Delivering Race Equality in Mental Health Care: a review

by Melba Wilson, National Programme Lead,
Delivering Race Equality (DRE) in mental health care

New Horizons
A shared vision
for mental health

DH Department of Health

policy into practice into
National Mental Health
Development Unit

Equalities in
Mental Health

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FOREWORD

by Louis Appleby CBE,
National Director for
Mental Health in England

Good mental health is not just important for individuals' health and happiness but it is fundamental to the well being and prosperity of our society. So it's vital that everyone can access the services they need to promote their mental health.

It is almost five years since the Delivering Race Equality (DRE) in mental health care programme began its work to tackle inequalities and improve mental health services for people from Black and minority ethnic (BME) communities. This was no small task – DRE's remit was both challenging and complex. It involved working with organisations and services across England as well as many different groups from service users and frontline staff to commissioners and policy makers.

Today, thanks to DRE's work, we have a much better understanding of the issues around race, ethnicity and mental health. Through innovative projects, research, data gathering, community engagement and a significant new workforce of community development workers, we have a strong base from which we can continue to improve services for people from BME communities.

DRE's work has informed New Horizons: towards a shared vision for mental health, our new vision for mental health in England, which builds on the 1999 National Service Framework for Mental Health (NSF). New Horizons and its associated equality impact assessment described the evidence for the – often very serious – inequalities in mental health among some ethnic groups. The roots of these inequalities lie in social, not biological, factors so the responsibility for remedial action extends to all the agencies that influence public mental health and well being. There are two ongoing challenges for tackling inequalities:

> **Today, thanks to DRE's work, we have a much better understanding of the issues around race, ethnicity and mental health.**

- For commissioners – the duty to understand, respect and meet the needs of their BME population. Primarily this means recognising and addressing inequalities in mental health, but that requires dedicated work with communities and the third sector to make sure that services are personalised around their linguistic and cultural characteristics

- For public mental health initiatives – to compenstate for inequality by ensuring as a priority that activity supporting good mental health and well being is targeted at, or is at least equally effective for, ethnically diverse populations.

DRE's experience, expertise and research will help commissioners and others to meet these challenges. Under New Horizons, we will build on DRE's successes and work together towards our vision of a healthier, fairer and equal society.

FOREWORD

by Lord Victor Adebowale,
Chief Executive,
Turning point

The setting up of the DRE programme represented a significant investment by the government in attempting to improve the position of people from black and minority ethnic communities, who have mental health problems.

The programme marked a sea change in that it served notice that maintaining the status quo was no longer a viable option. This message was that change was necessary in how mental health services are commissioned and provided if the needs of people from diverse communities were to be adequately met.

I have had close and integral involvement with the programme from the beginning, and I remain committed to the values and ethos of what it has aimed to accomplish. DRE was an ambitious undertaking, and it led a number of groundbreaking and innovative ways of working. For example, the idea of focused implementation sites was a good one – as they provided an opportunity to test out the ideas and imperatives of the programme in a co-ordinated and comprehensive way.

Likewise, the DRE programme's emphasis on meaningfully involving people who use services, as well as their carers and families; and of reaching out to black communities to mine the resources and the resiliencies within them helped to ground the work of the programme as it sought to reach the potential set out for it.

Given my involvement and belief in the role of the third sector, I have also welcomed the DRE programme's partnership working with voluntary and community organisations. The importance of such partnerships can be seen in the work which is coming through the 79 national community engagement projects.

Over the years, there has much to value as a result of the existence of the DRE programme. The job is not yet complete, however, and more needs to be done to ensure that commissioners and providers learn the lessons and take continuing action to implement the learning that is emerging from the work of DRE.
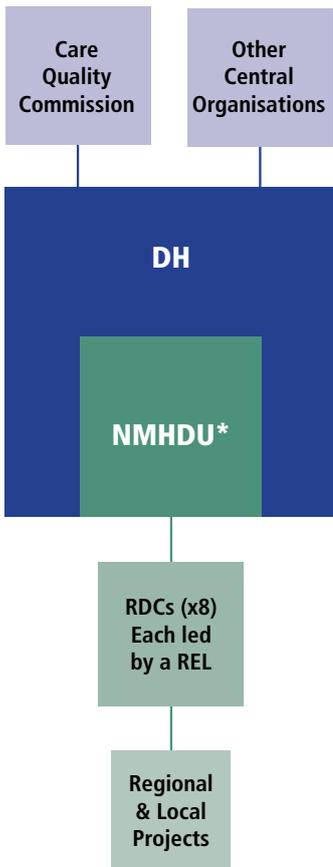
This will mean ongoing work to better assess people's needs; to ensure that people are more in control of their lives and outcomes in relation to their mental health needs, e.g., through embracing the personalisation agenda and promoting citizen involvement; and that we continue to seek ways to bring about not only better services, but also a better society.

I welcome the fact that the work of DRE will be actively influencing how the New Horizons mental health strategy will develop. It is important that the legacy and the aim of what DRE set out to do continues to be progressed through clear and visible linkage with new policy and guidance. There is still a long way to go, and we cannot be complacent about the real need for good mental health care which still exists.

> "
> The importance of such partnerships can be seen in the work which is coming through the 79 national community engagement projects.
> "

ABOUT DRE

This review looks back at DRE's work as its five year plan comes to an end. DRE has carried out an extensive programme of work and this review describes some of our key challenges, successes and learning. It also outlines how DRE's work will be taken forward under New Horizons.

DRE programme delivery structure

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┌──────────────┐   ┌──────────────┐
│ Care         │   │ Other        │
│ Quality      │   │ Central      │
│ Commission   │   │ Organisations│
└──────┬───────┘   └──────┬───────┘
       │                  │
┌──────────────────────────────────┐
│                DH                 │
│                                   │
│          ┌──────────────┐         │
│          │              │         │
│          │   NMHDU*     │         │
│          │              │         │
│          └──────┬───────┘         │
└─────────────────┼─────────────────┘
            ┌──────────────┐
            │ RDCs (x8)    │
            │ Each led     │
            │ by a REL     │
            └──────┬───────┘
            ┌──────────────┐
            │ Regional     │
            │ & Local      │
            │ Projects     │
            └──────────────┘
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* NMHDU replaced NIMHE and CSIP in April 2009

Background

The DRE programme was launched in 2005. It was a five year programme that aimed to support the development of better mental health services which met the needs of England's increasingly diverse population.

DRE was needed because it was felt that patients from BME backgrounds were not getting the mental health services to which they were entitled. There was and continues to be evidence to suggest that patients from some BME communities are more likely to be detained compulsorily, admitted to hospital, secluded and admitted through the criminal justice system than White British patients. In an extreme case, these inequalities were felt to have contributed to the death of David Bennett, a 38 year old African Caribbean patient who died in 1998 in a medium secure psychiatric unit after he was restrained by staff.

The DRE action plan was published alongside the Government's response to the independent inquiry into David Bennett's death. The recommendations in this response and the DRE action plan together made up an extensive programme of work for achieving equality of access, experience and outcomes for BME mental health service users. The programme aimed to change attitudes and behaviours as well as the way that mental health services were organised and provided. This was not about setting up separate mental health services for BME patients but about changing mainstream services so that the needs of an increasingly diverse population could be met.

Accountability and governance

DRE was a Department of Health (DH) programme and its action plan was part of DH's wider equality and human rights strategy. Initially, the programme was delivered by the National Institute for Mental Health in England (NIMHE) and then by the National Mental Health Development Unit (NMHDU), which replaced NIMHE in April 2009.

The actions identified in the DRE plan were to be implemented by all NHS and social care organisations in collaboration with the third sector and users and carers. Regional development centres (RDCs) were established and were based initially within NIMHE and their regions and later within the Care Services Improvement Partnership (CSIP). RDCs' remit was to integrate DRE programme work into the other NIMHE work for which they were responsible. To deliver this, eight regional Race Equality Leads (RELs) were appointed within the NIMHE development centres, to lead on a wide range of local, regional and national projects. Their role was to help ensure that work at a local and regional level met the spirit and intent of the DRE action plan.

ABOUT DRE
continued

The DRE action plan

The DRE action plan was a comprehensive framework of action that was built around three building blocks for change:

- More appropriate and responsive services
- Community engagement
- Better information.

The key work that was carried out under each of these building blocks is described on pages 8-21.

12 characteristics

The action plan also defined 12 characteristics that we hoped would describe mental health services by 2010. These characteristics and the extent to which they have been achieved are discussed on page 22 of this document.

78 actions

In order to deliver DRE's vision, the action plan defined 78 actions that would bring about change. These were to be carried out by a number of different organisations from NIMHE to PCTs. They ranged from strategic actions – for example, all NHS organisations were to put a race equality scheme and cultural capability framework in place – to operational actions, for example, NHS Direct was to provide a national interpretation service. Implementing the actions proved challenging and many organisations were unable to provide information that was of sufficiently high quality to measure performance. To address this, we developed the DRE Dashboard, which enables strategic health authorities (SHAs) to monitor their progress on race equality in mental health using data and information that is more readily available – see page 20 for more information.

Partners

DRE's programme of work was far-reaching and involved working with a wide range of partners and stakeholders. These included government departments, local authorities, SHAs, mental health trusts, the NHS University, NHS Direct and Primary Care Trusts (PCTs). We also worked with frontline staff, service users and people from BME backgrounds.

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> "

KEY CHALLENGES

Transforming the way that we provide mental health services to people from BME communities was never going to be straightforward or easy. DRE's ambitious programme had to tackle some complex issues if it was to be successful.

One of our successes has been to expose and achieve a better understanding of some of these issues, which will be used to inform future work to reduce inequalities. We also had to face other challenges, such as changes within the health and social care environment, which were beyond our control. In this section, we look at the main challenges that we faced and what we have learnt from them.

The complex nature of BME communities

The DRE action plan aimed to improve mental health services for all people of minority ethnic status in England. This included people of Irish and Mediterranean origin and East European migrants. It also covered specific populations, for example refugees and asylum seekers, older people and children and young people. The definition included a wide range of groups with very diverse needs, and understanding; and meeting the needs of all of these groups was always going to be a challenge.

Our work has developed an evidence base, which has helped us to better understand the demography of BME communities. We now have a clearer understanding of their needs, how they access services, how they want to access services and what commissioners and providers can do to improve services.

What works for one community will not necessarily work for another – the needs of an African Caribbean man who is afraid to engage with services are different from the needs of an Asian woman who may think that having a mental health problem is shameful. Our research has shown that different ethnic groups have varied perceptions about mental health services and want to access and use them in different ways.

However, differences do not arise just because of ethnicity. The demography of ethnic groups can vary in different ways. For example, if one ethnic group has a higher proportion of older people than another, their experience and perceptions of mental health services may vary because of age rather than ethnicity.

Equally, we cannot claim that all people within a community have the same needs. There is variation between and within communities. This is perhaps not surprising, as people do not experience mental ill-health in silos of race or age or gender.

People from BME communities have emphasised how important it is to see the person, not the stereotype, the person not the diagnosis. When talking about mental health, we need to talk about the complexities of understanding individuals in terms of race, culture, ethnicity, geography, sexuality and faith.

"

Our work has developed an evidence base, which has helped us to better understand the demography of BME communities.

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> To tackle inequalities in mental health, we must look at the root causes of mental illness.

Using statistics to measure improvements

DRE's action plan aimed to reduce the proportion of mental health inpatients from BME communities compared to White British inpatients and the disproportionate rate of compulsory detention for BME inpatients.

Our work has helped to identify the complex and varied reasons for the differences between ethnic groups and the evidence we have gathered has questioned whether those statistics alone can measure an improvement in services.

To tackle inequalities in mental health, we must look at the root causes of mental illness. Independent research suggests that a higher proportion of people from BME communities in the UK experience mental health problems compared to White British people. The reasons for this are complex. The most salient causal factors, and those amenable to impact, are social rather than bilogical or genetic. Factors that cause mental health problems are more present in the lives of BME communities that for White British communities.

Based on independent research that indicates higher rates of mental health problems, we might expect to see higher numbers of these groups using services. Given this evidence, it is now clear that admission and detention rates are not a good indicator of quality in mental health services, although they are an important reflection of the experience of BME service users[1]. If we want to reduce these figures in a meaningful way, we must address the social issues that cause mental health problems, such as poverty and social deprivation. Improving mental health services is still vital, but it is only part of the solution. Future work, under New Horizons, will take a public health approach to improving mental health for all.

High expectations

The scope of DRE's challenge was huge and expectations were very high – perhaps we could never have lived up to all of them.

There was also diversity of opinion about the work of the programme. Different stakeholders including users, carers and professionals, had different interpretations about what DRE should be doing and how we should be doing it.

There will inevitably be some stakeholders who feel that we have not achieved enough and that people from BME communities are still not getting the services that they are entitled to. We hope that this review can demonstrate what DRE has achieved and show how our work will be continued under New Horizons, through a joined up approach that tackles all inequalities.

External changes

There were a number of changes to the health and social care landscape and these had an impact on our work. These included:

- Organisational changes to NIMHE and the Care Services Improvement Partnership (CSIP), which were replaced by NMHDU

- The general shift to devolved decision-making to SHAs, which affected the accountability and governance of DRE

- Structural changes within the NHS through the reconfiguration of SHAs and PCTs

- The end of the NSF and launch of New Horizons. This has broadened the focus from improving mental healthcare services to embrace a public health approach to mental health.

KEY SUCCESSES

The DRE action plan organised its programme of work through three building blocks for change. Here, we look at the main activities that were carried out and what we learnt from them.

BUILDING BLOCK 1

APPROPRIATE AND RESPONSIVE SERVICES

" These sites operated for three years to tackle discrimination and inequality across mental health services in their area. "

The first building block for change was improving services so that they were appropriate, responsive and met the diverse needs of BME patients.

Focused Implementation Sites (FISs)

All NHS and social care organisations were asked to implement the DRE action plan but DRE also established 17 focused implementation sites (FISs) to lead these reforms and changes. The FISs brought together SHAs, PCTs and other public sector providers of mental health services; they also established links with voluntary and community organisations and users and carers. Their size and structure varied – some worked as part of a SHA, others worked across SHA boundaries.

These sites operated for three years to tackle discrimination and inequality across mental health services in their area. A wide range of projects were carried out to identify the needs of local communities and to test new and innovative ways of commissioning and delivering services. As pioneers of change, the FISs helped to identify and share best practice with other NHS organisations.

FIS evaluation

The original 17 FISs were reviewed between October and December 2006[2]. More than 32 review panel members and around 450 stakeholders across the then CSIP regions were involved. Evidence from project managers, service users, statutory and non-statutory sector staff, RELs and senior managers was taken into account.

The review highlighted areas of good practice, identified challenges and made suggestions for improvements at local, regional and national levels. Some of the best practice that was highlighted is summarised in the following:

- The Bradford FIS was one of a number of sites that were improving their understanding of faith and involving faith leaders to improve the recovery of patients. Their Jinn project delivered a more holistic approach to the care of male Muslim patients by including spiritual therapy

- Morton Hall Prison in the East Midlands was one of a number of projects showing good practice in the area of criminal justice. BME researchers were recruited from the prison community. The aim was to focus research on culturally appropriate assessment, communication and translation needs. The project aimed to create less fear of mental health services, provide a more balanced range of services and support compliance with the prisons Race Relations (Amendment) Act 2000

- The Manchester FIS worked to help ensure that practice-based commissioning would take into account specific arrangements for BME communities. They were also involved with contracting and procurement processes to make sure that equality and diversity were addressed

- The London Development Centre commissioned the London Health Observatory to analyse census data, clarify data trends, compare data to national census and make recommendations for addressing the issues arising from data.

The review also made a number of recommendations for how the work of the FISs could be supported and improved. This resulted in work that ranged from improved communication and business planning to better partnership working and the involvement of service users and carers.

> "Race, faith, ethnicity and culture all affect how mental illness and health are experienced."

Partnerships in Care

Partnerships in Care (PiC) is a private sector provider of secure mental health facilities with over 20 years' experience of caring for men and women with complex mental health needs. In 2007, PiC asked DRE if they could become a FIS to reinforce their organisation's commitment to equality of opportunity for both its patients and staff. Among other work, PiC: reviewed its HR policies; involved patients in staff induction training, councils, audits and clinical governance; and gathered better data by including analysis of ethnicity and gender for some of their reporting.

PiC's affiliation also benefitted the DRE programme by:

• Promoting access to private sector forums
• Helping DRE to share information and learning across the public and private sectors
• Promoting the programme's ability to make changes.

Steven Woolgar, Director of Policy and Regulation for PiC says, 'PiC has always focused on providing individualised care and involvement in the DRE Programme has helped move forward that work in a more structured and focused way. The PiC approach has been to integrate any DRE influenced changes into the way that we work and not as additions.'

Workforce development

The mental health workforce needs good cultural competency skills if they are to provide appropriate and responsive services that meet the needs of mental health patients. Race, faith, ethnicity and culture all affect how mental illness and health are experienced and these factors need to be taken into account when treating patients. DRE research found that there was little evidence of direct discrimination by practitioners but some reports indicate differences in how people from BME and White British groups experience staff. This shows the complexity of experiences that practitioners need to understand when they make assessments. Mental health organisations across the country said they needed a high quality training package. In response we developed the Race Equality Cultural Awareness Programme (RECAP).

One DRE report found, 'little or no evidence of direct discrimination on the grounds of race or culture that substantially interfered with relationships with services. Service users and carers were tolerant of ethnic differences as long as efforts were made to ensure effective communication and a high standard of care. There were many instances of mental health professionals working very successfully (in the opinion of the service users themselves) with service users from a very different ethnic background to their own[3].'

Race Equality and Cultural Capability

The Race Equality and Cultural Capability (RECC) training materials for mental health staff and NHS organisations, were developed by a training consultancy, Ferns Associates. After an initial pilot in four areas, the package included a set of pre-course reading materials, a series of work task templates and materials to support the teaching of 12 RECC sessions.

Race Equality Cultural Awareness Programme

Building on the RECC work and materials, DRE developed the RECAP, a two-day programme to help mental health professionals to develop their knowledge and understanding of racism and cultural differences, promote race equality, work positively with cultural differences and deal with the impact of discrimination. We also developed a five-day train the trainer course, which was delivered in 2009/10 by a national training team of 18 trainers.

An independent evaluation of RECAP showed that feedback by participants was very positive. Angela Kandola, Executive Director of AWAAZ (Asian Mutual Health Resource Unit), East Midlands said:

'The course broke down barriers between mental health service users. It was accessible, jargon-free and empowering – for instance, I saw one service user literally turn her life around after gaining confidence and self-esteem from the course.

Participants' comments ranged from 'vibrant, warm and supportive' to 'the most interesting, comprehensive and enjoyable training.'

The evaluation of RECAP recommended some improvements to the training programme, in particular to make the content of the course more operational and focused on improving professional practice. This research will be used to inform the future development of RECAP.

Clinical Trailblazers

DRE funded 20 organisations to run a range of projects that looked at how they could change and improve the clinical services they provided to patients from BME backgrounds. The projects ranged from an audit and interventions within a Home Treatment team to the development of a Wellness Recovery Action Plan (WRAP) for BME communities. Project members met regularly to support each other and seven of the organisations received additional funding to develop their projects further.

CASE STUDY

Developing culturally sensitive cognitive behavioural therapy for psychosis

> "As a result of this study, the CBT manual with guidance is being developed."

As part of the Clinical Trailblazers' programme, Hampshire Partnership NHS Foundation Trust carried out a study: Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions.

The study aimed to produce a culturally sensitive adaptation of an existing cognitive behaviour therapy (CBT) manual that was well suited to the needs of patients with psychosis from Black British, Black Caribbean and Black African, Bangladeshi and Pakistani minority ethnic communities. This would be accompanied by guidance for health professionals to enable them to deliver CBT that is culturally sensitive and responsive for patients with psychosis from these communities.

Interviews were conducted with 114 participants, including service users, lay members, mental health practitioners and CBT therapists in Hampshire and West London. The study results captured what the specific Black and Minority Ethnic communities (Black British, Black Caribbean and Black African, Bangladeshi and Pakistani) think about attributions to psychosis, help seeking behaviours and pathways which influence their choices on whether to engage with mainstream services or revert to traditional approaches. The key findings of the study are:

- CBT would be an acceptable treatment if culturally adapted

- The way that therapy is delivered needs to be adapted so that there is more pre-engagement and an understanding of a perspective where family and religion are at the centre of a person's thinking

- Some of the people interviewed saw the therapist as the 'expert' and expected them to have all the answers. This has implications in the therapeutic relationship between the CBT therapist and patient

- There were complex language issues. Even though the study focused on patients who speak English or can communicate with the use of interpreters, some would revert to their own language to be able to express a particular thought or feeling

- Understanding one's cultural background was highlighted as an important factor given that individual's cultural beliefs, norms and values influence their attitudes, behaviours and response to psychological problems. As a result of this study, the CBT manual with guidance is being developed.

A feasibility study of culturally adapted Cognitive Behaviour Therapy for psychosis for ethnic groups is underway in Hampshire, West London and Manchester.

KEY SUCCESSES
continued

Enhanced pathways into care

The Enhanced pathways into care (EPIC) project aimed to improve the pathways to mental healthcare for BME groups. The project was developed because people from BME backgrounds can have different, sometimes more coercive, pathways into mental healthcare compared to their White British peers. There was a lack of evidence about why this happens and how it can it can be improved. EPIC set out to identify the knowledge, skills and change processes that are needed to implement improved pathways.

Initially, there were four EPIC sites within NHS trusts in Sheffield, Durham, Birmingham and Manchester:

- In Sheffield, the EPIC project aimed to formalise partnerships between statutory and NGO services – see the case study below

- In Durham, the EPIC project aimed to improve access for people of Chinese origin

- In Birmingham, an assertive outreach team worked to move patients of Black African or Black Caribbean origin from containment to discharge

- The Manchester EPIC project worked across trusts to bring about a whole systems approach to change.

> "
> The success of this project led to the permanent employment of a worker from the Pakistani community by the NHS Foundation Trust.
> "

CASE STUDY

Bringing statutory and NGO services together in Sheffield

The Sheffield EPIC project, run by the NHS Foundation Trust in partnership with three community partners, aimed to formalise the partnerships between statutory and NGO services through a joint assessment and shared care plan.

An NHS employed Community Development Worker (CDW), worked one day a week at a Pakistani voluntary sector organisation. This link worker identified 16 Pakistani in-patients. Eight accessed the link worker for advocacy; four accessed the Pakistani Muslim Centre; two accessed home treatment via early discharge.

Outcomes
Length of stay fell by 12.5% among Pakistani in-patients, as community treatment options were extended. The patients reported increased satisfaction with services and the numbers being referred for treatment rose as knowledge of mental health conditions increased. People from the Pakistani community who suffered relapses after leaving hospital are now coming forward for treatment sooner.

The success of this project led to the permanent employment of a worker from the Pakistani community by the NHS Foundation Trust. The project also won a leadership award with the Health Foundation and group coaching was offered to develop leadership on BME healthcare. A 'How to do an EPIC' manual is being developed and will be launched in February 2010.

As a result, two further EPIC projects have been developed:

- The Sheffield Health and Social Care NHS Foundation Trust worked with Sheffield African Caribbean Mental Health Association (SACMHA) to measure and try and reduce the length of stay for African and Caribbean service users and improve access to the full range of services, including voluntary provision and crisis intervention. They also worked with wards and clinicians to understand better referral strategies and patient experience.

- The third Sheffield EPIC project aimed to help members of the Somali community to access services and to make sure that these services met their needs.

> "
> DRE has supported the development of DH guidelines for primary care, which aim to promote more effective working with refugees and asylum seekers.
> "

Refugee and asylum seeker communities

The reasons why people seek asylum – including war, genocide, torture and rape – and the actual process of seeking asylum and experiencing overt racism has a negative effective on asylum seekers' mental health. DRE has engaged with refugees and asylum seekers through the community engagement projects that are described in more detail on page 16. The findings of this engagement showed that many asylum seekers were unsatisfied with their GP and this led many to disengage with mental health services. Often primary care staff are unsure about the rights of asylum seekers to treatment and in some cases there was a lack of sensitivity to their situation. For example, one asylum seeker reported that,

'My GP gave me a diagnosis of 'Asylum Seeker' on a sick certificate. Being an asylum seeker is not an illness. I felt very depressed and angry[4].'

DRE has supported the development of DH guidelines for primary care, which aim to promote more effective working with refugees and asylum seekers. However, this is an area where further work is needed so that refugees and asylum seekers get the support and services they need.

Older people

There are currently about three million older people with a mental health problem in the UK and this is expected to rise by about a third over the next 15 years. DRE has called for greater collaboration between PCTs, mental health and other agencies and organisations that specifically focus on the needs of older people.

The NIMHE older people's mental health programme (now Mental Health in Later Life programme) developed a National Consensus statement, which was signed by a number of voluntary sector agencies. This called for a range of actions, including more person-centred care, better clinical pathways, improved access to services, a more socially inclusive approach to developing services, support for carers and improved skills training for staff. The Mental Health and Later Life programme has also developed guidance for commissioning mental health services for older BME people.

In April 2008, the Mental Health and Later Life, DRE and Gender Equality Programmes were brought together into the NIMHE Equalities programme. This was a key development and work is underway to strengthen links and integrated working between these programmes.

Children and young people

The DRE action plan called for improved services for children and young people through more collaborative working between child and adolescent mental health services (CAMHS), NIMHE and others. We wanted CDWs to bridge the gap between local CAMHS and BME communities – see the case study on page 13 for an example of how this was achieved in the North West.

KEY SUCCESSES
continued

> "CAMHS Cultural Competency train the trainer training has been delivered to CAMHS staff and CDWs across the North West"

CASE STUDY

DRE in CAMHS in the North West

Supported by a regional BME Child and Adolescent Mental Health Services (CAMHS) consultant, provided by NHS North West, CDWs across the North West of England have helped CAMHS partnerships to implement race equality action plans and deliver a number of successful projects and initiatives:

• In Lancashire, cultural competency training has been organised and will shortly be rolled-out. The aim is to help staff identify how to improve mental health services for children and young people. As well as informing Lancashire's commissioning cycle, the results will be shared across the region

• In Manchester, a mental health and well being toolkit to help young people support each other will be rolled out. Staff and parents will also receive training around the toolkit and it is hoped that the referral process and care pathway will be enhanced

• In Wigan, a community arts project in schools has targeted young asylum seekers and refugees, BME children and the mainstream population of children to express how they feel. A creative writing project has also enabled young people to explore mental health and well being

• In Liverpool, the CDW helped to establish an agreement that CAMHS Cultural Competency Training will be incorporated in all contracts for staff and service delivery roll-out will take place shortly. The Bridges Project, a drop in service for young BME children, adolescents and parents has developed as well as services to meet the needs of young BME adolescents facing forced marriage

• In the Wirral, Merseyside, clinical staff are supporting the development of a local young people's forum that addresses mental health issues experienced by children and young people from BME communities

• CAMHS Cultural Competency train the trainer training has been delivered to CAMHS staff and CDWs across the North West. This is now being delivered to other staff – for example medical staff in Lancashire.

Key learnings about appropriate and responsive services

There has been definite progress towards developing appropriate and responsive services for patients from BME backgrounds. A number of organisations and partnerships have engaged with local communities and developed innovative services across England. In addition, DRE has raised awareness about the needs of BME communities and the need to tackle inequalities is now being considered at a commissioning level more than ever before. However, there is still much more to do. Here are some of our key learnings:

• One of the key areas for improvement is how PCTs address the particular and differing needs of BME communities in the way they commission services

• The success of projects such as the Sheffield EPIC project (see page 11) have shown that services can meet communities' needs but they need to take the time to engage with them in a meaningful way. This engagement needs to inform at all levels – from commissioning through to the delivery and promotion of services

• Mental health problems can have a complex range of causes and a wide range of factors need to be taken into account when treating people. Services need to be flexible enough to address many issues and staff need to have appropriate cultural competency skills

• As with most public health transformations, change takes time. However, the pre-requisites to improved outcomes are now beginning to take root.

BUILDING BLOCK 2

ENGAGED COMMUNITIES

DRE engaged with people from BME backgrounds so that we could understand their needs and fears as well as the barriers that might prevent them from getting help. We wanted people from BME backgrounds to influence mental health policy and the way that services were provided. Engaging communities was also about changing the perceptions of mental health problems among BME communities to reduce stigma and promote treatment and recovery.

Community Development Workers

CDWs had and continue to have a key role in engaging and working with local communities. The role was developed to help bridge the gap between BME communities and health and social care services. CDWs worked strategically across NHS directorates and services but also directly with BME communities.

The importance of the CDW role must be particularly noted. They have been the focus and lead for exemplary work in many aspects of the DRE programme. CDWs have:

- Overcome barriers and taken up opportunities to build bridges
- Worked with communities to identify needs
- Worked to help reduce stigma and promote better understanding of mental health
- Acted as a necessary conduit for helping to bring about better access and outcomes.

Through the DRE programme, 450 CDWs had been recruited at the last count. DRE research has been commissioned, which we believe shows the positive impact CDWs have had.

The role

The role of CDWs varied from region to region, depending on local need. Flexibility within the role was key to its success but the four main tasks for each CDW were:

- To bring about changes to the way that services were commissioned, delivered and perceived. This included identifying gaps in services, improving mental health needs assessments and improving communication between BME community services and statutory services
- To identify and remove barriers to accessing services
- To improve services and develop joint working between statutory and community services
- To work with BME communities to help develop grass roots solutions and community

resources for mental health. They also helped to build relationships with local groups and networks so that they could have a more effective role within local partnerships.

CDWs were recruited, or the role commissioned, locally by PCTs but DRE developed a national support programme to help them develop the skills they needed to reach and communicate with BME groups. This included:

- A website with best practice case studies and updates on national programme activity
- Regular e-newsletters
- Toolkits that covered a range of topics from how to engage stakeholder partners to running events and working with the media.

Training around communications planning and delivery and media relations were run across the CSIP regions. National and regional networks were also set up to help CDWs to support each other and to build competencies.

Research

A report on how the CDW role was being implemented[4] identified the following as key to sustaining the role:

- Partnership infrastructures that enable CDWs to work across agency boundaries so that they are in a better position to influence statutory services
- Organisational frameworks to enable organisations to implement the role fully and build capacity
- Education and training for CDWs
- An evidence base that documents, disseminates and raises awareness about the wide range of work of CDWs.

A further report was commissioned to identify approaches aimed at supporting the development of organisational frameworks for CDWs[5].

> " The role of CDWs varied from region to region, depending on local need. Flexibility within the role was key to its success. "

KEY SUCCESSES
continued

CASE STUDY

Curtis Henry, CDW

"As a BME CDW it's crucial to understand your target audience. With this knowledge, you can ensure that people with mental health difficulties from BME communities are signposted to culturally appropriate services and complex needs are met," says Curtis Henry, who is a CDW based at Doncaster PCT.

Curtis was appointed as a BME CDW in March 2007, after extensive experience working with BME groups as a youth worker and later as a co-ordinator for a Caribbean community centre. "My work has always involved working with disadvantaged groups and engaging hard-to-reach communities. It's an extremely challenging but very rewarding role", says Curtis.

From the outset, Curtis has been involved in a variety of community engagement projects, including setting up a multi-cultural sports initiative for women from BME communities in Doncaster. After initial research found that many Muslim women in the area didn't feel comfortable exercising in public gyms, and that access to mental health information for this group was limited, Curtis developed a group where these women could exercise in a safe, private setting, as well as receive culturally appropriate mental health information. Feedback from users was positive.

On a strategic level, Curtis is leading on a Doncaster PCT project to evaluate the equality framework for commissioners. The framework is a checklist to ensure BME mental health needs are being met by services that are commissioned by the PCT.

Additionally, Curtis is working with the Improving Access to Psychological Therapies (IAPT) programme which seeks to provide improved access to psychological therapies for people who require the help of mental health services. It also responds to service users' requests for more personalised services based around their individuals needs. Doncaster PCT was a pilot for this programme, and Curtis now sits on the steering group in an advisory role to raise awareness about how IAPT relates to BME services and how to effectively engage BME communities about mental health issues.

Curtis also works with Tier Three professionals in CAMHS in Doncaster to raise awareness of adolescent mental health issues and to develop community-based pathways of care for children and families from BME communities in the area. After a year of engaging and building credibility with CAMHS, Curtis now works alongside the team, liaising closely with health practitioners and family therapists to establish, identify and widen access to BME specific mental health services.

Curtis says, "Too often the BME perspective is a bolt-on service, when it should be an integral part of providing any system. My work with IAPT and the CAMHS team is a way of passing on my knowledge about these communities to fully inform service provision."

Although Curtis has been involved with many BME community mental health projects, he admits that engaging younger people hasn't been easy. He explains, "Making young people aware of BME mental health issues and services has been challenging, particularly in terms of access, so we are keen to target schools with young people engagement work. Ideally, we would like to gain access to schools and talk to teachers about targeting BME children around mental health issues. I think it's incredibly important to reach children at an early age to demystify mental health and create awareness around services available to BME groups." Over several months Curtis has set up a series of meetings with young BME people to consult with them about mental health issues. He says, "To engage young people you need to get out into the communities and find out first-hand what they need. From here I hope to develop a better idea about how we can establish services which meet the needs of a variety of BME communities."

Community engagement projects

Between 2005-08, 79 community engagement projects were carried out by non-statutory community organisations across England. The projects engaged people from BME backgrounds to find out their views and opinions. The aim was to build capacity, through developing skills and competencies of people and groups in the non-statutory sector, to develop partnerships between the non-statutory and statutory sectors and to help providers offer new and innovative services to meet needs.

> " There was also an increased awareness of mental health and mental health services among BME communities. "

A community engagement approach was developed by the University of Central Lancashire (UCLan). It involved training and supporting BME organisations to carry out research among their communities and supporting them to connect with local services by setting up steering groups. These groups typically included local mental health service planners, commissioners and providers. This engagement ensured that the studies were compatible with local priorities and strategies, provided a mechanism for implementing the recommendations, and made it more likely that the community organisations' work would be sustained in the long term.

547 community researchers were recruited to carry out the research, 48 of whom were previous or current mental health service users. They collected data from almost 6,000 people from BME backgrounds. 935 of these people were previous or current mental health service users.

Each project focused on one or more of the 12 DRE characteristics for 2010 (see section 4 for the full list of characteristics). The findings for six of the characteristics have been summarised in UCLan's report on the process, findings and outcomes of the community engagement project[6].

Outcomes

UCLan's report described the outcomes for the following groups:

Community researchers

Community researchers acquired new skills and knowledge about mental health and mental health services during UCLan's training workshops and their work on the project. Some went on to obtain employment in the mental health field (including at least 20 as CDWs). 321 of them were awarded university certificates.

Community organisations

The community organisations' profiles were raised among local and regional mental health services and among the local BME populations. Links and partnerships between community organisations and primary care trusts were strengthened and there was an increase in community organisations' knowledge of, and engagement with, local BME populations. Some community organisations obtained funding to conduct further work related to the mental health service needs of BME populations.

BME communities

A survey on the outcomes of the community engagement project was carried out with 140 CDWs in August 2009. Of 72 CDWs who were aware of the project (including 42 who had been directly involved), 40% had observed improvements in mental health services for BME communities that had occurred as a result of the project, 21% were unsure if improvements were connected to the project, and 39% had not observed any improvements connected to the project. The most frequently reported improvements were that the project had highlighted BME communities' mental health service needs, and raised the profile of mental health in the communities. There was also an increased awareness of mental health and mental health services among BME communities.

CASE STUDY

Derbyshire Gypsy Liaison Group (DGLG)

Derbyshire Gypsy Liaison Group provides assistance and information to the Gypsy community in and around Derbyshire.

Their 2007 community engagement study explored the emotional and well-being needs of Romany Gypsies and Irish Travellers. A team of five, including two CDWs, interviewed 50 Irish Travellers and 100 Romany Gypsies. The study's recommendations have been progressed as follows:

• A further study was commissioned by West Midlands CSIP to explore the emotional well-being and mental health needs of older people. Its final report was Shoon te o Puri Folki (Listen to the Elders).

• Through outreach work and improved inter-agency working, there have been improvements to primary health care for people from Gypsy and Traveller communities.

• A swipe card system is being investigated to help Travellers provide information about their health at GP surgeries. The cards would hold their patient records in a protected format.

• DGLG are working with a Leeds-based organisation to provide a DVD package of information following the study's recommendation to provide information not just in written formats. Information is also provided through two leaflets as part of the older people's project.

• DGLG send out reports to agencies and offer training seminars on cultural aspects of life of Romany Gypsies and Irish Travellers. These have been picked up on by agencies outside Derbyshire, including those in Devon, Sussex, Kent and the North East.

> " Ambassadors have a role in shaping the implementation of the DRE Action Plan, both regionally and locally "

DRE ambassadors

The DRE Ambassadors programme was established three years ago to involve users and carers strategically in the DRE programme. There are 33 ambassadors across the nine English regions, including carers, former mental health service users and ex-offenders who have had mental health problems.

The ambassadors programme was founded by Lead DRE Ambassador Julie Jaye Charles and is a joint initiative with the Equalities National Council. It follows the Involvement Choice Advocacy National (ICAN) programme, which enables ambassadors to negotiate in their regions.

Their role helps to shape the implementation of the DRE Action Plan, both regionally and locally. Ambassadors work with RELs, CDWs as well as

health, social care and other professionals. Over the last 18 months, they have received training to help them to understand policy at both local and central government levels. Now, ambassadors are recruiting and training people from local BME voluntary organisations to act as advocates for BME mental health issues.

Julie says, 'The ambassadors programme supports individuals back into employment and education but, more importantly, it gives them a strategic voice that really influences local decisions.' She says that ambassadors can help to make sure that regional partnerships address the cross-cutting issues that people with mental health problems face. Julie says, 'It's not just about the interface of mental health services and supporting people to access those services. People don't have mental health problems in isolation, we

need to look at factors like housing, employment and education.' The programme was initially concerned with supporting people with mental health problems but now includes people with mental health as well as other multiple impairments.

Ambassadors will continue their work after the DRE programme ends, creating action plans out of the recommendations from the equality impact assessments that every public sector organisation must carry out. To help deliver these, the Equalities National Council has developed an Equalities Impact Assessment toolkit for ambassadors to use. The programme is also linking with the Department of Work and Pensions and DH on other service user activity.

> "The work of CDWs has informed policy at regional and national levels and helped to improve services. "

Key learnings about community engagement

There has been the successful engagement of BME communities through the community engagement projects and the day to day work of CDWs. This work has informed policy at regional and national levels and helped to improve services. Here are some of our key learnings:

- The majority of the community engagement projects recommended vastly increased BME community members' and service users' involvement in the planning, commissioning and delivery of mental health services.

- Community organisations recommended a number of ways of reducing fear of mental health services including:

    – education about mental health disorders

    – addressing the negative connotations of some terminology – for example, the word 'mental'

    – community based services rather than mainstream services

    – culturally sensitive support groups

    – partnerships with other organisations.

- One of the key challenges for community engagement is the fluidity of the term 'communities'. They are not static or fixed and people may identify with a number of communities. Work at a local level is important. For example, it would address the diversity of 'the South Asian communities', within which there are differences between genders, generations (especially between those who were born in and outside the UK), faiths and religions, and languages and dialects, as well as between those of Bangladeshi, Indian, Pakistani and Sri Lankan heritage. 'What works' for any one of these – or for any other BME population – may be inappropriate for another.

- CDWs need to be supported to work across disciplines, directorates and services so they are better placed to influence statutory services. Organisations need a better understanding of the role and should develop frameworks that allow CDWs to work strategically.

BUILDING BLOCK 3

BETTER INFORMATION

High quality information that can be used intelligently is vital if services are to better understand BME communities, provide services that meet their needs and measure progress. Over the last five years, as a result of the DRE programme, a wealth of information and learning has been produced. This has greatly improved the evidence base around mental health and BME communities.

DRE Research programme

The DRE programme has both commissioned research directly and been a catalyst for the development of other research and evaluation in relation to BME communities and mental health. Our research has helped us to improve ethnic monitoring, identify good practice and provide better information to patients. There were three main types:

- Original research that in some way addressed one or more of the 12 DRE characteristics. The subjects covered include prescribing, adapting cognitive behavioural therapy to BME communities and cultural consultation in forensic settings

- Evaluation of DRE work, including reviews of FISs, CDWs and the community engagement projects

- Research that was specific to DRE programmes, for example the 79 CE project reports and research into the DRE dashboard.

Count Me In Census

The Count Me In census was a new approach to gathering data about mental health patients. Commissioned by DH as part of the DRE programme, it was a joint initiative between NIMHE (now the NMHDU), the Healthcare Commission (now the Care Quality Commission (CQC)) and the Mental Health Act Commission (now part of the CQC).

The census is a headcount of all mental health inpatients that is carried out each year. It records ethnicity and information about inpatients pathways prior to admission. By recording numbers and encouraging service providers to keep records, the ccensus helps service providers take practical steps to reduce inequalities. 238 healthcare organisations take part, helping to give a comprehensive overview of mental health inpatients in England. It was also used to gather data to measure two of the DRE's action plan aims – to reduce the rate of mental health inpatients from BME communities and the rate of compulsory detention for BME patients. See section 4 of the census for a discussion of this aim.

Patients were asked about mixed sex accommodation to compare BME patients' experiences and to get the most out of the census as a general monitoring tool. In defining 'mixed sex', DH guidelines were used, for example anyone without access to single sex day areas is counted as not in a single sex ward. DH guidance is that single sex accommodation – separate sleeping, toilet and bathing facilities – is mandatory, but single sex wards – separate day areas as well – are not. In 2008, the Census asked for more specifics: whether patients had single sex sleeping accommodation, toilet and bathing facilities, and day areas. This helped to get a fuller picture of patients' experiences.

The findings of Count Me In both confirmed and challenged assumptions about BME communities and mental health services. For example, the first census in 2005 showed that people from Black African or Caribbean communities were three times more likely to be admitted to hospital than the population as a whole. They were also about twice as likely to be referred to hospital through the police or the courts. However perceptions that Black inpatients are more likely to be subject to measures like physical restraint or secluded were not confirmed. The group most likely to be restrained or secluded changed from year to year. The exception is the Other Black group, who have shown high rates of seclusion in all four reports.

> "Our research has helped us to improve ethnic monitoring, identify good practice and provide better information to patients."

KEY SUCCESSES
continued

CASE STUDY

West London Mental Health Trust: Using Count Me In data to benchmark change

West London Mental Health Trust has used Count Me In data for the years 2005 and 2007 to analyse and compare the proportion of BME and White populations within its catchment areas and admissions rates within specific services. The work was undertaken through its Clinical and Research Governance Committee. The work covers Ealing adult services, Hammersmith & Fulham, Broadmoor Directorates, West London Forensic and Older Peoples Services.

The findings indicated a disproportionate rate of admissions of the BME patient group when compared to the White patient group. The findings also suggested that Black patient groups "are also disproportionately admitted to the service when examined in relation to the local population census." In addition, in some services the rate of seclusion and incidence of restraint was higher in the BME patient group. The report identified three DRE service characteristics as key performance indicators from which the trust can benchmark improvements year on year:

- A reduction in the rate of admission of BME communities to psychiatric inpatient units
- Reduction in the use of seclusion in BME groups
- A more balanced range of effective therapies such as psycho-therapeutic and counselling treatments.

> " The indicators highlight the basic data needed to measure progress on race equality. "

The DRE Dashboard
The DRE Dashboard is a tool to help SHAs, PCTs and mental health trusts to measure their progress on race equality in mental health at local and regional levels. Launched in September 2008, it helps organisations to identify successes as well as gaps and risks.

There are a total of 26 indicators, covering a range of areas to aid understanding about access and outcomes. These are cross-referenced against the 12 DRE characteristics. The DRE Dashboard also set out to track six headline indicators as part of a national data collection exercise:

- Access to early intervention
- Access to crisis resolution/home treatment
- Use of assertive outreach services
- Access to psychological therapies
- Implementation of Supervised Community Treatment (SCT) (under the Mental Health Act 2007)
- Recruitment and impact of Community Development Workers (CDWs).

The resulting report, due for publication in December 2009, has focused on the first four community access indicators. The findings provide a rich source of information and analysis on regional data capture. Information on the use of SCT is available from the NHS Information centre through the KP 90 returns published in October 2009 (www.ic.nhs.uk/pubs/inpatientdetmh@0809) and the Mental Health Bulletin published in November 2009.

Information on CDWs has been described elsewhere in this review.

The indicators highlight the basic data needed to measure progress on race equality. Research so far has been positive and the outcomes will be used to inform New Horizons.

The benefits of the DRE Dashboard are that it supports:

- Early local engagement by SHAs, PCTs and mental health trusts
- Early awareness of any obvious major local issues/problems
- PCTs in assessing needs and targeting resources
- The collection of timely information on a regular basis.

> "
> A key success of DRE has been improving the information we have in relation to race and mental health.
> „

Key learnings about information, research and evaluation

A key success of DRE has been improving the information we have in relation to ethnicity and mental health. This has enabled evidence-based discussions about complex issues, which ultimately helps services to improve. Future work must build on this and continue to address how to develop metrics which better quantify and measure progress, for example in relation to meeting the competency requirements of World Class Commissioning. Key areas include good ethnic monitoring; developing a range of ways of improving demographic information; ensuring good links between information technology services and equality and diversity leads within trusts in order to effectively use the information to inform service development; and monitoring and review at board, management, ward and community levels.

THE 12 DRE CHARACTERISTICS

In 2005, the DRE action plan identified 12 characteristics which we hoped would describe mental health services in 2010. Below is an assessment of how we have progressed towards achieving the 12 characteristics.

1. Less fear of mental health care and services among BME communities and BME service users

Results from the Healthcare Commission's patient surveys indicate that rates of satisfaction with services are the same for BME and White British community treatment service users. However, some of the evidence from the community engagement reports shows that patients from some BME communities do fear services – particularly those with experience of mental health services.

2. Increased satisfaction with services

The Healthcare Commission's patient surveys show that satisfaction levels between BME and White British community treatment service users are similar. However, some of our research showed that different communities have different satisfaction rates.

3. A reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units

The Count Me In Census shows that there has been little change in the numbers of BME patients on inpatient wards. The fourth annual census, published in November 2008, showed that admission rates for BME communities are not falling and that some BME groups are three or more times more likely than average to be admitted. As discussed on page 7, higher rates of mental illness in some BME groups means that compulsory detention rates alone are not a good indicator of quality in mental health services, though they are an important reflection of the experience of BME service users.

4. A reduction in the disproportionate rates of compulsory detention of BME users in inpatient units

The fourth annual Count Me In Census (November 2008) showed that detention rates for BME communities are not falling. As discussed on page 7, higher rates of mental illness in some BME groups means that compulsory detention rates alone are not a good indicator of quality in mental health services, though they are an important reflection of the experience of BME service users.

5. Fewer violent incidents that are secondary to inadequate treatment of mental illness

The Count Me In Census shows there is no disparity between BME and White British inpatients in the incidence of physical assault, accidents and self-harm. DH funded a study (2008) by Queen Mary University of over 700 psychiatric inpatients in general adult psychiatric units across eight mental health trusts in England. They had been admitted on sections 2, 3 or 4 of the Mental Health Act 1983 or became involuntary patients within the first seven days from admission. The study found no association between ethnicity and the use of coercion reported by inpatients in psychiatric units.

6. A reduction in the use of seclusion in BME groups

The Count Me In Census shows no consistent disparity in the use of seclusion between BME and White British inpatients. The exception is with the 'other black' group.

7. The prevention of deaths in mental health services following physical intervention

Deaths following physical intervention are very low. Data up to 2006 (the latest year for which information is available) show an average of 2-3 cases per year. Their numbers are too small to demonstrate trends with any ethnic group.

8. An increase in the proportion of BME service users who feel they have recovered from their illness

Research shows there is no disparity between BME and White British groups in the proportion of service users who feel they have recovered from their illness. The 2008 Queen Mary study indicated that those from ethnic minorities have better outcomes on symptom improvement scales and scales rating 'satisfaction with life in general and different life domains' one year after admission. Healthcare Commission community patient surveys also show no disparity between BME and White British service users when asked about their feelings about their own mental health.

9. A reduction in the proportion of prisoners from BME communities

Home Office and Ministry of Justice figures show there was a slight decrease in the proportion of prisoners from white backgrounds between 2005 and 2007 (from 82% to 81% of total British national prisoners and from 75% to 73% of the total prison population). The Black or Black British proportion of the British national prison population increased from 10% to 11% in the same period, while the proportion in the total prison population stayed the same at 15%. The Asian or Asian British proportion of the British national prison population increased from 4% to 5% in the same period, while the proportion in the total prison population also increased, from 6% to 7%.

> **Patients from BME groups who were treated in the service also achieved at least as good outcomes as non-BME patients.**

10. A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective

The Healthcare Commission community patient surveys indicate that BME patients are less likely to get talking therapies, but also less likely to want them. However, BME patients who do want them are less likely to get them. The DRE clinical trailblazer report (2009) carried out by University of Southampton and Hampshire Partnership Trust (2009) indicated that factors affecting access to therapy include:

• Mistrust of services/practitioners

• Worries about confidentiality

• Poor availability of information

• Language issues.

For more information visit:
www.mentalhealthequalities.org.uk/our-work/delivering-race-equality/clinical-trailblazers/

Learning from the DRE programme is being incorporated into the rollout of the IAPT programme. The Newham IAPT site has been able to develop a service that BME communities access and that provides effective treatment for them. The ability for patients to self-refer to the service was a key aspect. Patients from BME groups who were treated in the service also achieved at least as good outcomes as non-BME patients.

11. A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services

CDWs, community engagement projects, the work of the DRE Ambassadors programme and a wide range of other initiatives and projects have been undertaken as part of addressing this characteristic.

12. A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities

Race equality training, clinical trailblazers, CDWs and the development of the DRE Dashboard have helped to improve and measure the skills of the mental health workforce. Evaluation and research, however, indicate that the understanding and impact of some of these initiatives has been variable.

Key learnings

The 12 characteristics were not all measurable indicators and a significant part of the DRE programme's work has been to identify ways that the programme can measure its success. Questions have been raised about the characteristics and a wider set of success factors may be needed going forward. Some of the key learning around the 12 characteristics has been:

• We need to collect data for longer if we are to measure ongoing trends rather than year on year fluctuations

• Data should be measured on a regional as well as a national basis

• There are some gaps in data and in some cases data from different organisations cannot be compared

• Differences between ethnic groups could be down to other factors – for example age or gender. A straightforward comparison between BME communities cannot be made

• Different BME groups need to be engaged and considered separately.

WORKING IN PARTNERSHIP

The DRE programme's work has involved working with a range of partners and organisations. This section looks at where we facilitated partnership working to improve outcomes for people from BME backgrounds.

> "The DRE programme is also undertaking a successful collaboration with Shift through the Breaking Through Barriers project."

- The DRE action plan's aim to promote greater access to a more balanced range of therapies for people from BME communities fitted with IAPT's aim to promote access to psychological therapies. DRE's work has informed and influenced the IAPT programme. We have been involved at a strategic level, contributing to equality impact assessments and at a local level through the work of CDWs. See the case study below for how IAPT is improving access to therapies in Newham.

- DRE worked with other NMHDU programmes to support the implementation of the Mental Health Act 2007, including the Three Keys initiative of adopting a shared, values-based approach in mental health assessment. This involves training a national cohort of CDW champions to develop the Three Keys approach to help improve the skills of mental health practitioners in working with diverse communities.

- The Race for Health programme is a DH initiative that works with PCTs to enable them to deliver measurable improvements in the health outcomes of people from BME communities. In 2007, we jointly collaborated on a Ministerial meeting with PCT and mental health provider trust chairs and chief executives. The Race for Health programme has developed performance metrics to enable measurement of improvements in the healthcare of people from BME communities. Mental health metrics are a key component of this. We hope to take this work forward through the development of Equality Dashboards within SHA regions.

- Shift is a DH funded initiative to tackle stigma and discrimination surrounding mental health issues in England. We have jointly commissioned a number of projects, including a film, Open Secrets, a photographic exhibition, a research project into the coverage of mental health stories in the African and Caribbean media and a BME media resources library. The DRE programme is also undertaking a successful collaboration with Shift through the Breaking Through Barriers project. This involves CDWs, working regionally, to improve mental health awareness in BME communities.

CASE STUDY

Improving Access to Psychological Therapies in Newham

Based at the Newham Psychological Treatment Centre, the Newham IAPT project is located in an area with a large local BME population. Newham successfully increased the number of BME people accessing its services to a figure that was closer to the ethnic distribution in the area's population as a whole following the introduction of a number of referral pathways. Patients from BME groups who were treated in the service also achieved at least as good outcomes, and have similar satisfaction rates, as non-BME patients.

Total numbers of annual referrals to the Newham service have increased from 614 (2006) to 1860 (2008). This has been accompanied by an increase in the proportion of BME referrals. In 2006, these accounted for 58.1% of total referrals, with this figure rising to 62.8% in 2007 and 63.9% in 2008 – the current BME population estimate for Newham stands at 66.2% (Office for National Statistics).

Lead clinician Dr Ben Wright stresses the importance of providing a culturally appropriate service once patients have been referred: "We telephone all patients to speak to them about any concerns before treatment begins – this is of real importance as BME patients in particular may be wary of treatment procedures. Our access materials are also translated into the main languages spoken in the area and we use interpreters in Punjabi, Hindi, Bengali and Urdu. All members of our team have significant experience of transcultural work."

LOOKING FORWARD TO NEW HORIZONS

The NSF was the blueprint for changing mental health services in the England over the last ten years. As it approaches the end of its ten year lifespan, it will be succeeded by New Horizons: a shared vision for mental health.

> " New Horizons also outlines the Government's commitment to tackling inequalities in mental health and access to mental health services. "

This will build on the success of NSF by supporting the local development of higher quality, more personalised services. New Horizons will take a public health approach to treating mental health problems. It will build a cross-government, multi-agency alliance that tackles the root causes of poor mental health and get support to people where and when they most need it.

New Horizons also outlines the Government's commitment to tackling inequalities in mental health and access to mental health services. It will build on the work of the DRE programme, consolidating this work into a wider mental health equalities context. This is because it has become increasingly evident that we need to consider all strands of equality together – ethnicity cannot be dealt with in isolation. Most people have multiple identities and multiple experiences of discrimination. The equalities programme aims to be responsive to the complex ways in which individuals identify themselves whilst being skilled in tackling the unique impacts arising from different forms of inequalities. New Horizons aims to ensure that we have an integrated approach.

New Horizons will promote race equality through:

- Assessments of local needs based on a better understanding of the ethnic composition of the local population
- Continuing consultation with local communities on the development of appropriate services
- Measures to ensure equality of access and outcomes, particularly to services such as early intervention teams and psychological therapies
- Identifying and addressing any inequalities in patient experience between ethnic groups
- Ensuring that staff receive training in cultural competence and in developing organisational competencies to promote equality
- Highlighting the importance of personalised care, by which services build the care they provide around the individual characteristics of the service user - their past experiences, family support, education and ethnicity.

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Other key publications

- Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England (NIMHE 2003)

- The Government's response to the independent inquiry into the death of David Bennett (DH 2005)

- DRE action plan

- The National Service Framework for Mental Health (1999)

- National Horizons: Towards a shared vision for mental health (2009)

- BME Inpatient Review – Royal College of Psychiatrists (2009)

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