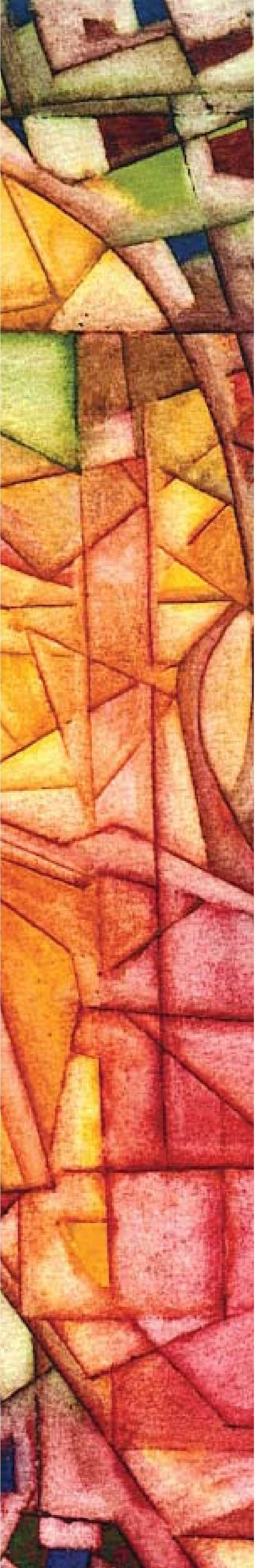

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Engaging and Changing

Developing *effective* policy for the care and treatment of Black and minority ethnic detained patients

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Engaging and Changing

Developing *effective* policy for the care and treatment of Black and minority ethnic detained patients

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LANCASHIRE

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Cover design

The artwork is by Christopher Bashford (1957 –2002). Painted in 1995, the design is part of a bigger picture called ‘Up the Garden Path’.

Executive Summary

On the 11 May 1999, the Mental Health Act Commission in collaboration with the Centre for Ethnicity and Health at the University of Central Lancashire and the Sainsbury Centre for Mental Health, visited 104 in-patient units in both the NHS and independent sectors.

The purpose of the visits (known as National Visit 2) was to examine aspects of the care and treatment of patients from Black and ethnic minority communities detained under the Mental Health Act with a particular focus on **ethnic monitoring, racial harassment, staff training in race equality and anti-discriminatory practice (ADP)** and **the use of interpreters.** The Sainsbury Centre published a preliminary report of the findings.

The initial results of the visit demonstrated not only how far mental health services had to go in addressing the basic components of an effective service for Black and minority community patients but also provided examples of good practice. Since the undertaking of National Visit 2, the priority given to this issue has been increased not only in terms of national policy development but also the legal framework; especially with the implementation of the Race Relations (Amendment) Act 2000.

It is in this context that the Department of Health subsequently commissioned this report, which is **primarily designed to provide guidance material in relation to the development of policies concerning the care and treatment of Black and minority ethnic detained patients in the areas of ethnic monitoring, racial harassment, the use of interpreters and the provision of culturally appropriate care and staff training.**

Sections 1 to 4 of the report

The first four sections of this report set out the background to the report and the methods employed in its production and discuss representation of people from Black and minority ethnic communities in primary and secondary mental heath care as well as service provider perceptions of pre and post detention issues

The report is based on

- Follow-up work around the four areas of concern highlighted in National Visit 2
- Additional areas as identified in the quantitative and qualitative data collected for National Visit 2 and, prior to this report, unanalysed.
- Supplementary information collected from a scoping study
- Additional information from the Centre for Ethnicity & Health's past work on mental health issues for Black and minority ethnic communities.

Methods

Mixed methodologies were employed to gather and analyse data: a questionnaire seeking information on policies and procedures about the four focal issues together with a synopsis of National Visit 2 was circulated to all NHS and independent mental health providers in England; a literature search was undertaken and some of the qualitative data arising from National Visit 2 was thematically analysed.

Pre and post detention issues

The focus of this report is the care and treatment of Black and minority ethnic patients and respondents to the follow-up survey identified the following pre-admission and after-care issues that affected such care:

- Stigma in some communities in relation to mental health
- Language difficulties
- Unfamiliarity with mental health systems and services
- Diversity in concepts of mental health
- Concerns about the ability of services to meet expectations of safety, privacy and dignity.
- The quality of referral information especially in relation to emergency admissions
- The shortage of crisis resolution and community treatment services as alternatives to hospitalisation.

A small but significant number of respondents reported no particular issues of concern. Primarily from more rural areas with very small minority communities it may be important to contrast such responses with those from similar areas who gave impressive evidence of responding to the needs of such communities.

Sections 5, 6,7 and 8 of the report

In these sections of the report the four issues that were the focus of National Visit 2 and the follow-up survey are discussed and recommendations made.

Recording and monitoring the ethnicity of detained patients

The recording and monitoring of ethnicity although mandatory in the NHS since 1995 continues to be problematic although it is important to report that the number of providers who have policies and guidance has increased considerably since National Visit 2.

The importance of understanding what is being recorded, how it is and why was emphasised by many respondents and it was clear that one of the reasons why some systems failed was the perception amongst some of those undertaking it, that at a local level it was a bureaucratic, intrusive and meaningless exercise. There was however a wide recognition of the contribution that effective monitoring can make to developing effective and relevant services and the report contains examples of good practice.

The following essential policy elements are recommended:

Essential policy elements for recording and monitoring ethnicity

5.2.1

- Patients should self-assign their ethnicity
- Secondary questions should be asked around language, dialect, religion, familial origins, diet etc.
- An information sheet designed for the patient that clearly outlines the purpose of recording ethnicity should be available within which confidentiality is guaranteed. This sheet should be available in multiple languages and/or in audio format

5.2.2

- The 2001 census categories should be used to record ethnicity
- CRE guidance on supplementary categories should be utilised to take into account local need
- Acknowledge that patients have the right to refuse to declare ethnicity

5.3

- Recording ethnicity should be an integral part of the admissions procedure
- If it is not possible to collect ethnic data on admission, the data should be collected as soon as possible thereafter
- Clear guidelines should be included in the policy about how staff should obtain information that is not immediately forthcoming

5.3.2

- All staff involved in recording, analysing and monitoring ethnic data should be trained to do so
- Training should equip frontline staff with the confidence and sensitivity to accurately collect data and with the knowledge of how that data will be used
- Policies should include a clear statement from Board level about the importance and significance of this exercise
- Commitment should be included in policies to harmonise and integrate ethnic monitoring systems across the trust/service and ideally regionally and nationally

5.4

- Information should be held at ward level, used to inform individual patients' care plans and be readily and easily available to staff, thereby benefiting patients' clinical care and observing patients' human rights
- Information should be fed into a Trust/service wide system
- Information should be used to identify local, national and regional trends

- Information should be used to monitor treatment regimes, complaints, use of therapies and activities, violent incidents, harassment incidents, self-harm, deaths, use of Mental Health Act, compulsory admissions, seclusion, care and restraint, applications to and outcomes of Mental Health Review Tribunals, requests for Mental Health Act Commissioner visits, and requests for SOADs
- Policies should include commitment to analysing collected data, disseminating findings and taking positive action
- Where possible/relevant joint data collection should be undertaken with appropriate local services

Dealing with racial harassment

Almost three quarters of the units visited in National Visit 2 had no policies for dealing with racial harassment directed at patients by staff or other patients and 11% of the patients whose case notes were examined had reported incidents of racial harassment. The follow–up exercise found a continuing lack of policies relevant to racial harassment perpetrated against patients in mental health units and it is this topic about which the most respondents asked for assistance in effectively addressing the issue.

The report recommends the following essential policy elements:

- Whilst it is important that racial harassment should be included in an establishment's anti-bullying or general harassment policies and that staff issues should be addressed within these, in a mental health setting, a separate section or a stand-alone policy aimed at protecting patients from racial harassment by other patients, by visitors or by staff should be established to acknowledge the special need for protection of these patients

6.3

- A clear definition of racial harassment should appear on the policy, encompassing the continuum of behaviours described in this section and including forms of subtle racism and disproportionate provision of inappropriate treatment

6.3.1

- Policies should acknowledge that all incidents of racial harassment are serious but that the manner in which they are handled should vary according to the nature and extent of the harassment
- Policies should acknowledge that all people, from all ethnic groups, are potential victims of racial harassment and all incidents of racial harassment should be subject to ethnic monitoring

6.3.1

- Policies should allow for all incidents to be recorded fully and monitored at Board level

6.4.3

- Staff training to enable staff to recognise subtle, overt and covert forms of racism; to instil the confidence necessary to challenge racial harassment and to recognise possible racist practice within themselves
- Encouraging an atmosphere where racial harassment is easily challenged and therefore less threatening by wide circulation of anti racist harassment messages for staff and patients by leaflets, notices, statements of intent and word of mouth
- Establishing and publicising the work of racial harassment advisors who can offer confidential support and advice to staff and patients who have concerns about reporting incidents
- Perpetrators of racial harassment should be listened to and worked with
- Taking steps to avert racial harassment spiralling to a dangerous level by paying attention to and dealing with early warning signs
- Instilling clear reporting and monitoring procedures that incorporate sanctions that take into account the seriousness of the offence and the nature of the incident.

Interpreting services

Patient records examined on National Visit 2 indicated that one in five patients from Black and minority ethnic communities did not have English as their first language, information about dialect was poorly recorded and that only 36 patients of the 51 not fluent in English had received the services of an interpreter. 50% of the units had policies on the use of interpreters although 75% used trained interpreters. In contrast 83% of the respondents to the follow-up exercise reported relevant policies and guidance although most were confined to issues of access and did not extend to other matters such as staff training in the use of interpreters.

The report recommends the following essential elements:

- A clear statement relating to the establishment's duty and commitment to providing interpreting services when needed in accordance with the NSF and Mental Health Act Code of Practice

7.2

- Family members, acquaintances and untrained staff should not be asked to act as interpreters at clinically significant events
- In the case of an emergency, untrained interpreters should be used only to communicate the minimum information necessary until a trained interpreter can be found
- Children under the age of 16 years should never be asked to interpret on behalf of family members

7.4

- Policies should recognise that although a patient may speak English, at times of stress or distress the patient may have reduced understanding or ability to express themselves in that language and interpreting provision should be made
- Policies should emphasise a minimum standard of when interpreters should be used and these standards should include use on admission, at assessment, during the formulation and delivery of care plans, at clinically significant meetings and at the introduction of new interventions
- Interpreters should be made available to explain treatment and care to carers where English is not the carer's preferred language

7.5

- Policies should, wherever possible, be jointly drawn up in partnership with Local Authorities and/or other services allowing shared access to a joint pool of interpreters
- Policies should note that telephone interpreters should only be used in cases of emergency
- Policies should include guidelines that give a point of reference for staff wishing to access interpreters

7.6

- Policies should include guidelines that advocate the use of interpreters trained in mental health issues or that advocate the use of mental health staff who receive professional interpreting training
- Policies should advocate the introduction of training courses for all staff who are expected to use interpreters
- Policies should include guidelines relating to the choice of and use of interpreters

7.7

- Recording the use of interpreters
- Monitoring that information, including details on length of time taken to provide an interpreter and frequency of use
- Evaluating the interpreting service and the quality of interpreting

7.8

- A statement encouraging the engagement of a range of befriending and advocacy community based organisations to attend to the day to day communication needs of Black and minority ethnic detained patients
- A statement about the use of bilingual staff as interpreters and/or befrienders that takes account of the training needs of these staff and provides guidelines that ensure that their formal employment roles are not compromised

Race Equality and Anti-Discriminatory Practice Training and the Delivery of Culturally Sensitive Care

Fifty-eight percent of the respondents to the follow-up exercise indicated they had policies or guidelines on training in race equality and anti-discriminatory practice and delivering culturally sensitive care. This compares favourably with the 25% of units visited on National Visit 2.

Although comparisons between responses to the original exercise and the follow-up are difficult to make in terms of ascertaining any overall improvement, it is notable that where training was provided, there was evidence of a shift in emphasis from what could be loosely termed as training in 'cultural diversity' to an ADP or race equality model. The main aim of the latter should be to enable participants to identify patterns of institutional racism, remove barriers to race equality and create "accessible and appropriate services for Black and minority ethnic users."

Consequentially, this section looks at staff training in issues that directly and indirectly impact on the delivery of culturally sensitive care and the following recommendations should be seen as important building blocks toward culturally appropriate care and treatment that need to be accompanied by others, many of which are identified elsewhere in this report.

8.3.1

- Policies should include a clear statement about the organisation's intention to deliver care that is culturally and religiously sensitive to the needs of all patients
- Policies should aim to include a repertoire of responses to the provision of culturally appropriate care and treatment
- Policies should link into existing ethnic monitoring policies in order to collect accurate and meaningful baseline data

8.3.2

- Polices should include the establishment of information packs – the packs should be prefaced with a warning about the limitations of use
- Information packs should be drawn up in conjunction with the local community, taking into account any key issues relating to patient catchment areas, and updated periodically to reflect the changing population
- Information packs should be widely distributed and easily accessible to those providing care and treatment to Black and minority ethnic patients

- Training should be provided around the use of the packs. This should include discussion of the notion of stereotyping and the limitations of amassing knowledge on cultural diversity through this medium

8.3.3

- Consultation fora and transcultural committees should be established as part of the repertoire of responses
- Fora and committees should be adequately staffed, funded and supported with clear terms of reference and a mechanism for reporting to the Board
- A commitment should be made at Board level to address as fully as possible any issues raised within these fora/committees
- Policies should harmonise with policies on the provision of interpreting services to address clinically necessary and social communication needs
- Policies should address matters of cultural isolation by advocating access to and the provision of culturally specific newspapers, magazines, videos etc.

8.3.4

- Religious and spiritual needs should not be overlooked. Policies should include provision of worship space, access to faith leaders and raising awareness amongst staff about religiously/culturally significant dates
- Policies should aim to create strong links with local religious/faith groups

8.4.1

- Anti-discriminatory practice training and race equality training should be a core component of all other staff training packages

8.4.2

- All staff, regardless of their patient contact remit, should receive training in equality and diversity issues
- Training should include components that consider an organisation's policies and functions along with challenging discrimination and prejudice
- Training should be practice-based
- Training should be undertaken jointly with other services within the establishment

8.4.3

- Policies should ensure that training is provided at induction for new staff
- Policies should make provision for an on-going programme of refresher courses
- Training should be embedded in the staff appraisal system

Sections 9 and 10 of the report

In its final two sections, the report discusses wider issues of policy development and highlights with recommendations, the importance of forging links ***outside*** a unit for effective change to be made ***inside***.

Designing, developing, implementing and maintaining effective policies: cross-cutting issues and cross-cutting solutions

In its 9th Biennial Report the Mental Health Act Commission recommends a strategic, holistic, multi-dimensional approach to the development of effective and relevant services for people from Black and minority ethnic communities with long-term mainstream funding. The four policy areas referred to in sections 4 to 8 of this report are central to such an approach but do not stand alone: they are interactive and effective policies in all four policy areas are necessary for any one policy area to be successful.

The report recommends the following essential elements for policy developments in pursuit of this objective:

9.2

- Policies should not be produced in isolation. The interactive nature and potential for impact of one policy on others should be explored during policy development

9.3.5

- Policy development should take into account:

  Demographic information

  Patient information

  Staff/workforce issues

  Responsibility, dissemination and accountability

  Service performance

9.4

- Where a Black and minority ethnic lead exists, that person must be adequately supported and resourced and should work toward mainstreaming Black and minority ethnic issues

9.5

- Establish and nurture partnerships with external agencies

9.6

- Establish and nurture partnerships with local community based organisations

The report concludes with a discussion of organisational change and community engagement, contending that it is only by working with communities that meaningful and equitable changes in service provision can be introduced and sustained.

Section 1
Background

1.1 Synopsis of National Visit 2

On 11 May 1999, Mental Health Act Commission members and staff visited 104 in-patient units in both the NHS and independent sectors in England, ranging from the three high security hospitals to ordinary acute services. Information was obtained from 104 Unit Managers, 119 Ward Managers and from the case notes of 534 detained Black and minority ethnic patients.

Information on gender was recorded on 525 of the 534 patients. Of these patients 71% were men and 29% were women.

The visit was undertaken in three stages: an announced visit to the Unit general manager (section A), an unannounced visit to the ward manger (Section B), and the examination of 534 randomly-selected patient files (Section C) on those wards.

The whole process was not simply meant to highlight poor practice, but also to identify current good practice. The process also aimed to raise awareness of the basic but essential issues of care and treatment for Black and minority ethnic patients among the managers and practitioners interviewed. This has to some extent been achieved as can be evidenced by the analysis of the data from a questionnaire which was sent to 80 of the NHS Trusts visited: overall, the data suggest that the visit had raised people's understanding of the issues and changes were already underway to develop their services in these areas – many respondents requested more detailed guidance.

The initial results illustrate how far the mental health services have to go in effectively addressing what are – in the final analysis – fundamental components of an effective mental health service. The MacPherson Report, the Race Relations Act (Amendment) Act 2000 and the Human Rights Act all underline the centrality of this challenge for mental health services in the immediate future.

A preliminary report of the findings has been published by the Sainsbury Centre for Mental Health and headline findings are reproduced within this report.

1.2 National visit 2 – follow up

The results of National Visit 2 suggest a number of areas worthy of further examination in the follow-up project:

Ethnic monitoring: Identifying and publicising areas of improvement in the use of data derived from ethnic monitoring.

Racial Harassment: Finding 59 recorded instances of racial harassment among the patients whose notes were selected for the original exercise, is of great concern, given the number of filters operating – i.e. an incident has to be reported to staff, acknowledged as racial harassment, and recorded in the case notes. Further analysis may shed light on the nature of the obstacles to progress in addressing staff training needs around this issue.

Staff Training in Race Equality and anti-discriminatory practice (ADP) and the delivery of culturally appropriate care: Ascertaining any improvements to staff training packs, identifying barriers to progress and highlighting initiatives that can be shared.

Interpreters: Analysis of qualitative data on use of interpreters.

Further examination of the data and information gathered through a national scoping study may identify further areas for the development of effective practice guidelines. This follow-up exercise therefore aims:

- to build on the awareness-raising exercise instigated by National Visit 2 amongst those responsible for the well-being of detained patients from Black and minority ethnic communities; and
- to supply those responsible with guidelines and materials to enable them to develop effective policies that will deliver culturally sensitive care and treatment.

Objective

To produce a report containing examples of effective practice and guidance material in relation to Black and minority ethnic detained patients based on:-

- Follow-up work around the four areas of concern highlighted in National Visit 2
- Additional areas as identified in the quantitative and qualitative data collected for National Visit 2 and as yet unanalysed.
- Supplementary information collected from a scoping study
- Additional information from the Centre’s past work on mental health issues for Black and minority ethnic communities.

1.3 Methods

1.3.1 Research instrument

A seven-page questionnaire, divided into six sections, was designed. It covered areas such as policies, procedures and guidelines on ethnic monitoring, racial harassment, race equality and anti-discriminatory training and the provision of interpreters. The questionnaire asked for samples of documents and also for examples of existing initiatives, which could be shared. Respondents were asked to report on any perceived barriers to service development and also for their concerns around pre-admission and aftercare. The questionnaire requested details of any other issues not identified in the main body of the questionnaire and also asked specifically for information on any issues relating to the mental health needs of refugees, asylum seekers and travellers. The questionnaire is provided in Appendix 1.

1.3.2 Data collection

In January 2002 the questionnaire, a synopsis of National Visit 2 and a covering letter from was posted out from the Department of Health, Mental Health Branch, to the Chief Executives of all Trusts incorporating secure units, other NHS Trust and independent providers in England. The Mental Health Act Commission provided the addresses. A deadline for completion and return of the questionnaire was set at 11th February.

Few replies had been received by the deadline. However, many telephone calls and email messages had been received which highlighted that the return rate had been affected by delays in sending out some of the questionnaires, coupled with delays in the questionnaires being passed on from the Chief Executives' offices to the leads on mental health issues. A reminder letter was therefore circulated with an extended deadline given of 29th March 2002. One hundred and twenty-three responses were received.

1.3.3 Literature search

A literature search has been on going during the life of the project. The following sources have been used:

- Kings Fund Library
- Department of Health Publications Database
- Minority Ethnic Health Awareness Bulletin
- Electronic databases, BIDS etc
- Documents collected by the Centre for Ethnicity & Health, University of Central Lancashire, including work undertaken in the area of mental health service provision for Black and minority ethnic communities.
- Documents resulting from the original National Visit 2
- Documents resulting from the follow-up scoping study
- Legislation and policy documents including the Race Relations (Amendment) Act 2000, the Human Rights Act and the National Service Framework for Mental Health.

1.3.4 Data analysis

Thematic analysis of some of the qualitative data arising from National Visit 2 has been undertaken along with a thematic analysis of the data resulting from the 123 responses to the follow-up exercise.

Two workshops were held in which the research team reviewed the policies and guidelines submitted by respondents to the follow-up exercise, highlighting elements of effective practice using criteria as suggested by the literature review. Their findings were then discussed in a focus group and wider consultation was undertaken with practitioners in the field.

Section 2

Overview of the legislative and policy framework

2.1 Mental health and Black and minority ethnic communities

As James Nazroo points out

> *"the relative prevalence of mental illness amongst different ethnic groups in Britain is probably one of the most controversial issues in the health variations field."*[3]

An important component of that controversy has been the over-representation of Black people amongst those detained under the Mental Health Act[4] and in the secure psychiatric system. How ethnicity and individual ethnic groups define themselves is controversial[5] but not withstanding – the pattern of people (described variously in primary research as 'Black Caribbean', 'Black African', 'Black Other' and 'Afro-Caribbean') being considerably more likely to be admitted under the Mental Health Act than their white counterparts remains. Until recently, the limited research about people from Asian groups suggested intermediate rates of formal re-admission and that they were not more likely to be so re-admitted than their white counterparts.

More recent research has found that when rates of sectioning are presented as number per unit of ethnicity specific population, there are striking differences between ethnic groups. Black and minority ethnic people are more than six times more likely to be sectioned than whites;

> *"the rate of sectioning for Asian people is sixty five percent higher than white people, whilst those from other minority groups experience a rate of sectioning that is intermediate between those for Black and Asian people."*[6]

Two main themes emerge from research to explain the differential treatment of Black people in psychiatry.[7] The first suggests that personal instability provoked either by internal (biological) or external (increased exposure to social stresses in their environment) factors explains, for example, over- representation of Black people in psychiatric institutions. The second suggests that institutional processes explain the way in which Black people are pathologised by psychiatry – particularly emphasising the ethno-centric location of western psychiatry.

2.2 The National Policy Background

Mental health is one of the areas identified in *Saving Lives: Our Healthier Nation*, within which there was a particular focus on suicide rates. The aim of reducing the number of suicides by one fifth by the year 2010[8] was incorporated as a Public Service Agreement (PSA) target and is a mental Health objective in the Priorities and Planning Framework (PPF) for the NHS.

Current policies and guidance issued by the Department of Health aim to cover the breadth of services provided by a range of authorities. The overall strategy is to ensure an integrated system of mental health provision that is sensitive to need, whilst maintaining a nationally consistent, high level of service, within the context of Clinical Governance and the economic principles of Best Value.

In *Modernising Mental Health Services* [9] the government sets out its proposals to improve service provision for adults. It addresses inequalities of access and delivery and describes specific service objectives and proposals for investment. Over three years following its publication, £700 million was allocated for investment in the reforms of mental health services. The need for organisational partnerships and nationally agreed standards is emphasised with the aim of raising quality and efficiency whilst ensuring national consistency. *The Health Act (1999)* [10] places a duty of partnership on health and local authorities, which provides a format for flexibility through pooled budgets – a theme further identified in the *NHS Plan*[11] with the creation of Care Trusts to commission and provide health and social care in a single organisation.

In addition to organisational co-operation, particular emphasis is placed on the importance of involving and working with recipients of mental health services. The establishment of the Commission for Patient and Public Involvement by April 2003 is an indicator of the centrality of this objective in current health policy generally. More specifically in relation to mental health, the inclusion within the Government's proposals for reform of the Mental Health Act[12] of a duty on Ministers to ensure that independent advocacy services are made available to those subject to compulsion under the new legislation is a further indicator of the importance of this theme. The need to involve carers is underpinned by the 1*995 Carers Act*[13], which recognises the needs of carers and their right to a separate assessment. The issue of public safety and public confidence is also highlighted in the basic principles of this document's proposals.

In setting out its vision of a modern health service, *Modernising Mental Health Services*[14] introduced the means of actioning its proposals through the *National Service Framework for Mental Health*[15]. It is here that national standards are defined and service models for mental health provision are given. *The National Service Framework* establishes standards against which progress is expected and against which performance will be judged. The External Reference Group chaired by Professor Thornicroft, which helped to shape decisions on service delivery, developed ten guiding principles. These principles included the need for mental health services to be accountable to the public, service users and carers. Also people with mental health problems can expect services to be well suited to those who use them and non-discriminatory.[16] The document offers examples of good practice and service models that reflect service priorities and national standards.

A range of health and welfare policies support the *National Service Framework* and within these there is a number of recurrent themes. The need for a non-discriminatory mental health service, which is sensitive to a diverse population with diverse needs, is recognised in consultation papers, policy documents and statute alike. It is reinforced by guidance for mental health practitioners who are required to consult and work in partnership with service users and carers, emphasising the need for sensitivity to cultural, racial, religious and sexual diversity. Social exclusion is seen as both a cause and a symptom of mental health problems. Reducing the level of social exclusion is also targeted in social policy. It is accepted that reducing discrimination against people with mental health problems will strengthen and promote individual well-being.

Within both the *National Service Framework* and *Modernising Mental Health Services*, recognition is given to the disparities of diagnosis and treatment among Black and minority ethnic populations. This is seen as a key area for service improvement and models of good practice are singled out. Tackling discrimination is seen as a pre-requisite for equal access to health and social care. This stream of policy development will shortly culminate with the publication and implementation of the Government's Vision for Improving Black and Minority Ethnic Mental Health Services.

In recent years pursuit of the policy objectives referred to above have been enhanced by the creation of important new developmental and monitoring structures within the NHS. The Commission for Health Improvement (which in due course will become the Commission for Healthcare Audit and Inspection, subsuming, amongst other things, the functions of the Mental Health Act Commission) is now the principal monitor of standards in the NHS and will include in its inspections compliance with the Race Relations (Amendment) Act 2000 (see below). The National Institute for Mental Health in England (which is part of the Modernisation Agency) has been established to help frontline staff in health and social care to implement policy to improve outcomes for people using mental health services. Enabling staff to recognise better the diversity of the communities they serve including race, culture and gender values is undoubtedly going to be an important component of their work.

2.3 Mental Health and Black and Minority Ethnic Communities – The Legal Background

The law is a significant consideration in relation to the delivery of health and social care generally. It is particularly significant for mental health care because it is almost the only aspect of health provision where compulsion in the face of refusal is, in certain circumstances, legally authorised. The use of compulsion under the Mental Health Act has long been a matter of concern for many people from Black and minority communities: a concern that is shared by Government and those responsible for the delivery of mental health care.

In their report, the Expert Group established to review the Mental Health Act suggested that

> *"In so far as anti-discrimination legislation such as the Race Relations Act 1976 … does not extend to persons subject to the exercise of compulsory powers, [we] would recommend that such protection should be so extended."*[17]

The Mental Health Act Code of Practice sets, as one of its guiding principles that people should

> *"be given respect for their … diverse backgrounds as individuals and be assured that account will be taken of their age, gender, sexual orientation, social, ethnic, cultural and religious background, but that general assumptions will not be made on the basis of any one of these characteristics."*

Since the publication of the Expert Committee's report there have been two legal developments that form an important part of the context for this report – the Race Relations (Amendment) Act and the Mental Health Act.

2.3.1 Race Relations (Amendment) Act 2000

The extension of the *Race Relations Act 1976*[19] to all public authorities (consequent upon the publication of the *Macpherson Report*[20] by way of the *Race Relations (Amendment) Act 2000*[21] and the imposition under the latter Act on listed public authorities of a general duty, in carrying out their functions to have due regard to the need to:

- eliminate unlawful racial discrimination
- promote equal opportunity
- promote good relations between persons of different racial groups.

This duty has important implications for all those involved in the provision of health and social care to people from Black and minority ethnic communities.

The Act also lays upon certain Public Authorities specific duties to help them meet their general duty. These include publishing a Race Equality Scheme, assessing and monitoring all their policies and functions for adverse impact on race equality and implementing special monitoring measures in relation to their employment of people from racial groups. It is clear that one of the public functions to which the Act extends is compulsory detention under the Mental Health Act.

2.3.2 Reform of the Mental Health Act

In 2000 the Government published proposals for reform of the Mental Health Act in a Green Paper[22], followed in the same year by a White Paper[23]. Subsequently a further consultation document (*Mental Health Bill-Consultation Document*[24] was published in 2002, along with a *Draft Mental Health Bill*[25] and *Explanatory Notes*.[26]

The Government's proposals envisage a new legal framework especially in relation to the use of compulsion (including enhanced compulsory powers in the community), safeguards, sharing information, giving informal carers consultation entitlements and securing increased protection from those with mental disorder who pose a serious risk to others. A number of the proposals are controversial and the Government is currently considering the comments it has received from its most recent consultation exercise including those from Black and minority ethnic communities.

Mental health legislation has to be seen in the context of the broader legal framework and in particular the obligations imposed on public authorities by legislation such as the Human Rights Act 1998.[27] The incorporation of the European Convention of Human Rights into domestic law has important implications for mental health care, especially by those who deliver such care.[28]

The challenge faced by all those involved in the delivery of mental health care, especially where it involves the use of the Mental Health Act, is to ensure that an explicit component of any definition of quality care is not only the observation of the relevant law but also of the values implicit within it. This is of particular importance for people from Black and minority ethnic communities.

Section 3

Over-represented in secondary care and under-represented in primary care: the UK's Black and minority ethnic population – who are they, what are the issues and what can be done?

3.1 Who are they?

There is a growing body of literature relating to the inequalities experienced by some Black and minority ethnic groups in relation to mental health diagnosis and treatment. An important component of the debate has been the over-representation of Black Caribbean and Black African people amongst those detained under the Mental Health Act[29 30 31 32 33]. Within this context, nothing has been more central than concern about over-representation in the secure mental health services. 1997 figures showed that 30% of the patient group in Medium Secure Services and 16% in High Secure Services were predominantly Black African and Caribbean.[34] There is conflicting evidence relating to the experience of South Asian groups. Raleigh notes that compulsory admissions and police contact occur as often, or less often, among Asians as in whites.[35] Evidence gathered for the Mental Health Act Commission's Ninth Biennial report, however, clearly shows that within all Black and minority groups there is over-representation of patients detained formally and informally when compared to the group classed as 'white'.[36]

Table 1 – Mental Health Act by Ethnicity in England and Wales

Ethnic Group	**Mental Health Act Data**				**Census Data**
	1996/7 (n=29,426)[1]	1997/8 (n=33,552)[2]	1998/9 (n= 35,097)[3]	1999/2000 (n=40,024)[4]	
	%	%	%	%	%
White	84.0	83.3	85.0	88.2	94.5
Black Caribbean	5.4	6.2	5.2	3.6	0.9
Black African	2.7	2.5	2.4	1.7	0.4
Black other	1.8	2.0	1.5	1.1	0.3
Indian	1.7	1.6	1.4	1.5	1.5
Pakistani	1.3	1.0	1.4	1.2	0.9
Bangladeshi	0.4	0.6	0.4	0.4	0.3
Chinese	0.3	0.3	0.3	0.2	0.3
Other groups	2.4	2.5	2.4	2.1	0.9

1 ethnicity not known (1996/7) = 2,102 – not included in table
2 ethnicity not known (1997/8) = 1,505 – not included in table
3 ethnicity not known (1998/9) = 1,204 – not included in table
4 ethnicity not known (1999/2000) = 5,029 – not included in table

Caution must be exercised in the use of these data, which are reliant on population figures provided by the 1991 census, which is now considerably out of date. They are further hampered by a shortfall in responses to the Commission's request for information for the table is based on information provided by 269 establishments out of a possible 281. Finally, the data are possibly distorted by the large number of 'ethnicity not known'.[37]

Table 1, as well as highlighting the disproportionate representation of detained Black and minority ethnic people, also illustrates the relevance of ethnic monitoring by highlighting the large proportion of patients whose ethnicity is not known. This issue is discussed in detail in section 5 of this report.

A further point for consideration illustrated by the table is the use of ethnic categories. This issue is also discussed in section 5, but it is worthwhile to note here that the category classed as 'white' will include many people from minority ethnic communities. The original NV2 exercise looked at the care and treatment of Black and minority ethnic communities and limited this definition to skin colour. Polish, Irish, Italian and countless other white minority ethnic people were not included in the survey. This follow-up exercise has made no such distinction. The arrival of relatively large numbers of refugees and asylum seekers in the UK has, since NV2, begun to have an impact on a system that was already struggling to cope with the needs of diverse cultures. This situation has added to the fundamental problems that have been a recurring concern to the Mental Health Act Commission, the Department of Health, the Commission for Racial Equality and many organisations and individuals involved in the provision of and receipt of mental health services. There are now the added complexities of coping with people who have a unique set of social and psychological problems associated with recent trauma and flight from their home countries. For example, the difficulties associated with identifying, accessing and training interpreters for people from well established Black and minority ethnic communities whose first language is not English, can only be exacerbated in relation to groups of people about whom service providers have little knowledge and understanding of language, cultural and religious needs. If, indeed, mental health services in large cities are having difficulty in addressing these basic issues, then how will those in rural areas, who have little experience of any Black and minority ethnic communities, provide appropriate care and treatment for the newly-arrived, dispersed, refugee and asylum seeking population?

3.2 What are the issues?

It would, of course, be misleading to characterise the level of admission under the Mental Health Act of people from Black and minority ethnic groups as the only important mental health issue. Indeed, the rate of therapeutic coercion almost certainly points not only to more fundamental concerns about the adequacy of health and social care provision, but also to more deep-rooted demographic, economic and social characteristics and to individual and institutional racism.[38 39 40] Social characteristics are identified, for instance, by Bhugra et al who note that primary health care services are currently severely under-utilised by people from Black and minority ethnic communities. They offer the hypothesis that pathways to care for many people from these communities are different from that of the white population. This evidence is supported by a survey of a South Asian population in East Lancashire, conducted by Bashford et al who found that for this community:

> *"The most accessible point of access and entry to mental health services appears to be through community networks of family, friends, and specialist South Asian staff from these communities engaged in primary care work or community development type work."* [42]

Turning to a demographic and economic context, Black and minority ethnic people tend to be concentrated in areas of deprivation and are over-represented in areas undergoing regeneration. That minority ethnic groups are concentrated in deprived areas sets in train a number of propensities to suffering from the wider features of economic decline. However, rarely is ethnicity prioritised as a major strategic issue within regeneration policy at the national, regional or local level.

Much research has commented on the high levels of poverty, deprivation, educational disadvantage, and discrimination in the labour force among these communities.[43] In addition a growing body of research points to the over-representation of Black and minority ethnic groups within the criminal justice and mental health arenas.[44] These issues are further compounded by the lack of access to appropriate and accessible health and welfare services.

Correlations between quality of care and ethnic background have been made, notably by Nazroo, who puts forward the possibility that language, and thus difficulty communicating with doctors, may have a strong bearing on quality of care, and given that many Black and minority ethnic communities are located in inner city areas they are therefore more likely to have poorly-resourced general practices. He concludes by stating that:

> *"Differences in the rates of mental illness among different ethnic groups might not be a consequence of dimensions of ethnicity per se, such as culture or biology, but of the differences in the demographic and socio-economic profiles of different ethnic groups."*[46]

These inequalities are discussed by Bashford et al in a review of local services for a South Asian population in northern England which is usefully documented against the National Service Framework for Mental Health's seven standards. The authors conclude that

> *"… there needs to be a systemic approach to tackling discrimination within mental health service development."*[47]

3.3 What can be done?

The Mental Health Act Commission's Ninth Biennial Report poses the question ***"Services for Black and minority ethnic people – what is to be done?"*** The Commission goes on to recommend a strategic, holistic, multi-dimensional approach with long-term, mainstream funding to service development whilst acknowledging that

> *"certain issues must be addressed within such an approach and, where such an approach is slow in starting, should be addressed immediately."*[48]

The issues referred to have been the focus of this follow-up survey:

- Recording and monitoring ethnicity
- Dealing with racial harassment
- Interpreting services
- Race equality and anti discriminatory practice training and culturally sensitive care.

This report, of the follow-up survey, is an opportunity to advise and assist those responsible for the establishment and implementation of policies and guidelines in the areas identified above. It will seek to share elements of effective practice reported by the respondents to the survey, by the literature and by the focus group consultation. It will also discuss issues that the respondents have raised as being potential barriers to service development within these areas.

The authors of this report concur with the Mental Health Act Commission's view that policies and guidelines should be established without delay. It is also essential that there is clear understanding about how these basic policy functions interact and how these policies can improve the care and treatment of detained patients. This report, therefore, goes beyond the Mental Health Act Commission's primary remit and highlights issues raised around pre-detention, after-care and initiatives that would fit the description of strategic, holistic and multi-dimensional. The report seeks to identify and share effective practice in establishing and implementing policies. Essential elements of these policies, will be arrived at on the pages of this report by discussion of some simple questions (who, what, why, when etc.), followed in the final section by a discussion of what is effective practice and how effective policy is designed and implemented.

It is hoped that this report will go some way towards developing an understanding of the complex relationship between the Black and minority ethnic experience of mental health services and addressing the claims of institutional racism in mental health services in general, and psychiatry in particular, and the institutional processes that 'lock out' the valuable expertise and knowledge that exists in the wider community, that could, if harnessed, have sustained and lasting benefit to the care and treatment of these very vulnerable people.

Section 4

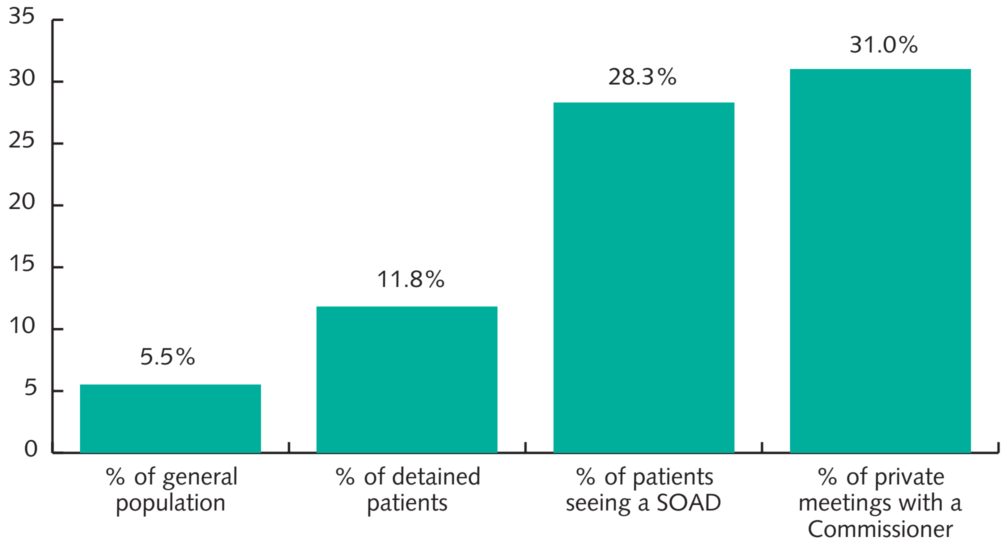
Pre and post detention issues: service providers' perceptions

4.1 Introduction

The focus of this report is, of course, to identify effective practice in the care and treatment of Black and minority ethnic patients once they have been detained. The Mental Health Act Commission, however, in its Ninth Biennial Report highlighted the significant rate of Second Opinion Appointed Doctors (SOADs), service referrals and requests for Commissioner support from Black and minority ethnic detained patients, (see figure 1) concluding from these data that there is now a more heightened

> *"need for research into the possibility of institutional racism both pre and post detention."*[49]

Figure 1:Increasing Proportionate Uses of Services for Detained Patients by Black & Minority Ethnic Groups 1999/2000



4.2. Service providers' perceptions

The results of this follow-up survey show that many of the issues identified as barriers to effective practice have their basis outside the detained setting. That is, within the community, within society at large, and, within psychiatry in general. In the follow-up survey respondents were asked to identify any pre-admission or after-care issues that they thought might affect the care and treatment of Black and minority ethnic detained patients. In many instances, the issues raised around pre-admission were also problematic in the provision of after-care and these are summarised below.

4.2.1 Stigma

Many providers highlighted significant levels of stigma about mental health within some Black and minority ethnic communities, particularly South Asian communities. This stigma, they claimed, was in part responsible for people from these communities tending to access services only at times of acute crisis and fundamental breakdown; for further isolation and loss of contact with their communities during hospitalisation; and for failure to engage adequately with services following discharge from hospital. Stigma was reported as being responsible in some instances, and with particular reference to the traveller community, for denying patients a socially supportive environment to return to after discharge.

4.2.2 Language

Where English is not the first or preferred language of the patient, nor indeed of the carer, respondents cited a major difficulty on admission, particularly when an interpreter is required at short notice. Language issues continue during after-care, posing significant barriers to service provision. These issues are discussed further in section 7 of this report.

4.2.3 Unfamiliar systems

One provider noted that alienation from statutory services in general is common amongst many people from Black and minority ethnic communities. Social exclusion, isolation, institutional racism and knowledge that the Black experience in the mental health system is one of controversy, combine with a lack of knowledge about the system and a resultant fear of it. This view was echoed in part by many respondents who saw the lack of staff from Black and minority ethnic communities as being an extra barrier. This was reported as particularly noticeable in forensic settings and in units outside the larger cities where the Black and minority ethnic population is smaller. Asylum-seeking communities, because of their recent arrival will be unfamiliar with all statutory services. It was reported that amongst asylum-seeking communities there is a perception that diagnosis of mental illness may in some way jeopardise asylum applications or revoke refugee status. This perception can lead to increased anxiety throughout the admission process and isolation from after-care services.

4.2.4 Diversity in concepts of mental health

Concepts of mental health, within some Black and minority ethnic communities, encompass a variety of different beliefs, ranging from supernatural models, religious models and naturalistic explanations.[50] A small number of respondents to this follow-up survey highlighted the need for those treating detained Black and minority ethnic patients to be aware of, and sensitive to, such beliefs. One respondent also noted the need for adequate assessment tools for Black and minority ethnic patients, lamenting that those currently used were Eurocentric in design and hampered effective assessment. Others reported a lack of culturally appropriate treatment options, within the detained setting and within the community, which could enhance the well-being of Black and minority ethnic patients.

4.2.5 Safety, dignity, privacy

A small number of respondents spoke of their own concerns about being unable to meet patients' needs in terms of accommodation preferences. South Asian women were highlighted as being particularly shocked at being offered mixed-sex accommodation along with bathroom and toilet facilities that were accessed through male sleeping areas. A number of providers also noted that as well as being culturally aware when admitting patients from Black and minority ethnic communities, staff also need to be able to detect and confront racism from other patients that are being admitted. One respondent reported that they had refused admission to two white patients displaying racist tendencies because of the presence of Pakistani patients within their unit. (See Sections 7 and 8 for further discussion of racial harassment and staff training issues).

4.2.6 Referral information

A number of respondents raised issues about communication breakdowns with referral agencies and, in particular, at times of emergency admissions. One respondent reported that Irish people tend to be admitted most often through Accident & Emergency Departments, whereas Black Africans are most often referred by other services, including the police and contended that:

> *"The effectiveness or absence of liaison services will therefore have small differential effects on ethnic groups."*

Concern was also expressed by a small number of respondents about assessment being undertaken in police stations and called for better co-operation between hospitals and the police. Another respondent lamented the lack of information that appeared with the patient. In some instances the patient's name is not recorded, and when this is coupled with a patient who does not speak or understand English, the problems of adequately admitting and assessing that patient are significant. Another respondent spoke of the propensity of admissions staff to be influenced by racial stereotyping when making their assessments. One respondent hoped that the introduction of ethnic profiling within primary care would ***"make it a lot easier to provide appropriate secondary care."*** A small but significant number of independent providers reported the minimal amount of influence they can have on pre- and post-admission issues, with one independent provider advising that because their catchment area is so vast, they rarely have contact pre- or post-admission with carers or family members.

4.2.7 Alternatives to hospitalisation

The shortage of crisis resolution and community treatment services was raised by a number of respondents. Even those establishments in large cities spoke of a dearth of evening and weekend community services and other alternatives to hospitalisation. Whilst this, of course, affects all patients, regardless of their ethnicity, the tendency for people from Black and minority ethnic communities to access services at times of crisis arguably leads them to being more likely to be admitted to acute services than the white indigenous population.

A lack of ***"a co-ordinated approach and a planning between existing services"*** was reported by one respondent, whilst others echoed this view in a variety of ways, lamenting the lack of outreach work aimed at engaging people from Black and minority ethnic communities with mental health services, mental health promotion, and cross-boundary working. One provider asked for protocols that would help them to engage better with the families and carers of Black and minority ethnic patients; the need to explain fully the importance of prescribed treatments and the dangers of providers using inappropriate treatments or service users rejecting treatment altogether was highlighted. Others spoke of their inability to engage with the wider community and the difficulties experienced in developing and sustaining networks with communities that could benefit care and treatment.

Where treatment within the hospital setting was considered culturally appropriate, there was a concern that once outside the setting the patient's health would deteriorate. Lack of care homes and nursing homes that offer culturally appropriate care and treatment, the lack of culturally appropriate support for the carers of Black and minority ethnic service users were cited as contributory factors. This was particularly an issue in rural areas where there are reportedly few support networks available outside the hospital setting for Black and minority ethnic detained patients; one provider in a largely rural area reported that ***"discharge needs to be in an area/culture that can cater for their needs."*** Service providers who have large numbers of asylum seeking communities within their areas spoke of the need for effective liaison between a wide range of agencies that could cope with the particular needs of asylum seekers in relation to housing, benefit advice, education and social services and, also in some instances deportation and repatriation for those whose applications have been unsuccessful.

4.2.8 No problems!

Of great concern is the small, but significant number, of responses that reported no particular issues within the pre- and post-detention area or within any area of the questionnaire. They often phrased their answers in terms of providing a holistic, patient-centred approach that would assure culturally appropriate care and treatment, but failed to give examples or raise any issues about barriers that they had faced in providing that care and treatment. A small number of respondents mentioned that they did not have – or had never had – any patients from Black and minority ethnic communities. One said that they

> *"did not think we ever would have, but we are confident that we could deliver appropriate care and treatment if necessary."*

Within the larger conurbations where the proportion of Black and minority ethnic communities is greater, the acknowledgement of the need is greater too. Responses in these locations have been more innovative and have encompassed a recognition of the fact that the skills and knowledge required for providing appropriate care and treatment lie not only within the unit responsible for delivery, but also within other agencies and within the wider community. Innovation has also, however, been found outside these conurbations. The challenges faced by providers within some of the rural areas where the Black and minority ethnic population is smaller, are arguably greater, yet the acknowledgement of need and responses to that need has, in many instances, been impressive.

The penultimate section of this report will discuss a number of initiatives that have been undertaken to address the issues outlined in this section. Focussing on joint working, partnerships and community engagement they offer the beginnings of the holistic, mainstream, multi-dimensional approach advocated by the Mental Health Act Commission.

Section 5

Recording and monitoring the ethnicity of detained patients

Headlines from NV2

Whilst only half the units visited had policies on recording patient ethnicity – in practice, actual recording was done everywhere. The key difficulty is the limited use to which it is put – 14 units in fact did absolutely nothing with the data. One third of Managers used the data to examine gaps in services, whilst half did deploy them in service planning and development.

5.1 Introduction

Recording and monitoring the ethnicity of in-patients, although mandatory within the NHS since 1995, continues to raise many problematic and sometimes complex issues for service providers. Department of Health guidance on collecting ethnic category data highlights the particular difficulties encountered in a mental health environment, stating that:

> *"There is no set time to collect this information as the administrative clerking may be dependent on the state of the incoming patient. Some units carry out this procedure on the ward after the initial assessment."*[51]

The follow-up exercise found that 93 of the 123 providers, (76%), stated that they had policies, procedures or guidelines pertaining to the recording and monitoring of the ethnicity of detained patients. These figures compare favourably to the 50% in the original exercise. The submission rate of those guidelines, however, was low suggesting that such policies, procedures and guidelines may not always be in the form of a composite document. Rather, they appear in various documents used at different stages of the admissions procedure. It also suggests that, in some instances, advice on how to implement such procedures is not always produced in a written form. A small number of service providers (4) stated that they did not at present have an ethnic monitoring system. There were, however, a number of documents submitted that contained what appear to be elements of effective practice and these will be highlighted throughout this chapter. Before doing so, however, it is useful to discuss some of the issues that were raised during the follow-up exercise.

Understanding *what is being recorded, how it is to be recorded and why it is being recorded* is essential to effective ethnic monitoring. A number of issues were raised around recording and monitoring ethnicity by those taking part in the follow-up exercise. Many of these issues have also been derived from further analysis of the data collected during NV2. These issues are discussed here and suggest that the three essential questions *what*, *how* and *why* are not always clearly understood by those responsible for policy development. Possible solutions suggested by the literature, by the focus groups that formed part of this exercise and by the service providers who took part in the survey are offered as the basis of effective practice in ethnic monitoring.

5.2 What is being recorded?

5.2.1 Ethnicity

> *"Ethnicity is not a single dimension of experience but a composite of identity, beliefs, expectations, cultural history and language. Many of these components are liable to change over time across successive generations."*[52]

The terms 'race', 'culture' and 'ethnicity', have plural, and often ambiguous, meanings. Ethnicity is often defined through appearance and social perceptions.[53] In recent years, self-definition has become an acceptable mode of defining ethnicity. Singh argues that not only does this force individuals to pigeonhole themselves, it relies on the potential outcome of the definition. He offers the example that someone may self-assign the label of 'Black' in a context of racism, 'Asian' when referring to their geographical background and 'Sikh' when constructing a religious identity. The Mental Health Act 1983 Code of Practice[54], however, gives clear instruction that patients should self-assign their ethnicity.

The most recurrent issue raised around recording, during the follow-up exercise was raised by 15 respondents who spoke of the difficulties sometimes encountered when attempting to record the ethnicity of patients. Reluctance, inability, mistrust, and confusion on behalf of the patient were all cited as reasons for patients withholding this information. Table 1 on page 17 evidences the extent of this problem. This illustrates that in the period 1999/2000, 11% of the 45,053 returns made to the Mental Health Act Commission on uses of the Mental Health Act, were recorded as *'ethnicity not known'*. Notwithstanding the guidance given by the Mental Health Act Code of Practice, one provider noted that, even when following this code ***"a clear statement may be very difficult to obtain."*** Some providers felt that in order to comply with the Code of Practice they were forced to leave the question of ethnicity unanswered; others felt that they had to record what to them was obviously incorrect information; one respondent requested

> *"ideas on how to resolve the problem of recording the cultural group that the patient identifies with, rather than their background."*

Whilst another respondent noted that some patients may

> *"underplay their ethnicity, often considering it unimportant, which is sometimes contrary to the views/wishes/instructions of family members."*

These comments, whilst reflecting the very real, practical concerns of those responsible for recording ethnicity, also indicate a lack of understanding of the complex nature of ethnicity. The opening quotation goes some way toward explaining the need for ethnicity to be self-assigned. Enabling patients to self-assign their ethnicity and then disagreeing with their designation defeats the object of the exercise. Recording 'Black' when a patient assigns him/herself as 'white', although clearly that patient is 'Black', only records skin colour, not ethnicity. Recording 'Indian' when the patient assigns him/herself as 'British', because that patient's family members insist the patient is 'Indian', only serves to record the ethnicity of the patient's family members, their composite of identity, beliefs etc., not the patient's.

Where respondents appeared to have fewer issues around recording ethnicity, it appeared to be because of a combination of asking secondary questions, e.g. religion, dietary requirements, first language spoken, dialect and written language. This practice is borne out by the literature, where it is noted that:

> *"Ethnic categories, however carefully defined, do not correspond with cultural, linguistic, dietary or religious preferences and needs … it may be more profitable for research and planning purposes to use a range of variables such as language, religion."*[56]

Many of the policies submitted for this follow-up survey included forms that asked a combination of these questions: Hertfordshire Partnership NHS Trust's policy also requested information on cultural customs and practices. On occasion these forms were backed up with an information sheet for patients, produced in multiple languages. These clearly outlined the purpose of recording ethnicity and assuring patients of confidentiality.

Essential policy elements

- Patients should self-assign their ethnicity
- Secondary questions should be asked around language, dialect, religion, familial origins, diet etc.
- An information sheet designed for patients that clearly outlines the purpose of recording ethnicity and guarantees confidentiality should be available. This sheet should be available in multiple languages and/or in audio format

5.2.2 Ethnic categories

Self-assigning ethnicity does, however, lead to consideration of Singh's assertion that patients are forced to pigeonhole themselves, often into categories that may not be of their own choosing. A further recurring theme of the follow-up exercise was around this issue.

Findings from NV2 showed that the widest attempts to capture ethnicity were made by using the 1991 census ONS categories.[57] Indeed, it is the use of these categories that is advised in the Mental Health Act Code of Practice, being the most up-to-date when the last edition of the Code was published. The follow-up exercise has confirmed that many units have now moved on to the 2001 categories[58]. However, even these raise issues for those responsible for recording. A number of units spoke of the difficulties in recording the ethnicity of white ethnic groups. Those units that have a large refugee and asylum seeking population within their catchment area had identified a need to supplement the 2001 categories with additional ethnic groups such as Bosnian and Croatian. Many of these units were following the guidance given by the Commission for Racial Equality (CRE)[59]. The literature also evidences the necessity of using accurate descriptors and to pay particular attention to frequently neglected white minority ethnic groups.[60] [61] Many other units, of course, may receive people whose ethnicity is not included in the 2001 categories. South London & The Maudsley Hospital, for instance, has recently introduced a new extended list of classifications, based on the 2001 census but including additional categories, mainly representing refugee groups within their catchment area. Effective practice would be for all units, regardless of the ethnic composition of the community they serve, to use the 2001 census categories, taking note of the CRE guidance to avoid patients having to pigeonhole themselves into categories that may not be of their own choosing.

It is important to note that patients do have the right to refuse to declare their ethnicity. However, in order to maximise data collection, this option should not be offered immediately. The refusal should, of course, be accepted if necessary.[62]

Essential policy elements

- The 2001 census categories should be used to record ethnicity
- CRE guidance on supplementary categories should be utilised to take into account local need
- Acknowledge that patients have the right to refuse to declare ethnicity

5.3 How should ethnicity be recorded?

The Department of Health guidance on collecting data in a mental health environment, advises that simple and clear questions be asked and that information can be collected on the ward after the initial assessment, at subsequent assessments, at assessment prior to discharge or at some other time, possibly when a relative or advocate can help the patient.[63] These guidelines should be viewed with some caution: our survey suggests that this information should be gathered at the first available opportunity. Leaving the collection until assessment before discharge is only an option of the last possible resort. It will of course be better than nothing but it will not benefit the patient's care and treatment programme during the patient's hospital stay. The collection, furthermore, should be an integral part of the admissions procedure, not something undertaken separately that may arouse suspicion. The assistance of family members or advocates will at times be necessary, but staff should bear in mind the discussion above.

Essential policy elements

- Recording ethnicity should be an integral part of the admissions procedure
- If it is not possible to collect ethnic data on admission, the data should be collected as soon as possible thereafter
- Clear guidelines should be included in the policy about how staff should obtain information that is not immediately forthcoming

Issues raised around the *'how'* question fell into two distinct categories: staff training and systems.

5.3.1 Staff Training

Education and training needs for frontline staff are paramount in order that accurate and meaningful information can be produced. Three units spoke of the difficulty in getting staff to collect the information. One reported that

> *"Many staff don't have the language/experience to ask the appropriate questions, let alone with sensitivity."*

Whilst another respondent acknowledged that ***"There is a need for training in this area."*** Further difficulties arose through the recording of ethnicity being undertaken in different circumstances, i.e. collecting the information from records made within the community and recording being undertaken by a variety of staff, such as, reception staff, admissions staff and clerks on wards. Unless accurate information is recorded, monitoring is meaningless and therefore units that identify and train specific staff to undertake recording and do not rely on the accuracy of data collected outside the unit are likely to be more successful in their quest for accuracy and consistency. Training should equip staff with the necessary knowledge to collect data. The training should focus on the local use of the data to ensure relevance at a local level and thereby generate the confidence in staff to deal with the issues raised with sensitivity and thoroughness. Staff should be aware that they have the support of senior management in undertaking this task.

South London & The Maudsley Hospital have introduced half day workshops designed to enhance the quality of data captured on a newly established ethnic monitoring system and further workshops are planned. The Department of Health guidelines emphasise the need for training on the introduction of the new ethnic category data, but warn that training should not be limited to this period of introduction but that it should become an integral part of new staff training programmes. The Department of Health advocates the use of a training pack developed by themselves, from material produced by South Buckinghamshire NHS Trust, and designed to be tailored for local need.[64]

5.3.2 Systems

As types of units vary, so do the systems used to record and monitor ethnic data. Some units had sophisticated electronic systems, although the amalgamation of Trusts and the introduction of the new 2001 census categories that coincided with this follow-up survey appeared to be causing some problems. A number of units spoke of working toward a Trust-wide electronic system. On the other hand, some of the smaller, independent providers and trusts who historically have not had a significant Black and minority ethnic population acknowledged that they had either only informal manual systems, whilst some had no system in place. Clearly, the introduction of fully integrated systems, harmonised nationally, appears to be the way forward. Making ethnic monitoring a high political priority and locating it at the centre of race equality policies is needed to ensure the huge potential it offers in the modernization of the NHS.[65] In the main, where systems were reported as being inadequate to the task, steps were being taken to rectify this, although it was clear that nationally harmonised ethnic data collection is still a distant goal.

Issues around the cost of systems were raised. Discussion on the system used obviously impacts on the use to which the resultant data will eventually be put and these issues will be raised later in this section. However, it was noted that whether an integrated or stand-alone system is used the policy and guidelines should be the same to ensure quality and consistency in data collection.

Essential policy elements

- All staff involved in recording, analysing and monitoring ethnic data should be trained to do so
- Training should equip frontline staff with the confidence and sensitivity to collect data accurately and with the knowledge of how that data will be used
- Policies should include a clear statement from Board level about the importance and significance of this exercise
- Commitment should be included in policies to harmonise and integrate ethnic monitoring systems across the trust/service and ideally regionally and nationally

5.4 Why record ethnicity?

So far, this chapter has dealt with recording issues: what is to be recorded and how it is to be recorded. This section looks at the *why* question. The simple answer to this question is that effective ethnic monitoring will directly benefit service users' care, treatment and quality of life on the ward and enhance service development through planning and research. This section therefore considers the analysis of the data collected, the use of the information derived from the exercise and issues surrounding monitoring procedures.

Findings from NV2 expressed concern that ethnic monitoring data was under-used. Possibly one of the reasons for this is the patchy and piecemeal way in which data has been recorded. Lack of completeness and widespread inaccuracies can lead to reduced confidence in the data by service planners and researchers. It is, however, at the local level that recording ethnicity and supplementary questions (for example, around language and religion) can impact significantly on the quality of individual patient care. The importance of transferring this information to the ward setting is paramount, informing those responsible for the day-to-day care of the patient about what are fundamental aspects of the patient's daily life.

As well as impacting on the daily care and treatment of current patients, ethnic monitoring can enhance service development in a number of ways. It is an effective tool for rooting out inequality in service provision and for assessing the impact of local, regional and national health policies. Several of the responses received in the follow-up survey spoke in terms of using the data to complete submissions to the Mental Health Act Commission, or of being able to provide a breakdown of their patients' ethnicity as and when required. Others saw their monitoring as an integral part of service development, used within the clinical governance structure, to identify trends both within the hospital setting and within the community and to highlight possible inequities in the use of compulsion, seclusion, care and restraint, and to monitor incidences of harassment. However, as one respondent noted ***"Analysis requires action and that is not always forthcoming from the top."*** Even the most effective ethnic monitoring system can only produce information; what is done with that information is key to reducing inequalities for Black and minority ethnic detained patients.

The work of Brent, Kensington, Westminster and Chelsea NHS Mental Health Trust (BKWC) is worthy of note. The Trust has formulated a number of principles for the analysis of ethnic data and identified a series of key issues to be tackled in order that future ethnic monitoring should be as comprehensive, accurate and useful as possible. Their report discusses many of the issues raised here.[66] The report is followed up by a Trust-wide action plan that covers many issues relating to race equality and by the inclusion of so many initiatives suggests that:

> *"Ethnic monitoring can stimulate (or release) real energy and enthusiasm for pursuing the goals of racial and religious equality and social justice."*[67]

BKWC's report and action plan also raises an issue highlighted by other respondents – that ethnic monitoring does not and should not take place in a vacuum. Successful policies are informed from outside the unit as well as from within. A number of respondents and the focus group expressed the necessity of involving local community groups in the formulation of policies and disseminating their policies within the community. Consultation with the community is seen as essential to allay anxieties that ethnic monitoring can provoke.[68] [69] The involvement of local services – particularly Social Services and independent services that may operate within a mental health unit in the joint collection of data, was also recommended and, subject to maintaining confidentiality, sharing that data.

Essential policy elements

- Information should be held at ward level, used to inform individual patient's care plans and be readily and easily available to staff, thereby benefiting patients' clinical care and observing patients' human rights
- Information should be fed into a Trust/service wide system
- Information should be used to identify local, regional and national trends
- Information should be used to monitor treatment regimes, complaints, use of therapies and activities, violent incidents, harassment incidents, self-harm, deaths, use of Mental Health Act, compulsory admissions, seclusion, care and restraint, applications to and outcomes of Mental Health Review Tribunals, requests for Mental Health Act Commissioner visits, and requests for SOADs
- Policies should include commitment to analysing collected data, disseminating findings and taking positive action
- Where possible/relevant joint data collection should be undertaken with appropriate local services

5.5 Conclusion

Ethnic monitoring systems sometimes fail because those undertaking the monitoring perceive the exercise to be bureaucratic, intrusive and meaningless at a local level. On the contrary, the discussion above highlights the very real practical application of sound, accurate data. Many of the issues raised by the respondents clearly support this view. The collection of data on ethnicity, coupled with data related to issues such as language and religion will undoubtedly have a real impact, not only on service development, but more importantly, on the delivery of comprehensive, holistic care programmes.

We have set out guidance above to aid the development of clear and concise policies, incorporating answers to those questions *what*, *why* and *how* on recording and monitoring ethnicity. We therefore hope that this raft of policy elements will lead to the development of effective polices on recording and monitoring ethnicity and that the action arising from those policies will do much to enhance the care and treatment of Black and minority ethnic detained patients.

Section 6
Dealing with racial harassment

Headlines from NV2

Almost three quarters of units visited had no policy for dealing with racial harassment by either patients or staff although the quality of policies that were available was high. Eleven per cent, that is fifty-nine, of the patients whose case notes were examined had reported incidents of racial harassment.

6.1 Introduction

It is on closer inspection of the reported incidents, highlighted by NV2, that some idea of the challenges in recognising and dealing with racial harassment are encountered. Perusal of these case notes has raised a number of questions that were echoed in part by respondents to the follow-up survey and considered further within the focus groups. These are discussed below.

6.2 Why have a racial harassment policy for patients?

Both NV2 and the follow-up exercise found a distinct lack of policies on this subject. Sixty-four of the 123 (52%) providers responding to the follow-up exercise stated that they had policies, procedures or guidelines on dealing with racial harassment of Black and minority ethnic detained patients by other patients, or by staff. In reality, the majority of the policies examined dealt with staff harassment and bullying issues in general, encompassing racial harassment but neglecting harassment of patients by other patients or by staff. In all of the areas of concern highlighted by both NV2 and this follow-up exercise, racial harassment is the area in which the greatest number of providers has acknowledged that their existing policies fall short of requirements or that they need help in establishing a policy from scratch.

The focus on workplace or staff harassment is unsurprising and, although not the subject of this report, such policies clearly begin to create an atmosphere in which all forms of racial harassment can begin to be eliminated. The presence of a workforce whose ethnicity broadly reflects the patient community it serves is widely reported to be an effective tool for tackling inequality in mental health services. Moreover, with a recent survey finding that 40% of all Black and minority ethnic nurses report racial harassment from work colleagues and more than 64% report suffering racial harassment from patients,[70] the need for such policies is essential.

A small number of providers responding to the follow-up survey expressed in various ways that they had a zero tolerance policy on all forms of harassment and that staff were ***"aware that any form of harassment is intolerable"*** and that there is ***"a need for vigilance."*** One provider went further, suggesting that the existence of a policy specifically addressing racial harassment could be construed in itself as racist arguing that they had a zero tolerance policy for harassment that aimed at equality of treatment for all.[71] This over-reliance on generic policies is of great concern. The NHS Zero Tolerance campaign is strongly focused on violence and abuse directed at staff and there appears to be a reluctant acceptance within the literature that patient behaviour in a mental health setting may have limited scope for change.[72] Outside the mental health setting, an inspection report into the community care services for Black and minority ethnic elders, notes that policies and procedures on elder abuse:

> *"Did not identify areas of concern that might be more relevant for black elders, e.g. racial abuse/harassment … staff particularly identified the need for policy and procedural support in dealing with racial abuse/harassment which occurred in situations between service users (especially in residential care settings), between staff, by staff or by service users on staff."*[75]

Many of the respondents to this follow-up survey also recognised the shortcomings of all-encompassing policies in dealing specifically with racial harassment of patients, particularly in a mental health environment where:

- the actions of the alleged victims and alleged perpetrators may or may not be attributable to their mental illness;
- the insidious, subtle nature of some forms of racial harassment is often poorly understood;
- overt and covert forms of racism can have damaging effects on the care and treatment of already vulnerable people; and ,
- there is a history of institutional racism that has seen people from Black and minority ethnic groups disproportionately represented and subject to inequalities in treatment regimes.

The Department of Health has recently published National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICU) and Low Secure Environments in which it recommends that as a minimum all PICU/Low Secure units should have:

> *"A clear policy statement on equal opportunities and racial harassment which all staff and patients are aware of. The policy should cover staff/patient and patient/patient harassment."*[74]

Only nine respondents to this follow-up survey submitted a mixture of policy statements and guidelines that dealt with the issue of patient-to patient and staff-to-patient harassment.

Essential policy element

- Whilst it is important that racial harassment should be included in an establishment's anti-bullying or general harassment policies and that staff issues should be addressed within these, in a mental health setting, a separate section or a stand-alone policy aimed at protecting patients from racial harassment by other patients, by visitors or by staff should be established to acknowledge the special need for protection of these patients

6.3 What is racial harassment?

NV2 defined racial harassment as

> *"A continuum of behaviours, including use of inappropriate and offensive language, possession of racist materials, written abuse (e.g. racist slogans), verbal abuse, threats, intimidation, and actual physical attack. Anything along this continuum, which the patient regards as racial harassment, should be accepted as such … it is important to note that racial harassment is not only something which is 'done to' patients in the form of verbal or physical abuse, but it is also about the non-provision of appropriate services for black and minority ethnic groups."*

This broad definition, although useful, highlights the complexities of recognising and addressing some forms of racial harassment. This, of course, is made all the more difficult within a mental health setting where paranoia and delusional behaviour can sometimes cast doubt on a patient's claim of racial harassment or indeed on any claim the patient may make. Two further elements identified by the follow up survey and further analysis of the original data could be said to be missing from the above definition:

- subtle racism, which, by its very nature makes reporting and challenging very difficult; and,
- a form of institutional racism not covered by non-provision of appropriate services, but one that is well-documented as existing in psychiatric services: the disproportionate provision of inappropriate treatments for Black and minority ethnic patients.[76]

The above complexities would suggest the significance of implementing and adhering to sound racial harassment policies addressing the needs of patients.

Essential policy element

- A clear definition of racial harassment should appear on the policy, encompassing the continuum of behaviours described above and including forms of subtle racism and disproportionate provision of inappropriate treatment.

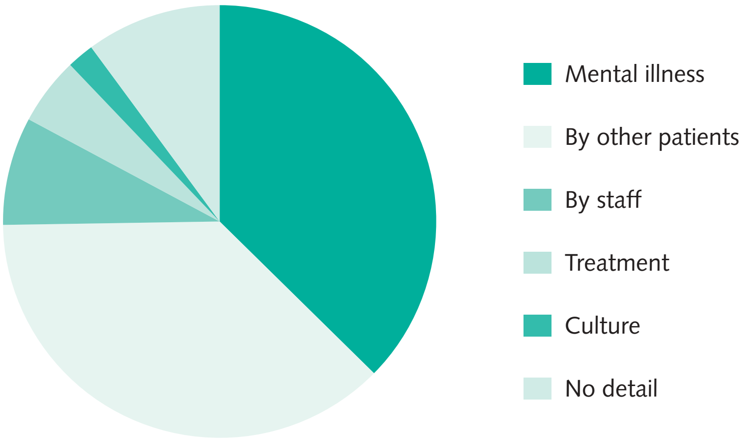
6.3.1 Are all forms of racial harassment as serious as others?

The definition of racial harassment outlined in section 6.3.1 and the added elements of subtle racism and disproportionate treatment demonstrate the need for a high degree of awareness amongst those responsible for delivering care and treatment to Black and minority ethnic detained patients. A number of respondents requested guidance on what constitutes indirect harassment, whilst others spoke of the challenging behaviour of many of their patients and the prevalence of derogatory behaviour directed at many people, regardless of their ethnicity. One provider reported that

> *"There is a level of harassment (not specifically racial harassment) that is seemingly accepted within the culture of the mental health services."*

Further analysis of the 59 case notes highlighted by NV2, illustrate this argument more fully, as figure 2 shows below:

Figure 2: Analysis of incidents of racial harassment



- Twenty-two of the case notes recorded that the patient's claims of racial harassment could be attributed to mental illness – in other words they were not considered to be incidents of racial harassment
- Eight cases were reported as being perpetrated by (or allegedly perpetrated by) 'another Black person', 2 of which were attributed to the alleged victim's mental illness and 1 to the mental illness of the perpetrator
- Fourteen recorded verbal/physical abuse from other patients (ethnicity not recorded). Two of these were incidents reported by staff who expressed concern about the patients' vulnerability and inability to protect themselves
- Five recorded verbal abuse by staff
- Five case notes were non-specific
- Three were complaints about treatment issues
- One case was about denying religious expression.
- One case was about feeling that the ward system racially oppressed the patient.

The case notes provide a snapshot of the pertinent issues, many of which were also raised by our survey respondents. The preliminary report for NV2 expressed great concern on finding 59 recorded instances of racial harassment amongst the patients whose notes were selected, representing 11% of the total cases. This concern was greater given the numbers of filters operating, in other words, an incident has to be reported to staff, acknowledged as racial harassment and recorded in the case notes.[77] The case notes, unfortunately, do not always record how the issue was resolved or what steps were taken to ensure that such incidents did not recur. In some instances, such as, racial harassment by staff, the reporting and investigation procedure is clearly outlined in the unit's disciplinary procedures or sometimes subject to an external investigation. Even with this structure one of the case notes reported that the staff member was ***"only joking."*** It is worthy of note that a number of incidents were reported as being perpetrated by ***"another Black person."*** The reason for reporting the ethnicity of the perpetrator is not clear in these instances, but, it does highlight the need for awareness that just as anyone, regardless of their ethnicity, can be a victim of racial harassment, so a person from any ethnic group can be a perpetrator.

In the instance where a patient was denied religious expression (a Rastafarian was forced to remove his headwear at meal times) the complaint resulted in a change of policy. Other issues, however, are less clear-cut. As one provider noted:

> *"Patient to patient harassment is a more difficult area it relies on staff having the confidence to state what is acceptable and what is not."*

Effective policy should aim to instil that confidence into staff and to create an environment where reporting incidents and monitoring those reports becomes commonplace. South West London & St George's Mental Health NHS Trust have tackled this problem by outlining a procedure for dealing with racial harassment. This procedure states that ***"the Trust considers all incidents of racial harassment as serious"*** and differentiates two routes for a member of staff who can ask a series of questions that will lead to the matter being dealt with formally or by a more informal approach. Usefully, the Trust builds into its policy the need for a written note of even the more informal incidents. Further, the Trust employs the services of Staff Support Advisers who can offer confidential advice to staff on, amongst other things, which procedural route to take. Whilst, clearly, staff play a major role in protecting vulnerable patients, effective practice should also take into account the patient's and carer's need for information about racial harassment and reporting procedures and assure them that the Trust will not accept any form of this behaviour.

Essential policy element

- Policies should acknowledge that all incidents of racial harassment are serious but that the manner in which they are handled should vary according to the nature and extent of the harassment
- Policies should acknowledge that all people, from all ethnic groups, are potential victims of racial harassment and all incidents of racial harassment should be subject to ethnic monitoring
- Policies should allow for all incidents to be recorded fully and monitored at Board level

6.4 How can we deal with racial harassment?

6.4.1 Patient-to-patient

> *"Whilst it has been possible to curb the excesses of certain racist staff through the introduction of policies and the threat of disciplinary action, it has not been possible to curb the behaviour of those racist patients who use racist abuse in the knowledge that they face no censure. After all, how do you legislate against attitude?"*[78]

This quotation is taken from a short essay on the experiences of a Black patient within a secure psychiatric service in which he documents a sea change in thought and practice within the service, but laments that policies and sanctions are unable to respond to racially abusive patients. However, there appears to be a dearth of literature that examines this important area.

Analysis of the case notes and the issues raised by respondents and within the focus groups further highlights the need to lay down clear procedures aimed at potential victims and potential perpetrators, clearly outlining the sanctions that can be applied against patients who are racially abusive. Respondents talked in terms of ***"having difficulty in knowing where to place a patient who is being racially abusive"*** or wanting to know ***"what sanctions can Trusts apply against patients that are perpetually racially abusive?."*** One provider had been advised by the Crown Prosecution Service and by the police that patients could only be cautioned, as the wards were considered as dwellings.

The case of David Bennett, whose death, whilst struggling under restraint, following an incident sparked by racial abuse directed at him, starkly illustrates the tragic results that can occur when a case of racial harassment is inappropriately handled. The tragedy further reinforces the seriousness of racial harassment within a mental health environment.[79] Moving a victim of racial harassment to another ward for safety reasons is widely considered inappropriate.

However, when it is necessary to physically separate victim and perpetrator, staff are often faced with the difficulty of finding a ward that will receive the perpetrator. Of the case notes outlined above that covered patient-to-patient incidents, the majority that noted the outcome of the reported incident, revealed that it had been handled or resolved by talking or reasoning with the patients involved. In some instances, the perpetrators of the incident had been moved to another ward. In one instance, the perpetrator had been moved into seclusion. Racial harassment is unlawful, but it is not clear what effective sanctions can be applied to patients compulsorily detained under the Mental Health Act when the racial harassment reaches the level of severity indicated in the case of David Bennett. Summoning the police or moving a patient into seclusion reflect a desperate situation and effective policy on racial harassment should aim to deal with situations before they spiral to this level. Paying attention to early warning signs, providing training for staff to recognise and challenge all forms of racial harassment, providing support to staff and patients from harassment advisers, reporting and monitoring incidents and widely publicising the existence of a racial harassment policy will contribute to the creation of a culture where racial harassment between patients can be dealt with more effectively. It is important also to listen and work constructively with the perpetrator in order to begin to address their behaviour and attitude and not simply to respond punitively.

6.4.2 Staff-to-patient

The issues raised above about patient to patient racial harassment broadly fall into two categories – recognising racial harassment and applying effective sanctions. The suggested solution was to create a culture, through policy development, where racial harassment would not be tolerated. The issues surrounding staff-to-patient harassment are similar, though the sanctions of course differ and should be clearly and unequivocally spelt out in any policy document. Perusal of the documents submitted for this follow-up exercise report that in harassment incidents (not necessarily racial harassment incidents) all claims are investigated and sometimes, members of staff are suspended or moved during the investigation. Where the investigation concludes that the nature of the incident is serious the incident may be reported to the police – staff may be dismissed.

6.4.3 Harassment by the institution

The evidence outlined in section 3 concerning over-representation of Black and minority ethnic groups in admissions under the Mental Health Act, the rate of therapeutic coercion for these groups and the unwitting discrimination that sees many Black and minority ethnic people denied access to services was discussed in focus groups as part of this follow-up survey and the question was put to the participants

> *"Does this constitute racial harassment, if so, should it be included in an establishment's Racial Harassment Policy?"*

Opinion was divided on this. Views were expressed that racial harassment was too 'aggressive' a word to describe unwitting forms of discrimination. On the other hand, the outcome of unwitting discrimination can be as, if not more, distressing than any individual form of racial *harassment*, as the following illustrates:

> *"There can be little doubt that the experience of psychiatry by Black patients is substantially different from that of the majority of white patients, with themes of dominance, coercion and control made more explicit and pervasive within most medical practices and clinical procedures, such as diagnosis, hospital admission and treatment."*[80]

The analysis of incidents of racial harassment outlined in Figure 2 identifies three cases where patients had reported being racially harassed in relation to treatment offered, one case where a patient had been denied religious expression and one where the patient felt that the ward system oppressed him. In order to effect the necessary change in culture discussed earlier, staff and patients need to be aware that issues such as these can be reported as racial harassment and that the incidents will be investigated, monitored and action taken.

Essential policy element

- Staff training to enable staff to recognise subtle, overt and covert forms of racism; to instil the confidence necessary to challenge racial harassment; and to recognise possible racist practice within themselves
- Encouraging an atmosphere where racial harassment is easily challenged and therefore less threatening by wide circulation of anti- racist harassment messages for staff and patients by leaflets, notices, statements on intent and word of mouth
- Establishing and publicising the work of racial harassment advisors who can offer confidential support and advice to staff and patients who have concerns about reporting incidents
- Perpetrators of racial harassment should be listened to and worked with
- Taking steps to avert racial harassment spiralling to a dangerous level by paying attention to and dealing with early warning signs
- Instilling clear reporting and monitoring procedures that incorporate sanctions that take into account the seriousness of the offence and the nature of the incident

6.5 Conclusion

The importance of establishing an effective policy that deals with racial harassment, between patients, from staff and by the institution cannot be overstated. The following extract from Hansard, recording the debate on mental health and racism provoked by the death of David Bennett, illustrates this:

> *"Of particular relevance to this debate is the fact that he (the coroner) stated that many NHS trusts do not take racism seriously and that all trusts should have a written and active policy on dealing with racial abuse … It has been established that David was racially abused by other patients on several occasions before the incident that caused his death – there was no indication of that being addressed by staff … He complained to his family that he felt he was being treated unfairly because he was black, and he told staff that he felt white people were treated better.*
>
> *The trust's internal inquiry identified a case in which a member of staff had racially abused another patient, and an incident of racial abuse against Rocky (David) by another patient started the chain of events that resulted in his death."*[81]

It was gratifying that many of the respondents to this survey recognised a need for policies addressing racial harassment directed at patients. It is of concern that a significant number felt that an all-encompassing zero tolerance policy was adequate. It is the hope of the authors of this report that this section will convince those responsible of the need for a specific policy and aid in the development of written, active policies on this important area of concern.

Section 7
Interpreting services

Headline issues from NV2

The issue of the availability, training and use of interpreters has been a long-standing area of concern for the Commission. Commission visit reports have continued to suggest that this area remains a low priority for service providers, since its first biennial report in 1985.

Half the units visited had a policy about interpreters and three quarters used trained interpreters. Two thirds however had used relatives and friends as interpreters; this must raise serious concerns about compromising objective decision-making by staff.

One in five patients (in the survey) did not have English as a first language and between them, spoke 26 languages. Information about dialect was poorly recorded and particularly worrying was the fact that only 36 of the 51 patients not fluent in English had ever used an interpreter.

Accurate information on languages spoken, particularly dialects was poorly recorded – this has obvious implications for planning and delivering quality care as well as accessing appropriate interpreters.

7.1 Introduction

One hundred and two of the 123 respondents (83%), to the follow-up survey stated they had policies, guidelines or procedures on the provision of, access to and the use of interpreters. This compares favourably with the 50% reported by the original exercise. A significant number of the policies dealt only with issues around access to interpreters, however, and once again, the submission rate of these policies was low. The National Service Framework for Mental Health emphasises the importance of interpreting services across all its seven standards. The Mental Health Act Code of Practice clearly instructs Local Authorities and Health Authorities to ensure that Approved Social Workers (ASWs) and doctors receive sufficient guidance in the use of interpreters and to make arrangements for there to be an easily accessible pool of trained interpreters. Whilst the policies submitted reflect this need for interpreters, the guidelines submitted with them do not always fully address how this need is to be met.

Essential policy element

A clear statement relating to the establishment's duty and commitment to providing interpreting services when needed in accordance with the NSF and Mental Health Act Code of Practice

Issues raised by respondents to the follow up exercise mainly surrounded access, cost, training, reluctance of professionals to use interpreters, assessment of need, and the shortage of interpreters and translated materials to meet the needs of refugee populations. These issues are discussed below, with illustrations from the literature to clarify definition

7.2 What is an interpreter?

> *"The term 'interpretation' emphasises the exchange of connotative meaning between languages so that both effect and meaning are conveyed."*[82]

In a mental health setting this exchange of connotative meaning is particularly necessary. Language communication is not the only barrier to understanding and non-verbal communication and cultural characteristics and explanations are essential components of effective assessment, care and treatment. Sanders outlines three models of interpreting: the linguistic; the professional team; and the client centred or advocacy model. She goes on to illustrate a number of attributes and drawbacks to the use of these particular models in a health setting:

- The linguistic model is reported to be appropriate when the only barrier to understanding is a language barrier; when the client is articulate and assertive, understands the structure and culture of the service and knows their rights. Telephone interpreting services are cited as an example of the linguistic model.
- The professional team model, that was the basis for the development of linkworkers in health settings, is advocated as a powerful model if properly implemented. The interpreter in this instance is a member of the service provider's team and their job is to improve service to the community in question through their knowledge of it. The effectiveness of this model is reported as being dependent on the commitment of the service team and their recognition of the professional skills of the interpreter.
- The client centred or advocacy model provides, through continual support of a client, an interpreting service along with representation to the service provider in an effort to ensure that their client's needs are met. The strengths of this model are that it is most likely to meet the client's needs as well as to optimise use of the service provider's time. In this model the interpreter is part of a community or agency based team and has the support and on-going training necessary to challenge institutional practice and work for change.[83]

The fusion of the roles of advocate and interpreter are noted in the last of the models described above. This fusion is arguably responsible for a lack of clarity about the function of an interpreter and the reluctance of some professionals to use them. One respondent noted that ***"professional staff do not want to use interpreters – they feel that they interfere too much."*** This subject is discussed in a report published by the Joseph Rowntree Foundation who found that there is a need for a clear distinction to be made between advocacy and interpreting. Interpreting was found as a necessary component of advocacy services for South Asian groups, whereas advocacy groups serving other members of the population saw advocacy and interpreting services as sharing the same aim of improving communication, but as distinct and separate services.[84]

The three models outlined above have one common denominator, that is they all are based on a professional approach to interpreting services and, with exception of the linguistic model, the approaches call for knowledge of the setting (for instance mental health) that surrounds the patient. The use of family members and staff untrained in interpreting was highlighted in NV2 and although few of the respondents in the follow-up survey acknowledged the use of untrained interpreters they did report a number of barriers to accessing interpreters that may lead to the conclusion that this practice is still common. The National Service Framework for Mental Health accepts the reality of emergency situations where family members may be called on to interpret. This practice, however, is not condoned by the literature and many authors point to the disadvantages of using family members and acquaintances to interpret in highly personal and confidential situations.[85 86 87] There is also widespread agreement that children under the age of 16 should never be used as interpreters.

Essential policy element

- Family members, acquaintances and untrained staff should not be asked to act as interpreters at clinically significant events
- In the case of an emergency, untrained interpreters should be used only to communicate the minimum information necessary until a trained interpreter can be found
- Children under the age of 16 years should never be asked to interpret on behalf of family members

7.3 When should an interpreter be used?

There are legal as well as moral obligations to provide interpreting services to patients whose first language is not English. The models outlined earlier give a general illustration of the various areas of need and begin to describe the most appropriate way in which that need should be met. It is also, however, essential to recognise that a patient may be able to speak English fluently but, whilst under stress or distress, may prefer to speak in their first language. Williams notes that bilingualism is not a simple matter of having two equal languages always available

> *"… much more depends on context, on feelings and … upon the health or ill health of the speaker."*

He goes on to note that the Mental Health Act is deficient in this respect and is

> *"predicated on the assumption that the use of another language is a technical problem."*[88]

As one respondent to this follow-up survey noted,

> *"How do you assess need, whose choice is it that an interpreter is needed, clarity is needed on who can interpret, when and what for."*

The following sections attempt to provide that clarity.

7.3.1 Explanation of rights

The Mental Health Act 1983 imposes on Hospital Managers a statutory duty to provide information to patients about detention, consent to treatment, rights of appeal and other legal matters. The Mental Health Act Commission emphasises that services must be sensitive to the capacity of each individual patient to understand those rights. Rights should be explained, as far as possible, in a way that the patient understands, which includes use of appropriate language and the provision of translated materials.[89]

7.3.2 Assessment and review

An interpreter should be available during assessment and at all subsequent reviews. Sufficient time should be set aside for these meetings. A guide to running these meetings with an interpreter is given in section 7.5.

7.3.3 Care planning and interventions

An interpreter should be present when the care plan is drawn up. Patients have a right to be involved in the compilation of the care plan. Unless this exercise is undertaken in a language that they understand, it is unlikely to contribute to effective care and treatment.

The care plan should take account of the language needs of the patient, including arrangements by which interventions will be delivered. This should include an indication of when an interpreter is required to be present. In particular, an interpreter should be available at the introduction of new interventions and at all clinically significant meetings.

7.3.4 Carer

If a carer is present at any meeting at the patient's request, and that carer's first/preferred language is not English, then an interpreter should be provided. This provision should be made regardless of whether the patient's preferred language is English. In other words, the patient should not become the interpreter for their carer.

7.4 Costs

A significant number of respondents to the follow-up survey mentioned the high financial costs of providing interpreters. It is notable that it is within this area of the survey, more than any other that cost appears to be the greatest issue. It is also notable that in this area of provision of interpreters the cost is, in many instances, known at 'the point of sale'. The benefits in terms of delivering effective care and treatment and in complying with legislation arguably outweigh the financial costs involved. A small but significant number of the policies and guidelines submitted included price lists from independent interpreting agencies. Whilst many policies incorporated a paragraph assuring staff of the establishment's commitment to providing interpreters, it was felt that the inclusion of the price lists could force staff to make decisions within this area of need, based on budgetary issues, rather than following strategic direction. Whilst it is not the intention of this report to publicise bad practice, it is felt that once a unit has established the need for an interpreter at strategic level, staff should follow policy in the same way that other decisions are made about cost-effectiveness rather than being forced into making budgetary decisions.

Essential policy element

- Policies should recognise that although a patient may speak English, at times of stress or distress the patient may have reduced understanding or ability to express themselves in that language and interpreting provision should be made
- Policies should emphasise a minimum standard of when interpreters should be used and these standards should include use on admission, at assessment, during the formulation and delivery of care plans, at clinically significant meetings and at the introduction of new interventions
- Interpreters should be made available to explain treatment and care to carers where English is not the carer's preferred language

7.5 Access to interpreters

Access to interpreters that can cover the range of necessary languages and have the ability to work in a number of settings, along with the associated costs involved, appeared to be the most cited barrier to delivering an effective interpreting service. As mentioned at the outset of this chapter, many of the guidelines submitted covered access only and appeared in the form of a list of staff members, community organisations or independent interpreting agencies that could provide interpreting services.

The Mental Health Act Code of Practice recommends that Local Authorities and Trusts should consider co-operating in making provision for interpreter services. A significant number of respondents to this survey appeared to have partnership agreements with Local Authorities on interpreting services. For example, South Birmingham Mental Health Trust reported that they have signed up to the Birmingham Integrated Language and Communication Strategy. The strategy is citywide, is underpinned by a patient profiling exercise and works on the provision of interpreters trained to DPSI (Diploma in Public Service Interpreting) level and provides training in the use of interpreters for professional staff. The strategy also includes a dedicated service for refugees and asylum seekers, ensuring that their specific needs are met. Issues around partnership working are discussed in sections 9 and 10 of this report.

Other respondents reported that they used a number of professional agencies, advising that the greatest problem in accessing interpreters was during times of emergency admission and that by signing up to more than one agency there was less chance of being disappointed. A number also spoke of using telephone interpreting services in cases of emergency, but acknowledged the limitations of this practice in a mental health setting. In many instances it would appear that the need for an interpreter is known at referral and so the time between referral and admission can be used in finding a suitable interpreter. However, in emergency admissions or, as highlighted in section 5, when ethnic monitoring information is incomplete and a patient's language and dialect has not been accurately recorded, policy should include guidelines giving a point of reference for staff to access interpreters, along with an emergency contact for out of normal working hours.

South London and Maudsley NHS Trust has produced a useful report on the Trust's interpreting services, which includes identifying the National Register of Public Service Interpreters and the Institute of Linguists as potential sources of interpreters. The Trust's report recommends the use of National Register interpreters for work with post-traumatic stress patients who need the consistency of working with one interpreter, which cannot at present be guaranteed by their current interpreting service. The report further recommends that a half time worker should be employed for a period of two years to develop policies and procedures, monitor the use of interpreters and negotiate with interpreters for specific work.

The professional model outlined at the outset of this chapter appears to be utilised by a small number of large Trusts who have mainly South Asian populations. They employ one or two full time interpreters who can interpret for the larger Black and minority ethnic communities on a Trust-wide, full-time basis.

Essential policy element

- Policies should, wherever possible, be jointly drawn up in partnership with Local Authorities and/or other services allowing shared access to a joint pool of interpreters
- Policies should note that telephone interpreters should only be used in cases of emergency
- Policies should include guidelines that give a point of reference for staff wishing to access interpreters

7.6 Training needs

Many respondents reported having good access to interpreters, but spoke of the interpreters having only a limited understanding of mental health issues:

> *"There are difficulties at times with the knowledge base of the interpreters, therefore we are unsure how much clinical information is understood."*

Another provider notes that whilst they had a well developed interpreter service in their area ***"the lack of interpreters trained in mental health issues limits their usefulness."*** Tees and North East Yorkshire NHS Trust provides free training for interpreters on mental health law and the Mental Health Act. Another Trust had developed a ***"robust service but needed more money to train and pay for sessions."*** Some respondents had attempted to overcome this barrier by training their own bilingual mental health staff as interpreters. Hounslow & Spelthorne NHS Trust include a code of practice for interpreters in their Language Interpreting Policy. This gives guidance to bilingual staff that includes advising them of their right to a basic training course for interpreters; to withdraw if they do not feel confident about speaking the required language; and, to decline if they are being called away from their work too frequently. The Trust's code of practice goes on to list a number of principles that should be adhered to by all interpreters, including issues around confidentiality, impartiality, and respect.

Respondents to this survey also highlighted training for professional staff in the use of interpreters. One respondent reported, ***"There is a reluctance amongst some staff to use interpreters."*** The difficulties already highlighted in accessing interpreters, in paying for them, and in being certain that their understanding of the clinical situation is precise arguably lends some understanding to their reluctance. There are also a number of other issues arising from the use of untrained interpreters that surround confidentiality, and as Robinson notes,

> *"Even with a correct translation, the lack of subtle non-verbal cues makes assessment difficult."*[90]

The Mental Health Act Commission has issued guidelines to its Commissioners on the use of interpreters. These guidelines should be useful to service providers, could be incorporated into policy and form the basis of a training course for service providers on the choice of and use of interpreters:

Choice of interpreter

- An interpreter should be used for people whose language preference is other than English. If there is doubt about language preference an interpreter should be used.
- Consideration may need to be given to the sex, age, and class of the interpreter and to any implications of religious or political differences.
- Friends or family members or ad hoc interpreters should not be used.

Preparation for interview

- Ensure the interpreter is able and willing to assist in the interview and understands its purpose.
- Clarify the respective roles and expectation and the necessity of not only a word for word translation of replies, but also how it is said (such comments may need to be shared by the interpreter once the interview is ended).
- Discuss any special concepts or terminology to be used in the interview.
- Ask the interpreter if they have any suggestions to make on protocol or social observance that may assist in the course of the interview.

During the interview

- Allow time to organise the seating and make introductions. The interpreter will also need some time to introduce him/herself to the client.
- Use straightforward language as far as possible, speaking directly to the patient.
- Check that the interpreter understands the meaning of what you are saying and that the patient has understood correctly. Allow the interpreter the opportunity to interrupt if necessary for clarification.
- Be alert to non-verbal communication.
- Remember
  - the responsibility for the interview is yours;
  - the pressures on the interpreter, allow him/her enough time;
  - the pressures on the patient, allow him/her to express him/herself;
  - the interview will feel more laborious because of the extra communication.

After the interview

- You may need to discuss the interview with the interpreter, as he or she may wish to say things that could not be said during the interview and you may need to check that your understanding of the non-verbal communication is correct.

Essential policy element

- Policies should include guidelines that advocate the use of interpreters trained in mental health issues or that advocate the use of mental health staff who receive professional interpreting training
- Policies should advocate the introduction of training courses for all staff who are expected to use interpreters
- Policies should include guidelines relating to the choice of and use of interpreters

7.7 Recording, monitoring and evaluating

Procedures for recording the use of interpreters, monitoring that information and evaluating the services used should be built into all policies. Where possible, efforts should be made to ensure some measure of continuity of interpreter for patients. Staff, patients and carers should be able to feed back their views, through an evaluation framework, on the quality of the interpreting service provided.

Essential policy element

- Recording the use of interpreters
- Monitoring that information, including details on length of time taken to provide an interpreter and frequency of use
- Evaluating the interpreting service and the quality of interpreting

7.8 Day-to-day communication

So far, this section has been limited to the use of professional interpreters in order to fulfil legal and clinical need. There are, of course, a number of day-to-day communication needs that are necessary to enhance in-patients quality of life. Many providers report on the use of bilingual staff and the engagement of local Black and minority ethnic community-based organisations to fulfil that need. These initiatives will be discussed in more detail in sections 9 and 10 of this report. It would appear that the value that these links with the ‘outside world’ provide to patients whose linguistic and cultural isolation makes them particularly vulnerable is an essential element to their effective recovery. Whilst some members of Black and minority ethnic community groups may indeed be interpreters themselves, access to befriending and advocacy groups for the day to day needs of Black and minority ethnic detained patients should be an essential element of any interpreting policy.

Essential policy element

- A statement encouraging the engagement of a range of befriending and advocacy community-based organisations to attend to the day to day communication needs of Black and minority ethnic detained patients
- A statement about the use of bilingual staff as interpreters and/or befrienders that takes account of the training needs of these staff and provides guidelines that ensure that their formal employment roles are not compromised

7.9 Conclusion

The range of barriers cited to interpreting service provision evidences the inadequacy of policies that address access-only issues. The key policy elements recommended throughout this section give clear guidance to policy-makers about the use of different types of interpreters and encourage them to formalise within policies the need for interpreting to be extended beyond clinically significant meetings by the inclusion of befriending and advocacy services for patients’ day-to-day needs.

Section 8

Race Equality & Anti-Discriminatory Practice Training and the Delivery of Culturally Sensitive Care

Headline issues from NV2

The Patients' Charter and the Mental Health Act Code of Practice requires health services to respect all individuals' dignity, privacy and cultural and religious beliefs and staff need appropriate training and information to equip them to provide mental health care sensitive to the needs of all patients.

Two thirds of units had no training policy on race-equality and anti-discriminatory practice relating to patients.

Although some examples of good practice training were identified, the majority of these training packs did not directly address issues of race equality; most were aimed at improving staffs' understanding of a range of religious and cultural issues in respect of patient care – though it should be noted that many were well researched and comprehensive in their coverage.

8.1 Introduction

Seventy-one of the 123 providers (58%), in the follow-up exercise stated that they had policies, procedures or guidelines on training in race equality and/or anti-discriminatory practice (ADP) for staff and the provision of care sensitive to the needs of Black and minority ethnic detained patients. Although comparisons between responses to the original exercise and the follow-up are difficult to make in terms of ascertaining any overall improvement, it is notable that where training was provided, there was evidence of a shift in emphasis from what could be loosely termed as training in 'cultural diversity' to an ADP or race equality model. Before considering the issues raised by the respondents to the survey, this section will begin with a short discussion from the literature on the provision of cultural diversity, anti discriminatory practice and race equality training.

8.2 Cultural diversity, race equality or anti-discriminatory practice?

Providing training and information packs for staff aimed at delivering care and treatment, that is culturally sensitive, to patients from Black and minority ethnic communities is seen as essential in order to raise awareness. However, this practice is also widely criticised within the literature. Commentators warn that such information packs and training run the risk of creating stereotyped images[91] and can cause offence to clients who are approached with predetermined assumptions about their cultures.[92] There is also the issue of the limited nature of such training packages, which cannot hope to comprehensively cover many features of the world's ethnically diverse cultures and customs in any meaningful way.[93] [94]

In recent years cultural diversity training has begun to give way to training in race equality and anti-discriminatory practice. Ferns and Madden promote a practice-based approach to training. The main aims of such training should be to identify patterns of institutional racism, remove barriers to race equality and create ***"accessible and appropriate services for Black and minority ethnic users."*** They stress that understanding a given culture is not enough to prompt a non or anti-racist stance; what is actually required is a ***"personal understanding of institutional processes that perpetuate racism."***[95] McKeown and Stowell-Smith, also issue a warning over reliance on training that simply raises awareness. They apply a critique arguing that such training focuses on raising the awareness of individual mindsets, thus ignoring the racism inherent in the institution of forensic psychiatry. They point to the case of a high security hospital, where managers assigned the task of changing the hospital's culture of racism defined the problem at the level of nurses and their attitudes and value systems. McKeown and Stowell-Smith suggest that such an assessment may well fail to address problems because the structure behind the staff remains intact and that such an approach is a ***"mere palliative to the effects of institutionalisation and medicalisation."***[96]

The above discussion highlights the complexities inherent in attempting to train staff or provide them with appropriate guidance and materials that will overcome the inequities that have already been well documented within this report. Two studies have been selected to illustrate the significance of these inequalities; the first addresses the over-representation of Black and minority ethnic detained patients and the perceived inequities in care and treatment within mental health settings; the second addresses the attitudes of those involved with patients on their pathway to care.

The first study by Koffman *et al* builds on the already much evidenced higher rates of psychiatric admissions, compulsory admission and diagnosed schizophrenia in Black and minority ethnic groups. In order to test this evidence in the North and South Thames regions, researchers carried out a point-prevalence survey of all adult acute and low-level secure psychiatric in-patients in all NHS and 7 private psychiatric units in the area. 3710 adult acute and 268 low-level secure psychiatric patients were surveyed, 75% of whom were defined as white, 16% Black and 4% Asian. The research found that:

- A high proportion of the Black population were admitted to psychiatric units;
- Black patients were more likely to be admitted under section;
- They were more likely to be located in locked wards;
- They were more likely to have an in-patient diagnosis of schizophrenia;
- They were more likely not to be registered with a GP.

The researchers concluded by reporting that access to, and appropriateness and quality of care needed examining from a minority ethnic point of view, and that racism awareness and staff training needed ***"to be incorporated into mental health service provision as a matter of priority."***[97]

The second study, by Browne, employed semi-structured interviews, case notes and statistics, to uncover deviations from laid out procedures within mental health services. The researcher points out a perceived need for latitude in the way psychiatrists deal with patients, which in turn leads to differential procedures.

The interviews revealed a strong association between race and dangerousness in the minds of many involved personnel, and numerous quotes are provided from police representatives, GPs and case notes to illustrate it. One police viewpoint is that physical restraint is justifiably used more in cases where verbal communication is difficult, and one of only six GPs who were willing to co-operate with the research stated that it is the ***"physical make-up of Black people which predetermines the presence of schizophrenia."*** The researcher then highlights similar levels of 'flexibility' in the way forensic sections are administered, again providing some startling statistical evidence to back up his hypothesis.[98]

The short review of the literature above suggests significant barriers to overcoming existing inequalities in mental health services by staff training alone. Staff training in the provision of care that is culturally sensitive is viewed as essential – but limited in its nature. ADP training is seen as valuable in addressing attitudinal issues around discrimination and prejudice in general, whilst race equality training focuses on the Black and minority ethnic experience. Neither race equality training nor ADP training alone equips staff with information on fundamental issues concerning the religious and cultural issues of diverse communities. A combination of approaches is advocated and these will be considered again at the end of this section when staff training issues will be examined in more detail. Before that, however, this section will look at some of the issues, other than staff training, that impact on the provision of care and treatment to Black and minority ethnic patients.

8.3 A repertoire of responses

Throughout this report reference has been made to cultural appropriateness and cultural sensitivity. These terms, although in common usage, are often poorly understood by those who are responsible for delivering services. Sangster *et al* argue for a need for greater clarity and propose that cultural sensitivity forms the building blocks for culturally appropriate ways of working, and that cultural appropriateness provides the mechanism through which cultural competence is achieved. They go on to call for a repertoire of responses to achieve a culturally competent service, which is defined as a service that is:

> *"perceived by Black and minority ethnic users as being in harmony with their cultural and religious beliefs and not just provided by people who are, or assumed to be, culturally sensitive."*[99] [100]

Development of policy within the area that is the subject of this section would, therefore, appear to be reliant on the production of a ***"repertoire of responses"***,[101] including staff training, to raise awareness, assess need and deliver culturally appropriate care. The following initiatives, which could be viewed as building blocks toward culturally appropriate care and treatment, are offered for consideration for the formulation of effective policy.

8.3.1 Baseline data

We have already reported, in section 5, of the need for collecting useful, accurate and meaningful baseline data relating to ethnicity, culture, diet, religion, language and dialect. This should be considered the first building block, fundamental to the provision of culturally appropriate care and the initial stage in assessing need.

Essential policy element

- Policies should include a clear statement about the organisation's intention to deliver care that is culturally and religiously sensitive to the needs of all patients
- Policies should aim to include a repertoire of responses to the provision of culturally appropriate care and treatment
- Policies should link into existing ethnic monitoring policies in order to collect accurate and meaningful baseline data

8.3.2 Information packs

The development of policy within this area would appear to be effective if it incorporates the provision of materials designed to guide staff on some key elements relating to culture, faith and ethnicity. As with the original NV2 exercise, respondents to the follow-up survey forwarded many good examples of information packs. South Warwickshire Combined Care NHS Trust, for example, has produced a guide *'Respecting religious and cultural beliefs'*, which is worthy of note. The guide is well-researched, covers an A-Z of beliefs from Atheism to Zoroastrianism, outlining key points about religion, culture, hospital procedures, dietary needs, care of the dying and death rituals. Crucially the guidance is prefaced with sound advice to staff that warns them of the importance of seeking advice from the patient and carers about the patient's preferences. ***"If in doubt ask. Better that than risk offence."***

A small number of other packages were received that reflected the culture, beliefs and customs of local Black and minority ethnic communities. Two of these packages had been devised with the co-operation local Black and minority ethnic community groups. Whilst less comprehensive than others in the scope of their coverage these packs were considered by the research team to have an intrinsic value in the depth of their local-based knowledge.

None of the respondents advised on how they distributed the packs, although a small number of them did report that the packs had been used as the basis of training sessions.

Essential policy element

- Polices should include the establishment of information packs – the packs should be prefaced with a warning about the limitations of use
- Information packs should be drawn up in conjunction with the local community, taking into account any key issues relating to patient catchment areas, and updated periodically to reflect the changing population
- Information packs should be widely distributed and easily accessible to those providing care and treatment to Black and minority ethnic patients
- Mandatory training should be provided around the use of the packs. This should include discussion of the notion of stereotyping and the limitations of amassing knowledge on cultural diversity through this medium

8.3.3 Transcultural committees, consultation fora and communication

Along with the information packs discussed above, a further building block that was used to provide culturally sensitive care and treatment was highlighted by respondents as the development of transcultural committees or consultation fora. These committees/fora took varying shapes and formats, according to the size and the demographic profile of the catchment area of the units in question. Essentially, their remit appeared to be sharing information; offering support to staff, carers and patients; raising awareness amongst staff about cultural and religious issues; and progressing Black and minority ethnic issues. Often, these initiatives were 'championed' by a specific Black and minority ethnic lead and were well supported at Board level. Interestingly, many of the initiatives had developed as a result of generic consultation with staff and patients.

For instance,

- Ashworth Hospital established a cultural forum after conducting a service-wide consultation with patients and staff concerning patient involvement and engagement.[102] Ashworth's consultation found that the needs of its women and Black and minority ethnic patients, as expressed in the consultation, were different from those expressed by the remaining patients. The consultation elicited a number of views and suggestions for service improvement. These will be addressed through the cultural forum, which will also provide an opportunity for Black and minority ethnic patients to meet with each other, access newspapers, magazines, films, food, and music. The forum will also provide opportunities for patients to discuss and address issues relating to cultural needs. Additionally, Ashworth has a transcultural committee, chaired by a Non-Executive Director that includes representation from many service areas within the hospital, including the patient involvement cultural co-ordinator.
- Partnership NHS Trust have organised meetings for groups of Black and minority ethnic patients and have recognised the need to support patients who wish to attend such meetings.

The essential nature of this support is highlighted within Ashworth's *Listening to Patients* consultation document, where they noted that at the first meeting arranged for Black African and Black Caribbean men, only 3 out of a possible 61 patients attended. Taking advice from the patients that did attend, to support and encourage attendance from the rest, the organisers reconvened the event and noted that

> *"Though this event attracted considerably more patients than the first, there were less than a quarter of Ashworth's black African and Caribbean patients present."*[103]

Support for staff is also essential. One provider reported that:

> *"We had a cultural forum for five years, but it ended because of staff disinterest – the patients have missed it."*

Clearly, if staff were disinterested in administering medication, it would not be accepted that they should not do so. If such fora are to be established then there is a need to ensure staff commitment. Their existence should not be reliant on any one interested person; rather, they should be considered an integral part of service delivery and adequately staffed, funded and supported.

Transcultural committees should work to clear terms of reference that include the membership of senior management and mechanisms for reporting to the Board.

In addition to the communication channels outlined above, the provision of interpreting services, as identified in section 7 of this report, is crucial to addressing the communication needs of detained patients whose first language is not English. Befrienders and advocates were also highlighted in section 7 as being particularly necessary for those patients who find themselves lonely and culturally isolated in a detained setting. Access to culturally specific magazines, newspapers, videos, radio etc and translated materials that explain, for instance, patient rights, treatment regimes, ward routines etc were all highlighted as necessary components of delivering culturally appropriate care and treatment by respondents.

A number of respondents mentioned that the Mental Health Act Commission's translated leaflets that explain patients' rights should now be provided in more languages to address the needs of refugee and asylum seeking populations.

Essential policy element

- Consultation fora and transcultural committees should be established as part of the repertoire of responses
- Fora and committees should be adequately staffed, funded and supported with clear terms of reference and a mechanism for reporting to the Board
- A commitment should be made at Board level to address as fully as possible any issues raised within these fora/committees.
- Policies should harmonise with policies on the provision of interpreting services to address clinically necessary and social communication needs
- Policies should address matters of cultural isolation by advocating access to and the provision of culturally specific newspapers, magazines, videos etc.

8.3.4 Religious and Spiritual need

A number of respondents reported on their activity around meeting patients' spiritual and religious needs. Many noted that they provide contact lists of local faith groups and leaders. Some issue a calendar of religious festivals to wards. This raises awareness within staff that, for some of their patients, a given date has a special religious significance for patients and signifies to those patients that their special day is observed. Many spoke of providing space for worship and of having regular visits from leaders of many faiths.

Tees and North East Yorkshire NHS Trust is one of many of the respondents that reported supplying contact details of faith groups and faith leaders to wards. The Trust also reports making alterations to its existing chapel so that it will be suitable for worship, meditation and prayer by people of all faiths. Additionally, the Chaplain of this Trust arranges seminars twice a year with faith leaders. These seminars are aimed at raising awareness of mental health issues within faith groups and sharing information on the specific needs of the patients that follow those faiths.

East London and the City Mental Health Trust has a department of Spiritual, Religious and Cultural Care that provides a service to patients based on an internationally recognised model of provision. The model reportedly uses co-ordinators who establish strong links with diverse faith communities, support people to maintain their own links whilst they are using mental health services and aids them to form supportive relationships with staff.[104]

Essential policy element

- Religious and spiritual needs should be respected. Policies should include provision of worship space, access to faith leaders and raising awareness amongst staff about religiously significant dates
- Policies should aim to create strong links with local religious/faith groups

8.3.5 Dietary requirements

Many respondents spoke in terms of providing culturally appropriate food to patients. For example, halal meals and specific menus to cater for Black African and Black Caribbean tastes were most often cited and no barriers were noted to provision in this area. An interesting initiative was reported by South London and Maudsley Trust, which could be useful in identifying dietary preferences for less well established Black and minority ethnic communities, as well as providing a template for patient consultation in this area. The Trust set up a 'food group' undertaking a number of pieces of work using a range of methodologies. Central to the initiative was the use of a 'food workbook'. Patients were invited to work through the book, expressing concerns, ideas and solutions about the provision of food. A number of issues were raised about choice, specific dietary needs, quantity and quality of food. An action plan has been produced to

> *"make improvements to the quality of the food experience on wards and within in-patient units."*

8.3.6 Personal care

A number of respondents spoke of recognising the need for Black African and Black Caribbean patients to be able to access specific products for skin and hair care. West London Mental Health Trust, after much debate, has set up a specialist hairdressing service for its Black patients. Units with smaller numbers of Black African and Black Caribbean patients could emulate this practice by inviting in specialist mobile hairdressers.

8.4 Race equality and anti discriminatory practice training

The issues that have already been discussed in this section have been described as building blocks for delivering care and treatment that is culturally sensitive. In this context, staff training could be described as the cement that binds those blocks together. We have already raised a number of staff training issues within earlier sections of this report and indeed within this section itself. The opening debate from the literature in this section would suggest that there is a tension between those advocating cultural diversity training and those who favour race equality and/or anti-discriminatory practice training. The issues raised, however, might lead us to take this analogy further and conclude that if staff training in cultural diversity is the cement that binds the blocks together, then race equality and anti discriminatory practice training is the water, the essential ingredient, without which the cement will not set.

Issues raised by our respondents around training included who should be trained, when should they be trained and how can mandatory training be effectively delivered? Additionally, a significant number of requests were made for examples of the core components of training packages and requests were made for ready-made packages. These issues will be discussed next.

8.4.1 Training packages

A number of respondents forwarded leaflets, flyers and handouts from training days and seminars relating to cultural awareness, race equality and anti-discriminatory practice training. Perusal of these leaflets alone is not enough to be able to advocate them as effective practice. Effective practice in this area would be as dependent on delivery and follow-up action, as on content. This is particularly the case in race equality and ADP training which, by challenging people's values and assumptions, can prove to be very threatening and destabilising if not handled sensitively.[105]

The value of providing discrete ADP training packages was queried by one Trust who noted that:

> *"The consensus is that it had little impact. We need to develop a training plan which influences all other training packages."*

This observation is backed up by the literature, where it is noted that treating race equality and ADP as discrete areas runs the risk of marginalisation – a specialist subject for those who are interested, but not a mainstream issue.[106] An essential element of effective policy, therefore, is advocated as race equality and ADP training becoming a core component of all other training packages.

Essential policy element

- Anti discriminatory practice training and race equality training should be a core component of all other staff training packages

8.4.2 Who should receive training?

We have already identified a need, in earlier sections of this report, for certain staff to receive training in order to undertake specific functions, for example, ethnic monitoring. There is, however, a need for all staff, regardless of their contact with patients, to receive some training around equality and diversity issues. Mindful of McKeown and Stowell-Smith's[107] remarks at the beginning of this section, that awareness raising training can only change individual mindsets and not institutions, it must be recognised that people can change institutions and that all staff have an ability to impact on the institution, either negatively or positively. ADP and race equality training equips staff with the knowledge and confidence to begin to address institutional racism. In addition, staff employed by services provided within a unit (for instance social services) also impact on the institution and should be in receipt of this training. Mandatory training, across all service areas, introducing the concepts of race equality and ADP, raises awareness of the issues of all forms of discrimination and prejudice within the individual and also has the added advantage of producing a collective of individuals from which action to address discrimination is more confidently taken.[108] Furthermore, such training that includes, as core components, issues such as an organisation's policies and functions along with looking at individual attitudes can go someway to challenging the racism contended by McKeown & Stowell Smith's earlier argument.

The Guild Community Healthcare Trust, for instance, has recently completed a Trust wide staff training programme in Equality & Diversity in the Workplace. The programme was delivered through a series of one-day workshops that were attended by the entire workforce. The workshops aimed to increase awareness of issues such as individual prejudice and discrimination and also looked at current legislation and workplace policies relating to equality and diversity. A self-assessment exercise to allow staff to recognise attitudinal change was incorporated as part of the evaluation process.

As with the Guild Community Healthcare Trust a number of respondents had reported that ADP training within their service was mandatory. There was some concern expressed by other respondents that even where training was mandatory, lack of interest from staff and lack of commitment from middle level management, made effective delivery of this training difficult. One respondent noted that because of the small numbers of Black and minority ethnic patients within that service, management sometimes felt justified in refusing to release staff from normal duties to attend training sessions. ADP training is not solely about addressing racial prejudice and discrimination; it encompasses all forms of discrimination and prejudice. Effective policy should seek to mainstream ADP training, embedding it into **all** staff training programmes, as mentioned earlier and also into staff recruitment, induction and appraisal systems.

Lack of interest from staff has arguably been effectively combated by the North East London Mental Health Trust, which has innovatively commissioned a play *'In the Dark'*. The play is performed by the local community arts group and highlights and illustrates the difficulties experienced by Black and minority ethnic patients, especially women, in hospital wards. The play is used as a training exercise with staff and is designed to provoke discussion.

Essential policy element

- All staff, regardless of their patient contact remit, should receive training in equality and diversity issues
- Training should include components that consider an organisation's policies and functions along with challenging discrimination and prejudice
- Training should be practice-based
- Training should be mandatory and mainstream
- Training should be undertaken jointly with other services within the establishment

8.4.3 When should training be delivered?

Along with the Guild Community Healthcare Trust, a small number of other respondents reported instigating service wide training programmes as part of their public duty under the Race Relations (Amendment) Act 2000. Key to the success of these programmes is locking training into policy so that new staff have the benefit of training at induction and that adequate refresher courses for existing staff are delivered periodically.

Essential policy element

- Policies should ensure that training is provided at induction for new staff
- Policies should make provision for an on-going programme of refresher courses
- Training should be embedded in the staff appraisal system

8.5 Conclusion

This section has outlined a repertoire of responses, including staff training, as essential elements for inclusion in policies on the delivery of culturally appropriate care for Black and minority ethnic detained patients. A recurring issue raised by respondents to the follow-up survey, within the focus groups and by wider consultation is that very often there is a perception that staff training in this policy area, and indeed the undertaking of culturally specific initiatives, is seen as an 'extra', rather than part of mainstream service delivery. Where the Black and minority ethnic patient population is small, or where funding is tight, the necessity of this 'extra' is sometimes questioned.

However, many of the initiatives highlighted in this section, for instance, Ashworth's 'Listening to Patients', South London & The Maudsley Trust's 'Food Workbook', the Guild Community Health Care Trust's ADP training, are mainstream initiatives – designed to improve the care of **all** patients. The impact of these initiatives on the care and treatment of Black and minority ethnic patients is, however, arguably more significant, simply because Black and minority ethnic patients begin their patient experience at a greater cultural disadvantage. Furthermore, that disadvantage is perpetuated by the dearth of staff, at all levels, whose ethnicity reflects that of the patient population. Without a culturally diverse workforce, culturally appropriate service development can only be achieved by positive action.

We strongly advocate that the responses outlined in this policy area are mainstreamed and that training around them is mandatory. This training should include as a core component race equality and ADP and ensure that ADP and race equality is included as a core component of all other staff training initiatives, service-wide. However, as will be discussed in the final section of this report, initiatives outside the detained setting can also have a significant impact on the care and treatment of Black and minority ethnic detained patients and in that section the role of Higher Education and Further Education establishments and their inclusion of ADP and race equality in professional training will be considered.

Section 9

Designing, developing, implementing and maintaining effective policies: cross-cutting issues and cross- cutting solutions

9.1 Introduction

In this report identifying effective practice has been limited so far to highlighting key elements of policies that, through evidence-based research and consultation, have been evaluated as effective. This section explores further the composition of effective policy, firstly, by examining the cross-cutting issues identified in the four areas so far discussed:

- Recording and monitoring the ethnicity of detained patients
- Dealing with racial harassment
- Interpreting services
- Race equality and anti-discriminatory practice training and the provision of culturally sensitive care

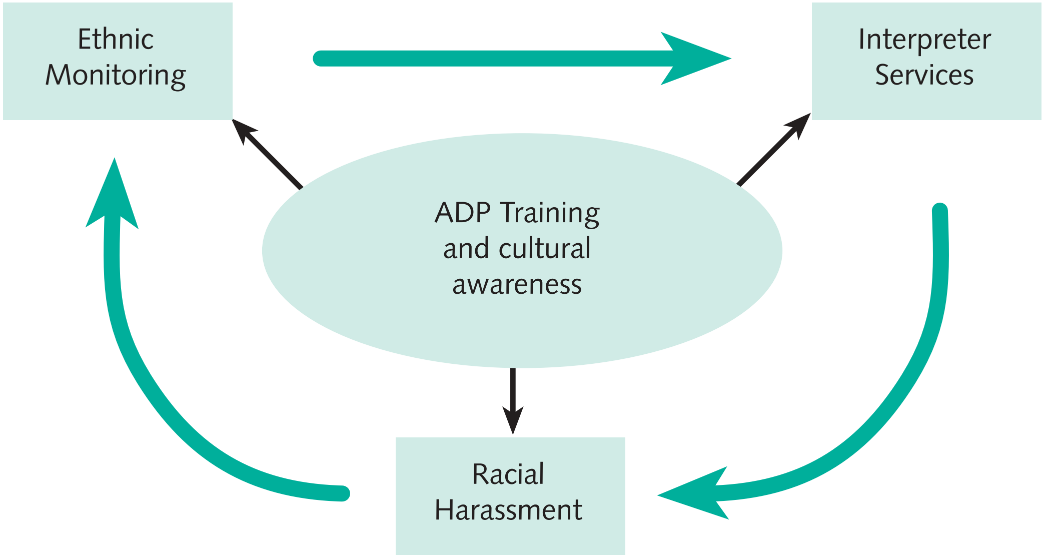
The section will then go on to discuss issues common to each of the areas of policy development. The section will then turn to the multi dimensional, holistic, strategic approach advocated by the Mental Health Act Commission as the way forward in policy development, with a discussion of leadership on Black and minority ethnic issues within a service, partnership working and community engagement.

9.2 Cross-cutting issues

None of the four policy areas outlined in sections 5 – 8 and identified in section 3 as being essential to the care and treatment of Black and minority ethnic detained patient stands alone. Figure 3 depicts the interactive relationship between the four areas, highlighting the necessity of effective policies in all four areas for any one area to be successful.

Figure 3 illustrates how effective ethnic monitoring systems inform interpreting services, monitor incidences of racial harassment, and highlight areas for training in culturally competent care and anti discriminatory practice. Interpreting services in turn inform ethnic monitoring services, aid in the detection of racial harassment and highlight areas for training. Effective racial harassment policies are reliant on ethnic monitoring data, sound interpreting policies and the cultural shift envisaged by ADP training. An essential element for policy development in any of one of these areas, therefore, is advocated as being the introduction of effective policies in all four areas.

Figure 3: Policy interaction



Essential policy element

- Policies should not be produced in isolation. The interactive nature and potential for impact of one policy on others should be explored during policy development.

9.3 Common elements for policy development

We have already highlighted what we consider, after evaluating the evidence, to be essential key elements for policies covering the areas outlined in sections four to eight of this report. There are, of course, a number of essential elements that are common to each policy area. These were discussed by the focus groups that took part in the survey and their findings are outlined below.

9.3.1 Demographic information

Across all policy areas the focus groups noted that, before beginning to construct polices, those responsible would need to have accurate and up-to- date demographic information. A mapping exercise of the area from which patients are drawn should be undertaken and include, not just the ethnic profile of the population, but also details of services on offer. This information should include mainstream services (mental health, social care, housing, etc;) local Black and minority ethnic voluntary groups that could provide support, advocacy and befriending services, mental health support groups, and faith groups.

9.3.2 Patient information

Policies across all areas should incorporate clear mechanisms for collecting information from patients and also informing patients clearly, concisely and in a suitable format about how that information will be used. Policies should make provision for patients to be able to double check information held about them.

9.3.3 Staff and Workforce Issues

Policies should aim to recruit a workforce whose ethnic composition reflects the community it serves. Clear implementation guidelines should be incorporated, which should be readily accessible and user friendly. Systems established around recording and monitoring policy implementation should not be so complicated that staff fail to adhere to them. Policies should encompass provision for adequate staff training around the policy area. Policies should be embedded in recruitment, selection, induction and appraisal systems.

9.3.4 Responsibility, dissemination and accountability

Policies should include mechanisms for monitoring, auditing, reporting and disseminating information on action taken. Policies should be considered ‘live’ – that is, open to development and change as the context within which they were created changes. Accountability should be addressed with a strategic lead named. An individual or groups of individuals should be named within the policy as taking lead operational responsibility.

9.3.5 Service performance

Policies should be realistic, monitored against achievement at regular policy reviews and subject to audit. The Priorities and Planning Framework for the NHS includes in its inequalities objectives ‘ensuring that service planning is informed by an equity audit and supported by an annual public health report by the Director of Public Health’.

Essential elements for policy development

Policy development should take into account:

- Demographic information
- Patient information
- Staff/workforce issues
- Responsibility, dissemination and accountability
- Service performance

9.4 Black and minority ethnic lead

Forty-eight of the 123 providers that took part in the follow-up survey reported that they had appointed a key individual to oversee Black and minority ethnic issues. Opinion on the desirability of such an appointment was divided. Consultation revealed that some saw such an appointment as risking the further marginalisation of Black and minority ethnic issues by abdicating collective responsibility for action. There was a risk that the appointment would, therefore, jeopardise mainstreaming Black and minority ethnic issues in favour of separate, possibly specialist, but fundamentally marginalized services.

However, what became clear during the analysis of the data from the follow-up survey was that where such a lead was present, the responses to the survey were most knowledgeable, insightful and practical. Rather than marginalizing services, many of those units that had appointed a lead person appeared to be undertaking a wide range of innovative work. In many instances the lead had been able to generate enthusiasm for the work at all levels of the service and importantly had been able to foster partnerships outside the service with other statutory and voluntary agencies and within the local community.

In the area of policy formulation, it was noted that an appointment of a key individual could be beneficial in driving forward policy development; harmonising new policy with existing policies; generating commitment from management, staff, patients, carers, outside agencies and the community in general; engendering ownership amongst those groups and thereby endorsement of policy; and keeping the policy 'live' by taking an active role in evaluation and audit.

It is possible that many of the appointments had been made in the light of units preparing Race Equality Schemes in order to comply with their public duty under the Race Relations (Amendment) Act 2000. There is a risk that the commitment from Board level for their appointments may dwindle once that duty has been fulfilled. What is clear, though, is that the division in opinion about the desirability of these appointments should be recognised insofar as they can only be successful with full backing from senior management and at Board level. The appointments need to be part of a designated equalities team, and to be adequately resourced, and their main objective should be to mainstream Black and minority ethnic issues into policies and practice.

Essential elements for policy development

- Where a Black and minority ethnic lead exists, that person must be adequately supported and resourced and should work toward mainstreaming Black and minority ethnic issues

9.5 Partnership working

This report has already highlighted the advantages for units to work in partnership with other related services in the design, development and delivery of policies.

Many units forwarded examples of initiatives that have been successful within the policy areas already described and have also had a wider impact on tackling inequalities within mental health services. For example:

- Birmingham Specialist Community Mental Health Trust, along with the Birmingham Integrated Language and Communication Strategy reported in section 7, advised of the establishment of the Birmingham Minority Ethnic Group Council – a strategic, multi-agency group led by the Trust, that incorporates (amongst other things) a Learning Disability Groups Action Plan group that focuses on culturally appropriate service development and delivery with the emphasis on Black and minority ethnic clients. The Trust also has a partnership with the Future Housing Association, set up to encourage and facilitate the entry into career pathways of people from a wide variety of cultural and ethnic backgrounds.

- Clatterbridge Hospital advised of the establishment of the Wirral Ethnic Health Advisory Group which has recently launched an ethnic strategy and a website.[109] The Group aims to improve the health of Black and minority ethnic communities in the North West of England by improving communication between providers and service users and increasing the understanding of the specific needs of diverse ethnic groups.
- North East London Mental Health Trust advised of the joint production of an ethnic minority resource pack by BHB Community Healthcare Trust and a voluntary advocacy group HUBB.[110]
- Norfolk Mental Heath Care is working with local agencies and the local race relations agency to form a project group, *'Eradicating Racism in Norwich and Norfolk'*.
- West Hampshire NHS Trust works with the Local Authority Social Cohesion group to address mental health and learning disability needs of people from Black and minority ethnic communities.
- Avon and Wiltshire NHS Partnership have established a Bristol Inner City Project, which works to unite carers of the Black and minority ethnic population.

Essential element for policy development

- Establish and nurture partnerships with external agencies

9.6 Engaging the community

Along with the many examples of partnership working with statutory services outlined above, units report having established firm partnerships with community based voluntary organisations, for example:

- Calderdale & Huddersfield NHS Trust has formed a transcultural committee to look at cultural, religious, dietary, advocacy needs and therapeutic assessments of Black and minority ethnic patients. This committee includes representation from local Black and minority ethnic community organisations.
- East London and the City Mental Health Trust has projects specifically aimed at young Black men delivered through its MELLOW Campaign (Men Emotionally Low Looking for Other Ways). Although not directly aimed at detained patients, the project is reported as working across East London communities and reaching people in non-traditional ways. The project aims to increase awareness of mental health issues, reduce stigma and enable people, to gain support through a variety of media. The MELLOW campaign is reported as a powerful mental health network that aims to stimulate and develop creative and sustainable solutions to reduce the over representation of young men of African origin in mental health care. The project has been developed in partnership with an independent steering group made up of local Black African and Black Caribbean citizens.
- The same Trust also supports the Zindaagi ("Life") project that is aimed at increasing awareness of issues specially affecting young South Asian women. The project is managed in partnership with Newham Asian Women's Project

and aims to co-ordinate and develop specialist services for young Asian women vulnerable to suicide and self-harm in the London boroughs of Tower Hamlets, Hackney and Newham.

- Warrington Community Health Trust reported that because of the small Black and minority ethnic population in their catchment area the Trust has made concrete efforts to

> *"go out to the voluntary groups and forums in order to create links with the Black and minority ethnic community."*

- Rotherham Priority Health Trust have invested in a local Asian women's support group with the dual purpose of increasing access to services amongst that community and building the capacity of the group around mental health issues enabling them to be involved in the monitoring and evaluation of mental health services.

Essential element in policy development

- Establish and nurture partnerships with local community based organisations

9.7 Conclusion

Many of the respondents that took part in this follow-up exercise requested examples of good practice that they could use within their unit. One provider noted that

> *"We sent for all of the good practice examples quoted in the NV2 report – none of them were of use to us."*

What has become increasingly clear throughout this exercise is that effective policy in one unit does not necessarily translate well into another. Moreover, in the authors' experience the learning that takes place in the development of the policy is key. Whilst we have viewed many excellent policy documents, it would be difficult to advocate their use in any other setting other than the one in which they were developed. Key elements were highlighted in sections 5– 8 for inclusion in policies and in this section essential elements for use in policy development have been discussed. Within this section there has been mention of cross- cutting issues; an acknowledgement that none of the policies under discussion exists in isolation, that each impacts on the other and also a realisation that many issues will be common to each policy area and that these issues will largely be localised. A number of cross cutting initiatives have been highlighted that largely come under the headings of partnership working and community engagement; essentially these issues highlight the necessity for external links to be forged ***outside*** a unit for effective change to be made ***inside***. The final section of this report will discuss this further.

Section 10

Organisational change and community engagement: developing effective practice inside by working effectively outside

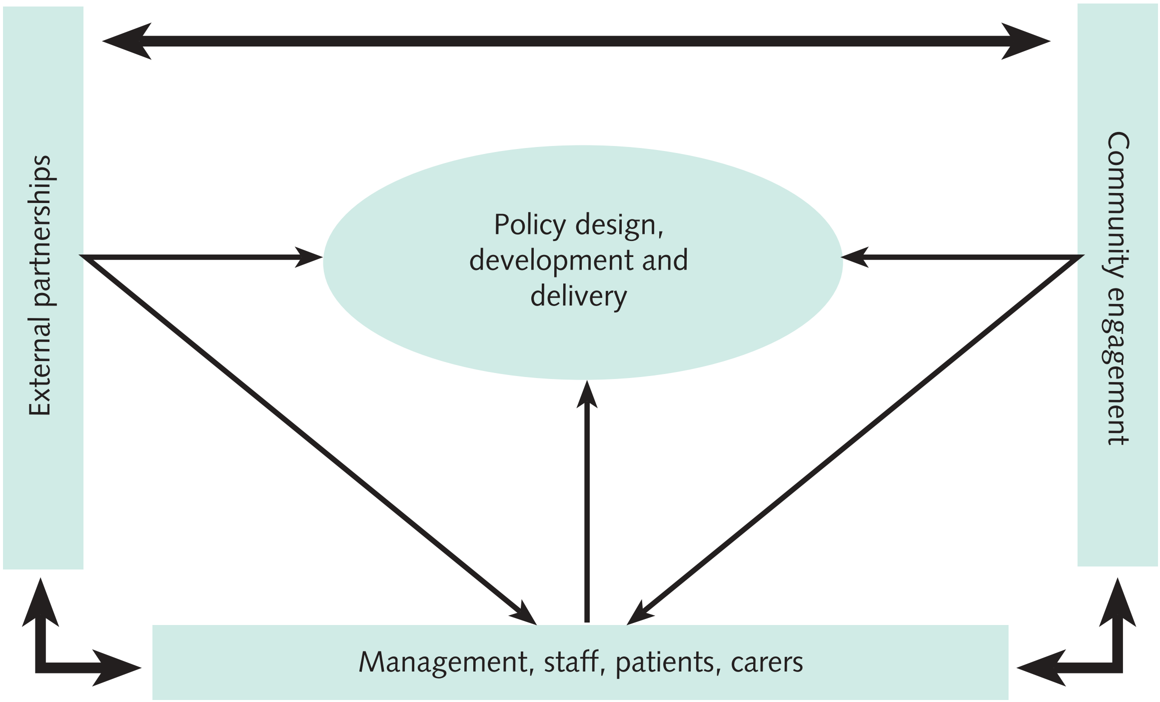
10.1 Introduction

Many of the issues and recommendations for policy and practice highlighted in this report, suggest the need for wider systemic change within mental health service provision if equality, and race equality in particular, is to become a reality. It is important to recognise, as has been emphasised throughout this report, that, the underlying problem relates to institutional processes. Implementing effective practice in one policy area is unlikely to be successful or sustainable without the necessary organisational changes to support race equality in practice. These changes are necessary both internally within the organisation and through more effective engagement externally with communities and other stakeholders. The recent consultation document for improving mental health services for Black and minority ethnic people recognises this need to look beyond the barriers of an individual organisation in order to address the institutional racism that has produced the well evidenced inequities in mental health service provision, adopting the stance that effective practice ***inside*** mental health settings cannot be achieved without effective practice ***outside***. This will be explored further within this section.

Figure 4 illustrates how this stance can enhance policy development, design and delivery within all of the four areas documented within this report by opening communication channels internally with management, staff, patients and carers; and externally with partnerships from mainstream statutory organisations, voluntary organisations and engagement with the wider community; developing wider ownership and thereby wider endorsement of policy.

A number of respondents to this follow-up survey had indicated that they were undertaking what could be termed a more holistic approach to addressing inequality. Some of their initiatives have been reported in section nine of this report under the headings of partnership working and community engagement. Eight others reported that they were currently undertaking an internal audit of their policies around the care and treatment of Black and minority ethnic patients, seven of these were using the *"Cultural Sensitive Audit Tool for Mental Health Services"* designed by the Sainsbury Centre for Mental Health.[111] It was notable, however, that where policies appeared most active it was where consultation and involvement of all stakeholders, including the wider Black and minority ethnic communities appeared most meaningful. Very often this appeared to be as a result of units taking a proactive approach to preparing Race Equality Schemes in accordance with the Race Relations (Amendment) Act 2000. Bearing this in mind, the remainder of this section will discuss organisational change and community engagement.

Figure 4: Policy design, development and delivery – inside/outside



10.2 Organisational change

A fundamental component behind the Race Relations (Amendment) Act 2000 is that the Act seeks to promote organisational changes that will address the issue of institutional racism. Such changes would require a significant shift in organisational practices and culture, as it is only through a whole organisational approach that the more subtle and hidden aspects of institutional racism will be dealt with effectively.

The approach to race equality is expected to be embedded within the overall modernising government policy arena and as such should be part of a broad organisational culture change. A ‘tick box’ approach will not be acceptable under the monitoring arrangements for the Act. The duty to promote race equality is not the same as the provisions for outlawing discrimination. This is an important distinction as the Amendment Act seeks to drive up standards from which individuals will benefit rather than result in particular outcomes for individuals.

A key concept concerned with the provisions of the Amendment Act is ‘mainstreaming’. This is defined as:

> *“…the organisation improvement and evaluation of policy processes, so that … equality perspective is incorporated in all polices at all levels and at all stages, by the actors normally involved in policy making.”*

The administrative guidelines for mainstreaming include:

- ***Consultation*** with Black and minority ethnic representatives;
- ***Assessment*** of likely impact of policies on Black and minority ethnic groups;
- ***Monitoring*** of policy implementation and service delivery; and
- Action to ***remedy*** any unexpected and unjustifiable outcomes for Black and minority ethnic groups and communities.

Within the NHS, responding to the needs of a diverse multicultural society is recognised in the NHS Plan.[112] The Department of Health has published a race equality agenda and launched the *'Equalities Framework for the NHS, the Vital Connection'* that includes clear requirements for the NHS to promote race equality.[113]

It is evident from both legislative and policy drivers that a broad organisational change approach to race equality is necessary. So what does this mean in practice and what do mental health services need to do?

10.2.1 Making a difference inside

Any attempt by an organisation to address race equality, either through policy design and implementation or specific initiatives based on evidence of effective practice, must be supported by an environment where equality, particularly race equality issues, are understood by everyone in the organisation. Without this organisational commitment, staff groups are left feeling alienated and de-motivated resulting in poor service delivery.

Existing staff groups, expected to take on new ideas and responsibilities on top of already heavy workloads, need to understand the reasons behind the developments and have ownership of them in order to avoid a build up of resentment.

Given these issues, it is paramount that equality initiatives are incorporated into a wider strategy, which would include long-term planning around recruitment and retention. Such a strategy is the basis of the Race Equality Schemes called for under the specific duties of the Race Relations (Amendment) Act 2000. The main aim of such a programme is to ensure that all staff (whatever their ethnicity) can deliver a service to all those with mental health problems.

This is exactly the kind of approach that has been adopted by the Mental Health Act Commission and the Royal College of Psychiatrists in their attempts to address race equality and ensure that they meet their duties under the Amendment Act. The following is taken from the Race Equality Scheme of the Mental Health Act Commission:[114]

In 1996 the Commission Board undertook a comprehensive examination and review of equality issues within the organisation. It recognised that it needed a clear vision statement and a long-term realistic implementation programme to have significant impact on the care and treatment of Black and minority ethnic (BME) detained patients. In 1997, two years prior to the publication of Macpherson report, the Commission put in place a programme of activity to address the wide range of inequalities and adopted the following Equal Opportunities Policy Statement:

> *"The Mental Health Act Commission is committed to the eradication of discrimination and the promotion of Equal Opportunities in all its services. The Commission will therefore discharge all its duties recognising that every individual has a legal and moral right to an equal and non-discriminatory high quality service."*

All staff, commission members and representatives therefore will:

- provide an equal service to all regardless of their; age, colour, culture, gender, health, status, mental ability, mental health, offending background, physical ability, political beliefs, race, religion, sexuality or other specific factors which result in discrimination;

- in the exercise of their duties be committed to the promotion of good practice and equal access to all service users by purchasers and providers of mental health services taking into account our diverse society.

The Mental Health Act Commission will take action through the quality assurance and monitoring process to ensure the implementation of its policies which are above.

In turn all staff, Commission members and appointees will expect that all those who receive a service from the Commission will not use offensive language or actions, harass or victimise or act in a manner that is discriminatory and oppressive."

The Equality of Opportunity Statement also identified three key areas for implementation; monitoring and quality assurance; training and development and service provision. This Race Equality Scheme will be incorporated within the Equality Opportunity Policy with specific related work plans.

The MHAC has a long-standing commitment to addressing race equality, highlighting shortfalls and offering ways to tackle the inequality witnessed by Commissioners during their visits to detained patients. The Commission Board took the decision to oversee the implementation of the Equality of Opportunity Programme. It was this commitment at the highest level of the Commission that undoubtedly has contributed to the success of the Equality Strategy to date. The strategy will continue, taking into account the implications of the RRAA particularly through implementation of this Race Equality Scheme. The current phase will build on activities and influence the way the Commission works with other organisations. It will re-affirm the Commission's continuing commitment to addressing racial inequality in the care and treatment of Black and minority ethnic patients detained under the Mental Health Act (1983) and implant sound principles of equality into its own internal policies and practices."

The above demonstrates the comprehensive approach adopted by the Commission to its Race Equality Scheme and how this cannot be envisaged without consideration of the organisation as a whole.

The Royal College of Psychiatrists has set out a three-year programme of institutional review and change within its Race Equality Scheme:[115]

The Royal College has a long-standing commitment to addressing race equality having first established a special committee to review the issues in 1987. The most recent assessment of College functions and policies resulted in Council report CR92 'Report of the Ethnic Issues Project Group' (February 2001) which made the following ten recommendations:

1. The College should undertake a systematic review of its structures to determine whether or not there is evidence of institutional racism[116]
2. The review should specifically include scrutiny of the College's role in the appointment procedures for psychiatrists, including the short-listing procedure
3. The College should not tolerate any racially discriminatory behaviour from its members
4. Dialogue should continue with all relevant user groups, including Black user groups
5. All psychiatrists should be trained to be culturally sensitive in their interactions with people and culturally competent in their therapies
6. Particular effort should be made to meet the training expectations of psychiatrists on the Overseas Doctors' Training Scheme in the UK and Ireland
7. Members of the College should be made aware of the possibility of discrimination or abuse when applying mental health legislation to Black and other ethnic minorities
8. Psychiatrists should work with their employing authorities to ensure equal access and appropriate services for all in the local community
9. Epidemiological studies should include Black and other ethnic minorities in a community study
10. An Ethnic Issues Committee should be established

The College has already enacted the first and last of these i.e. establishment of an Ethnic Issues Committee and commissioning an external audit of College structures. As one of its first activities, the Ethnic Issues Committee has reviewed and updated the recommendations in CR92. The external audit of the College is nearing completion of its first year and findings from this and the review work undertaken by the committee have informed the development of this Race Equality Scheme.

Both these organisations are at the leading edge of implementing thorough race equality change programmes that are in keeping with the legislative duties and are most likely to result in sustained and systemic change within their respective organisations.

It is worth quoting from the interim report on the organisational review for the Royal College of Psychiatrists on the process of undertaking the Race Equality Scheme:

> *"This is not a semantic exercise; it must be part of the process of change and have ownership within the highest levels of the College. 'Equality of opportunity' is dependent upon a 'sound implementation programme' with policy statements conveying an 'image' of what the organisation stands for. The need for a clear policy statement matched by commitment, conviction, monitoring, setting standards, delineating responsibilities and specifying outcomes on equal opportunities for organisations is therefore essential."*[117]

The specific duties of the Race Relations (Amendment) Act 2000 lend themselves well to undertaking a comprehensive organisational review of practice and policy in this area. The template for such a change process would consist of: a clear statement of intent that is endorsed at the highest level of the organisation and strategic aims that result in a defined programme of action with clear objectives. In terms of the specific duties, there would be an assessment of all policies and functions that identifies all areas with adverse impact on different racial groups and the identification of action to address this in respect of access to services. This would take place as part of an ongoing process with monitoring and reporting systems including publication of results and action taken and there would be effective measures to ensure all staff are trained and equipped with the right skills and knowledge to carry out any determined actions. Finally, the whole process would be subject to wide consultation and review.

So, the Race Relations (Amendment) Act 2000 provides a template by which organisations, regardless of whether they have duties under the Act, can address the internal organisational change processes that are required to make race equality a reality. However, as suggested in the introduction to this chapter it is not enough to address organisational change from within, this must be supplemented by addressing change outside the organisation, in particular through community engagement.

10.3 Community engagement

The Race Relations (Amendment) Act 2000, as discussed above, requires public authorities to consult with Black and minority ethnic communities about their service delivery, involving them in assessing the appropriateness of services. Policy makers and planners of services can be in little doubt about their duty to consult and involve Black and minority ethnic communities, however, legislation fails to advise how this should be done.

Indeed, there is currently a strong drive across all government policy areas to consult with and involve the public. In the health and social care field this is translated as user involvement and the public in general defined as the user. The NHS Plan: A Plan for Investment, A Plan for Reform (2000)[118], emphasises the need to encourage the participation of the public in healthcare. This strategy of involvement or participation builds on earlier policy edicts, for example, Our Healthier Nation (1999)[119] and can be seen in, for instance, the National Neighbourhood Renewal strategy where it is recognised that the most effective interventions are the ones where the community is in the driving seat, with a strong emphasis on Local Strategic Partnerships *"not only to welcome involvement but to actively seek it out."* This drive to involve is most obviously evidenced by the inception of the proposed Commission for Patient and Public Involvement who recognise that public and patient involvement should be genuine, not token, and that those who have in the past been ignored or marginalized should be given a voice:

> *"Only by involving local communities can we gain better understanding of how local services need to be changed and developed. By creating local ownership of health services we can improve the quality and responsiveness of those services and reduce health inequalities."*[120]

Consultation, involvement, participation are all embedded in policy and legislation. However, at worst these loosely defined terms can be interpreted as little more than a 'tick box' approach. At one end of the spectrum these terms can be limited to consultation with perceived 'community leaders' and 'professional users' or, at the other end of the spectrum, they can have the scope and breadth of effective community engagement.

10.3.1 What is community engagement?

In section four of this report, a number of pre-and post-detention issues raised by the respondents to this survey were highlighted. These included: stigma, language, unfamiliar systems and diversity in concepts of mental health. The perception was that these issues were rooted within the community. Issues such as referral information and alternatives to hospitalisation were also raised and an acknowledgement that many of these issues could only be tackled in partnership with outside agencies. In section nine some initiatives to address these issues were outlined, many of which go beyond consultation and seek to address some of the fundamental causes of inequality in mental health service provision. This report makes clear that a number of barriers to service provision exist for people from Black and minority ethnic communities. Many of these barriers are constructed from a lack of knowledge or mistrust within communities about mental health services; and a lack of knowledge within services about the needs of the communities. It is the belief of the authors of this report that the only way in which equitable provision of culturally appropriate services can be achieved and sustained is by effectively engaging communities with mental health services.

The remainder of this section will describe the Centre for Ethnicity & Health's model of community engagement, which, has been designed to dismantle the barriers mentioned above.[121]

The Centre for Ethnicity & Health defines community engagement as

> *"The simultaneous and multifaceted engagement of supported and adequately resourced communities and relevant agencies around an issue, or set of issues, in order to raise awareness, assess and articulate need, and achieve sustained and equitable provision of appropriate services."*[122]

Hence, community engagement is about sustained change; in communities and organisations, in policy and practice.

10.3.2 Principles and premise of community engagement

Community engagement is built on the principles of equality and social justice. It acknowledges that barriers to public health and social care services exist for many people and that these barriers are often rooted in the failure of agencies to adequately recognise the complex social, cultural, religious, economic and generational experiences of distinct communities. It further recognises that within communities there is a lack of awareness about a range of health and social care issues and services. Around some of these issues (for instance mental health) and within some communities, stigma and denial exist. Community engagement takes as its starting point the premise that the community itself has the greatest ability to reach its own members in order to raise awareness and assess need and that agencies have the responsibility to develop services to meet that need. The complete body of knowledge needed to develop and deliver services appropriate to the needs of all people, to raise awareness, to educate, and to disseminate information does not lay wholly with the community or with the agencies. Hence, creating an environment where communities and agencies can share that knowledge will fill the gaps. Through the process of community engagement social capital[123] is utilised to effect organisational change and effective services, the product of organisational change, in turn, increases social capital – a virtuous circle is created.

10.3.3 Benefits of community engagement

Community engagement is a means to an end. The end is defined here as the design, development and delivery of policies that are sensitive to the cultural and religious needs of Black and minority ethnic detained patients. However, the process of engagement has a wider range of benefits to all participants and an impact on service design, development and delivery that is not restricted to one narrow policy area.

For instance, public participation in planning health services is increasingly recognised a contributory factor to improved public health. Communities involved in engagement work potentially strengthen their resilience around health issues. In fact, effective community engagement has the potential, not only to raise awareness of mental health issues, identify gaps in services and assess need, but also to improve access to services. Individuals from disadvantaged communities who undertake community engagement exercises will improve their knowledge, skills and confidence. The dearth of staff from Black and minority ethnic communities in all sectors of mental health services, (nursing, ASWs, residential, day, domiciliary and social care support staff, psychology and occupational therapy), has been highlighted as a factor in perpetuating the inequalities that exist for Black and minority ethnic people in the mental health arena. Community engagement raises awareness amongst communities of the potential career opportunities in any given service area and also introduces organisations to a potential pool of new recruits.

The voluntary sector within the community will also be strengthened by community engagement. Community groups will improve their links with the wider community and also with statutory agencies – emerging evidence from the Department of Health's Substance Misuse Needs Assessment project,[124] [125] indicates that of the 47 community organisations that took part in the project a substantial number (in excess of 50%) continued to work in partnership with local health and social care providers, in many instances becoming gateway services to drugs agencies. This benefit is extended to the statutory agencies who through the engagement process will raise the profile of their agency, improving the standing of the agency within the community and also building partnerships with other agencies both in the voluntary and statutory sector.

Community engagement is clearly an effective means of consultation; it enables agencies to not only focus attention on 'community leaders' and 'professional users' and in so doing challenges traditional leadership within the community, enabling the wider community voice to be heard. The engagement process addresses long-term institutional issues that can result in suspicion, lack of trust and lack of confidence. Community engagement results in community ownership of local health strategies and agencies benefit by the community's endorsement of their work.

The model of community engagement, described above, includes a framework of activity that is undertaken jointly by the community and agency in question, facilitated by an external body. The framework could be a consultation exercise, a needs assessment or awareness raising exercise. For instance, in section five of this report it was noted that barriers to recording and monitoring ethnicity are rooted both within the organisation and within the community. The community is perceived as suspicious about questions relating to ethnicity; staff lack confidence to request this information. Undertaking an awareness raising exercise around this issue could, arguably, begin to dismantle this barrier.

The model seeks to adopt a multi-agency approach. The issue of mental health does not exist in a vacuum and by engaging with related agencies, underlying issues can be addressed. We have seen in section eight that there are a number of complex issues that prevent the delivery of culturally appropriate care. A community engagement initiative designed to build the capacity of an organisation around the cultural needs of a community would go someway to addressing this. By adopting a multi-agency approach, including Higher Education and Further Education institutions within the exercise, the need for race equality training and anti-discriminatory practice to be incorporated into mainstream professional educational programmes could begin to be more widely recognised.

10.4 Conclusion

In section three of this report the inequalities experienced by Black and minority ethnic people in mental services were considered and the question asked, ***"what can be done?"*** The position was taken that there was a need for a strategic, holistic, multidimensional approach to service design, development and delivery. This section has proposed that changes are necessary that address issues both internally and externally and a combination of organisational change and community engagement is offered as the holistic, multidimensional approach.

Addressing the four policy areas, central to this report, mark the beginning of the required changes. These changes are essential, but can only impact at a local level. Many examples of effective practice have been shared, but it has been noted that often these examples exist in isolation. In some instances, effective practice within one service area of a Trust is unheard of in another. Regrettably, within one hospital it was reported that services for Black and minority ethnic people varied from ward to ward. Far reaching change needs to be brought about locally, regionally and nationally – effective practice needs to be shared on all levels, as does the level of understanding and awareness of the central issues that have been featured within this report. The National Visit 2 exercise and this follow-up survey have begun to raise awareness. One Trust responding to this follow-up exercise noted:

> *"It has proved painful to see how little we are currently doing to address the needs of people detained from Black and minority ethnic backgrounds. As a Trust we are now debating and planning how we can improve our performance in this crucial area."*

Mental health services are currently undergoing a dynamic transformation. Positive change at national level has been witnessed through the establishment of the National Service Framework for Mental Health, which has a strong emphasis on health promotion and has as a central feature the principle that people with mental health issues should not be marginalized. The NHS Plan's explicit statement that NHS resources will always bear in mind cancer, heart disease and mental health, raises mental health services from the low baseline where it has previously languished to a position of equality with other health services. The establishment of the National Institute for Mental Health in England, connecting research and service development promises to push forward this transformation. These three innovations are amongst others that hold out much hope for the future of mental health services in general. However, just as mental health services, in relation to other health services, are beginning this period of transformation from a very low baseline, so too, as this report has shown, are Black and minority ethnic patients in comparison to white indigenous patients. The national initiatives outlined above, coupled with the Race Relations (Amendment) Act 2000 will hopefully disproportionately benefit Black and minority ethnic patients. Added to this is the forthcoming publication and implementation of the Department of Health's consultation document "Inside/Outside: A Vision for Improving Black and Minority Ethnic Mental Health Services" which is intended to go someway toward addressing many of the long standing areas of concern that have been the subject of this report.

The authors of this report hope that its dissemination will improve practice at a local level. They further hope that this local improvement can be enhanced by the publication and implementation of the long awaited Vision for Improving Black and Minority Ethnic Mental Health Services – in the hope that along with the many major changes currently being applied to mental health services these initiatives will enable policy makers and planners of services to ***engage and change*** in order to develop effective policy for Black and minority ethnic patients.

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Appendix 1

Section 1

Health Authority Area: ....

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Name of Trust/Independent provider: ....

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Address: ....

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Key contact: ....

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Telephone No: ....

Email: ....

1.1 Was your establishment included in National Visit 2?

☐ Yes

☐ No

A synopsis of the Visit is included – please answer your questions to the best of your ability using the synopsis as a guideline.

Section 2

2.1 Do you have any policies, procedures or guidelines on:

Recording and monitoring the ethnicity of detained patients

☐ Yes

☐ No

Dealing with racial harassment of Black and minority ethnic detained patients by other patients, or by staff.

☐ Yes

☐ No

Training in race equality and anti-discriminatory practice for staff, and the provision of culturally-sensitive care to detained patients

☐ Yes

☐ No

The provision of, access to, and the use of interpreters

☐ Yes

☐ No

Please enclose copies of any policies, procedures and guidelines that you have relating to any of the above.

Please indicate below if you were a part of the NV2 and submitted these policies to the Visiting Team and have not changed them since the Visit or as a result of the Race Relations Amendment Act (2000) then it is not necessary to re-submit.

Yes - *previously submitted & unchanged.*

As well collecting data on the four topics outlined above, the NV2 also collected data on a number of other issues that effect the care and treatment of Black and minority ethnic detained patients, e.g. therapeutic activities that reflect the patients cultural and religious needs, dietary requirements, personal care needs and information on and/or access to any Black and minority ethnic organisations.

2.2 Have you any examples of initiatives in these areas or others that could be highlighted as examples of effective practice?

Please use the space provided to tell us more about any initiatives that you have instigated and please feel free to forward us copies of any documents that you may have.

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Section 3

Can you specify any particular issues, concerns, barriers or developments with respect to any of the areas listed below?

Please also detail any support, guidance or future assistance that you feel would be of help to you in developing services in these areas.

Recording and monitoring the ethnicity of detained patients

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Dealing with racial harassment of Black and minority ethnic patients by other patients, or by staff.

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Training in race equality and anti-discriminatory practice for staff, and the provision of culturally sensitive care

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Provision of access to, and use of interpreters

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.... *(please feel free to use additional sheets)*

Section 4

Can you identify any pre admission issues that would affect the care and treatment of Black and minority ethnic patients?

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Can you identify any aftercare issues that would affect the care and treatment of Black and minority ethnic patients?

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.... *(please feel free to use additional sheets)*

Can you provide any literature e.g. local reports, surveys, guidelines or policies relating to mental health issues for Black and minority ethnic patients?

☐ Yes

☐ No

If yes, please enclose or provide details of where the research team can access them.

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Is there an individual in your organisation who takes the lead on Black and minority ethnic issues? If so, could you please provide full name, title, telephone and email address?

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.... *(please feel free to use additional sheets)*

Section 5

Is there anything else you might like to add that would advise our work on the care and treatment of Black and minority ethnic detained patients?

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Section 6

Are there any specific issues, not already addressed, that you would like to raise in respect of the mental health needs of Refugees, Asylum Seekers and Travellers?

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.... *(please feel free to use additional sheets)*

The purpose of this questionnaire is to collect data that will contribute to a report that aims to share effective practice. It is not our intention to publicise bad practice nor is it within our remit to follow this up. Only those establishments providing examples of effective practice will be named in the report.

Please return this form by ***11th February 2002*** along with any enclosures to:

Moira Winters, Centre for Ethnicity & Health, University of Central Lancashire,
Preston PR1 2HE.

If you wish to discuss this form or any aspect of this project please telephone either Moira Winters on 01772 892788 or email mawinters@uclan.ac.uk or Kevin Mantle on 0207 7972 4364 e-mail kevin.mantle@doh.gsi.gov.uk (Department of Health – Mental Health Services Branch)

If you would like an electronic version of this form please contact Moira Winters

Produced by the Department of Health
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For more copies of this document, please contact your local development centre or the central team in Leeds.

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