in health status or a more benign service experience and positive outcome for black and minority ethnic groups. If anything, the problems experienced by minority ethnic groups within our mental health services may be getting worse<sup>3</sup>.

At present, there is no national strategy or policy specifically intended to improve either the mental health of minority ethnic groups or their care and treatment within mental health services. Previous approaches taken to address these problems have been either fragmented or selective. As a result, the 'ethnicity agenda' within mental health services has tended to become either marginalised or ignored. Although there have been significant policy and service development within mainstream mental health services over the last five years, national initiatives such as the Mental Health National Service Framework (MHNSF) and the NHS Plan for Mental Health do not adequately address the particular needs of black and minority ethnic groups<sup>4</sup>.

The problems and challenges associated with ethnicity and mental health are complex and not amenable to either simple solutions or a single approach. Progress and change in this area is dependent on an inclusive process, involving politicians, policy makers, service providers from both statutory and voluntary sectors, service users and carers and most importantly, black and minority ethnic communities themselves. This

document, which sets out a plan for reform, therefore, does not explicitly focus on individual professional groups such as doctors, nurses, social workers or individual organisations or agencies in primary care, secondary care or social work.

What we are aiming to achieve is the identification of a common agenda for change and action for change based on equal partnership and common ownership. We also aim to set out the prerequisites for change, both in terms of analysis and practical tasks, and a clear vision and an explicit direction for reform. This document is a starting point.

## Aims and Objectives

This document sets out proposals for reforming the service experience and service outcome of people from black and minority ethnic groups who experience mental ill health and who come into contact with mental health services, as users or carers. The plans set out in this document also aim to improve the overall mental health of people from black and minority ethnic groups living in England. The main focus for change is the pervasive ethnic inequality that currently exists within mental health services. The central objective of this initiative is to reduce and eventually eradicate such disparities and, by doing so, make mental health services appropriate for and relevant to a multicultural society.

The success of this initiative is dependent on a range of reforms within mental health services. The methodology for change set out here can be effective and successful only within the broader framework of the development and wider implementation of modern and progressive mental health services in England, as anticipated in the MHNSF and the NHS Plan. The specific aim is to build upon the MHNSF and the NHS Plan, making them more relevant and more appropriate to the needs of black and minority ethnic groups living in England.

It must also be remembered that mental health services are provided in a range of settings, and ethnicity issues must be properly considered in all of them. In particular, the NHS needs to think about how it provides mental health services to prisoners from black and ethnic minority groups. Funding responsibility for prison health services in England is to be transferred from the Home Office to the Department of Health from April 2003. This is the first step in a process over the next 5 years that will see prison health become part of the NHS. Primary Care Trusts will then become responsible for the commissioning and provision of health services to prisoners in their areas. This means that when considering the recommendations contained in this document, the needs of prisoners will need to be taken into account.

The success of this initiative is also dependent on the co-ordination of changes within the NHS with other significant developments in the area of race relations such as the effective implementation of the Race Relations (Amendment) Act (2000). It also draws from the strengths within our minority communities and aims to harness those to the

successful implementation of progressive reforms within mental health. The adoption of the Human Rights Act (1998) provides an additional imperative to improve the experience of black and minority ethnic patients within the mental health system and to respond, in a more direct way, to the needs of minority ethnic communities. This work marks a starting point for a set of co-ordinated activities, which must take place over the next few years, aimed at making our mental health services non-discriminatory, appropriate and truly sensitive to the needs of multicultural Britain.

## Underlying values and principles

We must begin by acknowledging the problems of mental health care as it is experienced by black and minority ethnic groups:

- that there is an over-emphasis on institutional and coercive models of care;
- that professional and organisational requirements are given priority over individual needs and rights;
- that institutional racism<sup>5</sup> exists within mental health care.

To change this it is essential to place progressive community based mental health at the centre of service development and delivery. Those who use mental health services are identified, first and foremost, as citizens with mental health needs, which are understood as located in a social and cultural context<sup>6</sup>.

The analysis that underpins the specific recommendations contained in this document owes a great deal to the struggles and demands of the black and minority ethnic communities in the UK, over the last fifty years or more<sup>7</sup>. Fundamentally, the history of migration and settlement in this country has been about seeking rightful entitlements and equal rights by migrants and their descendants, and challenging racism both at the individual and institutional level. Mental health has been a site of such struggles for as long as black and ethnic minorities have been part of British society.

A number of pragmatic proposals are set out in this document, which will need to link up with other initiatives aimed at combating discrimination and social exclusion. Improving mental health services and ensuring better service outcome for people from minority groups cannot be the sole responsibility of those working within mental health. The specific recommendations and objectives set out here are direct and practical responses to the problems currently experienced by black and minority ethnic groups within psychiatry as evidenced by service user testimonies, community responses and academic literature.

Although there is much evidence that attests to the extent and significance of the problems facing minority ethnic groups within mental health services, the solutions recommended are not based necessarily on gold standard of evidence or effectiveness. There are two main reasons for this. Firstly, the types of reforms that are recommended here have rarely been implemented and, secondly, research on service evaluation and organisational changes has, by and large, ignored the ethnic or cultural dimension of service efficacy or outcome. The recommendations that are set out here are, however, consistent with reforms and priorities around ethnicity currently underway in other public services in the UK.

The actions and reforms, outlined in this document, are intended to make mental health services non-discriminatory and ensure that mental health organisations work towards race equality and embrace cultural and ethnic diversity. The actions are meant to be specific, practical, measurable and open to scrutiny, monitoring and evaluation. It is believed that anti-discriminatory practice will follow from ensuring the eradication of discriminatory attitudes and practice, rather than the other way round. Thus, the success of this initiative, at least initially, relies on effective management and performance measures, rather than a change in organisational culture or values as a pre-requisite for reform.

Most importantly, this initiative aims to identify solutions to the problems around race and ethnicity within the mainstream of service development rather than in segregated or otherwise specialised services or initiatives. The analysis that underpins this is informed by the view that the difficulties experienced by minority ethnic groups within mental health services are indicative of fundamental contradictions within psychiatry as a whole, both in theory and practice, and the way mental health services are organised, rather than a direct product of the specific cultural or ethnic requirements of people seeking mental health care.

# The Case for Action

It is estimated that there are over 6 million people in England who are designated as from black and minority ethnic groups<sup>8</sup>. Black, Irish and other minority ethnic groups experience high levels of social and material deprivation when compared with the majority white population. The social exclusion of minority ethnic groups is complex and varies according to the economic, social, cultural and religious backgrounds. This complexity is not always understood or appreciated, partly because there are limited data available about the overall and specific experiences of minority groups. However, there is sufficient evidence to demonstrate that people from minority communities disproportionately experience various aspects of social exclusion affecting almost every aspect of life in contemporary Britain<sup>9</sup>.

Nowhere is this disparity between various ethnic groups more apparent than in health and health care. Generally, people from minority ethnic groups experience much worse health than the ethnic majority in this country. The Fourth National Survey of Ethnic Minorities found that minorities were more likely than white people to report fair, poor or very poor health, limiting long-standing illnesses and a registered disability<sup>10</sup>. Minority groups, relative to the white majority, report significantly higher scores of psychological distress, a high prevalence of diabetes, poor self assessed general health, and a severe lack of social support<sup>11</sup>. Poor physical health amongst minority ethnic groups is also reflected in relatively higher mortality among migrants<sup>12</sup>. Among the Irish, increased mortality persists into second and subsequent generations<sup>13</sup>.

Despite the higher levels of ill health and disability amongst the minority ethnic groups they appear to have poorer access to health services<sup>14</sup>. Whether this is due to variations in help-seeking behaviour, inaccessibility of health services or some other factors is not clear. There is also emerging evidence that within the health service, ethnic variations exist in access to particular types of medical interventions<sup>15</sup>

The marginality and social exclusion experienced by minority ethnic groups in the UK are likely to be significant in understanding the mental health experiences in these communities and their access to mental health services. These experiences vary across the country; people in rural areas face a particular isolation compounded by their experience of discrimination. There is a well-established link between structural inequality and variations in health status in all communities<sup>16</sup>. The ethnic inequalities evident in most aspects of public life are likely to have a bearing on the mental health

of black and minority ethnic groups. Findings from recent surveys appear to confirm this<sup>17</sup>. Psychiatric illness rates are generally higher in minority ethnic groups and they also experience significant social adversity but have poorer social networks and support. There are ethnic differences in access to mental health services. Most tellingly, there are significant and sustained differences between the white majority and minority ethnic groups in experience of mental health services and the outcome of such service interventions<sup>18</sup>.

The relationship between ethnicity and mental health has been the focus of much debate and dispute in this country for several years now. Over the recent past, this debate has moved on, from earlier preoccupations with *race differences* and ethnic or cultural *predispositions* to mental illness, to considering *ethnic inequalities* in service experience and outcome, linked to the *aversive experiences* of black and minority ethnic groups in contemporary British society and its institutions, including mental health services.

There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority do. In addition, disease burden associated with mental disorder appears to fall disproportionately on minority ethnic populations.

There is a dearth of research on the mental health care experience of minority ethnic groups and on the outcome of mental health care in minority ethnic groups. A recent review commissioned by the Department of Health on research funded by the NHS R&D, in relation to the Mental Health National Service Framework (MHNSF) showed the absolute poverty of research in relation to ethnicity and mental health and the relative lack of commitment, over the years, to commission such work<sup>19</sup>. However, there is a body of evidence based on clinical and epidemiological research, clinical observations, anecdotal accounts and, most importantly, the testimonies of service users and carers which points unequivocally to the racially discriminatory nature of current mental health services and significant discrepancies in service outcome, between minority ethnic groups and the majority ethnic group<sup>20</sup>.

In reviewing what is known about the ethnic disparities within mental health it would be helpful to consider such evidence in the context of the MHNSF, the blueprint for reform and modernisation of mental health services in England. The MHNSF sets out seven national standards for mental health in five key areas – mental health promotion (including discrimination and social exclusion of people with mental health problems), primary care and access to care, effective services, carers and suicide. The main purpose of setting out clear standards of mental health care nationally is to reduce variations in services and to achieve an overall improvement in mental health care. It is important therefore to summarise what is known about ethnic disparities in mental health service experience and outcome under the seven standards set out in the MHNSF.



## Standard One: Mental Health Promotion

The MHNSF states that health and social services should promote mental health for all, working with individuals and communities and that these agencies should combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

- It is commonly accepted that mental health problems can result from the range of adverse socio-economic factors associated with disadvantage and discrimination and these can also be a cause of social exclusion. Nowhere is this more evident than amongst black and minority ethnic groups. The extent of social exclusion among these communities, the levels of racism and racial discrimination experienced by them in public life and, more pertinently, when they come into contact with institutional agencies are key determinants of psychiatric morbidity within black and minority ethnic groups<sup>21</sup>
- The gradient of psychiatric morbidity in children and adolescents is determined, amongst other factors, by low household income, coming from a one parent family, being in institutional care, poor school performance. These are particularly relevant to children from minority backgrounds. Individuals from black and minority ethnic groups are identified as more at risk of developing mental health problems than people from majority ethnic groups. Relative to the majority white population, minority groups (particularly younger people and those of African Caribbean and Irish backgrounds) appear to be at increased risk of hospital admission, and coercive care within mental health services<sup>22</sup>. The stigma associated with mental illness can be made worse by racial discrimination<sup>23</sup> and the access to appropriate assessment and treatment severely restricted as a result<sup>24</sup>. The risk of suicide and attempted suicide is elevated in some ethnic groups, most notably among South Asian women and the Irish<sup>25</sup>.
- Mental health outcomes of black patients are shown to be poorer in terms of readmissions. Poorer clinical outcome has been associated with living alone, unemployment, conviction and imprisonment<sup>26</sup>.

## Standard Two: Primary Care

The MHNSF states that any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care, if they require it. Many people with mental health problems contact their GP, or another member of the primary health care team. However, this does not appear to be true for all black and minority ethnic groups.

- Research suggests that there are no major variations in registration with GPs and overall consultation rates between minority ethnic groups and the majority population. However, the capacity of GPs to recognise psychiatric disorder in black and ethnic minority patients appears to be more limited than in others<sup>27</sup>. There are indications that consultation rates for mental disorders, in particular, anxiety and depression, may be reduced in some minority groups, such as amongst South Asians and the Chinese. Most recent evidence shows that Irish people had particularly high rates of consulting GPs for psychological problems<sup>28</sup>.
- Chinese groups tend to access their GP only after long delays and the GP is the first contact person for less than 40% of all individuals. Many individuals from minority ethnic groups encounter barriers when seeking help – including language, the discrepancy between the patient’s and doctor’s views as to the nature of the presenting symptoms, cultural barriers to assessment produced by the reliance on a narrow biomedical approach, lack of knowledge about statutory services, and lack of access to bilingual health professionals<sup>29</sup>.
- Black and South Asian patients are less likely to have mental health problems recognised by their GP<sup>30</sup> or the nature of their presentation wrongly attributed to mental illness<sup>31</sup>. GPs acknowledge that they feel less involved in the care of patients with severe mental illness from minority ethnic groups<sup>32</sup>. There is also evidence that GPs’ decisions to refer patients with mental health problems to specialist services are influenced by the patient’s ethnicity<sup>33</sup>.
- Police involvement and compulsory admissions for black and minority ethnic groups are strongly associated with the absence of GP involvement<sup>34</sup>.

### Standard Three: Access to Services

Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs.

- There are significant barriers to minority ethnic groups seeking and successfully accessing services. Furthermore they are much less satisfied with services when contact is made<sup>35</sup>.
- Cultural and racial stereotyping is a common experience in the context of assessment and decisions concerning treatment. This may well influence the types of services and diagnosis individuals from minority backgrounds seek and receive. There is evidence that stereotyping of Irish people as alcoholics obstructs treatment for mental health problems<sup>36</sup>. Interpreting services are often unavailable, which makes the diagnosis or assessment procedure both unreliable and highly stressful<sup>37</sup>.

- There is also ample evidence to confirm that black and minority ethnic groups are more likely than white people are to follow aversive pathways into specialist mental health care<sup>38</sup>.
- Rates of compulsory admission are markedly higher for black and minority ethnic groups in comparison to whites. The significant differences in the use of the Mental Health Act between ethnic groups are present at all ages<sup>39</sup>.
- There is greater involvement of the criminal justice system and, in particular the police, in the referral pathway of minority groups, including Irish people to specialist mental health care compared to white majority people and this is true for both compulsory and voluntary admissions to hospitals. Similarly, the referral to specialist services for minority groups is less likely to be through the health service agency than for white majority people<sup>40</sup>.

## Standard Four and Five: Effective Services for People with Severe Mental Illness

Each person with severe mental illness should receive the range of mental health services they need; crises are anticipated or prevented where possible; prompt and effective help is available if a crisis does occur; and timely access to an appropriate and safe mental health place or hospital bed, including a secure bed, as close to home as possible. Service users from black and minority ethnic communities commonly report that mental health assessments are undertaken from a perspective that does not accord any significance to their ethnic background. There is evidence that, for black people, who tend to be more critical of mental health services, home-based treatment is more acceptable than a hospital admission. Involving service users in the service planning process can help to develop more acceptable and culturally sensitive services.

- Patients from all minority ethnic groups are more likely than white majority patients to be misunderstood and misdiagnosed and more likely to be prescribed drugs and ECT rather than talking treatments such as psychotherapy and counselling<sup>41</sup>.
- Re-admission rates are higher in black and minority ethnic groups, they spend, on average, longer periods of time within hospitals and are less likely to have their social care and psychological needs addressed within the care planning process and the treatment that they receive<sup>42</sup>.
- There is evidence that the experience of acute care within psychiatric units for black and minority ethnic groups is less than satisfactory. Their rights and health care needs are less likely to be taken seriously when compared to majority white patients<sup>43</sup>.

- 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 also been an enduring feature of British psychiatric care<sup>44</sup>.
- Outcome of mental health care appears to be worse for black and minority ethnic groups than for white people. From the organisation and planning of mental health interventions, including care planning and community follow-up, to the levels of service satisfaction reported by service users and the social and clinical outcome in those with severe mental health problems, there appear to be clear ethnic differences. In most instances, minority groups appear to be more disadvantaged than majority white people<sup>45</sup>. The experience of minority ethnic groups, as described by service users and carers, would appear to support this claim<sup>46</sup>.
- New service models, introduced in the wake of the MHNSF and the NHS Plan, are likely to be more acceptable to people from minority ethnic groups in comparison to more traditional mental health services. For example, minority ethnic groups report greater levels of satisfaction in relation to Home Treatment/Crisis Resolution services<sup>47</sup>. Given the significance attached to treatment delay in accounting for the adverse experience of African Caribbean people in psychiatric care<sup>48</sup>, early intervention services have the potential to prevent aversive care pathways for minority groups. However, intensive case management has shown little differential effect in black patients<sup>49</sup>.
- Black and minority ethnic groups, particularly people from African Caribbean communities are also over represented in forensic settings. Similar trends are observed in remand and sentenced prison populations and forensic settings and may distort pathways into more appropriate care settings<sup>50</sup>.

## Standard Six: Caring about Carers

This standard is specifically concerned with carers and relatives of people receiving specialist mental health services. Health and social services must assess the needs of carers who provide regular and substantial care for those with severe mental illness, and provide appropriate care to meet their needs.

There is very little research on the perceptions, experience and level of engagement of carers from black and minority ethnic groups in relation to mental health services. Research on the experience of carers is generally patchy, but there has been little or no attempt to capture the black or minority experience within existing research. There is however several years of community experience in dealing with the concerns and requirements of carers and relatives from the minority groups and most of this information is available through several black and minority voluntary groups or the 'grey literature' that is produced through local surveys and stake holder events.<sup>51</sup>

- Relatives of black patients often feel unable to participate in treatment decisions and report little help in finding community services<sup>52</sup>.
- Relatives of black patients are concerned about the administration of large doses of medication in particular anti-psychotic medication<sup>53</sup>.
- Carers need information on the illness and how they can help support their relatives. Such information should be given at all stages, and where required in appropriate languages, supported by advocates or other mediating agencies.
- Carers want to remain involved in all aspects of care and they wish to be listened to, especially when the professional agencies are unaware of the cultural needs of minority groups<sup>54</sup>.
- There is a demand for culturally appropriate advocacy services to support and campaign on behalf of service users from minority communities and their carers<sup>55</sup>.

## Standard Seven: Preventing Suicide

The aim here is to ensure that health and social services play their full part in the achievement of the target set out in *Saving Lives: Our Healthier Nation*, to reduce the national suicide rate by at least one fifth by 2010.

- UK death certificates do not record ethnic data and in the verdicts of coroners' inquisitions ethnicity of the deceased is not included at present, which makes it difficult to establish suicide rate by ethnicity.
- National data show that women born in India and East Africa have a 40 per cent higher suicide rate than women born in England and Wales<sup>56</sup>. Young women of South Asian origin are a high-risk group for suicide, but may not have a previous psychiatric history. Being married does not appear to lessen suicide risk for this group. For young South Asian people cultural conflict has been suggested as a precipitating factor in suicide and parasuicide<sup>57</sup>.

- Significantly high rates of suicide have been noted among Irish-born people living in the UK for some time. Latest figures reveal 53% excess (higher than all other minority ethnic groups and the population of England/Wales) for all Irish people. Among young (20-29 years) people, 75% excess was found for males and three-fold excess for young women<sup>58</sup>. Recent work suggests that these rates may in fact be an under-estimate<sup>59</sup>.
- Less is known about suicide rates for black African and African-Caribbean people living in the UK. Young black women may be vulnerable to suicide and social risk factors may precipitate serious mental disorders and possibly suicidal behaviour in African and African-Caribbean people living in the UK<sup>60</sup>.
- A National Strategy for Prevention of Suicide has now been launched<sup>61</sup> within which specific strategies are set out to prevent or reduce suicide in high-risk groups.

In reviewing the evidence in relation to the standards set out in the Mental Health National Service Framework as they are applied to minority ethnic groups in this country, it is clear that there are significant and persisting differences in and inequalities in service experience and outcome between minority groups and the majority white ethnic group. Here an overview is provided of the nature and extent of such ethnic inequities within the NHS. Over the last two decades there have been a number of national and local initiatives aimed at making the health service more accessible and appropriate to the needs of minority groups. However, there is little evidence that such innovations have had any significant or enduring effect in reducing the adverse experiences within mental health services for black and minority ethnic groups.

# The Focus for Change: *Inside and Outside*

## Policy and Legal Context

The Mental Health National Service Framework (MHNSF) is unequivocal in stating that users can expect services to be non-discriminatory. The NHS Plan is part of the government's Modernisation Programme for the NHS and there is a clear commitment within it to ensure equality of access and non-discriminatory services for all.

Following the Race Relations (Amendment) Act (2000), all public authorities have an explicit duty to actively promote race equality. Their general duty is to:

- Eliminate unlawful racial discrimination
- Promote equality of opportunity
- Promote good race relations between people of different racial groups<sup>62</sup>.

This new public duty is not optional, and statutory health and social care organisations have to meet it, irrespective of the size of the ethnic minority population they serve<sup>63</sup>. This general duty is supported by a series of specific duties, applicable to both employment and service delivery. By ensuring that they are complying with the specific duties, public authorities will ensure that they are delivering on the general duty outlined in the Act<sup>64</sup>.

## Leadership

**Strong leadership is vital if health organisations are to meet the new public duty. A health organisation that is effectively promoting race equality will be able to show the following:**

- Board members and senior staff have made a public commitment to tackle unlawful racial discrimination, and to promote equal opportunities and good race relations in all areas of the organisation's work
- Board members and senior staff take a firm and steady lead on promoting race equality and good race relations, both inside and outside the organisation
- Board members and senior staff understand the guiding principles of promoting race equality. They make sure that these principles govern all aspects of their work. The Board has publicly stated that it is accountable for promoting race equality
- Board members and staff from ethnic minorities play an active and responsible part in all areas of the organisation's work. They are not marginalised, or expected only to concern themselves with the organisation's work on equality and diversity.

*CRE (2002b) Performance Guidelines for Health Organisations*

The recommendations set out here are therefore intended, not to add yet more standards and targets to overburden an already stretched service but to assist mental health service providers to meet their existing statutory obligations. If all mental health organisations meet their statutory obligations as set out in the Race Relations (Amendment) Act (2000), and are consistent with the guidelines provided by the Commission for Racial Equality, this will go a long way towards creating the culture and circumstances that will allow significant progress in dealing with institutional racism within mental health services.

## Focus for Change: inside *and* outside

The need for reform and change in mental health services is obvious. The focus for change is two-fold, the current provisions of mental health care and the black and minority ethnic communities themselves, the former requiring reappraisal of its policies and practices and the latter likely to benefit from investment in enhancing capability. This will be based on key initiatives for change, *inside*, within the services and, *outside*, within the communities. Three overlapping and complementary objectives are identified. Under each, further, more specific objectives are set out along with the expected outcome for each of the actions.



## Strategic Objectives

The three basic objectives are:

- to reduce and eliminate ethnic inequalities in mental health service experience and outcome;
- to develop a mental health work force that is capable of delivering effective mental health services to a multicultural population;
- to enhance or build capacity within black and minority communities and the voluntary sector for dealing with mental health and mental ill health.

The rest of this document is concerned with setting out the priorities for action to achieve these objectives.

## I. Reducing and eliminating ethnic inequalities in service experience and outcome

Under the Race Relations (Amendment) Act (2000) all organisations must have a **Race Equality Scheme** that sets out how they plan to address cultural diversity and ethnic equality within services, including service planning, delivery and training. There must be accountability and visibility to ethnic and cultural issues at Board level and performance management arrangements will include ethnicity as a key area where Trusts performance would be assessed.

### Services and Policies

#### The organisation has published a race equality scheme

- The scheme consists of a strategy and an action plan to meet the general duty and any specific duties under the Race Relations (Amendment) Act 2000.
- The scheme is a timetabled and realistic three-year plan, which came into effect on 31 May 2002 in England and Wales, and comes into effect in Scotland on 30 November 2002. The scheme is organised around achieving the results and outcomes described under "Outcomes of meeting the duty"
- The organisation reviews the scheme regularly, using existing systems and processes
- The scheme is publicly available, both in printed and electronic form. It is also available in other formats on request. Copies of the scheme have been distributed to all staff.

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Key components of the Race Equality Scheme in mental health organisations should include the following:

- Ensuring accountability and ownership in relation to black and minority ethnic communities
- Developing a culturally capable service
- Setting national standards to improve access, care experience and outcome
- Enhancing the cultural relevance of research and development.

The specific actions that are required in these areas are set out below, along with the expected outcome of such actions.

## 1. Ensuring Accountability and Ownership

One of the reasons mental health services in general have not been able to adapt successfully to meet the needs of people from minority ethnic communities is the lack of local community involvement in shaping and delivering services. This is a general problem within centrally managed organisations such as the NHS, with no explicit arrangements to ensure local accountability. This situation might well change with organisational changes currently underway<sup>65</sup>. A participatory and inclusive approach, with clear lines of accountability and ownership of services, is a pre-requisite for change, and will enable NHS organisations to meet the NHS Plan requirements for Patient and Public Involvement.

This can be achieved by the following actions.

- i Establishing consultation and discussion locally between various mental health agencies and other key stakeholders outside*

Every Mental Health Local Implementation Team should set up formal mechanisms for community and consumer involvement from minority ethnic groups (complementing primary care trust arrangements for public and patient involvement in other services). These arrangements should allow participation of the local ethnic minority communities in service planning, commissioning, delivery and evaluation of the effectiveness of the mental health services.

**The organisation has arranged to assess, and consult on, the impact its policy proposals are likely to have on the duty to promote race equality**

- The organisation has procedures for assessing its policy proposals for their possible impact on race equality
- The organisation takes steps to identify the full range of needs in the communities it serves, and makes sure everyone knows about its consultation plans and how they can take part.
- The organisation carries out assessments of its policy proposals by gathering as much information as possible on the subject. It consults staff, their representatives, users of services, and members of the public (including people from local ethnic minority communities) as part of these assessments.
- The organisation uses both formal and community-based approaches to consultation. For example, public meetings, surveys, outreach programmes, and contacts with community representatives, especially from groups it does not consult regularly
- The organisation considers other policy options when its assessments and consultations show that its policies could affect some ethnic groups adversely

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The 'inside' approach of improving the mental health services is dependent on participation and inclusion of the local community in service planning and development of existing services. The best way to ensure that the needs of the local communities are understood and met is to ensure local representation in the commissioning process and in the monitoring of various performance targets and quality standards. Although there has been increasing acknowledgement of the value of involving service users and carers in service planning and development, minority communities in general are still excluded within mental health planning and commissioning of services. Local initiatives ought to be encouraged to address this problem and the choice and inclusion of community representatives must follow clear and democratic processes.

**ii Establishing accountability and ensuring change through Clinical Governance**

Clinical governance provides a framework through which NHS organisations are accountable for safeguarding high standards of care and for improving services. The structures around clinical governance are already in place in mental health trusts. The methodology and mechanisms of clinical governance should be used to improve services for minority ethnic groups.

Ethnicity should be established as a key priority within clinical governance in all mental health organisations. There should be a methodology that allows consumer and community feed back, especially service user and family satisfaction with services provided. Regular feed back from the local community and other stakeholders must be sought using a common methodology and independent assessors. Organisations should undertake self-assessments of cultural and linguistic competencies of staff and there should be annual reports on the organisation's progress in relation to ethnic matters.

## 2. Developing a Culturally Capable Service

One of the basic requirements of service users within any care setting is that the extent to which their needs are assessed and understood and the type of interventions offered must all achieve a minimum common standard, and there should not be any discrepancy in this according to the ethnic or cultural backgrounds of the clients. Clearly, this is not the case at the moment and, as discussed earlier in this document, there are long standing and significant ethnic differences in the quality of mental health care. One way of tackling these inequalities is by focussing on the cultural capability of the organisation or improving the capacity of the organisation in providing high quality service, irrespective of the ethnic or cultural background of the people using the service. This is not simply about making services more aware or sensitive to the perceived cultural needs of individual users but is about improving the quality of care, by providing good quality but equal services to all those who come into contact with mental health agencies. In other words, "racial equality means quality"<sup>66</sup>. Developing cultural capability is not an end in itself; by making services more capable than they are at present it is expected that there would be an enhancement of the overall quality of care received by people from minority ethnic groups. The enhanced organisational capability that is sought through this approach is not merely around dealing adequately with cultural issues, identified as part of mental health care provided for minority ethnic groups but, more importantly, is about improving the overall quality of assessment, care, support and treatment provided for people from minority ethnic groups. The following approaches are advocated for enhancing the cultural capability of mental health services

### *i Developing the Workforce*

All organisations should actively promote and support the attitudes, behaviours, knowledge and skills necessary for the staff to work respectfully and effectively with people from minority ethnic communities. All organisations must develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent clinical, managerial and support staff who are trained and qualified to address the needs of culturally and ethnically diverse population. Methods for ensuring this are considered further in Section III.

*ii Statutory mental health providers must work collaboratively with local voluntary sector in developing and sustaining a variety of service models to meet the needs of minority ethnic groups*

The voluntary sector in this country has led the development of culturally appropriate services for minority ethnic groups. More often than not the statutory care providers have failed to follow this example and, over the years, the NHS and social services have not supported or sustained such innovations. The sustainability of such voluntary sector initiatives around ethnicity and mental health has also been problematic because of the lack of long term funding. In developing the capacity and competencies necessary to provide culturally appropriate services there is a need to develop diverse services, provided through both statutory and voluntary agencies. It is accepted that statutory agencies acting alone would not be able to ensure cultural competency or diversity within mental health services. Voluntary agencies and, in particular, local initiatives have a most important part to play in ensuring appropriate and adequate service provision in this area.

*iii Mental health services should ensure that services provided are congruent rather than conflicting with cultural norms.*

A culturally competent mental health service will be prepared to adapt the conventional ways of working to meet the needs of culturally diverse groups of people. Flexibility and adaptability in service provision, as well as awareness of different cultural norms are necessary to achieve this.

*iv Ensuring language access for persons who prefer a language other than English*

For non-English speaking people, the lack of appropriate language skills amongst mental health professionals and difficulties in accessing appropriate interpreter services make mental health care difficult and problematic. Mental health assessments and interventions are crucially dependent on language.

Ethnicity, culture, language along with other social factors affect the perception, availability, utilisation and, potentially, the outcome of mental health services. Therefore, the provision of high quality, culturally responsive, and language appropriate mental health services in locations accessible to ethnic minorities is essential to creating a more equitable system and thus reducing ethnic disparities in mental health care.

**The organisation has made arrangements for everyone to have access to information about its work, and to its services.**

- The organisation uses various methods to provide information, and to promote its services to all sections of the local community
- The organisation sets targets for access to its services and produces monitoring reports
- The organisation produces information about its services in various languages
- The organisation provides interpreters for users and carers when needed
- The organisation holds its public board meetings in places and at times that are convenient for people from all parts of the community
- The organisation has effective and efficient procedures for dealing with complaints about its services

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### **3. Setting national standards to improve access care experience and outcome**

This is aimed at helping the local services confront and deal with the institutional racism that is built into the organisational culture and professional practice, experienced by people from black and minority ethnic groups and communities. It is recommended that these standards need to be implemented nationally and the performance of individual organisations, against these measures, should be monitored systematically.

**Institutional racism is 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 or thoughtlessness and racist stereotyping which disadvantages minority ethnic people.**

*Sir William Macpherson, Chair of the Stephen Lawrence Inquiry (1999)*

Without an acknowledgement and understanding of the serious omissions and discrepancies within current service configurations in most local areas, which disadvantage ethnic minorities, there is little chance of making the services accessible, appropriate and acceptable.

## Ethnicity Data

It is fundamental to this understanding, and to the setting and monitoring of relevant standards and outcomes that services undertake ethnic monitoring, and that data can be analysed by ethnicity in local information systems. Self-identified ethnicity and the preferred spoken language of all service users must be documented routinely and recorded in information systems as well as in the patient's record. Without this information, no organisation can examine the outcome of its current policies and practices, or monitor its progress in addressing inequalities.

**It is incumbent on every institution to examine their policies and practices and the outcome of their policies and practices to guard against disadvantaging any section of our communities.**

*Sir Herman Ouseley - then Chair of the Commission for Racial Equality, in evidence to the Stephen Lawrence Inquiry (1999)*

It is recommended that four specific areas be targeted for change. These are primary care, pathway to secondary or specialist care, assessment of people from black and minority ethnic groups, and specialist mental health services

### *i* Primary care

Primary care settings are the most usual point of entry into mental health care for minority ethnic groups. Minorities are more likely to seek help through primary care or community agencies. In primary care, as in other parts of the NHS, knowledge and competence to manage mental health problems presented by minority groups is restricted.

Despite this, people from minority communities are more likely to seek help for their mental health problems through primary care, which is preferred to specialist mental health services. Explanations for such a preference might include fear of and/or lack of familiarity with specialist services. People from ethnic minority communities are also less likely to make or accept a strict distinction between mental health and physical health problems and the explanatory models relied on by different cultural groups might not be congruous with the explanatory models of Western psychiatry.

### Suggested Standards:

- All GPs have training in cultural awareness
- Culture and Mental Health becomes part of GP training.

- All patients presenting with mental health problems are assessed in their preferred language
- Variations in consultation rates, referral to specialist mental health services, use of psychotropic drugs for mental health problems in different ethnic groups are audited every year

Expected Outcome:

- Year-on-year reduction in variations by ethnicity

#### *ii Care pathways leading to inception into mental health care*

This objective deals with the concerns over the disproportionate numbers of minority patients who come into contact with mental health services, particularly acute care under coercion and through the involvement of police and courts. Similarly the disparities around the use of Mental Health Act require corrective action.

#### **Suggested Standards:**

- All services have access to crisis teams and crisis residential alternatives to hospital admissions.
- Patients under enhanced Care Programme Approach have crisis plans in place that specifically address how to minimise the risk of coercive interventions.
- Pathways to care and use of the Mental Health Act by ethnicity are audited

Expected Outcome:

- Ethnic variations in access to mental health services and pathways to care are reduced year on year.
- Admissions under the Mental Health Act do not show persistent ethnic variations.



**The organisation has arranged to monitor the effects of its policies on different groups**

- The organisation uses both established performance measures and its own indicators to monitor policies that are relevant to the duty for their effects on different ethnic groups
- The organisation sets ambitious but achievable targets to make continuous progress in promoting race equality
- The organisation has systems in place to make sure that race equality is part of its everyday work
- The organisation uses the results of its assessments and consultations, including ethnic monitoring, to improve the services it provides, and to reach all sections of the community

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*iii Assessment of people from black and minority ethnic groups*

All services should have a clear policy and practice around assessment of people from minority ethnic groups and this should take into account the significance of ethnicity, culture, language, and religion.

**Suggested Standards:**

- Assessment should be carried out with the individual, his/her carer or family members and, if necessary, with the support of an interpreter, translator or advocate.
- Assessments should aim to establish a care plan that will include individual religious, cultural and spiritual beliefs with clear identification of recovery and outcome.

Expected Outcome:

- User feedback from ethnic minority patients will show increasing satisfaction with their experience of the assessment process

*iv Specialist mental health care*

There are significant variations in the extent and quality of care received by ethnic minority groups within our mental health services. The generally unsatisfactory and poor quality of care ethnic minorities receive, in comparison to majority white group, may not be a universal feature within the mental health services as a whole, but there is considerable room for improvement.

### Suggested Standards:

- There is community access to the officers of the Trusts on a regular basis
- All clients, their families and carers should be given written information on legal status and rights, rights to advocacy and second opinion, interpreting services, professional roles and responsibilities and details of complaints procedures
- All mental health organisations such as Trusts will have an Equality Framework within which ethnicity audits would be carried out
- The findings of those audits or surveys will inform service improvement and development

#### Expected Outcome:

- The ethnic variations in key aspects of service experience and immediate service outcome would reduce on a year on year basis.

## 4. Enhancing the cultural relevance of research and development

There is an increasing recognition that research and development within the NHS should be closely linked to clinical and service concerns and the resources in this area are appropriately targeted. Welcome attempts are currently underway to make research more relevant, accountable and inclusive. The research governance arrangements being implemented currently also make research, audit and other evaluations within Trusts more transparent and accountable within organisations. R&D has a significant role to play in anticipating changes and improving service changes in relation to minority ethnic groups.

Two approaches are recommended

- iv Developing research methods appropriate for use with local black and minority ethnic groups and ensuring that all research includes consideration of ethnicity and culture.*

Research and Development carried out by NHS Trusts or to which NHS Trusts contribute patients will be appropriate to the culture and ethnicity of the population served by the Trusts. All research methods will be culturally appropriate and relevant. Minority ethnic groups will not be excluded from any research unless there are very good reasons for such exclusion.

## ii *Improving research governance in relation to ethnicity and cultural diversity*

Ethnic minority communities should not be excluded from research. All research must set out clearly their implications for ethnic and cultural minorities. R&D initiatives locally and nationally, must include consideration of ethnic and cultural matters. An ethnic or cultural component must be integral to all mental health research, thus making it relevant within a multicultural society. Ethical committees will need to develop the capacity to ensure that research is relevant and appropriate from a cultural perspective.

## II **Developing the Workforce**

This covers the second of the three objectives set out at the beginning. Like the first objective, reducing and eliminating the ethnic inequalities in mental health service experience and outcome, this objective is set for the mental health service as a whole, very much as part of the 'inside' approach. The NHS Plan introduced an Improving Working Lives Standard which makes it clear that every member of staff in the NHS is entitled to work in an organisation that can prove that it is investing in improving diversity and tackling discrimination and harassment. Having a diverse workforce at every level makes a vital contribution to being able to provide an effective, accessible and culturally sensitive service to minority communities.

The Macpherson report (1999) and the Race Relations (Amendment) Act (2000) together signal the duty on public bodies as well as individuals to eradicate discrimination in institutional settings. Training and education of the workforce is one important way in addressing inequality within the health service. In the MHNSF and in policy documents that promote changes in professional accountability and improved performance within public services, emphasis is placed on the valuable role of education and training.

What is often considered to be sound professional training is, at present, devoid of a cultural component. In understanding the discriminatory experiences of minority ethnic groups within mental health we need to look at institutional procedures, which, in turn, have their origin in professional practice. Such practices are, more often than not, informed by professional knowledge views or opinions, moulded and made relevant in particular historical and political contexts. As argued elsewhere, inequalities evident in the outcome of organisational interventions are, therefore, linked to professional practices. Thus discriminatory practice is not just poor practice.

Changing practice requires a great deal of concerted effort addressing, at the same time, individual skill deficits and learning needs as well as promoting innovations in practice, whilst ensuring organisational constraints on improved practice are also lifted. The education and training of health and social care professionals continue to

rely on separate, profession specific training programmes completed before certification to practice with little opportunity to engage with new ways of working and delivering effective interventions in a multidisciplinary or community setting.

Organisational constraints here include those resulting from the way services are commissioned and funded as well as professional bodies which require a particular style of practice in accord with professionally sanctioned approaches to the management of distress in a particular social and cultural context. In coming into contact with professional agencies, patients and their families from minority ethnic groups appear to be disadvantaged by conventional practice, which, in most other instances may not be experienced as so problematic. If the services for minority groups are to improve there is an urgent need to review current practices in mental health and, in particular, the knowledge and value base of many of our professional interventions.

It is essential to improve the cultural competencies and capacity of the mental health workforce in order to overcome some of these difficulties, including organisational constraints, professional bias and personal prejudices. Obviously there is a need to enhance the understanding and thinking around diversity and culture, marginality and exclusion, as they impact on mental health and the management of mental ill health. In addition, however, there are competencies and skills, with regard to inclusive, collaborative working, and community participation that are important in ensuring engagement with disaffiliated and largely disenfranchised groups of individuals. The limits of psychiatry and some understanding of what has come to be known as critical psychiatry<sup>67</sup> are also important elements in enabling the work force to deal with cultural and ethnic diversity and structural disadvantage.

Two key approaches are advocated in ensuring a culturally competent and capable workforce. First, it is recommended that all staff working within mental health services should receive mandatory training in Cultural Awareness<sup>68</sup>. Secondly, as part of the work of the Mental Health Care Group Workforce Team, there should be an emphasis on recruiting staff (professionals as well as in other capacities, for example, cultural mediators) from diverse cultural background so that the workforce in mental health reflects the population it serves as well as the population it treats.

### *i Enhancing cultural capability of mental health services through training in Cultural Competencies*

While there has been a general acknowledgement that training staff to acquire the competencies to work within a multicultural community is a good idea and that staff working with culturally diverse population should have training in this area there is no consensus on the content, style or delivery of such training. However, recent work in this area<sup>69</sup> has begun to specify the core competencies, skills, values and knowledge base which are to be included in training.

### Expected Outcome:

Individual level training has not delivered a change in practice partly because organisations can undermine innovation in practice that aims to meet cultural needs. Hence organisational change is essential to address alongside individual level training. As such training should occur at three levels – organisational, community and individual. The following recommendations are made for the successful implementation of the proposals to implement training in relation to cultural competency.

This training should take place at four levels:

- Undergraduate training leading to professional qualifications must include cultural competency components.
- Postgraduate and higher specialist training must include cultural competency components with specific certification for this issue.
- Continuing professional development activities should also reflect an adequate body of evidence to practise in a multicultural context.
- Providers acting at the Individual Level within each NHS Trust and Social Services Department must ensure that cultural competence/capability of its workforce is monitored.

These actions could be achieved by (i) setting training targets with the CEO or leading board member being responsible for meeting this target, (ii) through appraisals with Cultural Competence made part of the appraisal process for all professional staff and, (iii) establishing regionally based accreditation of courses in collaboration with training confederations.

The Mental Health Care Group Workforce Team, in collaboration with relevant professional bodies, should review the need for the development of a uniform training module or other means of ensuring consistency of approach on cultural competencies, which specifies the content and delivery of such training. Training in this area should be made mandatory for all professional staff working in mental health and a plan for delivering the training, within a two-year period, should be agreed and resources for this identified and earmarked.

Training in cultural competencies should be multidisciplinary and open to local non-statutory sector workers, as well as providing some preparatory phase of education in basic skills for those members of the workforce who have been out of touch with education for over five years. Training should include service users and/or voluntary organisations working with black and minority ethnic groups in their programme. Thinking skills as well as in practice analysis of common dilemmas in the students' work setting should be part of the training with a special focus on race, culture and ethnicity.

*ii Enhancing cultural capability of mental health services through ensuring a multicultural work force.*

One of the aims of the equality framework for the NHS *The Vital Connection - An Equality Framework for the NHS* (August 2000) is to recruit, develop and retain a workforce that is able to deliver high quality services that are fair, accessible and appropriate and responsive to the diverse needs of different groups and individuals. Like many of the other crosscutting themes, workforce development plans are specifically relevant to the developments on ethnicity and mental health. There are two main arguments why it is necessary to ensure that the workforce should reflect the communities in which they work (local population or local service users and carers). Firstly, equal opportunities in employment is a right and, the NHS, like all public bodies in this country must ensure that minority ethnic groups are not disadvantaged in recruitment and employment. The ethnic breakdown of staff within mental health services, however, does not show that the commitment to equal opportunity policies has resulted in anti-discriminatory employment practice. Organisations, at all levels, will have to address this problem.

The second reason for advocating the recruitment of a multicultural workforce is that cultural concordance between clinicians and patients is likely to be beneficial in the clinical context of assessments and interventions targeted at social systems. The cultural background of the staff will provide some advantages in understanding the mental health needs and cultural requirements of clients and families from the same culture. Similarly, the level of engagement between the worker and the service user will be enhanced (on the basis of easier identification, acknowledgement of commonality of experience, etc) if they share the same ethnic or cultural background. In fact, 'ethnic matching' has been advocated as a way of overcoming many of the problems black and minority communities experience within social care and mental health fields, notwithstanding the conceptual and organisational difficulties associated with such a policy.

Expected Outcome:

All the NHS organisations, at all levels, will have to ensure that there are plans in place to achieve the objectives set out in *The Vital Connection* and this document, so that the mental health workforce becomes representative of the population it is serving.

### III Engaging the community and building capacity: The role of community development workers

The third objective is to enhance the capacity within the black and minority ethnic groups in dealing with the burden of mental ill health and in tackling the inequalities inherent in the services provided. Any initiative aimed at improving the health care experience of particular communities must acknowledge the need for Patient Public Involvement and the important role that the communities themselves will have in bringing about change. In combating the ethnic inequalities that exist in mental health services black and minority ethnic communities will have to play a key role. The capabilities of the communities are an important consideration in this context. Capacity building within minority ethnic groups around mental health is therefore identified as a key aim.

Community development is advocated as an integral part of the attempts to improve our mental health services so that they can meet the needs of minority ethnic groups effectively and in a non-discriminatory manner. The proposed approach is *'inside/outside'* in its remit and recommendations. The assumption is that reform *'inside'* the mental health system must take place in tandem with investment and developments *'outside'* in order for the this aim to be successful.

It is proposed that capacity building around mental health must be an integral component of improving services for black and minority ethnic groups. The analysis here draws from the historical experience of the voluntary sector (particularly, the black voluntary sector) in responding to the plight of minority groups in relation to psychiatric services, by pursuing community involvement and participation in mental health. Additionally, community development models are advocated for enhancing the resilience and capacity of communities in dealing with health problems in less developed countries<sup>70</sup>. It is accepted that the problems within mental health services, especially around improving the quality of life of service users, cannot be addressed adequately without establishing *'therapeutic'* links with other community agencies; in particular seeking solutions outside of the arbitrary professional boundaries of mental health organisations. For example, the success of the co-operative movement in returning psychiatric patients to employment, and the campaigns against social exclusion would not be possible without broader community participation and community engagement with mental health<sup>71</sup>.

#### Community Development Workers

Community development or capacity building within particular communities is not a new idea. In different contexts, similar themes around enhancing communities' ability and preparedness to deal with social or health problems and in forging a harmonious relationship with statutory agencies and welfare programmes have been pursued, with mixed results. In this instance, the main aim is to build on the inherent strengths and

capacity of minority ethnic groups in dealing with mental health issues within the communities themselves. The idea that communities or people in general should reclaim their responsibility and ownership for their health and health care has its roots in both self-help and public health movements as well as in the cultural traditions of many minority ethnic groups. Community development, in this context, goes beyond establishing a 'link' between disaffected communities and governmental agencies or in establishing a methodology for enhancing the engagement of the communities in given programmes or initiatives around health or welfare.

Community Development Workers (CDWs) will make an impact on the experience of minority mental health and in reforming our community mental health services. At the same time, investment in CDWs will enable mental health organisations (both within statutory and voluntary sectors) to bridge the gap between western models of care, and the values and norms of the communities they are serving. CDWs will also give support to community groups to help them operate effectively and direct them to appropriate resources and funding sources.

This investment in CDWs will be a significant step towards achieving an inclusive approach in dealing with health inequalities both at the community and service level. This is also consistent with a public health approach in dealing with mental health problems. The potential for CDWs in highlighting and tackling health inequalities is clearly understood by those working in community agencies. The success of community mental health programmes, which form the basis of current priorities in mental health in this country, will be dependent upon strategies that facilitate the involvement of the communities in mental health. It is expected that CDWs will make this happen through facilitating community participation and ownership.

CDWs will therefore contribute to:

- Seeking out the strengths and capabilities within particular communities around mental health, managing and healing mental distress, dealing with social and cultural stresses contributing to mental illness and exploring ways in which such approaches could be used in a holistic way to manage mental health problems.
- Organisational development: identifying stakeholders, organising groups, working with volunteers
- Leadership Development: recruiting community leaders, creating training and development activities, delivering training and development activities
- High quality community development support
- Assistance to identify local concerns



- Support to develop skills, knowledge and confidence to become involved in creating local solutions
- Support for local groups so they can be partners in developing services and identifying gaps in current service provision
- Support to develop local networks and to become involved in self help projects
- Advice on finding sources of funding so that local residents can take action in meeting their needs.

The success of the CDWs is dependent on such workers being linked formally to existing organisational structures. Support, supervision and co-ordination of CDW activities are key issues that require further discussion and detailed planning. Similarly, the community development work that is anticipated through this investment needs to be linked to other service development priorities within mental health. The Development Centres of the National Institute for Mental Health in England could play a valuable role in supporting and sustaining this initiative.

# Conclusion

For the first time since the inception of the NHS, a national approach aimed at reducing and eliminating ethnic inequalities in health service experience and outcome is being advocated. The central principle that guides the NHS that there should be high quality and uniform services available, is reiterated in the context of tackling ethnic inequalities within mental health services.

The NHS and, in particular, the mental health services in this country are going through a period of significant change. The modernisation programme in mental health and the current investment in community services will mean significant gains for users, carers and those working in mental health services. The new national standards and service framework will reduce variations in service experience. Ethnicity is a key determinant of mental ill health and a critical influence on access to care and quality of mental health service experience. This document sets out a framework within which such inequalities could be addressed and eventually, tackled effectively.

The NHS, mental health services in particular, service users and carers, voluntary and other non-governmental organisations working within mental health, in partnership with black and minority ethnic communities in this country, will have to take concerted action in order to bring about specific change and improvement in mental health services, so that available services are not experienced as discriminatory or inappropriate. Action is needed at several levels - developing policy in relation to ethnicity and culture that is synergistic with the modernisation programme within mental health, making mental health interventions culturally congruent, improving the capabilities of the workforce, enhancing community capacity and raising awareness.

Specific and co-ordinated action is required to:

- reduce and eliminate the current ethnic inequalities in mental health service experience and outcome;
- develop the capabilities of the mental health workforce in providing appropriate and effective mental health services for a multicultural population;
- invest in community development of minority ethnic groups aimed at achieving greater community participation and ownership around mental health.

# Notes and References

- <sup>1</sup> [www.statistics.gov.uk](http://www.statistics.gov.uk)
- <sup>2</sup> Throughout this document the common term Black and Minority Ethnic groups is used to refer to people of minority ethnic status within Britain and refer to people classified as non-white within the Census and people of Irish origin, as well as individuals with similar self-assigned identities.
- <sup>3</sup> This is largely based on academic research, which continues to show a persistent pattern of ethnic differences in service experience and service user testimonies. See for example, Department of Health (2000); Jones (2002); Sainsbury Centre for Mental Health (2002).
- <sup>4</sup> The Government's plans for improving mental health services for working age adults are set out in the paper, 'Modernising Mental Health Services: safe, sound and supportive (Department of Health 1998). The Mental Health National Service Framework was launched in 1999 (Department of Health 2000). This covers the mental health needs of working age adults and specifically addresses unacceptable variations in services across England. There is no specific standard set for ethnic minority mental health within the NSF.
- <sup>5</sup> This is defined as a feature of institutions where there are pervasive racist attitudes and practices, assumptions based on racial differences, practices and procedures which are discriminatory in outcome, if not in intent, and a tolerance or acceptance of such differences. See, Macpherson (1999), and for an earlier definition of institutional racism, see, Carmichael and Hamilton (1968).
- <sup>6</sup> Strategies of deinstitutionalisation and the evolution of progressive community based alternatives are outlined in DeLeonardis et al. (1986).
- <sup>7</sup> Outside of the academic discourse around transcultural psychiatry, the first visible challenge to the mental health services for their treatment of black people was in the organisation of befriending services by families and carers of young Black people who were being detained in psychiatric hospitals in London and elsewhere. Some of the tensions associated with such community resistance were documented; for example, Black Health Workers and Patients Group (1980); Francis et al. (1989).
- <sup>8</sup> This is based on the latest National Census figures (2002), available from [www.statistics.gov.uk](http://www.statistics.gov.uk)
- <sup>9</sup> Hickman and Walter (1997); Modood et al. (1997)

- 10 Nazroo (1997)
- 11 Erens et al. (2001)
- 12 Marmot et al. (1984); Balarajan and Bulusu (1990); Balarajan (1995); Harding and Maxwell (1997); Wild and McKeigue (1997)
- 13 Raftery et al. (1990); Harding and Balarajan (1996, 2001); Abbotts et al. (1998)
- 14 Smaje and LeGrand (1997)
- 15 This is an area of growing international concern. Research in the US, and, to a lesser extent, in the UK, has shown that the ethnic origin of a patient may unfairly affect access to medical care such that equal treatment is not provided for equal need. See, Trevino (1999); Acheson (1998) and, for a recent study on ethnic differences in invasive management of coronary disease in the NHS, Feder et al (2002).
- 16 Wilkinson (1996)
- 17 Sproston and Nazroo (2002)
- 18 See, for example, Cochrane and Sashidharan (1996); Fernando (1988) Bhui (2002)
- 19 Wright et al. (2000)
- 20 Cochrane and Sashidharan (1996); Sandamas and Hogman (2000); Iley and Nazroo (2001); Jones (2002); Sainsbury Centre for Mental Health (2002); Bhui (2002).
- 21 Fernando (1986) Sashidharan (2001)
- 22 For a recent review of the evidence relating to young men of African Caribbean origin, Sainsbury Centre for Mental Health (2002). Much of the available research record on how Irish people access mental health services is on rates of psychiatric hospital admissions. Unfortunately these data are now dated, (Cochrane and Bal 1989), and there have been no major national published analyses of admission by either place of birth or ethnicity status since 1981. Nonetheless, the persistent pattern of significant excessive admissions for Irish people from 1971-1981 failed to lead to much interest in Irish health within ethnicity debates (Bracken and O'Sullivan 2001). Smaller more recent studies have produced conflicting results on Irish patterns of admissions to psychiatric care. One London study found that the pattern of Irish people having highest overall admission rates compared with Black and White British populations (Walls 1996), which replicated the prior national pattern found, while another study in Birmingham did not find an Irish hospital admission excess (Commander et al. 1999a). Data on sectioning of Irish under the MHA is harder to find due to monitoring issues, and therefore not as robust for this reason, as it is for the Black male population. However there is a strong perception among those working in Irish mental health that Irish men and women are particularly over-represented among those receiving ECT, being compulsorily detained, in secure units, (Farrell 1996; Butler 1999).
- 23 Rawaf and Bahl (1998)

- <sup>24</sup> Commander et al. (1997)
- <sup>25</sup> National statistics on suicide by place of birth rather than ethnicity, are the norm because of the lack of ethnicity data on returns from coroners' courts. However, raised rates have been found among South Asian women, (Raleigh and Balarajan 1992; Raleigh 1996). Similarly, higher than average rates of parasuicide or attempted suicide in young women of South Asian origin are noted (Bhugra et al 1999a; 1999b; Merrill and Owens 1988). Significantly high rates of suicide among Irish-born people of both sexes, with particularly high rates among young women are also reported. Rates have persisted for decades and increased over time. Latest figures reveal 53% excess (higher than all other black and minority ethnic groups and the population of England/Wales) for all Irish people. Among young (20-29 years) people 75% excess was found for males and nearly three-fold excess for young women. There is also concern in the Irish community about perceived high suicide rates among Irish men in prison, particularly Irish Traveller men. There is evidence that these Irish rates may be *under*-estimated (Raleigh and Balarajan 1992; Balarajan 1995; Neeleman et al. 1997; Bracken et al. 1998; Leavey 1999). Early British studies in Birmingham which focused on attempted suicide found Irish over-representation among suicide attempters with statistically significant rates for young Irish women (Burke 1976a; Merrill and Owens 1988), and more recent local analyses of acute psychiatric admissions in Haringey found a link among Irish people between a history of attempted suicide and admission for depression (Walls 1996). Recent studies of female suicide attempts, self-harm and ethnicity have excluded the Irish (Bhugra et al. 1999a; 1999b), even when Irish women clearly make up a large proportion (11%) of comparison 'white' attempters (Bhugra et al. 1999a; 1999c). This inevitably leads to erroneous conclusions being drawn about other ethnic minorities in comparison with 'whites'.
- <sup>26</sup> Bhui et al. (1998); Commander et al. (1999)
- <sup>27</sup> Shaw et al. (1999)
- <sup>28</sup> See, Erens et al. (2001). Evidence from community groups suggests that despite this general picture, there are some groups of Irish people (older people particularly homeless men, people with alcohol problems, Travellers) who do not access primary care for reasons of stereotyping, hostility, mental health problems not being addressed, lack of confidence, lack of knowledge of what services are available and who need support with accessing adequate services. Although GP registration rates among Irish people generally is high, it seems likely that some groups prefer to access emergency services for general and mental health problems, and this may indicate problems with GP recognition and Irish patient satisfaction with GP services or the greater prevalence of alcohol and mental health problems culminating in referral to Accident and Emergency Departments (see implications from Gater 2002). Overall, Irish community groups expressed a concern about the lack of apparent skills around mental health in general, and Irish mental health in particular, at primary care level. A recurring concern expressed has been the extent to which GPs fail to deal with mental health issues underlying presenting alcohol

problems among Irish people. There are two issues here, a) failure to treat depression, anxiety etc., as relevant to alcohol problems, b) stereotyping of Irish people. It seems currently unclear whether Irish people suffer disproportionately from general service problems around 'dual diagnosis' or whether Irish people are being disproportionately labelled as having drink problems on the basis of their cultural identity. One small study of attenders of an alcohol advisory agency in Camden found no evidence to suggest that there was stereotyping of Irish people by referral sources, including GPs (Kennedy and Brooker 1986).

- <sup>29</sup> Li and Logan (1999); Li et al. (1999)
- <sup>30</sup> Gillam et al. (1989); Odell et al. (1997); Bhui et al. (2001)
- <sup>31</sup> See, Wilson (1993) for the Black community perspective.
- <sup>32</sup> Bindman et al. (1997)
- <sup>33</sup> Bhui (1998) Commander et al (1999)
- <sup>34</sup> Cole et al. (1995)
- <sup>35</sup> Littlewood and Lipsedge (1989); Lloyd and Moodley (1992); Parkman et al. (1997); Callan and Littlewood (1998); Commander et al. (1999b); Greenwood et al. (1999); Bhugra et al. (2000); Callaghan et al. (2000). Irish community experiences are similar. For Irish users' views, see Walls (1996).
- <sup>36</sup> The issue of alcohol misuse is raised here due to the perceived importance among the Irish community of the links between alcohol misuse and mental health issues, the significant over-representation of Irish people in psychiatric admissions for alcohol disorders, the Irish over-use of community-based alcohol agencies, and the perceived offence and possibility of misdiagnosis of Irish people suffering mental distress due to a stereotype of Irish people which equates cultural identity with alcohol problems. There is evidence that particular populations of Irish people may have alcohol problems linked to mental health and wider disadvantages of isolation, poverty, being single men, particular employment histories, homelessness, marginalisation, poor general health, etc (Cochrane and Bal 1989; Harrison and Carr-Hill 1992; Harrison et al. 1993; Greenslade et al. 1995; Harrison et al. 1997; Commander et al. 1999a; Leavey 1999; Erens et al. 2001)
- <sup>37</sup> Jervis (1986)
- <sup>38</sup> Sashidharan (1993) Commander et al (1999) Bhui (2002)
- <sup>39</sup> This is an area where there has been considerable research over the years, more so than any other aspect of mental health care in relation to ethnicity. There is a uniformity of findings that people of African and African Caribbean backgrounds are more at risk than any other ethnic group in England to be admitted to psychiatric hospitals under the compulsory powers of the Mental Health Act. Over the years there has been little change in this discriminatory pattern of service experience. Findings in this area are also consistent with the excess of black people in other custodial settings, in particular prisons. This feature of mental health care

in England is not dissimilar to the ethnic bias in custodial psychiatric care found in other European countries and in North America. See, for example, McGovern and Cope (1987) Davies et al. (1996) Koffman et al. (1997); Fernando et al. (1998) Coid et al. (1999); Maden et al. (1999); Mental Health Act Commission (1999) Audini and Elliott (2002).

- <sup>40</sup> Sashidharan and Francis (1991) Bhui (2002) Sainsbury Centre for Mental Health (2002)
- <sup>41</sup> The debate around 'misdiagnosis' of black and other minority ethnic patients has a long history within Western psychiatry (see, for example, Littewood and Lipsedge (1982); Fernando (1988)). The cultural relativism of Western psychiatric categories, ethnic differences in clinical presentation, racial stereotyping or racism by clinicians, language problems have all been identified as potentially contributing to the difficulties with psychiatric diagnosis amongst minority groups. There is much less research on ethnic variations in other aspects of psychiatric interventions although there is strong suggestion of treatment bias, minority groups less likely to be seen as suitable for psychologically based therapies. For service user and community views, see, Wilson (1993, 1997)
- <sup>42</sup> Commander et al (1999); Sainsbury Centre for Mental Health (2002); Bhui (2002)
- <sup>43</sup> Warner et al (2000). As regards to in-patients detained under the Mental Health Act, the seventh Biennial Report of the Mental Health Act Commission (1999) noted: 'provision for patients from minority ethnic communities often remain basic, insensitive and piecemeal, leading to patients feeling alienated and isolated. It is dispiriting that the serious issues of inappropriate care and treatment of patients from black and minority ethnic communities, which were raised in the previous Biennial Reports, continue to cause concern and noted in reports of Commission visits'
- <sup>44</sup> There is considerable evidence to support the claim that there is an ethnic bias in decisions leading to secure psychiatric care. See, for example, Prins (1993); Fernando et al. (1998); Kaye and Lingiah (2000).
- <sup>45</sup> Bindman et al (1997); Parkman et al (1997) Commander et al (1999)
- <sup>46</sup> Wilson (1997); Sandamas and Hogman (2000)
- <sup>47</sup> Dean et al. (1993)
- <sup>48</sup> Harrison et al. (1989)
- <sup>49</sup> McKenzie et al.(2001). Whether the new service models such as Assertive Outreach, Crisis Resolution services, Early Intervention teams are having a positive impact on the care experiences of black and minority ethnic groups is far from clear. However, the priorities within these new services such as early access to specialist treatment, 24 hour access to acute care, alternative to hospital admissions and ensuring assertive and needs based follow up all appear to be addressing those aspects of mental health services where minority ethnic groups are currently disadvantaged.

- <sup>50</sup> NACRO, (1990); High Security Psychiatric Services Commissioning Board (1997); Fernando et al (1998) Bhui et al. (1998); Coid et al. (1999); Evidence suggests that Irish people are also over-represented in all areas of the criminal justice system (National Association of Probation Officers (1994).
- <sup>51</sup> See, for example, Francis et al (1989) Annual Report of ACMHA, Brixton 1985-1989; National Association for Black Mental Health (2002)
- <sup>52</sup> Most of the evidence in this area is anecdotal. Clearly, there is a dearth of formal research to carers' needs and experiences in general. The experience of carers from black and minority ethnic communities is particularly under-reported. Arksey et al (2002); Department of Health (2002).
- <sup>53</sup> National Association for Black Mental Health (2002)
- <sup>54</sup> Newbigging (2000)
- <sup>55</sup> Walls (1996); Joseph Rowntree Foundation (2002)
- <sup>56</sup> Raleigh and Balarajan (1992)
- <sup>57</sup> Merrill and Owens (1986); Raleigh et al. (1990) Raleigh (1996); Bhugra et al. (1999b); Department of Health (2001)
- <sup>58</sup> Burke (1976a); Merrill and Owens (1988); Raleigh and Balarajan (1992); Balarajan (1995); Bracken et al. (1998); Leavey (1999).
- <sup>59</sup> Neeleman et al. (1997)
- <sup>60</sup> Burke (1976b); Raleigh (1996); Whitley et al. (1999); Department of Health (2001); McKenzie et al. (2001).
- <sup>61</sup> Department of Health (2002c). Although minority ethnic groups in England are not identified as a 'high risk group' for suicide, the promotion of mental health in these communities, including Asian women, is identified as a strategic goal within the national strategy. In addition, the strategy calls for the routine collection of ethnic data from coroners' courts.
- <sup>62</sup> Department of Health (2002a)
- <sup>63</sup> Commission for Racial Equality (2002b)
- <sup>64</sup> Further information can be found at Commission for Racial Equality (2002a)
- <sup>65</sup> Department of Health (2001b)
- <sup>66</sup> Auditing for Equality: Auditing council performance against the Commission for Racial Equality's standard for local government, 'Racial Equality Means Quality' Compiled by Stella Dadzie and produced in association with the London Borough of Hammersmith and Fulham. (1999)
- <sup>67</sup> Ingleby (1980); Bracken and Thomas (2001)



- <sup>68</sup> There is no uniform set of definitions as to what is meant by this. Different people have used different words to describe this area of competency knowledge and skills around culture, such as cultural sensitivity, competency, capability and awareness, with varying emphasis on what is required. See, for example, Bhui (2001) . In this document we are using cultural awareness in the broader sense, to include sensitivity, skills and competencies. For an earlier history of the evolution of this concept and requirement, see Sivandan (1985).
- <sup>69</sup> Bhui & Bhugra (1997); Chirico et al. (2001); Royal College of Psychiatrists (2001)
- <sup>70</sup> Sen (1999)
- <sup>71</sup> See, for example, the need for inter-sectorial collaboration and national policies, The Sainsbury Centre for Mental Health (2001); also, WHO (2001).

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