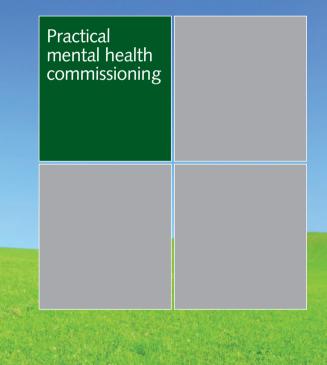# Joint Commissioning Panel
for Mental Health

Guidance for commissioners of
mental health services for people from black and minority ethnic communities

Practical
mental health
commissioning

Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Co-chaired by:

RCGP Royal College of General Practitioners

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adult social services

Mental Health Network
NHS CONFEDERATION

The New Savoy Partnership

Contents

Ten key messages for commissioners

1 Regardless of their ethnic background, everyone who uses a mental health service (or cares for someone who does) should have equitable access to effective interventions, and equitable experiences and outcomes. Commissioners have a legal duty to ensure this.

- Commissioners have the opportunity and responsibility to tackle ethnic inequalities in access, experience and outcomes in mental health care. This involves improving the *quality* of mental health care. It also requires tackling inequality and structural discrimination within the NHS. Structural discrimination refers to policies and practices within institutions that are intended to be neutral, but which result in adverse outcomes for particular groups.

- Commissioners have a legal duty – under public sector equality duties – to consider the mental health needs and care experience of people from BME groups[1]. These duties require care and treatment to be delivered to BME groups which will result in improved health outcomes, and the correction and removal of discriminatory patterns of care and treatment.

2 Every commissioner should address ethnic inequalities in mental health. To do this, they will need to develop their knowledge, confidence and competences.

- Commissioners need to fully understand the mental health needs of BME communities, and their experience of the local mental health system. Commissioners also need to recognise that the organisational culture and structure of NHS care can act as a barrier to overcoming health inequalities among BME groups.

- To gain this understanding, a co-production model for commissioning, procuring, and delivering services should be used (please see the JCP-MH guide on 'values-based commissioning').

3 Commissioners should identify and implement specific measures to reduce ethnic inequalities in mental health. These include collecting better data, specialist provision, enhancement or modification of existing services, and the scaling-up of innovations.

- Existing ethnic inequalities cannot simply be explained in terms of a 'variable disease burden'. Therefore, commissioners need to collect and use much better data about the experience and outcomes of mental health treatment among BME groups. Ethnic variations in service experience and outcomes are not routinely collected, not bench-marked, and not available for progress or performance to be measured against. This should be rectified.

- The procurement and provision of mental health services should reflect a commitment to ensuring race equality. Progress in reducing such inequalities must be measured, as well as the quality and safety of mental health services for BME groups (which should include measurements from the perspective of BME service users, their carers, and their families).

- Commissioners need to play a key role in challenging (and supporting) existing mental health services to make the necessary improvements.

4 Clinical Commissioning Groups and Health & Wellbeing Boards must develop local strategies and plans for improving mental health and wellbeing amongst BME communities.

- CCGs (and provider organisations) have a clear responsibility and accountability for BME mental health. Ultimately, they have the responsibility and are accountable for improving the quality and safety of mental health services for BME groups. When responsibility is diffused, it is not clearly owned: "with too many in charge, no-one is"[2].

- This should also include applying strategies aiming to promote health and wellbeing among BME communities. These should always include a commitment to address the social determinants of mental health that make BME communities more vulnerable to poor wellbeing (including the pre-determinants and antecedents of mental disorder and mental illness).

Ten key messages for commissioners (continued)

5   There should be targeted investment in public mental health interventions for BME communities. This should focus on reducing/moderating the adverse impact of social and material adversities (including racism) on these communities. These should also include activities to raise awareness and reduce stigma.

- NHS England has the responsibility to promote and facilitate joint and collaborative commissioning by CCGs and Local Authorities. This should give priority to community development, mental health education, and awareness programmes amongst BME communities. Community development initiatives should always aim to (a) improve the ability of BME groups to deal with health or social care problems and (b) forge a more positive and trusting relationship between these communities and mental health/social care providers.

- Mental health commissioning should recognise the impact of racism, interpersonal violence and conflict on the mental health and mental wellbeing of people from BME communities. Plans must subsequently be developed to reduce the experience and impact of racism and stigmatisation in the community, as well as within mental health services. This is because such experiences can (a) aggravate the course of mental disorder in BME communities and (b) undermine the quality of care of BME patients and carers.

- Public health population programmes should be (a) suitable for all communities, and (b) not heighten or worsen inequalities among BME groups.

6   From the outset, commissioners should involve service users, carers as well as members of local BME communities in the commissioning process. These individuals should be key in establishing the strategic direction and monitoring of mental health care and service outcomes.

- The principle of 'no decision about me without me' should be central to all commissioning activities.

- Clear guidelines on BME service user engagement, involvement, and co-production exist. The *Dancing To Our Own Tunes*[3] guidance should be followed by CCGs and Local Authorities for every step of the commissioning cycle.

7   Commissioners should ensure that service providers collect, analyse, report, and act upon data about ethnicity, service use, and outcomes. This should be part of a systematic attempt to mobilise local evidence in relation to ethnicity and mental health.

- The health care needs of BME communities vary in different parts of the country. Although national surveys and monitoring still provide helpful information, data on local service outcomes, their effectiveness, quality, safety, and service user/carer satisfaction is essential.

- There is a pressing need for annual audits in local mental health services that focus on service experience and outcomes by ethnicity. Such audits should be made public and easily accessible. They should include data on the quality of mental health care as measured against coercive interventions, and include measurements based on service user experience.

- Providers should be mandated by commissioners to complete Mental Health Minimum Data Sets, and to collect relevant ethnic data to determine whether high-quality, safe, and non-discriminatory care is provided to BME groups.

- The Evidence and Ethnicity in Commissioning (EEiC) project has highlighted all of the above problems, and is a useful resource for commissioners. (http://research.shu.ac.uk/eeic)

8   To create more accessible, broader, and flexible care pathways, commissioners should integrate services across the voluntary, community, social care and health sectors.

- Multiple points of entry into specialist mental health assessment/care are needed. This will require direct access through non-clinical routes such as community agencies, places of worship, the educational and social welfare system, housing providers, criminal justice and the voluntary sector (including BME agencies).

- In doing this, commissioners should invest in youth services targeted at BME groups, as this will help facilitate the early detection of mental health problems and appropriate interventions.

- Some BME groups, such as people of African and African Caribbean origin, may engage better with services specifically designed and delivered to address their needs, and prefer services delivered through community agencies such as BME third sector organisations. Consequently, mental health commissioning strategies should recognise the importance of increasing choice and the plurality of service provision available for BME communities.

9 Every mental health service should be culturally capable and able to address the diverse needs of a multi-cultural population through effective and appropriate forms of assessment and interventions.

- Mental health services tend to follow uniform models of care that assume that 'one size fits all'. However, mental health service experiences and outcomes are powerfully influenced by the ethnic and cultural background of patients (and arguably more so than in other aspects of health care).

- The quality of mental health care experienced by BME groups depends on the cultural capability of mental health services. Commissioners must ensure that mental health services that they commission are 'culturally capable', in that the service and workforce are able to deliver high-quality care to every patient, irrespective of patients' race, ethnicity, culture or language proficiency. A personalised service response is essential to achieve this objective.

- Such competencies and skills should exist within all mental health services (doing this means *mainstream care* will help attend to the cultural, religious and ethnic needs of people, and help meet the principle of equality of care which is a core value of the NHS[4]).

- Where the level of need, risk, or exclusion of generic services raises serious concerns about equity and equality, it is appropriate to provide specialist *short-term* or *alternative* care for particular marginalised groups. (This will also help optimise choice, as well as opportunities for individuals and groups from BME communities to become centrally involved in service provision.)

- A long standing concern reported by BME groups is about the disproportionate use of control and coercion within mental health services. Addressing this is key and requires both culturally competent staff and organisations/systems. Training courses or initiatives on recruitment (ensuring diversity within the workforce) cannot by themselves ensure clinical cultural competency skills. Other methods must be considered including cultural mediation and cultural consultancy services; the 'co-production' of services; development of alternatives to institutional care and increased involvement of BME peer workers and user involvement in the planning and delivery of care; and the presence of spiritual care teams in mainstream services.

10 Coercive psychiatric care is experienced disproportionately by some BME groups, in particular people of African and African Caribbean origin (black and mixed race origin). A number of strategies are required to reduce coercive care. These should include a greater focus on patient safety, greater plurality and choice of service providers to reflect the ethnic and cultural backgrounds of service users/local communities and more investment in patient advocacy.

- Commissioners should take practical actions to expand community residential alternatives to hospital admissions, and also increase community services that support psychosocial rehabilitation of BME service users. This means expanding community residential alternatives to hospital admissions, reviewing the use of Section 136 provisions, accelerating discharge from inpatient settings, and expanding step-down options from custodial care (especially where it is targeted at individuals in long-term and, often, forensic mental health care).

- Procurement and delivery of such services through third sector organisations from BME communities should be prioritised. Where such services already exist they should be enhanced. Where they do not exist, commissioners should explore, pilot and commission these options in co-production with BME communities and service users.

- Peer support services and advocacy services specific to the needs of BME communities should be an integral part of mental health service provision in diverse communities. Advocacy services should be commissioned in a way which improves quality, patient safety and access. Helping patients to use their rights would be an important step in addressing the disproportionate number of black patients currently subject to the provisions of the Mental Health Act and managed in restrictive settings[5].

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

• people with mental health problems and carers
• Department of Health
• Association of Directors of Adult Social Services
• NHS Confederation
• Mind
• Rethink Mental Illness
• National Survivor User Network
• National Involvement Partnership
• Royal College of Nursing
• Afiya Trust
• British Psychological Society
• Representatives of the English Strategic Health Authorities (prior to April 2013)
• Mental Health Providers Forum
• New Savoy Partnership
• Representation from Specialised Commissioning
• Healthcare Financial Management Association.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*[6].

The JCP-MH has two primary aims:

• to bring together people with experience of mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning

• to integrate scientific evidence, the experience and viewpoints of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

• provides practical guidance and a developing framework for mental health commissioning

• has so far published fifteen other guides on the commissioning of primary mental health care services[7], dementia services[8], liaison mental health services to acute hospitals[9], transition services[10], perinatal mental health services[11], public mental health services[12], rehabilitation services[13], forensic services[14], drug and alcohol services[15], community specialist mental health services[16], acute care (inpatient and crisis home treatment)[17], eating disorders[18], mental health services for older people[19], and child and adolescent mental health services[20]. It has also published guidance on implementing a 'values-based' approach to commissioning[21].

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WHAT IS THIS GUIDE ABOUT?

This guide describes what 'good' mental health services for people from Black and Minority Ethnic (BME) communities look like.

While all of the JCP-MH commissioning guides apply to all communities, there are good reasons (see P9) why additional guidance is required on commissioning mental health services for people from BME communities.

This guide focuses on services for working age adults. However, it could also be interpreted for commissioning specialist mental health services, such as CAMHS, secure psychiatric care, and services for older adults.

What are mental health services for people from BME communities?

WHO IS THIS GUIDE FOR?

The guide will be of particular use to:

- Clinical Commissioning Groups
- General Practitioners (GPs) and commissioning leaders
- Commissioning Support Organisations
- wider Local Authority commissioners
- voluntary and independent sector organisations

HOW WILL THIS GUIDE HELP YOU?

This guide has been developed by a group of mental health professionals, people with mental health problems, and carers with expertise and experience in the mental health of people from BME communities.

The content is primarily evidence and literature-based, but ideas deemed to be best practice by expert consensus have been included.

By the end of this guide, readers should be more familiar with the concept of mental health services for BME communities and:

- understand what an effective range of mental health services for BME communities should look like

- know the sorts of services and interventions that should be on offer

- understand how those interventions can contribute to achieving recovery outcomes and make improvements in public mental health and wellbeing.

BOX 1

What is ethnicity?

Ethnic groups have been defined on the basis of skin colour, self-defined identity, country of birth, and ancestral origin.

Everyone belongs to an ethnic group (so the principles in this guide can be applied to all groups, and not just ethnic minorities).

What is an ethnic minority?

The working definition of ethnic minority individuals suggested by the Royal College of Psychiatrists is *'those with a cultural heritage distinct from the majority population'*.[22]

What is a BME group?

Black and Minority Ethnic (BME) groups can be understood as:

- people living in England who are designated as belonging to a non-white ethnic group (according to the national census)

- which represent distinct groups

- and with their own identity recognised by themselves and by others.

Where do people get it wrong?

The Royal College note that people often (wrongly) use the terms 'race', 'ethnicity' and 'culture' interchangeably:

"...race describes [a person's] physical appearance

...culture refers to shared features that bind individuals together into a community..."

"The definition... of ethnicity... includes aspects of both race and culture; as well as other characteristics such as traditions, language, religion, spirituality, upbringing, nationality and ancestral place of origin. It is also a personal expression of identity influenced by life experience and place of habitation; it is a dynamic and changes over time."[22]

What are mental health services for people from BME groups? (continued)

Defining ethnicity can be complex (see Box 1).

This guide uses the term BME to include all non-white, ethnic minority groups living in this country.

This does not imply there is a single, homogenous ethnic or cultural group with static or unchanging needs. Differences will exist both within BME groups, and also between BME groups. These differences will include:

- socio-demographic characteristics
- language, culture and history
- experience of mental health problems and care pathways within mental health services
- experience of acculturation (the process in which members of one cultural group adopt the beliefs and behaviours of another group).

Mental health among BME communities

As noted on P11:

- important differences in health across ethnic groups, both in morbidity and mortality, have been repeatedly documented in the UK[23,24]
- significant differences in mental health and wellbeing exist between the majority white group and minority ethnic communities[23,24]
- disadvantage and discrimination have an adverse impact on the mental wellbeing and mental health in all BME communities[25,26,27,28]
- there is a need to ensure that mental health services and the wider community support BME communities, rather than add to their burden[29].

Mental health services for BME communities

This guide:

- is focused on the commissioning of 'good' mental health services for BME communities
- recognises that:
  - currently, there are significant and persistent ethnic inequalities in service experience and outcomes within mental heath services
  - BME communities report higher levels of dissatisfaction with mental health service experience (compared to the white majority group)
  - some BME groups are over-represented in some forms of mental health service care and others under-represented (in terms of their numbers in the general population, and in comparison to national average)
  - these differences cannot be explained simply in terms of variation in clinical need or variable access to services – instead many mental health services and care pathways may be inappropriate for diverse communities
- believes that:
  - as a general rule, there are few separate or specialist services for different ethnic groups in this country
  - specialist services for particular ethnic groups cannot be the norm, because specialist expertise and skills should exist within all services (doing this means *mainstream care* will help attend to the cultural, religious and ethnic needs of people, and help meet the principle of equality of care which is a core value of the NHS[4])

  - however, where the level of need, risk, or exclusion of generic services raises serious concerns about equity and equality, it is appropriate to provide specialist *short-term* or *alternative* care for particular marginalised groups. (This will also help optimise choice, as well as opportunities for individuals and groups from BME communities to become centrally involved in service provision.)

Prevention and early intervention

A comprehensive commissioning approach should include (a) direct service provision *and* (b) prevention and early intervention for those most at risk. This is highly relevant for BME communities as a variety of environmental and other contextual factors (such as social disadvantage, racism, and poor access to health care) can all have a significant bearing on the burden of mental ill health in this population.

Why are mental health services for people from BME communities important for commissioners?

There are at least eight reasons why mental health services for BME communities are important for commissioners:

1 Changing demography

2 Improving the quality of mental health care

3 Providing effective and appropriate care and enhancing wellbeing

4 Reducing morbidity and premature deaths

5 Cost-saving

6 Legal obligations

7 Accountability

8 Ethical and inclusive commissioning.

1   CHANGING DEMOGRAPHY

Mental health services need to adapt and reflect the significant demographic changes taking place in England. While the proportion of BME communities in the population has increased significantly in many urban areas[30], this has not always resulted in appropriate cultural adaptation of local mental health services.

2   IMPROVING THE QUALITY OF MENTAL HEALTH CARE

Commissioning has the real potential to tackle ethnic inequalities in mental health services, in access, experiences and outcomes of mental health care.

With guidance[31], commissioners can make positive changes through understanding the importance of social and cultural inequalities in the generation of mental distress and illness, and working to ensure that care services do not compound those inequalities.

3   EFFECTIVE AND APPROPRIATE CARE AND ENHANCING WELLBEING

Clinical Commissioning Groups have the responsibility for commissioning the best possible services for their patients and population.

As this includes populations that are diverse and multicultural, a single and uniform model of mental health care may not be appropriate. Instead, cultural differences and ethnic diversity in the local population will require services that are customised to varied needs.

This is arguably more important in mental health than in any other aspect of health care – culture, language, religious beliefs and ethnicity will all have a disproportionate impact on the origin, manifestation, experience and treatment of mental ill health.

Commissioning mental health care without special attention to cultural and ethnic factors is therefore unlikely to achieve effective and appropriate outcomes. Patient reported outcome measures in particular are likely to be influenced heavily by culturally competent health care[32].

4   REDUCING MORBIDITY AND PREMATURE DEATHS

There is evidence that BME communities experience significant problems in accessing mental health services and also in negotiating their exit from specialist (especially institutional) care[33].

Culturally informed commissioning (which in effect is commissioning informed by the views and experiences of BME service users, their families and communities) will improve access and contribute to recovery. A commitment to effective and culturally appropriate mental health commissioning is therefore likely to reduce the overall morbidity from mental ill health in BME communities. Additionally, early detection of mental health difficulties and instituting appropriate treatment (as well as assessment and monitoring of physical health) is likely to reduce premature mortality associated with serious mental illness[34].

Why are mental health services for BME communities important for commissioners? (continued)

5 COST-SAVING

Commissioners need to ensure they purchase services that perform well in relation to service user and patient satisfaction, risk management and re-admission rates. A study of mental health services in London, for example, found that reducing existing ethnic inequalities in mental health could make significant financial savings[35]. The cost of race inequality (based on unit costs and expenditure on mental health care pathways) was estimated at between £97.6 million and £109.5 million for inpatient and community mental health services, corresponding to 9.1% and 10.2% of total expenditure on all mental health services for working age adults in London in 2004/05[35].

The total cost of mental health services for an average black service user was 58% higher than the corresponding cost for an average white user. More than half of this difference was accounted for by higher spending on psychiatric intensive care unit (PICU) and medium secure care among black service users. There was also a large proportionate difference between black and white service users in average expenditure per head on contacts with assertive outreach teams.

6 LEGAL OBLIGATIONS

Commissioners and providers of health and social care services have a legal duty to offer services that are accessible and appropriate to all sectors of the community, irrespective of ethnic origin. Requirements under current legislation, including the Equality Act and Human Rights Act, mean that public bodies such as the NHS should provide services that are non-discriminatory and respect the needs of diverse communities. It could be argued that the persistent ethnic inequalities in service experience and outcome amount to a discriminatory

pattern of care. Commissioners need to understand the reasons for the unequal care experience of people from BME backgrounds in mental health services and commission services that reduce such inequalities.

7 ACCOUNTABILITY

In areas with significant minority populations, provision of mental health care will need to reflect the differing needs of a diverse population. Local accountability and involvement of local communities are essential to achieve this. This guide provides examples of how this can be done through effective local collaboration involving BME communities (see P20).

However, evidence shows that mental health organisations have not been able to meaningfully involve BME service users. Engaging service users is often replaced with engagement with 'community leaders', BME professionals, or the BME voluntary sector. This can result in 'proxy participation' which is "unlikely to yield an adequate understanding of black and minority ethnic service users' lives and what interventions (if any) are needed to ensure their safety, respect and dignity and to promote choice and independence."[36]

8 ETHICAL AND INCLUSIVE COMMISSIONING

Commissioning must be ethical and just. In order to achieve this aim, commissioners require a good and detailed understanding of how their local communities experience and understand mental health care.

Values-based commissioning (VbC) will help achieve this, as it aims to ensure that whatever is commissioned is driven by, supported, and owned by patients and carers[22] (see Box 2).

BOX 2

VbC is a process where commissioning practice rests equally on three pillars of scientific enquiry and formal evaluation; expertise and clinical skills; and patient and carer experience and perspective. These are all forms of evidence – and VbC demands that they are valued equally by all commissioning participants – hence, each respects the values of the others. Decisions are accordingly negotiated and co-produced and this happens at each stage of the commissioning cycle.

Clinician and user contributions are integrated into not just commissioning strategy but, importantly, the mechanics of procurement and contracting as well. VbC requires shared leadership and network support so that the result is collectively owned between all of the commissioning participants and, through effective engagement, the organisations and entities they represent. VbC leads to better value since patients and carers often advocate more cost-effective developments and interventions.

What do we know about the current provision of mental health services for people from BME communities?

People from BME communities face many of the same challenges as those experienced by the majority white community in mental health care.

However, research over the last 50 years has repeatedly shown that BME communities have more adverse experiences and negative outcomes within mental health care compared to the majority population in relation to:

- inequalities
- access
- experience of care
- within BME group differences
- between BME group differences[24].

This section considers these issues in turn, and concludes by reviewing the wider policy debate about why BME communities continue to have more adverse experiences.

Inequalities

It would appear that despite targeted programmes such as *Delivering Race Equality (DRE)* ethnic inequalities within many mental health services have remained entrenched and, if anything, have become consistently worse in almost every area earmarked for improvement[37].

The *Count Me In* census (focused on the mental health inpatient population in England) over a 5-year period (2005 to 2010) found that there was little or no sustained progress in reducing ethnic disparities in care, especially in the rates of admission, detention under the Mental Health Act or coercive practices such as the use of seclusion[38,39].

Access

Ethnic minorities appear to be disadvantaged even before they reach specialist mental health care. Problems with access to primary care and mental health promotion have been reported, and it has been contended that people from BME backgrounds *do not get* the mental health services they want or need[40,41].

Psychological services such as *Improving Access to Psychological Therapies* (IAPT) also appear to be more inaccessible for people from minority communities[42]. Black people are also reported to be more likely to be turned away from mental health services when they seek help[43]. Furthermore, BME groups tend to report more dissatisfaction with mainstream services compared to community sector or voluntary organisations providing mental health care, and mainstream services are often perceived as more likely to misunderstand their situation and experience[44].

Experience of care

The extent and nature of the experiences of BME people within mental health care are well described[39,40]. Ethnic differences are apparent in most aspects of mental health care in the UK with significant and ethnic inequalities in:

- access to care and treatment, pathways into care (both primary and specialist care)
- diagnosis and risk assessments
- choice of treatment and care including psychological therapies
- use of the Mental Health Act
- quality of emergency care and work with police, local government and providers
- referrals to forensic mental health care and coercive treatments
- length of stay in hospitals
- access to community facilities
- quality of care experience
- and satisfaction with care[39,40,41].

In short, it would appear that minority groups are often worse-off than the white majority population in their psychiatric experience.

At the same time, commissioners need to be careful not to automatically conclude that these differences always represent social injustice.

Understanding these problems through the 'lens' of the local context is important as such differences may reflect preferences and choice, or better coping and resilience. Where there are discrepant levels of service use/uptake, this could reflect need in terms of a higher incidence or greater severity of mental health problems by the time people contact services. It is also possible that people from BME communities are more likely to be admitted or detained because there are no alternative models of care which are attractive or provide a safe and effective service for them.

Consequently, it is important to ensure that these considerations and local factors are taken into account within Joint Strategic Needs Assessments, audits, and local action plans to ensure equality.

Differences between groups

There are significant differences *between* minority ethnic groups in the way they access and experience mental health services.

Perceived coercion in relation to psychiatric hospital admission is associated with non-white ethnicity. People of African origin, in particular, appear to have a more negative experience and poorer outcome, say in comparison to people of Indian origin, when they come into contact with mental health services[33].

What do we know about the current provision of mental health services for people from BME communities? (continued)

There is also clear and consistent evidence of "over-representation" of particular BME communities in the coercive and custodial aspects of psychiatric care[40,41]. At the same time, there is "under representation" of some BME groups in terms of referrals to specialist mental health services and within specific treatment categories, such as those receiving psychological therapy[45].

Why do BME groups have more adverse experiences of mental health care?

In addition to a growing research literature, there have been several recent reports and inquiries in England about mental health care for BME communities (Box 3). Taken together, this research and reviews have noted that:

- **socio-economic factors** play a key part in determining higher rates of poor mental health and wellbeing in BME communities including:

  - higher levels of poverty
  - lower levels of income and benefits receipt
  - higher levels of unemployment
  - poorer educational achievement and qualifications
  - poorer housing compared to the general population (see Box 3).

- **societal experiences of racism and discrimination** faced by BME communities can erode the emotional, spiritual and intellectual resources essential to psychological wellbeing, and contribute to an increased risk of mental health problems, contingent on social context[46].

- the impact of **discriminatory processes, structures and attitudes within mental health care** impact on the quality, appropriateness, and outcome of mental health interventions and care provided to people from BME groups, compounded by a failure to systematically monitor, challenge and correct such discriminatory processes and their outcomes.

BOX 3

Delivering Race Equality

Delivering Race Equality (DRE)[47] has been the only national policy specific to BME mental health. It arose out of (a) recommendations to reduce ethnic inequalities, service experience, and outcome in mental health (as a response to the National Service Framework and NHS Plan for mental health); (b) *Inside Outside*[41], and (c) followed the findings and recommendations of the Independent Inquiry into the death of David Bennett[48]. In doing this, the Bennett Inquiry raised the issue of institutional racism within the NHS (drawing on the initial use of the term in the Macpherson report on the Stephen Lawrence enquiry), and along with policy initiatives from the Department of Health made specific recommendations aimed at making mental health services non-discriminatory and appropriate to the needs of people from BME communities. This guidance draws on its key findings.

Centre for Social Justice

A review of mental health care by the Centre for Social Justice showed that BME communities are not well served by mental health services; according to this review, in addition to poor access to services, BME communities also experience greater deprivation of liberty[29].

Mind report on crisis care

Mind has produced a briefing to Clinical Commissioning Groups on improving acute and crisis services for BME communities[49]. Recommendations include better consultation and engagement with BME groups in commissioning services and ensuring that staff deliver person-centred care that takes cultural differences and needs into account. CCGs should commission a range of care options that meet a diverse range of needs; this may include crisis houses, sanctuaries and recovery houses, retreats/respite care, peer/survivor-led services, BME provided services, host families, and crisis-focused therapeutic programmes. The importance of empowering people from BME groups by providing appropriate information, access to advocacy services, and ensuring that they are engaged in, and have control over, their care and treatment is also emphasised.

What should good mental health services for people from BME communities look like?

In this section, we set out eight priorities for commissioning mental health services for people of BME origin:

1   Public Mental Health

2   Improving and enhancing care pathways

3   Alternatives to coercive services and specific actions to reduce detentions under the Mental Health Act

4   Making specialist mental health care culturally competent and appropriate to BME needs

5   Enhancing support and advocacy

6   Measuring and monitoring change

7   Increasing choice and plurality in service provision for BME communities

8   Increasing the involvement of BME service users, and investing in BME user-led services.

These priorities are inter-related and should be considered at each stage of the commissioning cycle.

1   PUBLIC MENTAL HEALTH

Public mental health is concerned with ensuring that people at a higher risk of mental disorder and poor wellbeing are appropriately prioritised in public mental health initiatives, as well as within mental health care services[12].

Given the often higher levels of mental health problems in some BME communities, (for example, amongst people of African and African origin), and the relatively poorer uptake of mental health services (for example, amongst people of Pakistani background), there is a need for specific public mental health initiatives targeted at this community.

The existing guidance on public mental health commissioning by the JCP-MH[12] identifies the importance of a detailed plan with a seven-stage commissioning cycle (assessing local need; local assets/resources; local service provision; analysis of interventions; a plan for intervention; procurement of interventions; and evaluation of the impact of interventions).

This guide contends that within each stage of this commissioning cycle it is important to assess the impact on BME populations, and that specific requirements and outcomes in relation to ethnicity are made explicit.

In addition to this, this guide recommends three key initiatives for CCGs and Health and Wellbeing Boards when developing strategic plans to address public health of the local population:

• a programme of community development

• education and awareness programmes

• addressing racism and discrimination.

Community development

Community development was identified as a key priority within the first national strategy for improving mental health care for people from BME communities[41]. This was subsequently integrated within the NHS mental health plan and was further prioritised within the Delivering Race Equality programme[50].

In this policy context, the aim of community development has been two-fold: (a) to improve the capacity and preparedness within communities for dealing with social or health problems, and (b) to forge a more positive relationship between community and health/social care agencies.

As part of the DRE programme a number of Community Development Worker (CDW) posts were established. The outcome of this initiative has been mixed[51].

One of the reported reasons for this was the dilution of the seniority and purpose of the CDW, resulting in CDWs working primarily to improve community engagement with mental health care providers, and not dedicating equal resources to community development.

What should good mental health services for people from BME communities look like? (continued)

Mental health promotion and raising awareness

Mental health promotion is an important component of strategies to promote mental wellbeing and facilitate mental health care.

Improving wellbeing at a population level frequently depends on better housing, community cohesion, safety and security. This is because the disproportionate number of people from BME groups in inner-city areas with higher rates of poverty, crime, and poorer and more disorganised services, can make for greater challenges to resilience and wellbeing.

Prevention of stigma and discrimination is also one of the core objectives of mental health promotion, as this may account for the increased risk of mental disorders of some of the BME groups[52]. In such situations, mental disorder can lead to further stigma and discrimination resulting in social exclusion, loss of employment and other inequalities that, in turn, further undermine mental wellbeing.

Consequently, there is a need:

- to target anti-stigma and anti-discrimination programmes, such as *Time to Change*[53], on specific BME groups and adapt them appropriately. *Time to Change* already has, in phase 2, a specific focus on BME communities (especially, African Caribbean) with 25% of funds given to BME projects. In response to criticisms in phase 1, a number of BME projects are now part of the programme.

- to ensure local commissioning support and prioritise local stigma and discrimination campaigns that are appropriate to the needs of local BME communities (for example, the *Revolving Door*[54] initiative on P21).

- for CCGs and Health and Wellbeing Boards to commission and evaluate mental health promotion strategies targeted at specific BME groups, taking into account culture, language and mental health priorities within each community.

Racism as a public mental health issue

There should be a clear research and intervention strategy to address the impact of racism on the health and wellbeing of both BME groups and, more broadly, the general population.

Racism can impact negatively on the health and wellbeing of all communities. Racist attitudes, behaviour, and attacks can have profoundly enduring and damaging effects on the mental health of BME communities. Racial discrimination can also be a cause of ill health and poor educational and employment prospects among ethnic minority people[55].

Those reporting some form of racial attack are almost three times more likely to have depression, and almost five times more likely to have psychosis than people reporting no harassment[56]. The available scientific evidence suggests that racism can adversely affect mental health status in at least three ways: (i) racism in societal institutions can lead to truncated socioeconomic mobility, differential access to desirable resources, and poor living conditions which adversely affect mental health, (ii) experiences of discrimination can induce physiological and psychological reactions that can lead to adverse changes in mental health status, and (iii) in race-conscious societies, the acceptance of negative cultural stereotypes can lead to unfavorable self-evaluations that have deleterious effects on psychological well-being[57,58,59].

2 IMPROVING ACCESS AND EXPANDING THE CARE PATHWAY

There is good evidence that some BME groups do not access specialist mental health services along conventional or planned pathways[60,61].

Instead, these groups tend to follow more aversive care pathways into specialist care, usually involving agencies outside of the health care system, which then provide a point of entry into mental health care. Consequently, this can delay the provision of care and treatment to the person concerned.

Given the problems that have been identified in relation to access, there is a need for a broader definition of 'pathways to care' that:

- include the ways people seek help in the community *before* making any contact with statutory services[62]

- improves access through establishing multiple points of entry into mental health care (e.g. through the voluntary sector, places of worship, as well as non-health care settings where people are likely to present with mental health difficulties)

- considers both an individual's entry into mental health care services through the points listed above, *and* their exit to these contact points.

To achieve this, BME voluntary sector services will need to play a central role in acting as a bridge between mentally unwell people and GPs/other statutory services. Along with service user and patient organisations, they are also likely to be the most effective agents for service user advocacy and rights[63], particularly in deprived areas where access to early and effective health care is usually problematic.

Availability of youth services and early intervention for mental health problems are also advocated as a way to ensure easier and less aversive access to effective mental health care and in reducing the likelihood of coercive interventions. Integrated models of youth services (a) based on multiagency working (social care, criminal justice, education and heath) that (b) intersect with acute mental health care pathways and primary care, with (c) early and seamless access to specialist assessment, could be of enormous benefit to BME communities. In particular, there is a major challenge in managing the 'upstream factors', contributing to much of the mental morbidity in specific groups, such as young black men.

Similarly, there is a need to expand and strengthen the transitional support/services available to young people coming out of care, and in the intersection between criminal justice and social care.

As people from BME communities often seek help for their mental health problems through primary care (rather than being referred to specialist mental health services), there is a need for primary care agencies to work more effectively with BME groups.

3 ALTERNATIVES TO COERCIVE SERVICES AND REDUCING DETENTIONS UNDER THE MENTAL HEALTH ACT

Findings from the Care Quality Commission relating to the Mental Health Act and *Count Me in Census* show that black people are more at risk of being detained under the Mental Health Act, and more likely to be held in secure psychiatric care than any other ethnic group[64]. Research shows that 40% of black men detained in high secure care, for example, do not require that level of security and could be managed in less restrictive and more therapeutic settings[64].

These higher than average rates of detention under the Mental Health Act amongst BME groups (in particular, black people or black people of mixed heritage) often result in care pathways which often include a disproportionate use of secure psychiatric facilities (increasingly in private hospitals) and long duration of inpatient care. These can not only lead to disengagement and high levels of dissatisfaction amongst service users and their families, but also have long-term negative consequences in terms of recovery and social inclusion[65].

This guide contends that commissioners of mental health services for ethnically diverse populations should have specific plans (including joint crisis plans) to minimise or reduce the negative impact of mental health care for BME communities. This means developing services that are supportive and helpful rather than coercive and custodial.

Re-shaping care pathways into mental health care

Re-shaping acute care pathways into mental health care (particularly in relation to hospital admission) may be key.

The findings of the recent inquiry into crisis and acute services by Mind[66] *Listening to Experience* reflected a long-held view by many people from BME communities that acute care pathways are inflexible and have a bias towards the medical management of crisis (dominated by considerations of risk) rather than individual needs.

To address this, it is necessary to expand the options available to people in crisis or when they are at risk of hospital detention/ admission. Alternatives to hospital detention are scarce and under-developed in most places (not withstanding the significant additional investment in crisis and home treatment services over the last decade). It is important therefore to invest additionally in a network of crisis residential alternatives to hospital admission, suitably resourced and capable of delivering 'things that people said they need in a crisis'.

Crisis and respite houses, for example, are not always part of the acute care pathway and where such options are available they are not integrated into mainstream services. There are also problems in accessing such alternatives either directly from the community, or by self-referral. Commissioners should therefore consider extending the provision of such services to include BME third sector and service user-led organisations.

Use of Section 136 provisions

One area of major concern for BME communities is the use of section 136 provisions under the Mental Health Act, and the over-reliance on police stations as a "place of safety" for people detained under this provision.

What should good mental health services for people from BME communities look like? (continued)

We support the suggestion that recourse to police stations as a convenient local option to psychiatric alternatives or because the health-based place of safety is regularly full, should be phased out with police cells only used on a genuinely exceptional basis[29]. It is important to seek community-based alternatives to current practice of using police stations as entry points to specialist mental health care. Therefore CCGs should commission services which can serve the purpose of section 136 detention, while ensuring that facilities adhere to agreed standards on places of safety[67].

Discharge and step down

Another strategy to reduce the burden of coercive care is to hasten discharge or step down from custodial care, especially where it is targeted at individuals in long-term (and, often, forensic mental health) care. Local commissioning of services (again, including BME specific services and BME third sector providers) that prioritise early discharge, active support and rehabilitation should be essential components of such a plan. Currently, many of these individuals are in 'out of area placements' at a cost of £690 million annually, with nearly two-thirds of the cost of such placements coming from NHS commissioners[68].

4 IMPROVING CULTURAL COMPETENCE AND APPROPRIATE SPECIALIST MENTAL HEALTH CARE

One of the fault lines within contemporary mental health care for BME communities is within specialist mental health services. In particular, acute care and hospital settings are key.

As we have already noted in this guidance, there are long established and enduring patterns of ethnic inequalities in service experience and outcome within specialist care. An important issue reported by BME communities is the disproportionate emphasis on control and coercion, and the resulting 'circles of fear' and 'circuits of control'. A priority for making mental health care acceptable and appropriate to BME communities is therefore to make the experience of mental health care less 'toxic', with more of an emphasis on care and support rather than control and containment.

A number of recommendations have been made over the years in addressing this problem. However, many of these have been either ignored or marginalised within mainstream mental health. The reasons for this are complex but the lack of effective and accountable commissioning of acute mental health services is increasingly understood as a major problem. The new commissioning arrangements within the NHS, in particular, the requirement placed on CCGs to develop and commission services appropriate to local needs, offer significant opportunities to address some of these issues.

Previous work has suggested training as a mechanism to improve the cultural competency of staff (see Box 4). However, there is more to making services culturally capable than enhancing staff competencies in dealing with cultural minorities. This is because it is not just individual practitioners that need to be culturally competent, but rather the systems of an entire organisation must be geared to deliver safe, effective

and culturally competent care. Short training courses or initiatives on recruitment (ensuring diversity within the workforce) cannot alone ensure clinical cultural competency skills.

There are many ways to improve cultural capability within the organisation. One example of this is the model of 'cultural mediation' or 'cultural consultancy'. The cultural consultation model has been shown to be cost-effective, includes in-service training and addresses the patient's narrative in care. Commissioners need to be informed that although Human Resources and quality interventions are distinct, they can be combined for an organisation to improve. Cultural consultancy models used in East London (narrative-based assessment which foregrounds service users and patients' stories) show that links between commissioning and service delivery can be made alongside training and prioritising shared-decision making for a more compassionate service[69]. The East London study showed less need for emergency care and nursing care, with significant savings for patients otherwise stuck in assertive outreach teams. Staff became more confident and skilled, and clinical, managerial and commissioning policies were optimally aligned.

Another way of approaching this organisational challenge is to focus on the *quality* of service experience (as reported by service users and carers from BME communities), and to aim to ensure greater choice and autonomy for patients. Co-production of services with service users and community agencies and increasing the choice of services available, including services from BME third sector organisations, will ensure services that are more congruent with the needs of cultural and ethnic minorities. We provide several examples of this later in this guidance (P21).

Spiritual care teams in mainstream services can also enable staff to recognise culture and belief as legitimate contexts in which to better understand mental health and emotional issues arising in all communities, and faith as a means for reflection and resilience and a protective factor in preventing escalations such as suicide and violence.

BOX 4

One of the earliest definitions offered was by Cross *et al*. They defined cultural competence as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations"[70].

A "culturally competent" health care system has been defined as one that acknowledges and incorporates – at all levels – the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs[71].

A systematic review of evaluated studies of cultural competence (all from the US) found that there was only limited evidence on the effectiveness of cultural competency training and service delivery. It was suggested that further work was required to evaluate improvement in service users' experiences and outcomes[72]. Other studies have reported that training mental health staff in cultural awareness had little impact on the discrepant service experience of people from BME communities[73].

5   SUPPORT AND ADVOCACY

Patients, service users and carers from BME backgrounds face particular difficulties in accessing and using support services over and above those faced by their white counterparts. For example, support and advocacy services often fall short of meeting their needs[74]. In particular, the uptake of independent mental health advocacy (IMHA), which is an entitlement under the Mental Health Act in England, is poorer amongst BME groups[75]. Under-utilisation of services such as IMHA by BME groups cannot be attributed to their lack of interest in receiving support; for example, it has been suggested that the commissioning of IMHA services has led to a failure to provide adequately for BME patients[63].

IMHA and similar services help in ensuring service user voices are heard and their rights are protected. For many BME patients (and their carers) independent advocacy will help them in challenging the language and cultural barriers that often discriminate against BME service users. There is a strong argument to commission BME specific support services including peer support and mental health advocacy with a user-led perspective.

6   MEASURING AND MONITORING

Commissioning mental health services for BME communities should be based on an assessment of local needs and on strong evidence.

New innovations (in particular community-based programmes) are often not subject to evaluation or audits. Much of the evidence attesting to their effectiveness (or otherwise) is neither collected or used systematically in the context of health care commissioning. This is a major problem in relation to ethnic health commissioning[76] and, therefore, the effective mobilisation of wider evidence is essential.

In practice, as the Evidence and Ethnicity in Commissioning (EEiC – http://research.shu.ac.uk/eeic/) project has shown, mobilisation and use of evidence in health care commissioning for ethnic minority communities is hugely problematic. An exclusively evidence-based culture "can impede progress on ethnic inequalities, with the potential result that an absence of evidence will both undermine the confidence of commissioners to invest in new initiatives and provide justification for maintaining the status quo of inaction"[76].

This may be because most of the service innovations in addressing ethnic inequalities in mental health have been short-term and project-based. Furthermore, it has mostly been service providers (from the third sector) who have brought about these changes rather than commissioners. This has often curtailed the collection of systematic evidence of efficacy and, more critically, even when such projects have been successful, there is "little evidence of resultant knock-on effects for commissioning organisational policies or practice"[76].

Accessing, interpreting and applying evidence regarding ethnic inequalities in health and healthcare is often challenging. However, there must be robust strategies to address these issues and, as the EEiC project notes, commissioners can do more to access relevant information on assessing the effectiveness and quality of services and measuring outcomes. Similarly, systematic collection of ethnic data in relation to mental health services should be considered essential and this should inform the commissioning process. There should also be a commitment to enhance data sources and drive improvements in data collection and use.

What should good mental health services for people from BME communities look like? (continued)

7 IMPROVING CHOICE AND AVAILABILITY IN SERVICE PROVISION

Ethnic inequalities in mental health are a persistent and enduring problem, despite recent national initiatives set out to address this problem (such as *Delivering Race Equality*).

The seemingly intractable nature of this problem may be understood as a result of the lack of choice and availability in service provision, as well as a cultural problem within the NHS in adapting to the needs of multiethnic and multicultural population. It would appear that minority ethnic communities engage better with services specifically designed and delivered to address their needs, and prefer services delivered through community agencies such as BME third sector organisations[77].

At present, BME communities have little choice in relation to the kind of services they can access, and in some instances the service interventions available to them may not meet their needs or be acceptable to the community.

Consequently, mental health commissioning strategies should recognise not only the diversity of the local population, but also the diversity of local needs within this. It will therefore be important to ensure a range or plurality of service provision. In addition, specific actions are required to enhance the capacity of BME third sector organisations to provide all aspects of mental health care, while ensuring the basic values framework for commissioning services. The pioneering work of BME organisations, from the voluntary sector and involving service users, in the way of outreach and community-based support for people with severe and long-term mental health problems, provides a useful template for future commissioning plans (P21).

8 INCREASING THE INVOLVEMENT OF BME SERVICE USERS AND INVESTING IN BME USER-LED SERVICES

BME service users continue to face barriers in participating in involvement initiatives. The idea that BME service users are 'hard to reach' is still entrenched in organisational cultures and practices. The problem with this idea is that the onus of participation is placed on communities and groups of people rather than critically rethinking structures for involvement and the barriers that might exist.

Consequently, commissioning processes will need to rethink these structures and work to reduce barriers, be clear about the process and purpose of involvement, and monitor opportunities for involvement for BME service users and the impact this has on the commissioning process.

Recent research has shown that services that are user-led and based on the concept of peer support can make an important contribution to supporting mental health and maintaining mental wellbeing[78,79]. The case for commissioning BME peer-led services is that the 'experiential expertise' that BME service users bring to the process of designing, developing and delivering services is based on their understanding of shared cultural and ethnic identities, knowledge of local communities, and an understanding of their mental health needs and what works in supporting wellbeing. The mental health commissioning strategy should recognise this specialist knowledge and experience that BME service users have, and subsequently support the work of BME user-led organisations alongside the broader BME voluntary sector and mainstream mental health services.

An important first step to improved service provision is ensuring the meaningful involvement of service users and patients in designing, developing and delivering services. Barriers to meaningful involvement have been identified in several reports and these include:

- negative experiences within services
- lack of space acknowledgement of existing racism and space to discuss this within involvement initiatives
- lack of role in decision making
- and replacing service user voices by that of the broader community[3,36,80].

A key piece of work by the National Survivor and User Network and Afiya Trust, *Dancing to Our Own Tunes*[3], suggests: "If there has to be meaningful involvement of service users and survivors from black and minority ethnic communities in mainstream initiatives, there has to be structural changes in hierarchies, ways of working, assumptions, power structures within institutions, resource allocation, the location of decision making, and the way people are treated within mental health services and outside them".

In a review of voluntary sector services that have been successful in engaging black service users, Christie[81] identified a number of ingredients of good practice; these included:

- working in partnership
- advocacy in securing people's rights
- empowering service users
- retaining a focus on core activities
- strategies for preventing people from unnecessarily entering the statutory mental health system
- cultural sensitivity
- outreach work to engage positively with people
- and involving families and the community in mental health care.

Findings from the Evidence and Ethnicity in Commissioning (EEiC) project[76] have identified three major obstacles to progress in addressing ethnicity in health. First, there is ambivalence at national and local level regarding the importance of addressing ethnic inequality as reflected in its marginalisation from other key policy

priorities, the limited resources allocated, and lack of performance monitoring. Second, there is a lack of skills and/or confidence in dealing with ethnic diversity and inequality. Third, the increasing emphasis on evidence-based policy and practice has inadvertently undermined the ethnic inequalities agenda because data and evidence are lacking, together with a failure to mobilise the available evidence effectively. Consequently, these factors hamper action towards understanding and addressing deeply ingrained ethnic inequalities.

BUILDING ON PREVIOUS WORK

Unfortunately, previous recommendations in policy guidance such as *Inside Outside* and *Delivering Race Equality* have not been fully implemented. Furthermore, with the demise of the DRE programme, there is no longer a specific national framework for improving services for people from BME communities.

Therefore a need exists to restate the key recommendations from previous reports aimed at reducing ethnic inequalities within mental health services, and it is critical that these are taken into account when commissioning services. These include:

- *The Independent Inquiry into the Death of David "Rocky" Bennett* recommendations[48]: 1/2/3/15 (cultural/ race awareness), 6 (racist abuse), 7 (CPA), 8 (workforce), 8/9/13 (restraint), 14 (schizophrenia), 16 (2nd opinion) and 16 (secure care).

- *The Royal College of Psychiatrists* have provided specific guidance to commissioners regarding the use of section 136 under the Mental Health Act and providing 'place of safety' as an alternative to police stations and acute psychiatric beds[67]. The Royal College of Psychiatrists have also issued detailed guidance on improving staff skills and addressing staff needs in relation to providing appropriate and culturally competent mental health care[82].

- *Breaking the Circles of Fear* (Sainsbury Centre for Mental Health 2002)[40]. This report set out specific recommendations to break the 'circles of fear' that characterise the relationship between black people and mental health services. These included establishing a gateway function (programmes to support the reintegration of black service users), supporting the community, improving access, creating sensitive services, workforce development and capacity building.

- *The independent inquiry by MIND into acute and crisis services*[66] and a subsequent investigation based on Freedom of Information requests to mental health trusts led to a briefing targeting all CCGs[49]. This included recommendations to commission crisis services from a range of providers including specialist providers in BME including crisis services/crisis houses in collaboration with BME third sector providers. Commissioners are asked to set specific standards with providers to embed shared decision-making in their practices through joint crisis care planning, taking into account the diverse needs of the local communities.

- *The National Service Framework and the NHS Plan for Mental Health*[83,84] set out detailed guidance and service models which were subsequently underpinned by significant investments in mental health care. Those services created under the 1999 National Service Framework (such as Crisis Resolution and Home Treatment, Early Intervention and Assertive Outreach) went some way towards reducing the reliance on hospital-based care and thus providing more appropriate services to address the needs of people from diverse backgrounds. In particular, services such as Crisis Resolution and Home Treatment (CRHT) and those based on models of

Assertive Community Treatment appear to have been beneficial for people from BME backgrounds[85]. It is important to ensure continued investment in these service models is maintained and service fidelity is not compromised. Early intervention, alternatives to hospital admission (including detention under the Mental Health Act), early discharge from hospital care and sustained and assertive community support and follow-up are of critical importance in addressing the aversive nature of mental health care experienced by many BME communities.

- *Delivering Race Equality* (DRE)[47]. The three "building blocks" that the DRE identified (appropriate and responsive services, engaged communities, and better information) are essential for delivering race equality through mental health commissioning. The specific actions set out under the heading of developing appropriate and responsive services (DRE Action Plan) should inform commissioning strategy and plans.

- *Dancing To Our Own Tunes*[3]. In 2008, the National Survivor User Network (NSUN), in partnership with Catch-a-Fiya (the national BME mental health service user network hosted by Afiya Trust) undertook a consultation to explore the barriers and solutions for meaningful participation of BME service users in mental health initiatives. The subsequent report, *Dancing to Our Own Tunes*, identified several barriers to partnership working. A charter and a set of guidelines were developed to help local and national organisations to identify and build upon the strengths and opportunities for innovative and effective partnership working. There are specific guidelines in relation to values, setting up partnerships, management and good practice[3].

What good looks like – case-examples

The following examples are derived from an online survey of various BME stakeholder groups on the issue of quality in BME service provision (see www.jcpmh.info for more details).

1   AFRICAN CARIBBEAN COMMUNITY INITIATIVE (ACCI) – WOLVERHAMPTON

African-Caribbean Community Initiative (ACCI) is a long established black voluntary sector mental health project in Wolverhampton – www.acci.org.uk.

St Jude's is a specialist service, set up by ACCI, offering emotional support and assistance for African-Carribean men who have serious and enduring mental health and substance misuse problems (often perceived as one of the most challenging client groups, and by other providers as 'beyond help').

Set-up for men who have enduring mental health problems and are engaged with forensic and other criminal justice-based services, St Jude's is one of only a few services in the country providing community-based care for this group. Support workers staff the service 24 hours a day, with this providing additional support for the six resident clients who are routinely targeted by local drug dealers.

St Jude's offers a service to manage client's money (an appointeeship scheme agreed with the Department of Work and Pensions). This involves a budget being drawn up for food, clients being encouraged to save, and negotiations about how any remaining money is spent. Unlike other services where people in this client group are 'contained', ACCI aim to incorporate what the clients want to achieve (including therapeutic intervention), and ACCI work with other agencies – such as the YMCA, police, probation and local community mental health team – to achieve this.

"It is a valued service, and costs a fraction of what would be paid out to keep these men in forensic care, where the evidence shows that they don't get any better. The through-put at St Jude's is not that great but we are working with a group that have such a high set of needs that keeping them stable and in the community is an achievement."

2   WANDSWORTH COMMUNITY EMPOWERMENT NETWORK (WCEN) – LONDON

WCEN is an independent charity which supports a network of community and faith-based organisations and people who are working collaboratively to improve the way public services are designed, delivered and received – www.spaa.info[86].

Using a process where professionals and citizens or community groups come together to develop and deliver services, WCEN projects have included:

- Black Church Leaders being trained in systemic family therapy (opening up the possibility of a redesigned pathway into mental health services)

- Improving Access to Psychological Therapies initiatives being co-produced in local community sites (e.g. churches and mosques), widening the range of venues where services can be delivered

- the identification and enablement of local community champions to act as 'early engagers' of people in their networks who are vulnerable and cut-off from services

- the 'strengthening families programme' which involves the sharing and exchanging of parenting, life skills, and experiences by communities and families (facilitating the development of individual and group resilience)

- the provision of emotional support for the local Tamil community via a Hindu temple, which has helped to highlight specific mental health needs in local BME communities.

At the core of WCEN's work is a genuine integration of health and social care systems with social and community networks . This requires a shift of leadership and resources from the 'centre' to local communities, to enable citizen-led innovation and management for social productivity.

3 CUSTOMISED SERVICES, CARES OF LIFE PROJECT – LONDON

The Cares of Life Project was an innovative new service designed to encourage black people to seek help for mental health problems. Based in Southwark, south London, and launched by South London and Maudsley NHS Foundation Trust (SLaM), it involved a team of six (mostly black) psychology graduates being recruited as community health workers to provide a range of services.

Based in a building used by voluntary organisations, and advertising their services by visiting churches, barbershops, local voluntary groups, and events (where a 'Health Bus' promoted the service and offered simple physical health checks and the opportunity to talk), the service worked directly with people and only referred those with complex mental health problems for specialist help.

Some of those people who came to the 'Cares of Life' project were offered immediate treatment with the community health workers, while others were given a first appointment three months later. In addition, a research team undertook an evaluation where participants were assessed at the point of their first contact, and then again three months later to find out what difference the project had made (comparing the effectiveness of the 'rapid' versus standard three-month wait treatment). When the pilot for this project finished in 2005, The Cares of Life service continued subsequently with a smaller team and demonstrated that effective and culturally acceptable psychosocial interventions could be delivered in the community to individuals from BME groups with anxiety and depression with no significant cost implications[87].

4 REVOLVING DOORS – BIRMINGHAM

'Revolving Doors' is a training resource developed in partnership between mental health providers (Birmingham & Solihull Mental Health Trust) and local BME communities.

Targeted at health professionals, the local BME community, statutory organisations, third sector organisations and service users, the project has been introduced to other regions (including London, Brighton, Nottingham and Bradford) and has been further endorsed by the National BME Network.

The training resources aim to enable participants to understand and address the impact of stigma and discrimination related to mental ill health. Designed around a film that gives participants a community perspective of mental health and mental health provision, the training aims to give the participants skills and strategies to challenge discriminatory attitudes and behaviours about mental health in their places of work and community.

The training was designed by service users working alongside the local community, health professionals, and other statutory stakeholders.

Feedback from the training events indicates that an overwhelmingly high number of participants successfully obtained a greater awareness of stigma associated with mental health as a result of the training. An equally high number have identified areas within their practice that can be improved or actions that can be taken within their own communities to address stigma and discrimination.

What good looks like – case-examples

5 MAAT PROBE – SHEFFIELD

MAAT Probe was formed in 2009 by members of the Sheffield African Caribbean Mental Health Association (SACMHA). SACMHA is a small charity that has provided mental health outreach and advocacy for the African Caribbean community in south Yorkshire for over 20 years.

MAAT Probe aimed to establish why so many black inpatients on acute psychiatric wards had such negative care experiences. The group was awarded just over £2,000 by *Open Up*, an initiative run by the lottery funded anti-stigma campaign *Time To Change*, to bolster grassroots mental health projects.

The group began by surveying local service users and found a high level of unhappiness and dissatisfaction with inpatient services, with particular concerns about control and restraint techniques in mental health facilities. The survey findings were published in a report called *Can You Handle The Truth?*

Given the report's focus on the use of restraint and control procedures, MAAT Probe came up with an intervention that staff could use when confronted by difficult situations on the ward. This was based on 'respect' for the service user and negotiation and discussion between staff and service users, without the imminent threat of physical interventions.

With an emphasis firmly on prevention, changing culture and care, techniques designed to cause no pain or panic were refined in conjunction with service users, many of whom had experienced control and restraint. Aspects of culture and ethnicity were interwoven with this

teaching, and MAAT Probe subsequently developed a training programme for staff that was implemented in local mental health services and delivered (by MAAT Probe) to all acute care nurses.

As reported in *The Voice* newspaper, Robin Cox, a member of MAAT Probe said "after our long campaign and working in partnership with the Sheffield Care Trust, they said that our persistence gave them the incentive that they needed to improve the service delivery to African-Caribbean service users and all other ethnicities"[88].

6 CANEROWS AND PLAITS, WANDSWORTH – LONDON

In 2008, Canerows and Plaits (Canerows) formed under the umbrella of the user-led mental health and arts organisation, Sound Minds. Based in Battersea, South West London, the charity had a track record of campaigning on BME mental health issues, often using music and arts as a vehicle.

Due to higher rates of (a) admissions to acute wards, (b) sectioning, (c) admission to services via police contact, and (d) negative reported experiences of control and restraint among local BME groups, Canerows was set-up to address these difficulties through peer-led services.

In 2008, funding from three sources was pooled to employ a part-time project worker (who was also a service user), and the 'Ward Visiting Scheme' was piloted for one year. A positive independent evaluation in 2009 helped Canerows to secure three year project funding from Comic Relief.

The 'Ward Visiting Scheme' provides dedicated non-professional time to talk, and 'ordinary human kindness' from people who have themselves had experience as inpatients. With weekly visits to five hospital wards in two locations, Ward Visitors not only talk with patients, but also routinely invite them to complete questionnaires about their experience. The results are aggregated and fed-back on a six monthly basis to local NHS managers.

In the last year, Ward Visitors have also been able to start offering support for patients after they have left hospital. The 'Canerows Community Service' is envisaged to be complementary to existing mental health services, and interventions include a weekly cup of coffee and a chat, to games of tennis, to accompanying people to local services. Canerows has also opened a weekly one day drop-in, 'Mama Low's Kitchen', at a local community centre, again staffed and managed by service users. With shared staff between the Ward Visiting Scheme, the Community Service and Mama Low's Kitchen, a coherent system of peer support and consultation is successfully taking shape[79].

www.soundminds.co.uk
www.canerows.co.uk

7 KINDRED MINDS – SOUTHWARK, LONDON

Kindred Minds is a mental health project founded by service users/survivors from BME communities in the London borough of Southwark. Since January 2013, the project has been part of Social Action for Health (a community development charity in East London) with funding from the Big Lottery, Reaching Communities fund.

All activities at Kindred Minds including staffing, volunteer recruitment and planning involve the work of BME service users who set the rules, terms of references and agenda, chair meetings, attend national conferences, and define models of 'recovery'. This, in effect, has helped form an independent, collective user voice with a strong emphasis on making changes to improve mental health services. Access to Kindred Minds is open and does not depend on personal budgets or referrals.

One of the main activities is a fortnightly social drop in called 'PoP-In'.

Each fortnight has a specific theme such as a discussion on benefit changes and their affects on people, or a talk on what 'culture' means to each participant, learning about their own and other cultures.

Kindred Minds' activities often have a strong creative thread including works with Talawa Theatre, Britain's foremost black theatre company (with performances at The Oval House Theatre and Theatre Peckham). Members have commented on the personal benefits of being involved:

"It gave me a chance to act like somebody without a head full of problems… gave me a chance to act problem-free or able to deal with challenges in life and difficulties and problems sufficiently".

http://safh.org.uk/our-work/ kindred-minds/

8   TOWER HAMLETS CULTURAL CONSULTATION SERVICE (TOCCS)

Mainstream mental health services often fail to provide culturally appropriate services for people from BME groups. This has led to attempts to bridge this gap, and reach a shared understanding between providers and users about the nature of their mental health needs, and how best to address these.

Cultural consultation is one method – as a clinical process it owes its origins to anthropological critiques of mental healthcare and includes attention to therapeutic communication, research observations, and research methods that capture cultural practices and narratives in mental healthcare.

The Tower Hamlets Cultural Consultation Service (ToCCS) was set up to improve service user outcomes by offering cultural consultation to mental health practitioners[69]. This involved practitioners working alongside cultural consultants to address immediate clinical challenges among BME groups, and to produce a shared care plan. The ToCCS team consists of a clinical psychiatrist, a forensic trained mental health nurse and an outcomes manager. An evaluation based on nearly 900 contacts and 36 complex cases over an 18 month period showed positive outcomes in terms of clinician's perceptions about the usefulness of the service and significantly reduced service usage by the clients[69]. The service also provides organisational consultation and training to other mental health teams. Cultural consultation is seen as both an effective and direct clinical intervention that improves functioning, meets patient needs, and reduces costs per patient by reducing reliance on emergency care and nursing care.

Supporting the delivery of the mental health strategy

No Health without Mental Health, which underpins the national strategy for mental health, emphasises outcomes and effective treatment focused on recovery for all ages[6]. This also applies to all ethnic groups, including ethnic minorities.

Commissioning that invests in the provision of effective and appropriate mental health services for people from BME communities will support the delivery of *No Health without Mental Health*.

The national strategy sets out six shared objectives. The actions attached to these objectives, however, do not make specific reference to BME groups (aside from a broad commitment to implement the Equality Act 2010).

Additional and supplementary actions - as outlined in this guide - are therefore necessary if the national strategy is to positively impact on the current care experience of people from BME backgrounds.

Shared objective 1:
More people will have good mental health

Commissioning high quality mental health services which are appropriate to the needs of BME communities will help reduce current ethnic inequalities in mental health care. This will make services more easily accessible for BME groups, increase engagement and help with recovery.

Shared objective 2:
More people with mental health problems will recover

Commissioning high quality, culturally competent mental health services will contribute to greater social inclusion of people with mental health problems from BME communities. 'Socially inclusive' services will help tap into the full potential of community and social resources, and this will help people with mental health problems to have a good quality of life.

Shared objective 3:
More people with mental health problems will have good physical health

Commissioning high quality services for minority ethnic groups will prevent deaths by suicide and reduce the risk of poor physical health and premature mortality by achieving improved mental wellbeing and mitigating the adverse effects of psychiatric treatment and institutional care.

Shared objective 4:
More people will have a positive experience of care and support

Culturally appropriate care and treatment based on respect and the need for autonomy will make services more accessible and acceptable for people from BME communities. This is also likely to reduce the aversive nature of BME mental health experience, and those using mental health services will have greater choice and control over their care and treatment. Specific actions to reduce the compulsive and custodial nature of psychiatric care experienced disproportionately by BME communities will result in more people having a positive experience of care and support.

Shared objective 5:
Fewer people will suffer avoidable harm

Commissioning high quality services based on values that emphasise cultural competence, autonomy and choice will mean that fewer people from BME communities will suffer avoidable harm, especially related to compulsory or custodial care.

Shared objective 6:
Fewer people will experience stigma and discrimination

High quality services for BME communities that are inclusive and recovery-orientated, with an emphasis on positive care experience for service users and greater engagement with carers, are likely to improve public understanding and attitudes towards mental health. This will result in fewer people experiencing stigma and discrimination as a result of their mental health difficulties.

Expert Reference Group Members

- **SP Sashidharan**
  (Co-Chair)
  Mental Health Rights
  Glasgow

- **Kamaldeep Bhui**
  (Co-Chair)
  *Professor of Cultural Psychiatry
  and Epidemiology;
  Hon Consultant Psychiatrist*
  Barts and The London School
  of Medicine and Dentistry

- **Jayasree Kalathil PhD**
  Independent researcher and writer
  Survivor Research

- **Joy Warmington**
  CEO
  brap – equalities and human
  rights charity, Birmingham

- **Lakhvir Rellon**
  Director, Community Engagement
  Birmingham and Solihull NHS Mental
  Health Foundation Trust

- **Marcel Vige**
  Head of Equality Improvement
  Mind

- **Paul Grey**
  Independent consultant
  Grey Services

- **Peter Lewis**
  Medical Director
  Birmingham & Solihull NHS Mental
  Health Foundation Trust

- **Jonathan Campion**
  *Consultant Psychiatrist and
  Director of Public Mental Health,*
  South London & Maudsley NHS
  Foundation Trust, and *Director
  of Population Mental Health,*
  UCLPartners

- **Chris Fitch**
  Research and Policy Fellow
  Royal College of Psychiatrists

- **Neil Deuchar**
  Co-Chair
  Joint Commissioning Panel
  for Mental Health

- **Swaran Singh**
  *Professor of Social and
  Community Psychiatry*
  University of Warwick

- **Zenobia Nadirshaw**
  British Psychological Society

- **Nundita Reeteo**
  Community Connections 3

- **Sidra Shirjeel**
  Community Connections 3

- **Patrick Vernon**
  Every Generation Media

- **Rezina Hakim**
  Policy and Campaigns Officer
  Mind

Development process

This guide has been written by a group of experts on BME mental health. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts.

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