Real Voices *- Survey findings from a series of community consultation events involving Black and Minority Ethnic groups in England*

"We have been marginalised for too long in the mental health service, and now is the time to work together to make our impact. We must remember that communities have the *real voice*"
Bengali woman, aged 40 – 49 years, at London south Asian event

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Executive Summary

Of those in the four designated ethnic minority groups, 50% of BME respondents were Asian, 23% were Black, 17% Chinese and 10% Irish

41% questionnaires were returned from events in Birmingham and 37% from London

72% respondents were female and 20% male (8% missing data)

60% respondents were aged under 49 years

21% respondents were service users; 18% were carers; 31% worked in mental health

Of those who commented positively or negatively about the quality of mental health care, Black people were most likely (53%) and Chinese people least likely (22%) to comment negatively

Black (61%) and Asian people (52%) were more likely than Irish (42%) or Chinese people (38%) to think that lack of community interest was a problem

Chinese (84%) and Asian people (83%) were more likely than Black (78%) and Irish (75%) to see a lack of BME staff as a problem

Chinese (89%) and Asian people (86%) were more likely than Black people (74%) or the Irish (59%) to rate language issues a problem

Black people (78%) and Asian people (61%) were more likely than Irish (49%) or Chinese people (44%) to see staff racism as a problem

Irish (94%) and Black respondents (88%) were more likely than Asian (86%) or Chinese people to see a lack of staff cultural awareness as a problem

Black people (84%) and Irish people (75%) were more likely than Asian (73%) or Chinese people (70%) to see a lack of government interest as a problem

93% BME respondents felt that service access was problematic

62% BME respondents did not feel that services were sufficiently sensitive to culture

Of those with experience of services, 49% said they had experienced racial discrimination in mental health services: Black people (66%) and Asian people (49%) reported racism more often than Irish (45%) or Chinese people (17%)

94% respondents supported the key aims of Inside Outside of training in cultural competence, reducing mental health inequalities and developing communities

78% BME respondents felt that Inside Outside proposals would improve mental health services for BME individuals

Introduction

There is a fault line around ethnicity within contemporary mental health. Even a cursory survey of British mental health services will reveal that people from black and minority ethnic backgrounds are severely disadvantaged in all aspects of mental health care. In fact, nowhere in mental health care can we see any evidence of people from black and minority ethnic backgrounds faring as well as, or better, than native-born white people. This is, to some extent, a universal finding: people who are marginalised or otherwise disadvantaged in society at large are similarly 'at the bottom of the pile' when it comes to mental health services.

Over the last fifty years, in the UK, there has been a gradual accumulation of evidence, based on research studies, service user testimonies, informal surveys, formal inquiries and narratives of carers and mental health workers that shows unambiguously that people from black and minority ethnic backgrounds have discrepant and largely negative experiences of mental health services when compared to the white majority. What is more alarming than the persistence of such clear and significant ethnic disparities in service experience and outcome in a modern liberal democracy like Britain, is the seeming acceptance or tolerance of this seemingly racially discriminatory pattern of service provision and mental health care within the National Health Service.

For the first time since the inception of the National Health Service, there now appears to be a sense of urgency in acknowledging not only the extent and nature of ethnic inequalities in service provision, but also the recognition that we need to consider corrective action. Within the modernisation programme of the NHS, race equality is beginning to find some prominence. As far as mental health services are concerned, an ambitious programme of reform and service innovation is currently underway. In this context, the government appears to be prepared to listen to what minority ethnic communities in this country have been saying for a long time, that the practices and procedures of mental health services are racially discriminatory and the experiences of services of people from black and minority ethnic communities are unremittingly negative. As part of the reform of mental health services the government has made a commitment to address this problem as something that requires specific corrective action and a national strategy. For the first time we now have the outline of such a strategy in the form of a wide range of proposals and a blueprint for change. The publication of *Inside Outside*, the proposed government strategy to improve mental health services for black and minority ethnic communities in England, marks a turning point in the history of black people's struggle for appropriate and high quality mental health services.

As part of developing a national strategy to improve mental health services for minority ethnic communities it was agreed from the outset that there would be an extensive process of community consultation. This took the form of community events, targeted at specific minority ethnic communities, held at different venues nationally. The meetings were organised through local community resources or groups and were held in Birmingham, Bristol, Bradford, London and Manchester over a 4-month period between December 2002 and March 2003. This document is the report of these events, capturing, we hope, the real voices of our communities.

Community Consultation Events: background and format

There is increasing recognition of the need to involve the general public in developing national and public policies that have a direct impact on their lives. Often, in the past, the formulations of government policies in areas such as health care have not been so inclusive. Public consultation was something which took place after policies were formulated, often involving experts in the field, politicians and civil servants. The history of policy innovations in mental health over the years has followed this pattern, with little involvement of service users, carers and the general public in developing and implementing national policies or plans.

With the current emphasis on inclusive government and the wider acknowledgement of the benefits of social and community participation in shaping the direction, as well as content of government policies, we are now beginning to see the emergence of new and innovative methodologies for community participation and ownership in areas such as health care. In this context we need to recognise the requirement to involve people or population groups who are generally disaffiliated from the normal political processes, and whose needs are less visible compared to others, because of their minority status in society at large. Policy development and service innovation, especially if they are specifically targeted at such marginalised and disadvantaged groups ought to seek and ensure full participation of those communities, and must provide an opportunity for them to express their views and aspirations.

In developing a national strategy aimed at improving mental health services for people from black and minority ethnic communities in England, it was considered imperative that we should seek such community participation from the outset. The External Reference Group which was set up to oversee the development of the national strategy included a number of people from black and minority ethnic communities. Their contribution to the process of debating and agreeing on a set of policies and procedures to tackle the ethnic and race bias in mental health services, proved to be invaluable. In fact, many of the proposals contained in the initial strategy document, *Inside Outside*, are based on the particular community experiences of the people concerned. However, the representation from black and minority ethnic communities at this level was necessarily limited to those with professional or personal experience of mental health services and did not constitute a representative segment of the communities concerned or, more relevantly, the breadth of views from particular stakeholder groups such as service users and carers.

One way of capturing the broader perspective on the need for reform and strategies for change within mental health services is to consult with the communities separately and to ensure that such consultation exercises are as inclusive as possible. We, therefore, set out to meet with the various minority ethnic groups through community consultation events at different venues nationally, always emphasising that the meetings were locally organised and that the events were accessible to the local communities.

From December 2002 until March 2003, the Department of Health funded ethnic minority community consultation events among south Asian, Chinese, Irish and Black communities in England. These meetings were organised by the local community groups, usually with a background of involvement in local mental health service

provision. The meetings were publicised locally and each meeting was targeted at a particular minority ethnic community although participation was not restricted to that community. There were 14 such events in total. The following table gives the details of the meetings:

Date	Location	Ethnic community targeted	Number of questionnaires returned
14/12/02	London	Chinese	0 * no questionnaires available at this event
13/1/03	Manchester	Chinese	26
19/1/03	Birmingham	Chinese	52
22/1/03	London	Chinese	6 * focus group
29/1/03	Manchester	Irish	6
4/2/03	London	South Asian	125
4/2/03	Birmingham	Irish	25
5/2/03	London	Irish	10 * women only event
10/2/03	Birmingham	South Asian	63
18/2/03	London	Irish	20
26/2/03	Bradford	South Asian	66
27/2/03	Bristol	Black	20
10/3/03	London	Black	33
14/3/03	Birmingham	Black	74

At each of the meetings, there was a general presentation of the plans to develop and implement reform within mental health services, in order to improve the service experience and outcome for black and minority ethnic communities. This was followed by workshops and plenary sessions during which local people had an opportunity to talk about their views and reactions to the proposals. All the attendees were also asked to complete a questionnaire that sought their opinions and views concerning mental health services in general and more specifically their experiences of mental health services. The questionnaire also gave them an opportunity to express their views on the key proposals of the Inside Outside report. People were asked to respond to 17 sets of questions covering (i) personal details (ii) views and experiences of current mental health services and (iii) views on the Inside Outside report. There were 3 open questions. This report is an analysis of the questionnaire data collected at the community events.

The Community Consultation Questionnaire: data and analysis

A copy of the English language version of this questionnaire is at Appendix 1. Translations into various south Asian languages and Cantonese were available to respondents as required. The completed questionnaires were checked and verified by an independent researcher (PW). All the questionnaires were collected at the end of each consultation event. Where appropriate the answers were translated into English. Data were checked for internal consistency after data entry using the SPSS. Qualitative analysis of open-ended responses was carried out with the aid of NUD*IST4. For a fuller description of the methods used, see Appendix 2.

Much of this analysis compares overall responses and differences between communities. The intention is not to emphasise divisions among communities, but rather to explore if there are community-specific views on mental health services as well as examine the extent to which the various ethnic minority communities share certain assumptions and views concerning mental health services.

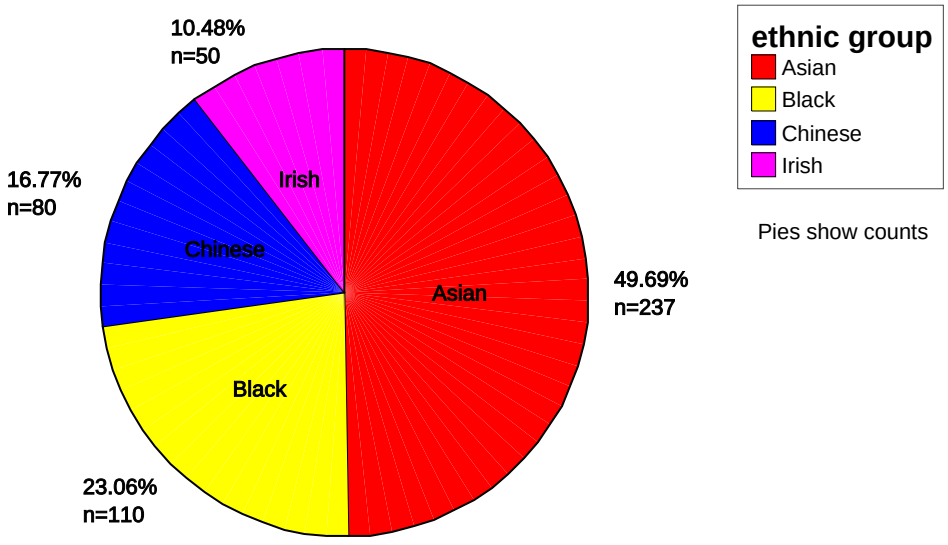
Results

- Quantitative analysis

General Background

A total of 526 questionnaires were returned. For most of the quantitative analysis that follows we were able to use 477 out of the 526 returns as these were assignable to clear and pre-determined ethnic minority categories, as shown below.

Chart 1.1 ***Breakdown of ethnic minority background of respondents***



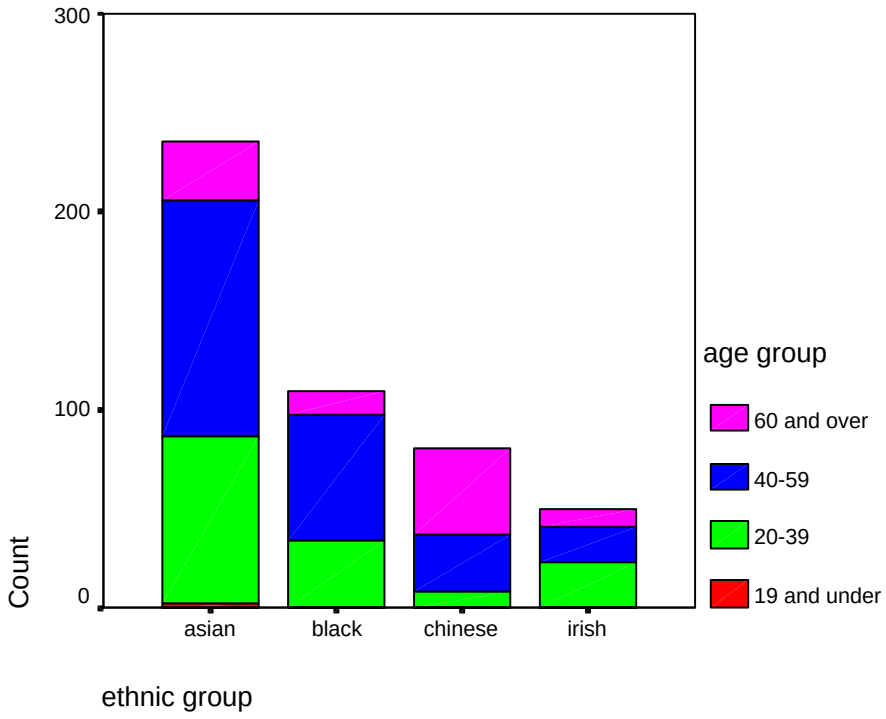
Nearly half of the questionnaires returned were from the Asian events (48.3%) which took place in London, Birmingham and Bradford. Most of the questionnaires were returned from events held in Birmingham (40.7%) and London (36.9%). However, the breakdown of questionnaires returned from various locations varied among communities, as shown earlier. The majority of respondents heard about the events primarily through community networks and organisations (51%) and work (32%). Much smaller numbers heard of the events through either friends (14%) or the media (2%).

Demographic profile of respondents

The profile of respondents was skewed in favour of females (72%; 8% missing data). A greater proportion of men (36%) attended the Asian events (V=.169. p<.0005) and a much higher proportion of women (84%) attended the Chinese events compared to other events (V=.122, p=.011).

There were differences between the various ethnic communities in the age profile of those returning the questionnaire. Most notably, the age profile of the Chinese respondents was much older (Chart 1.2). Among the Chinese respondents, 54% were aged 60 and over compared with 20% among other ethnic groups (V=.399, p< .0005). Age differences were also significant for Black respondents compared with others (V= .205, p = .001): 38% Black respondents were in their 40s compared with 23% of others. Among Asian people, 12% were in their 20s, compared with only 5% of other ethnic groups (V=.236, p< .0005).

Chart 1.2 ***Age group by ethnicity***



Views and experiences of current mental health services

- Service users

One in five of those who responded to the questionnaires (21%) had experienced mental health services as a user. There was some variation according to ethnicity (Table 1.1), although these differences in service use were not statistically significant.

Table 1.1 ***Service users by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	N
Mental Health Service User	Yes	21.5%	20.0%	15.0%	24.0%	97
	No	78.5%	80.0%	85.0%	76.0%	380
Total		237	110	80	50	**477**

- Workers in mental health

Other experience of mental health services was gained through working in mental health. Overall, nearly a third of respondents had experience of working in mental health (31%). This experience was largely through employment within the voluntary sector and making links with statutory services, rather than through employment within statutory services. Again this varied according to ethnicity as well as age. Significantly more Black respondents (V=.170, p<.0005) and fewer Chinese respondents (V=.204, p<.0005) had experience of working in mental health (Table 1.2). People aged 39 and under (38%) were more likely to work in mental health than older people (27%; V=.108, p=.014).

Table 1.2 ***Experience of working in mental health by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Mental Health Worker	Yes	27.0%	41.8%	7.5%	34.0%	133
	No	73.0%	58.2%	92.5%	66.0%	344
Total		237	110	80	50	**477**

- Carers

Eighteen per cent of the respondents had experience of caring for someone with mental health problems (Table 1.3). The proportion of carers was highest among those from the Black community (26%; V=.126, p=.006), and lowest among Chinese respondents (11%), compared with others.

Table 1.3 ***Numbers of carers by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Mental Health Carer	Yes	16.0%	26.4%	11.3%	16.0%	84
	No	84.0%	73.6%	88.8%	84.0%	393
Total		237	109	80	50	**474**

Therefore, 52% (271 out of 526) of those who took part in this survey had direct experience of mental health services, as service users, as carers or having worked in mental health services, either within the voluntary or statutory sectors. The proportions of respondents falling into any of these categories were 64% of Black respondents (V=.155, p=.001), 56% of Irish respondents, 48% Asian respondents and 29% Chinese respondents (V=.186, p<.0005). Black respondents were significantly

more likely and Chinese respondents significantly less likely when compared to other ethnic groups to have direct experience of mental health services.

- Perceived quality of care

Those who had experience of mental health services were asked to rate the quality of care they had experienced, from very poor through to excellent on a five-point scale. Only those who had direct experience of care commented (247 out of 271 people with experience commented). These categories are regrouped (Table 1.4) into negative (poor, very poor) and positive (good, very good, excellent).

Black community respondents were least likely to report the quality of their care positively (47%) compared with Chinese respondents (78%), but it should be noted that numbers of Chinese respondents with experience of care were relatively small. While Black community respondents were more likely to report negative than positive experience of care this situation was reversed for all the other groups. The results for the Chinese respondents were significant (V=.144, p=0.029).

Table 1.4 ***Perceived quality of care: positive/negative by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	Total
Quality of care	Negative	42.1%	52.8%	22.2%	37.9%	96
	Positive	57.9%	47.2%	77.8%	62.1%	134
Total		121	53	27	29	**230**

* Those who answered 'Don't know' are excluded here

Black community respondents were also most likely to report their care as very poor (21%) compared with 7% of the Irish, 11% of Chinese and 14% of Asian respondents. Asian respondents were more likely to report their care as excellent (6%) and Black respondents least likely (2%), although again these numbers are small (Table 1.5). None of these differences was statistically significant.

Table 1.5 ***Perceived quality of care: very poor-excellent by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Quality of Care Rating	Very poor	14.5%	20.7%	10.7%	6.7%	36
	Poor	24.4%	27.6%	10.7%	30.0%	60
	Good	33.6%	32.8%	50.0%	40.0%	89
	Very good	13.7%	8.6%	21.4%	16.7%	34
	Excellent	6.1%	1.7%	3.6%	3.3%	11
	Don't know	7.6%	8.6%	3.6%	3.3%	17
Total		131	58	28	20	**247**

- Six potential factors affecting adequacy of services for BME communities

All respondents were asked about the significance of a list of issues which might present problems in getting better mental health services for people from minority ethnic communities. These were; (i) lack of interest in mental health services within ethnic minority communities, (ii) too few mental health staff from ethnic minority communities, (iii) language problems such as no interpreters, (iv) racism of staff, (v) lack of cultural awareness amongst staff, and (vi) general lack of interest by government in improving services for people from ethnic minority communities. People were asked to respond to each of these items by ticking yes, no or don't know responses.

I. Interest by Ethnic Minority communities

Fifty per cent of ethnic minority respondents felt that communities themselves lacked interest in mental health services. Black and Asian respondents were more likely than Chinese or Irish respondents to identify lack of community interest as a problem (Table 1.6). Black respondents were significantly more likely (V=.128, p=.035) and Chinese less likely (V=.126, p=.039) than others to attribute blame to community disinterest. There were age differences in perception of lack of interest within communities (V=.194, p<.0005). Twenty eight per cent of those aged 20-29 years felt this was a problem, compared with 44% those over 60 years and 70% those aged 40-49 years.

Table 1.6 ***Lack of interest with BME communities by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Lack of BME Group Interest	Yes	52.0%	60.9%	38.2%	41.9%	205
	No	22.3%	24.1%	27.6%	37.2%	103
	Don't know	25.7%	14.9%	34.2%	20.9%	100
Total		202	87	76	43	**408**

II. Availability of BME staff within mental health services

Eighty one per cent of respondents felt that having too few staff from ethnic minority communities represented a problem in getting better services (Table 1.7). On this issue the Black community responses were significantly different to others (V=.156, p=.005): over 16% of black people said this was not a problem compared with 5 to 7% of other groups.

Table 1.7 ***Problem with lack of BME staff by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Too few staff from BME groups	Yes	82.9%	77.8%	84.4%	75.0%	357
	No	6.9%	16.2%	5.2%	6.3%	38
	Don't know	10.2%	6.1%	10.4%	18.8%	45
Total		216	99	77	48	**440**

III. Language difficulties

Eighty nine per cent of Chinese and 86% Asian respondents felt that language problems were obstacles to getting better services (Table 1.8). This compares with 74% of the Black community and 59% of Irish community respondents. These differences were only statistically significant for Asian (V=.138, p=.018) and Irish (V=.211, p<.0005) respondents when compared with others. There were some sex differences in responses on language issues (V=.132, p=.023), as women were more likely than men to say that they did not know if this was a problem. Younger people (aged 39 years and under) were more likely than older people to say they did not know if language issues were a problem or to say they were (V=.166, p=.002).

Table 1.8 ***Language issues by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Problem With Language Issues	Yes	86.3%	73.5%	88.7%	59.1%	343
	No	7.1%	12.2%	8.5%	13.6%	39
	Don't know	6.6%	14.3%	2.8%	27.3%	42
Total		211	98	71	44	**424**

IV. Racism of staff

Sixty one per cent of the respondents agreed that that racism of staff was a problem within services (Table 1.9). More black people rated this as a problem (78%) compared to others, the difference proving to be statistically significant (V=.196, p<.0005). Sixty one per cent of Asian people who answered this question also felt that racism of staff was an obstacle to achieving appropriate services, as did 49% of Irish and 44% of Chinese respondents. Relatively high numbers of Chinese people said that racism among staff was not a problem (32%; V=.200, p<.0005).

Table 1.9 ***Racism of staff as a problem by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Racism of Staff A Problem	Yes	61.2%	77.8%	43.5%	48.9%	256
	No	13.1%	11.1%	31.9%	17.0%	68
	Don't know	25.7%	11.1%	24.6%	34.0%	97
Total		206	99	69	47	**421**

V. Cultural awareness amongst staff

Eighty four per cent of ethnic minority respondents felt that a lack of cultural awareness amongst staff was a service problem, with the Irish overwhelmingly (94%) feeling this to be the case (Table 1.10). Compared with other ethnic groups, Chinese respondents stood out as not knowing whether staff cultural awareness was a problem and being least likely of all communities to regard this as a problem, a finding which was significant (V=.243, p<.0005). Nonetheless nearly two thirds of Chinese respondents felt that lack of staff cultural awareness was a problem in getting better services.

There were significant age differences in how people responded to this question (V=.157, p=.008). People aged 30-39 years overwhelmingly felt that this was a problem (92%), whereas people aged 60+ less likely to say this was a problem (73%).

Table 1.10 ***Perceived lack of cultural awareness among staff by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Lack of staff cultural awareness	Yes	86.5%	88.0%	64.4%	93.9%	367
	No	5.1%	7.0%	12.3%	2.0%	28
	Don't know	8.4%	5.0%	23.3%	4.1%	42
Total		215	100	73	49	**437**

VI. Lack of Government interest

Three quarters of respondents felt that there was a governmental lack of interest in improving services for their communities (Table 1.11), and this was particularly felt to be the case among Black community respondents (84%; V=.133, p=.021). Fewer Chinese respondents (70%) than others felt this to be a problem.

Age was a factor in beliefs about whether the government was interested in services for BME groups (V=.158, p=.008). Eighty five per cent of people aged 30-39 years felt the government lacked interest compared to an average of 75% people. Younger (aged 20-29 years) and older people (aged 60+) were less likely to know if this was a problem (28% and 19% respectively) compared to an average of 15%.

Table 1.11 ***Problem of lack of governmental interest in services for BME groups***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Govt. lack of interest in BME services	Yes	73.3%	84.2%	69.7%	75.0%	328
	No	9.0%	9.9%	15.8%	8.3%	45
	Don't know	17.6%	5.9%	14.5%	16.7%	62
Total		210	101	76	48	**435**

Access to services

In addition to identifying problems in improving services for minority ethnic communities, people who completed the questionnaire were also asked about their experience of accessing services and whether they thought that services currently available are ethnically and culturally sensitive to the needs of minority groups.

Accessing services was overwhelmingly regarded as problematic. When asked to rate the difficulties associated with access to services on a 3-point scale (a big problem, a problem, no problem) over 60% Black, Asian and Irish respondents rating this as a big problem (Table 1.12). Overall, 93% people felt that service access was a problem. The difference in views of access was significant in the case of Chinese respondents compared to others (V=.165, p=.008).

Table 1.12 ***Problems accessing services by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Is mental health service access a problem?	Big problem	61.7%	66.3%	44.6%	60.4%	263
	A problem	31.3%	28.8%	41.9%	35.4%	145
	Not a problem	4.7%	4.8%	8.1%	4.2%	23
	Don't know	2.3%		5.4%		9
Total		214	104	74	48	**440**

Ethnic sensitivity of services

People were also asked if they felt that current mental health services were culturally sensitive to the needs of minority ethnic groups. The results show that 62% respondents did not feel that mental health services were sufficiently culturally sensitive but with large variations in satisfaction among the various ethnic groups (Table 1.13). Only 2% of Irish people and 10% Black people felt that services were sensitive enough, whereas 21% of Asian and 31% Chinese respondents were satisfied that services were sufficiently sensitive. Comparing different community responses,

83% Black people and 80% Irish people overwhelmingly felt services were not sensitive. These proportions were reduced among Asian respondents (60%) and in the case of the Chinese, many more people felt they did not know whether they were (46%), than stated definitively that services were not sensitive (24%). Findings of dissatisfaction were significant for Irish people (V=.152, p=.007), and Black people (V=.243, p<.0005), when compared to others, whereas results for Chinese people showed a significant pattern of uncertainty about or greater relative satisfaction with the cultural sensitivity of services (V=.351, p<.0005).

There were age differences in perceptions of cultural sensitivity of services (V=.268, p<.0005). Older people (aged 60+) were less likely to say that services were not sensitive (30%) compared with people in their 30s (76%) and 40s (73%).

Table 1.13 ***Views on whether mental health services are sufficiently culturally sensitive***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Services Sensitive to Culture	Yes	21.0%	9.5%	30.9%	2.2%	77
	No	60.3%	82.9%	23.5%	80.4%	269
	Don't know	18.7%	7.6%	45.6%	17.4%	87
Total		214	105	68	46	**433**

Experience of Racism

One question asked whether people had experienced racial discrimination in mental health services (Table 1.14). Forty nine per cent of those with service experience claimed they had experienced racial discrimination. Two thirds of Black community respondents (66%) with experience of services felt they had experienced racial discrimination compared to 49% of Asians and 45% of the Irish. This contrasted sharply Chinese people with service experience: only 17% of Chinese people with service experience reported racial discrimination within mental health services. The results for Black (V=.194, p=.007) and Chinese (V=.248, p<.0005) respondents were significant compared to others.

Table 1.14 ***Experience of racial discrimination in mental health services by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Experience of Discrimination	Yes	49.3%	66.2%	17.2%	45.2%	132
	No	39.1%	27.9%	75.9%	48.4%	110
	Don't know	11.6%	5.9%	6.9%	6.5%	24
Total		138	68	29	31	**266**

Views on the Inside Outside Report

In this section, views on three key aspects of the Inside Outside report are analysed as are respondents' views on whether proposals will affect change and what other actions are needed to improve mental health services for BME communities.

- Training for cultural competence
One of the key tenets of Inside Outside is the need for training in cultural competency across all areas of staffing within mental health services. Respondents endorsed this proposal with only 2% feeling that this was not important (Table 2.1). Irish respondents were much more likely than others to regard this training as very important (86% compared with an overall 69% respondents).

Table 1.15 ***The importance of training in cultural competence by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Training in Cultural Awareness/ Competence	Not important	1.9%	1.0%	5.2%		9
	Fairly important	12.6%	8.6%	9.1%	4.0%	45
	Important	17.3%	13.3%	16.9%	6.0%	67
	Very important	64.0%	75.2%	64.9%	86.0%	309
	Don't know	4.2%	1.9%	3.9%	4.0%	16
Total		214	105	77	50	**446**

- Reducing inequalities in care and service delivery
On the key aim of reducing ethnic differences in care and delivery of services, again this proposal was almost wholly endorsed by respondents (Table 2.2). Less than 1% felt that this aim was not important. However there were again some differences between different groups: Chinese respondents were most likely to answer that they did not know if this was important or not and Irish and Black people were much more likely to feel that making changes to reduce inequalities was very important. Overall ethnic differences in beliefs about reducing inequalities were significant for Asian respondents (V=.222, p<.0005), Black respondents (V=.203, p=.001), and Chinese respondents (V=154, p=.032), compared to others.

Table 1.16 ***Reducing ethnic inequalities in care and delivery of services by ethnic group***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Reducing Ethnic Differences in Care and Service Delivery	Not important	1.4%		1.3%		4
	Fairly important	13.7%	6.9%	6.4%	10.0%	46
	Important	30.2%	12.7%	25.6%	10.0%	102
	Very important	50.9%	78.4%	55.1%	74.0%	268
	Don't know	3.8%	2.0%	11.5%	6.0%	22
Total		212	102	78	50	**442**

- Developing ethnic minority communities

On the third key issue of developing ethnic minority communities to deal more effectively with mental health issues within their communities, again this was regarded as important by nearly all of the respondents (Table 2.3). However, Black (83%) and Irish (81%) community respondents were more likely than others to view this aim as very important, and this reached statistical significance for Black respondents (V=.211, p=.001). Differences for Asian (V=206, p=.001), and Chinese (V=.196, p=.002) respondents also reached significance when compared with other groups.

Table 1.17 ***Developing ethnic communities to deal with mental health***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Developing Ethnic Minority Communities to deal with mental health	Not important	.5%	1.0%			2
	Fairly important	14.0%	2.0%	5.1%	2.1%	36
	Important	20.3%	13.0%	29.1%	16.7%	86
	Very important	59.9%	83.0%	54.4%	81.3%	289
	Don't know	5.3%	1.0%	11.4%		21
Total		207	100	79	48	**434**

- Whether plans will affect change

The majority of respondents (78%) felt that if measures proposed in *Inside Outside* were implemented, that services would improve for people from minority ethnic backgrounds (Table 2.4). Irish (86%) and Chinese (82%) people were particularly enthusiastic about the possibility of the report plans making a difference. However, more Black people than others (7% versus 4%) did not feel that improvement would occur. This comment needs to be balanced against the views of 74% of Black respondents that improvement would take place, presumably if plans were implemented.

There were some age differences in whether plans would affect change (V=.156, p=.003). Those 39 years and under were less likely (68%) to think the plans would

make a difference compared with others (82%), and most likely to say that they did not know (27%), compared with others who were older (14%).

Table 1.18 ***Views on the Inside Outside plans affecting service change***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Inside Outside report will improve services	Yes	76.7%	74.2%	82.1%	85.7%	343
	No	4.7%	7.2%		4.1%	19
	Don't know	18.6%	18.6%	17.9%	10.2%	77
Total		215	97	78	49	**439**

- Need for other actions

On the issue of whether any other actions not already proposed would benefit ethnic minority people with mental health problems, 49% respondents felt that other actions were needed (Table 2.5). As already noted, assessing these views has to be qualified by the fact that at the time of filling in questionnaires, respondents would not have had access to the detail of the changes and plans proposed in the full report. However, it may illustrate the strength of feeling about changes needed within mental health services. Black respondents were overwhelmingly of the view that further actions were needed (73%) and Chinese people much less so (15%). Therefore a strong association was found between being Black (V=.244, p<.0005) and Chinese (V=.343, p<.0005) with regard to the need for further action. Results for Irish people were also significant (V=.138, p=.022).

Table 1.19 ***Need for other actions to benefit BME people with mental health problems***

		Ethnic Group				
		Asian	Black	Chinese	Irish	
Other actions needed	Yes	50.3%	72.6%	14.7%	55.6%	196
	No	19.3%	10.7%	40.0%	4.4%	79
	Don't know	30.5%	16.7%	45.3%	40.0%	126
Total		197	84	75	45	**401**

- Qualitative Analysis

There were three open-ended questions as part of this survey. They were concerned with experience of racial discrimination within mental health services, cultural sensitivity of current services and actions needed in order to improve services. A qualitative analysis of the responses to these questions was carried out, and in the rest of this section, we provide the results of this analysis.

- Experience of racial discrimination within mental health services

Respondents who had reported experiencing racial discrimination were asked to describe their experiences. These descriptions covered a range of situations and circumstances. These included receiving poor quality services, a failure to acknowledge and resource cultural needs, being stereotyped and a few references to racially motivated physical and verbal abused. Respondents described common experiences of service users being patronised, ignored, misunderstood and treated with disrespect. BME staff also reported experience of discrimination as workers from minority communities. Throughout these testimonies, what was clear was that racial discrimination went beyond actual racist attitudes and behaviours and was additionally a feature of receiving worse services on the basis of ethnic minority status.

Many of the comments regarding services were about over-medication, lack of appropriate aftercare and counselling, not being given access to available resources, lack of information about treatments and feelings of general neglect. Failures included delays in systems and not getting adequate support and referrals. Worse service experience also included a perception of greater experience of invasive and coercive treatments and less access to non-medical alternatives. There was a clear view that this treatment receipt of inferior treatment at all levels of service provision was racially motivated.

The experiences of racial discrimination reported here reveal a number of categorisable facets of discrimination among service users, carers and workers. These aspects were not discreet, for example, failing to attend to cultural needs inevitably was felt to result in receiving poorer services. Experiences can be summarised as:

a) experiences of direct abuse
b) being stereotyped
c) failure to attend to cultural needs
d) a culture of being undermined
e) BME staff experience of discrimination
f) receiving poorer services because of ethnic background

a) Experiences of direct abuse

The experiences of direct abuse reported were from a few people who claimed they had been verbally and physically abused while in receipt of psychiatric care. This abuse involved direct physical and verbal racial abuse by other patients and staff. Comments included experience of ‘racist comments by other patients in hospital’ (Pakistani/Irish female user/carer/worker aged 30-39 years at Asian event in Birmingham) and experience of ‘verbal abuse/physical abuse/assault’(50-59 year old female worker at Asian event Birmingham).

The reporting of direct abuse of this sort was rare. More common was the experience of stereotyping of ethnic minorities’ culture. This in turn was linked to access to poorer service options.

b) Stereotyping

The issue of stereotyping of people from ethnic minorities in mental health services was illustrated in examples by people from Asian, Black and Irish backgrounds. For Irish people, stereotypes commonly had to do with alcohol use:

> My experience is with working with elderly Irish people with mental health issues and alcohol issues and presenting them to mental health services. The alcohol problem is the perceived cause of illness, it is purely presumption, before a proper assessment takes place
> (Irish female worker 30-39 years at Irish event Birmingham)

In a similar way, a Black female service user commented that her behaviour in hospital was stereotypically ascribed to cannabis use:

> The staff on a psychiatric ward decided between themselves that I was so calm the five months I spent on the ward because I have been smoking cannabis... I never touched cannabis at all
> (Black female service user 50-59 years at Black community event Birmingham)

Among Asian people, it was mainly women who commented on stereotypes of Asian women evidenced in mental health services. One female service user of Irish/Indian background, who is perceived as Asian, commented about her experience of racial discrimination thus:

> As a person of mixed parentage, by having my experiences in wider society of racism ignored, my experiences in my family of racial prejudice ignored, by assumptions being made that I am a submissive Asian woman and should have known that all Asian men are violent
> (Irish/Indian female aged 40-49 years, user/carer/worker, at Irish event London)

It was clear that stereotyping by staff reflected a dearth of knowledge and awareness of the cultures of diverse minority groups and showed an unwillingness at service level to engage meaningfully with BME patients.

c) Failure to attend to cultural needs

This issue of what constitutes cultural sensitivity will be addressed more fully later on comments on why services were not sufficiently culturally sensitive. However, it needs to be stressed that a failure to address cultural needs was understood as evidence of racial discrimination. Reference here was made to deficits in resources and sensitivities around food, language, respecting minority cultural norms and a general misunderstanding of ethnic minority cultural perspectives and needs. For Irish people, there was a general feeling that there was a lack of awareness about cultural issues in common with other groups, but an added issue of failing to recognise Irish people's cultural difference, particularly of second generation Irish people.

Experience of perceived discriminatory treatment in relation to culture was understood at two interconnected levels: the importance of culture was ignored by staff on the one hand, while at the same time cultural difference evoked staff aggression and disrespect:

> I have experienced staff dismissing the experience of a service user as irrelevant because it is based on cultural experience. I have also seen staff who have been aggressive and lack respect because the service user is from a minority community

(Black female worker 40-49 years at Chinese event Manchester)

Racial discrimination was inferred from the lack of willingness to resource specific needs. The lack of resources put into language support for example was regarded not only as racially discriminatory, but also considered responsible for later crisis presentations:

> Appointments at GP very difficult to make due to language problem. Lack of social and emotional support finds many women in presenting in mental health services in crisis
> (Asian female worker 30-39 years at Asian event Bradford)

More generally, the failure of mainstream professionals to understand cultural issues among minorities was regarded as amounting to racial discrimination. These failures around cultural and linguistic issues were believed to lead to the relative neglect of people from BME backgrounds within services:

> Cultural issues were not addressed or seen as an issue to be looked at. Individuals not being listened to
> (Black female user/worker 40-49 years at Irish event London)

> Language barriers. Unable to communicate left them unnoticed and unattended
> (Irish female 30-39 years at Irish event London)

d) A culture of being undermined

Many experiences were described in which people were treated with disrespect, not listened to and patronised or unnoticed as mentioned above. These subtle aspects of treatment were very common among those from Asian and Black communities suggest that BME patients have very little power and control within the professional-patient relationship.

> My experience is doctors not listening to the client before giving them medication
> (Black female carer/worker 40-49 years at Black event Birmingham)

> They treated me with disrespect. They were arrogant towards me
> (Asian service user at Asian event Bradford)

> It is hard to say or pinpoint, basically how you feel, when you are not heard
> (Asian female worker 50-59 years at Asian event London)

e) BME staff experience of discrimination

As well as descriptions of experiences of those in receipt of mental health care, BME individuals working in mental health also described their experiences of racial discrimination within statutory services. The quotes below are illustrative of the commonality of experiences of BME individuals in institutional settings, whether workers or service users. What is notable is the BME staff report experiences similar to service users of being undermined and unheard, and feel that in comparison to the ethnic majority, they fare less well.

> Constantly being undermined by colleague from white workforce in fulfilling my role and responsibilities
> (Asian male worker 50-59 years at Asian event in Birmingham)

> I have experienced discrimination as a staff member - segregation, opinions not viewed as important, unable to go on courses
> (Black female worker 40-49 years at Black community event Birmingham)

These features of discrimination; stereotyping, failure to address cultural needs, outright abuse, and undermining of people from ethnic minority backgrounds reveal different layers of racial discrimination among both service users and BME staff. These reveal some of the processes whereby people from BME communities are treated not only differently from others but also how these facets of discrimination impact upon the experience of poorer treatment within services.

f) Receiving poorer services

Comments spanned failures in all aspects of treatment ranging from outright abuse to inferior treatments options, threats of co-ercive treatments and general system failures. These experiences among BME clients were also mentioned by white majority respondents who had evidenced the treatment of their BME clients. Black community respondents were particularly vocal about their experiences of mental health services. The following quote is an illustrative summary of many of the views of Black respondents:

> Black people are very isolated, over-represented and always misdiagnosed
> (Black female worker 30-39 years at Black community event Birmingham)

Another Black respondent commented that discrimination was rife, with little attempt made by service providers to tackle the issue:

> Yes (racial discrimination) - on a grand scale - local and national – services inability and reluctance to recognise black issue/community issue, problems and barriers. Open in my face racial discrimination
> (Black female service user 40-49 years at Black community event Birmingham)

The comparison with white patients is important to make. BME respondents often explicitly stated that the treatment they received was inferior to the treatment of white people, as the quote below illustrates, and even when this was not explicitly stated it was implied:

> I was not treated the same as my white counterpart. I was not told about different services that mental health users should know
> (Black service user at Black community event London)

An Asian respondent commented that even of getting practical help for service users seemed to be racially discriminatory, and again that people from BME communities felt they were getting less than adequate support, again when compared with others:

> In terms of support from workers within the system ie, CPNs etc in terms of knowing our rights, what we can expect and the help we should receive - ie - especially filling in DLA forms (a simple practical need - but very important) to the service user. I have noticed that some people get more help than others
> (Asian female user/carer/worker 30-39 years at Asian event Birmingham)

Linked to the experience of fewer service options among service users from BME communities was the experience of drug treatments and invasive procedures mentioned below, which were felt to be more common among BME patients and linked to services failing to address the cultural needs of BME people:

> I have found services to be Eurocentric and insensitive to the needs of minority ethnic people. Preconceived ideas about Asian and Black people, who are much more likely to receive drug treatment and ECT than talking therapies
> (Asian male worker 30-39 years at Asian event Bradford)

Although their comments were not as numerous as those from Asian or Black communities, there were a number of comments from Chinese people describing how racial discrimination was enacted within service delivery:

> Cultural encapsulation as aligned to more institutional or subconscious factors affecting access, attitudes and processes in service delivery in a general and individual basis
> (Chinese female worker 20-29 years at Chinese event London)

Another Asian woman described the complexity of the various levels of experience of discrimination: being patronised, having cultural needs remaining misunderstood and unmet and having her trust of the system undermined by being sectioned:

> Dietary requirements are not met. Others relate to an inter-mix of discrimination to do with stigma and mental ill health - too ill to know what's good for her from white and other professionals that then inter-mix with sexism, homophobia and class. Ignorance of family and trust(ing) professionals got me sectioned. Treat us as whole beings - not just Black, Asian, etc
> (Asian female user/carer/worker 40-49 years at Asian event London)

Half of the people who had experience of services provided comments about their experiences of racial discrimination. It is only possible to summarise the main themes here with a few illustrations. What was clear was that few people were satisfied with mental health services and that people from all the communities in the survey had multi-faceted experiences of racial discrimination within mental health services. This was particularly notable among Black community respondents, whose accounts of mental health services were overwhelmingly negative.

One of the important issues to emerge was the way in which failure to address cultural issues competently within services was connected to experience of racial discrimination. The next section provides an analysis of how services were perceived as culturally insensitive, and how this might be addressed in practice. Dealing with cultural competence, is therefore, as accounts reveal, a necessary part of any approach geared to dismantling racism within British mental health care.

- Cultural sensitivity of mental health services

Those who answered that services were not sufficiently sensitive were also asked to explain why they felt this to be the case. These qualitative responses covered themes which ranged from a failure of professionals to understand the culture, religion, family life, histories and traditions of people from different communities, including their experience of racism. Insensitivity was also understood as not acknowledging the meanings attached to mental illness within different communities. At a practical

level, a lack of provision for language and dietary requirements and a general neglect of different ethnic minority cultural norms were seen as indicative of cultural insensitivity.

The medical model of care was strongly criticised as irrelevant to the experience of mental illness as it was seen to overlook the importance of cultural and social factors in relation to mental distress. Respondents also felt that psychiatry and mental health services were Eurocentric, or geared towards white western people, and as such had little to offer ethnic minority people with mental health problems. Psychiatric practices were therefore criticised at two levels: neglecting the evident contexts of illness and being ethnocentric. As a result, BME respondents felt that effective treatment for people from BME communities was virtually impossible within this narrow framework.

Respondents suggested many ways in which services could be improved to be more sensitive. These included increasing the knowledge and experience of the mental health workforce through delivery of education and training, the provision particularly of single sex wards, language resources, dietary provisions, involving and empowering users, ethnic-specific day centres and counselling services and employing more workers from ethnic minority backgrounds at all levels within mainstream services. The detail of these suggested actions is included in the next section on actions needed to improve services.

For most people, cultural insensitivity covered a range of factors highlighting a lack of adequate resources and failure to take wider experiences and cultural norms into account:

> Barriers such as language, culture and religious insensitivities still very prevalent. No attention paid to dietary needs and gender specific services
> (Asian male worker 30-39 years at Asian event Bradford)

> Simple things like cultural ignorance, lack of culturally similar workers - lack of taking into account service users experiences
> (Black female 20-29 years at Asian event Birmingham)

For many from the Chinese community the lack of awareness of Chinese culture and lack of adequate language resources were real problems in getting care which was culturally appropriate:

> Interpreters from city council/hospital do not have mental health training, eg, they cannot interpret the diagnosis into Chinese to the patients. DoH doesn't have the mental health leaflet in Chinese, it is hard for the staff to promote mental health issues among the community. CPN and social workers don't have training in Chinese culture, eg, family value and Chinese view of mental health
> (Chinese female 30-39 years at Asian event Birmingham)

Asian respondents, who were the majority of respondents, also emphasised the need to resource differences in language and dietary requirements, issues which were not given the same pre-eminence among Black and Irish respondents. As noted earlier, these deficits in provision were regarded as elements not just of cultural insensitivity, but of racial discrimination as the following Asian woman indicates:

> As a worker - observed discrimination in terms of poor quality services for Asian users - lack of interpreters, mixed wards, lack of appropriate day care, housing and counselling
> (Asian female worker 30-39 years at Asian event Birmingham)

This connection between racial discrimination and cultural insensitivity was also common among Black respondents, as the following quote illustrates:

> Services are not culturally appropriate. Providers and staff who provide and deliver mental health services in the NHS are not culturally competent. Mental health services are compounded with racism and racial inequalities
> (Black female 50-59 years at Black community event Birmingham)

Among other Black respondents, the knowledge of how Black people have been historically and continue to be disempowered by psychiatric practices was given as evidence of cultural insensitivity:

> In intervention ie high numbers of African-Caribbean young men in psychiatric hospital
> (Asian female 20-29 years at Black community event Birmingham)

> The historical aspect of black people's experiences with mental health issues/problems
> (Black male 30-39 years at Black community event Birmingham)

There appeared to be some differences in how different communities understood issues of cultural sensitivity. Asian and Chinese people seemed to lean towards practical remedies regarding the provision of culturally specific resources, whereas Black respondents focused more on the issue of how their community was over-represented within services and in disproportionate receipt of worst treatment options. Irish people on the other hand felt overlooked in relation to cultural issues:

> It's generally very difficult for organisations and services to really get to grips with Irish equalities issues - much training and development is needed
> (Irish male worker 30-39 years at Irish event London)

However, despite being overlooked within the ethnic minority agenda, Irish respondents also reported the lack of sensitivity towards and understanding of their cultural needs at the level of service delivery and had experience, common to other Asian, Black and Chinese minorities, of being stereotyped and pathologised. In a similar way to people from other minorities, Irish people regarded their treatment within mental health services as part of a wider social and historical experience of inequality and discrimination.

There was a general perception that practices of mental health care were currently ineffective in relation to people from BME communities, and therefore that the basic tenets of psychiatric practice needed to change in order to meet the needs of diverse communities. The main objection was that psychiatry was based on a medical model which did not address social and cultural contexts of mental ill health. This medical model was variously described as a construction which was western, white, British, Eurocentric, Anglo-Saxon and ethnocentric, and unresponsive to the needs of people from other cultures.

> Because I feel that a medical model does not address central issues of mental health for Asian people (and other minority groups), which are to me linked to social issues. 'Mental health' defined in western terms cannot address those issues, for either Asian or white communities. There is so little attempt to understand the context of illness through British mental health
> (Asian male 30-39 years at Asian event London)

> Models in psychiatry are ethnocentric. Racism is extensively influential in way people are diagnosed and dealt with
> (Asian male worker 60-69 years at Black community event London)

> The medical approach used in diagnosing and treatment does not take account of people's social/cultural experiences. When social and cultural factors are ignored, people are misdiagnosed and treatment and care are inappropriate
> (Black female 40-49 years at Black community event London)

> The methods imposed and experiences accepted are based on a white western model with no validation given to cultural norms
> (Black female worker 40-49 at Chinese event Manchester)

The lack of culturally sensitive services available was not only linked to a poorer experience for service users, carers and families from different communities, but was clearly understood as the cause of misdiagnosis and over-representation of people from BME communities in particular forms of coercive and inappropriate provision. A failure to deal with cultural issues meant that for many the experience was one of medication being the only available option. Again most criticism of worst service experience was from Black respondents:

> Most mainstream services are not sensitive to AC culture, we are often misunderstood and our views ignored. We suffer poorer experiences and outcomes from the services (mainstream) available
> (Black female worker 40-49 years at Black community event London)

> They pump them with medication. The diagnosis is wrong. Instead of proper care they put them in prison
> (Black male 60-69 years at Black event Birmingham)

Some people ascribed the failure of the medical model to not treating people holistically. Taking a holistic approach was regarded as the antithesis of the practices of current mental health services, an approach which it is later argued is one of the strengths of voluntary sector approaches to mental health. To many respondents, cultural insensitivity was typified by a failure to see a person in their wider context:

> Tackle only individual's mental health, do not look at a person in a holistic way, in the context of their life, family
> (Asian female user/carer 20-29 years at Asian event Birmingham)

In spite of the general negativity about current services, it was nonetheless felt that much could be done to improve the cultural sensitivity of mental health services for people from BME communities. Main areas suggested for improvement were around increasing knowledge and awareness about different communities among those working in mental health through training and education, and increasing the workforce representation of people from BME communities. A need for a range practical measures around dietary differences, language support, respect for religious practices, etc, were also clearly thought to be important alongside a real commitment

to financially resourcing culturally sensitive care outside as well as inside statutory mental health service provision.

Empowering users from different communities was also seen as essential to increasing cultural sensitivity. Although these suggestions for improvement were numerous, people nonetheless felt that none of these on their own would revolutionise mental health care, but rather than they were all integral to overall service improvement. However, in spite of the majority view that cultural matters needed to be dealt with, there was comment from a few people that tackling BME needs would become an integral part of mental health provision, rather than an addition to mainstream services. As well as mainstreaming equality issues, there was concern about not generalising care, and not losing the focus on each person as an individual. The importance of treating people as individuals and acknowledging the diversity of communities was also stressed:

> They are not meeting the needs of the individuals. They tend to put everyone in the same basket
> (Black female carer/worker 40-49 years at Black community event Birmingham)

The quantitative data described earlier show that the vast majority of respondents felt that services were not sufficiently competent in cultural issues. Here these qualitative data illustrate how cultural sensitivity is understood within BME communities. Measures proposed to address cultural competency are included in the next section. What is clear from the data discussed here is that cultural insensitivity is perceived by BME communities as evident in staffing, lack of resources, and in approaches to care, assessment and treatment, which are longstanding problems and appear integral to current psychiatric practice. The failure to address cultural issues in the ways in which they are relevant to people's lives is clearly felt to impact upon access to and relatively poorer experience of all aspects of service experience among BME communities.

- Actions needed to improve services

Respondents who answered that they felt there were other actions needed in order to benefit BME people with mental health problems were asked to specify what could be done. This was an opportunity for people to comment freely about what they saw as priorities for service reform. Some of the comments related to themes already identified in the Inside Outside report. Individual comments were subsequently analysed and eleven main themes, outlined below, were identified. These actions reflected two wider concerns: change in services was essential and plans needed to be followed by a commitment to implementation. The overwhelming need for change in mental health services is reflected in the following quote which makes clear that services have clearly failed people from minority communities and will continue to do so, unless this is actively and comprehensively addressed:

> We cannot simply rely on applying white models of treatment to improve uptake of existing mental health services. If the Black experience teaches us anything, it may be not good to get more Asians using the existing types of mental health services. What may be more useful is a collective re-think about mental health using culturally relevant ideas
> (Asian male 30-39 years Asian event London)

On the other concern about implementation, some people were clearly suspicious of progress being made in relation to BME communities and cynical about commitments to implement report recommendations. References were made to the experience of BME communities witnessing previous failures to implement policies. Appeals were therefore made that the Inside Outside report recommendations would be taken seriously at policy level:

> All these conferences and seminars are very useful. But in the end it is all paper work. So please we are expecting some positive solutions from this conference.
> (Asian female 40-49 years at Asian event London)

> Making sure plans on paper are put into action. In the past to the present day, there are policies but are they carried out?
> (Black female worker 40-49 years at Black event Birmingham)

Each of these concerns show that people from BME communities are clear that changes need to occur, yet sceptical about change actually occurring, based on a their past experience of disinterest in improving BME community mental health. In spite of these valid reservations, the following actions were proposed which would improve the mental health of BME communities, both within and outside statutory service provision. Some suggestions concerned changes in statutory services (Actions 6,7,8) while others had less direct relevance to statutory services, but rather focused on a range of ways in which ethnic minority communities, families and society at large might be empowered to more effectively deal with promoting mental health and preventing ill health within communities (Actions 1,2,3,4,5,9).

Action 1: Prevention, mental health awareness and education

Raising awareness of mental health, both within minority ethnic communities and the wider population as well as among health professionals, was a common theme among the majority of respondents and from people from all of the ethnic communities surveyed. Much of the rationale for this was that education and information was necessary in order to facilitate prevention and early detection, and to reduce fears and stigma associated with mental illness, both within ethnic communities themselves and within society at large.

> We need to look at preventative/support work before the treatment stage. Hence more educational, outreach and promotional work. Prevention is better than cure.
> (Chinese female 40-49 years at Chinese event Manchester)

> BME communities should be educated - health promotion support for carers.. to identify first signs of illness
> (Black female worker 40-49 years at Black event Birmingham)

A theme among Asian and Irish respondents was that every one should be concerned with mental health:

> Work should be done with communities to acknowledge mental health as an important part of a whole person. We all have a mental health but I feel this is not acknowledged so that when mental health becomes ill - individuals and communities can understand what has happened and deal with it with support
> (Asian female user/carer 20-29 years at Asian event Birmingham)

To raise awareness in ethnic, especially (among) Irish people that health care includes mental health care and is a normal concern - not a question of madness or mental illness (unless serious and neglected)
(Irish female 60-69 years at Irish event Birmingham)

For many people one of the goals of educating communities around mental health was to reduce the stigma around mental health:

> Overall health promotion – nationally - to destigmatise mental health, a relevance for whole (diverse) population, to normalise mental health and the seeking of help
> (Irish female service user 30-39 years at Irish event London)

> Promotion of mental health services within the ethnic communities - and educating the ethnic population so that the stigma of mental illness is reduced
> (Asian female 50-59 years at Asian event London)

Education was considered important for carers, families, communities, society at large and particularly GPs. There was some specific mention of what community education should involve and who should be targeted. There were concerns raised about the education of young people towards prevention of later illness. This was mainly ocused upon by Black community respondents and shows a clear concern with the mental health of young Black people. As well as working towards prevention, improving services for younger people was also a notable desire. The following Black respondents specified what community education should involve:

> (Education should involve) early signs of deterioration, links between life events stress and mental health, cannabis and the dangers targeting young black people, recovery what it means to BME communities, general national freephone helpline accessible 24 hours per day, educational programme targeting elders, younger people and adults
> (Black female worker 40-49 years at Black event London)

> It is essential to educate young children in mental health ..Positive promotion is essential even more so within minority groups as mental health is seen as a failure for the individual and for the family
> (Black female user 20-29 years at Asian event Birmingham)

The following Black respondent felt that early action would reduce numbers of young people being sectioned, an issue which emerged in other data where much of the concern among the Black community revolved around the specific and unequal treatment of young Black people within mental health services:

> More health promotion with young people in order for them to recognise health problems earlier on so that they do not become acutely unwell and then sectioned under MHA 1983
> (Black male 30-39 years at Black community event Birmingham)

Suggested ways of raising awareness and promoting mental well-being were through educational establishments, the media, in collaboration with other initiatives, through community organisations, religious venues, GP surgeries, databases, seminars, networking, etc. It was mainly Black and Asian people who came up with ideas on how wider populations might be educated about mental health. Asian people identified a clear role for the media, including the Asian media, and their community leaders.

Action 2: Resourcing and building community capacity

Many people felt that providing resources for community initiatives would reduce the need for accessing statutory mental health services, and particularly reduce crisis

presentations. The community sector was regarded as important as it provides culturally sensitive care, alternatives to medical approaches, and directly tackles mental health in its wider context of social and economic exclusion.

Providing funding and building the capacity of the community sector to provide sensitive ethnic minority community-based services were regarded as necessary, alongside improving statutory services.

> Fund care in the community adequately - allow ethnic diversity to be expressed. Maximise skills within voluntary sector. Support them financially
> (Black female 50-59 years at Black event Birmingham)
>
> Ensure mainstream funding is available for Asian voluntary sector to develop sensitive services
> (Asian male worker 50-59 years at Asian event London)
>
> Feel strongly that Irish community services are assisted to contribute to culturally competent services for Irish mental health users
> (Irish male worker 30-39 years at Irish event London)

Many felt that better partnerships between the statutory and voluntary (including ethnic minority voluntary) sector were needed. Issues of empowering communities and giving communities a more central role were mentioned. The need for better partnerships between the ethnic minority voluntary sector and statutory sectors was mentioned by people from all communities:

> Chinese voluntary sector needs to be given more opportunities and resources to assist mainstream services. Need for cross boundary commissioning
> (Chinese male 60-69 years at Chinese event Manchester)
>
> The role of religious bodies, religious leaders in taking partnership role with the mental health framework.
> (Asian male user/carer/worker 40-49 years at Asian event Birmingham)

However, being able to build stronger relationships *within* ethnic communities among all those affected by issues of mental health was also considered important. The following quote emphasises this importance of building community cohesion, and the sense that community divisions are sometimes the outcome of government manipulation of agendas:

> Working closely together users/carers/communities/workers - together we achieve, separated we fall - some government initiatives and the amount of consultation processes people have got to feed into often give the impression of the divide and conquer approach agenda
> (Black female user 40-49 years at Black event Birmingham)

Related to the question of partnerships between the BME communities and services was a common theme that measures to improve services needed to ensure that communities were given a central rather than a peripheral role in dealing with mental health and that the skills of people within the BME sector needed to be acknowledged:

> Not marginalised/not on the periphery be the centre, not patronising, ethnic minorities not a problem but an asset
> (Asian male 40-49 years at Asian event London)

> Community voluntary organisations be given more prominence. Enable people with relevant skills to play major role, not just relying on academics
> (Black female carer/worker 50-59 years at Black event Birmingham)

Some people felt that communities needed to lead on issues of community mental health. It was suggested that community leaders were needed in order to ensure change but that past experience had been of a reluctance to relinquish the power of mainstream institutions to communities:

> Facilitating the leadership voice among BME communities. CDWs a step in the right direction but it takes leaders with vision to drive forward longlasting change. The current system is afraid of powerful black voices and stifles it in many ways. When the government and other institutions are more open, the structural/systemic change will follow
> (Black female 30-39 years at Black event London)

The issue of empowering communities themselves and creating ownership within communities was mentioned by some respondents from Black and Asian communities. These comments below show the widespread beliefs that without community empowerment, strategies will not be effective, that challenging racism is a part of empowering communities and that consultation is needed with regard to all aspects of change.

> There needs to be a way of instilling ownership of the processes for communities (including subgroups) for this strategy to be effective at ground level
> (Black female worker 40-49 years at Chinese event Manchester)

> Empowering the communities through capacity building and challenge discrimination and racism
> (Asian 50-59 years at Asian event Birmingham)

> Empowering the communities, not dictating to them...Consultation in all areas not just in a few areas
> (Black female carer 40-49 years at Black event London)

It was generally perceived that the strengths of ethnic minority voluntary sector lay in providing culturally sensitive alternatives to psychiatric care which were non-medical and holistic. These approaches were deemed not only important for those suffering mental ill health but important also in preventing illness and improving community mental health.

> The role of complementary health in supporting the mental health treatment regimes
> (Asian male user/carer/worker 40-49 years at Asian event Birmingham)

> Within current Irish voluntary services more access to counselling/therapy/befriending for Irish users, support groups
> (Irish female 20-29 years at Irish event London)

> Raise the point of a non-medical approach for discussion. Building strong therapeutic environments...Options to include alternative and complementary therapies (get away from the drug companies agenda –profit)
> (Asian female user/worker 30-39 years at Asian event London)

Black and Asian people emphasised the importance of addressing spiritual aspects in relation to mental health:

> The essential focus of spirituality in the black psyche
> (Black female 40-49 years at Black event Birmingham)

> The spiritual aspect of mental health has not been mentioned. Alternative therapies such as herbal medicine, spiritual healing, etc., are also very important
> (Asian male worker 30-39 years at Asian event Bradford)

Although BME community respondents felt that there were obvious strengths within communities which could be built upon in order to improve overall community mental health, a minority of respondents also drew attention to experiences problems within and between ethnic minority communities which also needed to be acknowledged and confronted. These comments were few, but nonetheless illustrate that communities are diverse and that some communities feel they have not had their needs met in comparison with others.

There were comments from people within Asian communities that Muslim people feel discriminated against and that the needs of Muslims are overlooked at some levels of service provision compared with other Asian groups:

> We ourselves need to be aware of the fact that factions exist within the 'Asian' workers based on their religion or language etc. Time and again I have noticed that my clients have complained that Muslim patients feel discriminated against by non-Muslim workers and vice versa. This is really sad but true.
> (Asian female user/worker 60-69 years at Asian event London)

> I feel Asian service (locally) has not done any visible work in the Muslim community (which is) largely from Pakistan (and) is the largest ethnic community (locally) - this needs to be improved if there are to be change
> (Asian 30-39 years at Asian event Birmingham)

There was also comment from an Asian community respondent that there was too great a focus on the needs of the Black community in Bristol, and comment from a Black community respondent that the needs of the Black community were overlooked in Bradford. Irish people felt generally overlooked and not perceived as having specific cultural needs. Chinese people commented that they felt neglected within service provision, but largely explained this by needing specific (particularly language) resources which were currently widely unavailable. Chinese accounts seemed to reflect a belief that it was their specific needs which led to their being overlooked, rather than any perception that other groups fared better.

Action 3: Addressing wider social inequalities

The community sector was seen as an important locus for services which addressed wider issues of housing and employment which were of relevance to mental health. Respondents clearly felt that community mental health could not be treated in isolation from issues such as drug and alcohol use, unemployment, housing, education, experience of negative life events, etc, and it was in dealing with these contexts of illness which mental health could be improved.

> Health needs to be seen in the wider perspective - quality of life, social and economic factors
> (Asian male 40-49 years at Asian event London)

One suggestion was that the proposed new Community Development Workers should have a wide remit:

> Community Development Worker should work in various areas like youth, drug and alcohol abuse, mental health, employment, etc
> (Black male 50-59 years at Black event London)

Among others, mental health issues clearly needed to be tackled alongside wider inequalities and disadvantage:

> More integrated approach looking at employment issues, education and housing
> (Irish female carer 30-39 years at Asian event Bradford)

> Closer collaboration with other community initiatives
> (Black female carer/worker 40-49 years Black event Birmingham)

It was suggested that more community services were therefore needed which could access and support those with mental health problems and affect change in their local environments.

> Advocacy, supported housing, outreach, consultants counsellors - all these individuals should be available to Black and ethnic minority people from our own culture in all localities
> (Black female worker 30-39 years at Asian event Birmingham)

Action 4: Involving service users

Consulting service users and learning from their experiences were regarded as integral to plans to improve services. Overcoming difficulties of accessing users, consulting them properly, empowering users and providing support and advocacy were all suggested as important.

Among Irish people, there was comment that as the Irish community was at a different stage of development from other communities, accessing Irish users for consultation was important but possibly hampered by underdevelopment of the Irish community sector itself:

> Getting to consult with service users per se - how do we access them - particularly Irish service users. ... Recognition that the Irish community starts from a different place - need to develop/build on community structures in order to affect a valid consultation process
> (Irish male carer/worker 40-49 years at Irish event Birmingham)

Chinese community respondents also mentioned the importance of user involvement:

> Set up a consultation committee and invite representatives from users' group, Chinese community centre to discuss actual procedure/policy to implement the ideas
> (Chinese female 30-39 years at Asian event Birmingham)

Some Asian respondents felt that user evaluation of change was crucial. It was also noted that service users also needed empowerment:

> Service users themselves need to be recognised more so that they feel their experiences are valued and lessons for us all to learn from. However good we feel we are at supporting our service users, evaluation of this is very important by inviting the very people whom these services are for
> (Asian female carer/worker 40-49 years at Asian event Birmingham)

> It is not enough to say we asked the service users, asked them what? And why should it be assumed that they know what their entitlement should be, they need, empowering
> (Asian female 30-39 years at Asian event Bradford)

Action 5: Supporting families and carers

As well as empowering service users, quite a number of people felt that supporting families and carers was an important part of improving mental health experience.

> Work with families where possible. Mental ill health affects the carers and dependents too. Support services for carers
> (Asian female user/worker/carer 40-49 years at Asian event London)

> More support for the carers in terms of respite care and accessing services
> (Chinese female 50-59 years at Chinese event Manchester)

There was comment that failure to acknowledge the effects of mental health problems on the wider family compounded the possibility of greater mental distress:

> How to listen to the family and give support so they don't suffer and also break down caring for their siblings
> (Black female 60-69 years at Black event London)

Action 6: Educating the professionals and resourcing cultural needs

As was already mentioned in the section on cultural competence, mandatory training in cultural competence was regarded as crucial for of all staff working in mental health, including those in the voluntary sector in order to improve mental health services. It was suggested that training should involve understanding the backgrounds, histories and values of different groups and challenge ethnocentric models of thinking and practice, already mentioned in views on cultural sensitivity. It was felt that training should challenge institutional racism and be a clear organisational responsibility.

> All white staff mainstream mental health services needs ongoing training and awareness of ethnic communities, its culture religion and spiritual needs. At the moment this is not happening
> (Asian male worker 30-39 years at Asian event Bradford)

> Re-education of psychiatrists and police, also staff within the services re cultural awareness
> (Black female 50-59 years at Asian event Birmingham)

Although the vast majority of people were positive about the need for training, there was some scepticism expressed by a minority of people. The following respondent implies that training is not a cure-all, but rather change in practice needs to follow from training and that cultural competence evolves and requires ongoing work:

> Competent service delivery is far more essential than being sensitive. Awareness of cultural issues requires constant work
> (Asian female worker 30-39 years at Asian event Bradford)

A key theme throughout the comments of a large majority of respondents was the perception that GPs particularly were not able to deal with mental health and that therefore their training was particularly important. Better training for GPs was seen as essential in dealing with people's problems at an early stage, in order that they did not later end up in psychiatric care.

> Transcultural mental health and counselling training (accredited training programme) need to be offered. GPs need training in dealing and giving appropriate advice to patients so prevention work can happen rather than ending up in psychiatric care
> (Asian male 40-49 years at Asian event London)

Some respondents specified what training for health professionals should involve. Experience of working in multi-cultural areas was seen as an important part of training.

> There should be a basic shift in the education and training of professionals providing mental health services, ie Drs, GPs, CPN, psychiatrists. They should be taught black history and the achievements of black people. Psychiatrists use only the Eurocentric model. This should be changed. The doctors should be asked to do placements in the community who they will be serving after qualifying. Sometimes they come to an area like City and Hackney and they have not seen a Black person in all their life
> (Asian female 50-59 years at Asian event London)

Among Irish respondents there was an often repeated concern that they were usually excluded from diversity training. Nonetheless, there was some suggestion of what an Irish dimension within training might involve.

> Re. education on a race awareness training basis of statutory workers. It's compulsory in the service but does not include an Irish dimension
> (Irish female worker 30-39 years at Irish event London)

> I think a core component of the new role needs to be education/conveyance of pertinent information regarding cultural issues of the Irish e.g., history, spiritual background, etc
> (Irish female user/worker 30-39 years at Irish event Birmingham)

It was clearly felt that training was required in all sectors, at all levels of service provision and needed to be regarded as a clear organisational responsibility:

> The need to support the staff recruited, provide adequate training, to ensure that organisations realise that they have to change in order to keep staff, for race issues to be looked at in depth and organisations to understand that they have to make themselves more aware of issues
> (Indian/English user/carer 30-39 years at Chinese event Birmingham)

> All training in regards to cultural issues/awareness should be mandatory. Starting with management and speedily cascaded down as you will find higher management generally has an issue in regards to institutionalised racism
> (Black female 40-49 years at Black event Birmingham)

Alongside these comments were a number of suggestions which pointed out the importance of skills in listening to people and treating them as human beings. This was a finding which also emerged in data on experiences of racial discrimination, where many BME people felt they were undermined in a number of ways. What was clear was that people wanted primarily to be treated as human beings, and services were found inadequate in this regard. A part of training for cultural competence was therefore training to teach professionals the skills of being able to listen and show basic respect for patients:

> It would make a great difference if patients are treated as humans with feelings
> (Asian female user 60-69 years at Asian event London)

> Training given for staff to be able to listen and understand people's needs. GPs - doctors to take more time to listen to people's problems. .... to feel you are been heard
> (Female 50-59 years at Asian event London)

The following quote illustrates that perceived gap in understanding between the cultures of doctors and patients:

> Train those who are at the head of these affairs and train those who would be doctors etc., now that they may know how to deal with human beings. Come close to us, we won't bite
> (Black user 50-59 years at Black event London)

Similarly in relation to the proposal of Community Development Workers put forward in the Inside Outside report, it was felt that these new workers also crucially needed to have skills which showed they put clients' needs at the centre of their work:

> Employing community development workers is only part of the answer. They could be academics or robots. We need real people who care about people in true sense, morally sound not just interested in climbing ladder first. Put people first
> (Male 50-59 years at Asian event Bradford)

The lack of listening skills was perceived as linked to failure to diagnose accurately. Although the quote below infers that people may be wrongly labelled, the opposite situation was also described in comments whereby people's distress was not picked up.

> If only the profession would take their time to either listen to clients or patients before labelling or calling or assuming people are depressed or suffering from mental illness
> (Asian female carer/worker 50-59 years at Asian event London)

As noted earlier in the quantitative findings, the failure to provide specific services for particular groups was regarded by many people as a barrier to receiving adequate mental health care, a finding which was again echoed in accounts of how services lacked cultural sensitivity. A majority of people from the Chinese and Asian communities, emphasised again in proposals for actions the importance of translation services and culturally sensitive measures relating to single sex provisions and dietary

requirements. Training more people to provide particularly language support was therefore a common theme:

> Resources need to target areas of unmet need, eg support workers from some communities, access to translating and interpreting especially out of hours, community language courses for staff who are interested
> (Black female worker 30-39 years at Black community event London)

Action 7: Employing BME staff

Another important issue was that of employing people from ethnic minority communities as workers in mental health, an issue which also emerged as important to culturally sensitive provision. Although some people did not feel that this measure alone would bring improvement, it was nonetheless felt that having BME staff, particularly in more senior positions, would facilitate the delivery of a culturally competent service.

> Active involvement of local trust in selection and recruitment of ethnic minorities
> (Asian male worker 50-59 years at Asian event Birmingham)

> More Black/ethnic representation right at the top
> (African Asian woman worker 30-39 years at Black event Birmingham)

> More black and ethnic minority professionals could be incorporated in to more senior positions within the mental health treatment services
> (Black male 40-49 years at Black event Birmingham)

> People at the top are white dominant. Mainstream is the ultimate aim
> (Chinese male worker 40-49 years at Chinese event London)

> Under-represented in terms of senior management who could influence the mental health policy makers
> (Black male 40-49 years at Black community event Birmingham)

As well as a need for more BME staff generally, Chinese and Asian people were particularly concerned about the need for people with relevant linguistic skills as well. One of the main reasons for employing more BME workers was the presumption that they would have a better understanding and knowledge of the BME client groups compared with ethnic majority staff.

> Not enough black workers, not enough interpreters, not enough day care/housing projects for Asians
> (Asian male 30-39 years at Asian event Birmingham)

> Lack of mental health advocates (in clients' own languages) especially at GP centres. Lack of understanding of cultural diversity among the professional at mental health services
> (Asian female 50-59 years at Asian event London)

> Statutory sector should employed more staff who have the experience, knowledge and understanding of the client group
> (Chinese person 40-49 years at Asian event Birmingham)

> Mainstream workers not knowledgeable of Chinese community needs. Not culturally sensitive. Needs more bilingual staff
> (Chinese male 60-69 years at Chinese event Manchester)

> We need professionals who understand diverse ethnicity (own people)
> (Black female carer 60-69 years at Black community event Birmingham)

It was felt by some that even though the solution of employing more workers from BME communities would help, this would not necessarily invoke change unless professional norms themselves were addressed. As was clear in an earlier section, BME workers face discrimination within the workplace and as the following quote makes clear, current practices work to discourage BME workers from using their cultural skills in the workplace:

> The services are very resistant to responding to the needs of minority groups, impose Anglo-saxon cultural norms and use stereotypes to inform the way they relate to people of different ethnicities, workers from minorities are disempowered and discouraged from drawing on their own cultural competencies
> (Irish/Indian user/carer/worker 40-49 years at Irish event London)

However, there was some mention of the need for changes in workplace practices which went further than just employing people from BME communities and for support for and acknowledgement of the added problems facing BME workers who have to work inside, as well as outside the system. However, there was some minor level of criticism that some professionals from ethnic minority communities to distance themselves from their ethnic minority patients.

Action 8: Establishing clear performance targets; auditing services

A number of respondents felt that targets were needed in order to monitor the progress of plans to improve mental health services. It was felt that the quality of services provided should be monitored against performance indicators in service provision and greater accountability was needed in relation to decisions and actions taken by service providers. The Race Relations (Amendment) Act (2000) was suggested as one way to see whether targets were being met with regard to the experience of BME communities. Black community respondents were particularly vocal about the need for accountability within services:

> Indicators that are firmly set and committed with RRA 2000 amendment, forming RE schemes with trusts etc monitored by CHI, CRE - and also independent (community group) national monitoring body
> (Black female carer/worker 50-59 years at Black event Birmingham)

Apart from general comments on overall quality improvement, aspects of service provision which needed monitoring included assessments, diagnoses and treatment options, particularly in relation to medication and the use of detention.

> We need to be able to audit the service providers. We need targets. We need a measure of the provision quality.
> ('Other' female carer/worker 40-49 years at Black event Birmingham)

> Specific targets for trusts on use of medication, diagnosis of schizophrenia and detention rates, risk assessment etc, ie focus on issues that matter so that more general changes will follow
> (Asian male worker 60-69 years at Black event London)

There was a clear view that the power of psychiatrists and GPs to make decisions about treatments needed to challenged and controlled.

> I think an advocate should be compulsory at meetings with doctors psychiatrists and social workers whilst in hospital care. That way there is someone to contest the doctors before they label you as schizophrenic. The doctors and the consultants should be assessed and monitored because they are making the final decision
> (Black female user/worker 30-39 years at Black event Birmingham)

> Challenge GPs diagnosis and prescriptions
> (Asian female user/worker 30-39 years at Asian event London)

Another issue of concern was around providing clarity about targets which were supported at all levels of service and carried force, alongside sanctions to be used if targets were not met:

> There needs to be political will supported by clear targets. There needs to be clear leadership supported by clear measurable targets. There needs to be a will to make change starting from the top downwards
> (Black male 40-49 years at Black event London)

> How will it be monitored and sanctioned if agencies, trusts, medical staff are not performing according to recommendations?
> (Black female 40-49 years at Black event London)

Action 9: Gathering and sharing information; research

The importance of better networking, research, data collection and information sharing for BME communities was stressed by a majority of respondents from all communities. The needs for information varied according to specific perceived community needs.

Irish respondents commented on the need for collection of data on the Irish and linking research to Irish experiences as well as a need for better communication within the Irish sector in relation to mental health:

> Better collection and use of ethnic data in general and Irish data in particular. Challenging of readings of BME which looks at this issue in terms of 'visible groups'.
> (Irish male 60-69 years at Irish event London)

> Linking to academic research on these issues. Historical component/highlighting of postcolonial issues
> (Irish female user/worker 30-39 years at Irish event London)

> Action groups meeting regularly to discuss situations and network. Therefore making it easier for each organisation to access different services, eg., Irish community groups
> (Irish female 20-29 years at Irish event Birmingham)

Those at Chinese events stressed the need for more in-depth research which would harness methods used internationally and comparisons with experiences of Chinese and other communities of the diaspora:

> Funding of research into Chinese experiences of mental health services, sampling different generations, helpful/unhelpful aspects of structural/organisational and process-level aspects of services. Look into the utility of grouping Chinese and SE Asian groups in research such as used in America for the UK population
> (Chinese female worker 20-29 years at Chinese event London)

> Need resources to link into worldwide diaspora knowledge and experience, eg Chinese links with China/ Hong Kong/Vancouver..or Islamic psychiatric services worldwide
> (White English carer 40-49 years at Chinese event Manchester)

Black respondents mentioned their need for more research into the pathways into care of care African Caribbean people and also the need for networks for sharing information and skills nationally between organisations:

> Basic info sharing/website/ leaflet or as above a series of small conferences - regional - also develop small regional teams of black practitioners who engage with BME persons who suffer from mental health, youth, community workers, support teachers...they would be run medical/doctorate professionals. But a would steer the group??
> (Black male carer 30-39 years at Black event Bristol)

> More research into the pathway which leads people with AC backgrounds into hospital
> (Black male 30-39 years Black event Birmingham)

Among Asians, similar general needs were expressed including as the quote below indicates, greater networking among organisations and learning about good practice models already in existence:

> I think services should network, nationally and exchange visits, exchange information, learn from each other. Avoid duplication or re-inventing wheel again ie, there might be good work ongoing else UK other roles, etc
> (Asian male worker 30-39 years at Asian event Bristol)

What these data illustrate is the enormous needs which communities have for learning more about mental ill-health within their communities, and the commitment to using information to enhance the community contribution to improving mental health experience.

Discussion

Many of the ethnic minority respondents to the survey who attended the various community events were people with direct experience of mental health services, as users, carers or workers. This was particularly the case for Black people and less so for people from the Chinese community. Although large proportions of all ethnic groups reported the quality of the care they received as negative or poor, the Chinese group did not report their experience so negatively.

Six key issues were identified as contributing to ethnic minority disadvantage within mental health services; lack of staff cultural awareness (84%), too few staff BME staff (81%), language issues (81%), lack of governmental interest in BME communities (75%), racism of mental health staff (61%) and lack of interest of BME communities themselves (50%). It is clear that a lack of cultural competence in service provision, a perception of a lack of government interest in BME communities and the experience of racism are ranked as key obstacles to getting adequate service provision for BME communities as well as a perceived lack of government interest in BME communities.

The differences between communities are noted above: Irish people felt most strongly about the lack of staff cultural sensitivity, Black people were most likely to feel that lack of government interest and staff racism were problems, Chinese and Asian people felt most strongly that language issues were problematic as well as having too few staff from BME communities. Some of these reflect community-specific needs: Asian and Chinese people would be expected to rank language issues as important. The greater emphasis on racism of staff among Black respondents may be a reflection of the greater proportion within the Black community sample of people with experience of mental health services. Irish people's feeling about a lack of cultural sensitivity amongst staff appears to represent a common perception, illustrated in comments, that because they are a white minority, Irish people's cultural needs are often overlooked or little understood in relation to service provision. These issues of racism and cultural insensitivity were further explored in additional questions about experiences of racial discrimination (open question only to those with mental health experience) and views of cultural insensitivity within services (open question to all respondents).

Nearly half of the overall sample with direct experience of mental health services reported experiencing racial discrimination in services. This experience was reported in similar proportions by Asian and Irish people, was particularly marked for Black respondents and was significantly less so for Chinese respondents. The experiences of racial discrimination described were wide ranging and included direct racial abuse, stereotyping, failure to address cultural needs, receipt of inferior services and treatment, being undermined and neglected and generally experiencing less than equal treatment when compared to others.

A significant proportion of respondents felt that services were not culturally sensitive: less than a fifth of respondents felt that services responded adequately to their cultural needs. Again the extent of dissatisfaction was marked among all groups, but significantly raised among Irish and Black groups and significantly less marked among Chinese people, although there was a great deal of uncertainty expressed by Chinese people about this aspect of services. There were significant age differences in beliefs about cultural sensitivity in services and it may be that the reticence of Chinese people to ascribe cultural insensitivity to services may be an effect of their older age profile, or an effect of lesser overall service experience within the Chinese sample. However, this may also reflect between-group differences in how experiences are labelled: Chinese people may not be as prepared to talk about racism as other groups, and Irish people may also be less likely to ascribe negative or discriminatory experiences as racist, rather than, for example, as anti-Irish.

It may therefore be important to bear in mind that even though ethnic minority groups overall fare relatively poorly within mental health services, that experiences of services and how these are described need to be contextualised within the specific experiences of particular groups, not just in relation to mental health services but also their wider and sometimes divergent experiences as minority groups in England. How experiences are recognised, labelled and articulated may be a facet of cultural differences between minority groups, as well as the majority ethnic group.

These same issues are likely to affect differences in what is understood as cultural sensitivity. This varied from lack of relevant knowledge of different cultures among

mental health staff, to failure to understand the impact and experience of racism in people's lives, a failure to address differing cultural perceptions of mental illness and a lack of resources geared to meet the specific needs of different ethnic minorities. Medical rather than social models of care were felt to compound cultural insensitivity as were a lack of BME staff and poor training of all staff in cultural competence. Culturally insensitive care was clearly perceived by many to be linked to racial discrimination within services and reflective of wider experiences of racism within society at large. Although there was general dissatisfaction with the cultural sensitivity of services, and much agreement about solutions, there were differences in community views, invariably reflecting the need for addressing community-specific requirements to cater for people from different cultures.

It is worth noting that respondents from all communities ascribed their overall experiences to their ethnicity, even when they affect all communities. The issue of stigma surrounding mental illness is illustrative in this regard. Stigma associated with mental illness is a common experience within all communities, including the majority ethnic community. Many of the actions suggested to improve mental health services would also improve services across the board, without detracting from the specificity of experience of people from BME communities within mental health services. Although issues of medical approaches to care and perceived ethnocentricity of mental health services are valid concerns, it is arguable whether psychiatry at present is adequate to the task of effectively dealing with the needs of any community.

In spite of the almost wholly negative perception of current mental health services, respondents consistently outlined a number of ways in which services could start to address the needs of a multi-cultural population. The three key goals of the Inside Outside report; training in cultural competence, reducing ethnic inequalities and developing communities, were endorsed by substantial proportions of people from the four main ethnic groups and actions proposed to improve services reflected these concerns.

Training for cultural competence

Respondents clearly expressed their views that mandatory training of staff at all levels in cultural issues was a prerequisite for better services. Such training should address cultural awareness of different groups and should challenge racism and medical, ethnocentric approaches to care. Respondents also felt that training should be made available to staff at all levels of service, that it should be ongoing and that the outcome of such training should be measured by setting specific performance targets. The importance of language and other resources to cater for different minorities was identified by many as relevant to provision of culturally competent care. It was also felt that more staff from different BME communities should be employed at all levels of service as this would enhance cultural sensitivity of services.

The comments that GPs particularly needed not only training in cultural issues but also in mental health issues, suggests that GPs are not only perceived as culturally unaware, but lacking too in essential skills in recognising mental distress, which is in turn compounded by a lack of cultural awareness.

Reducing inequalities in services

All communities felt that reducing inequalities was an important goal and this was deemed particularly by Black and Irish respondents.. Respondents clearly felt that measures to enhance cultural competence would reduce inequalities. The experience of racism in mental health services was perceived as linked to unequal treatment and care experience. As well as racism and lack of cultural competence, other experiences of stereotyping, neglect, the inferiorising, pathologising and undermining of ethnic minority people, were also linked to poorer and unequal experience in mental services mentioned by all ethnic minority groups. It was suggested that the goal of reducing inequalities would be met by addressing these concerns in practice.

Different groups are likely to have viewed the issue of inequalities from the perspective of their specific knowledge and experience of their own communities There were particular concerns raised about the experiences of Black people of African Caribbean origin within psychiatry, including the over-use of ECT, sections, secure units and the general over-representation of people of African Caribbean origin within mental health services. Respondents in this survey were concerned about measures to reduce these inequalities, particularly among young people. This may partly explain why 78% Black people felt that reducing inequalities was very important, compared with much lesser proportions of Asian and Chinese people but it may also be a factor that greater proportions of the sample of Black people had experience of mental health when compared with other groups.

There was little support for the view that people from BME backgrounds should be encouraged to make greater use of mental health services. The experience of the Black community was noted in this regard as cautionary. Instead it was proposed that services needed to change in order to serve the needs of a multi-cultural population. This point was reflected in qualitative data on what actions were necessary in order to improve the experience of BME people with mental health problems. Many of these data point to the importance of community responses to mental health discussed later, but what was clear in relation to reducing inequalities was that people felt strongly that resources were crucial for supporting and promoting good mental health at community level, so that numbers coming into contact with poor quality services, when in crisis, were reduced.

Targets and performance indicators to monitor progress towards equality for BME people within mental health services were advocated at all levels within organisations. The Race Relations (Amendment) Act 2000 was suggested as a means to encourage employers to fulfil their obligations to race equality.

Community Development

The respondents overwhelmingly endorsed the third key goal of the Inside Outside report that of community development to deal with mental health along with improvement inside services aimed at reducing inequalities and enhancing the cultural skills of the workforce. Black and Irish respondents were particularly likely to see community development as very important.

Actions suggested by respondents towards the goal of community development included mental health promotion and primary prevention at community level, educating communities (but also, as mentioned earlier, educating GPs about mental

health) about mental health, supporting families, empowering users and challenging community stigma around mental health. Community sector development was seen as a crucial arm of culturally sensitive provision. Emphasis was placed on the need for adequate funding for development, building equal partnerships between voluntary and statutory providers with the ethnic minority voluntary sector being given a central role, and generally creating a sense of empowerment and ownership within communities in relation to mental health.

There was also a great deal of support for the development of alternatives to mainstream mental health services, provision of non-medical approaches to care including counselling, psychotherapy, support networks, and addressing the social and material disadvantages linked to poor mental health such as housing, employment, social support, etc. The importance of gathering and disseminating accurate and up-to-date information on BME mental health and building within-community networks was stressed. These actions while perceived as necessary to enhancing individual and community mental health were clearly linked to reducing the need for psychiatric interventions which were regarded as dehumanising, ineffective in the longterm, culturally insensitive and based on principles and practices at odds with how ethnic minority communities understand and experience mental ill health.

Methodological issues

It is likely that the generalisability of the findings from this survey is limited by the selective nature of the sample of respondents. Ethnic differences cited here reflect different characteristics in the profiles of the different ethnic community respondents. As noted earlier, some of the differences between the Chinese respondents may be due to their older age and more limited experience of mental health services when compared to others.

Respondents who came to these community events heard about these events through community networks and organisations, their friends, work, and to a lesser extent through the media. The disparities in numbers of respondents between communities may reflect different levels of organisational development within communities, and therefore different abilities of communities to mobilise themselves, and specifically people who are service users or have other experience of mental health services. To an extent therefore, the size and profile of the questionnaire sample is an effect of how different communities have formed and developed within England. However, as sizeable proportions of people who responded to this survey had experience of mental health services, the views reported here represent those to whom mental health services are most relevant within minority ethnic communities.

The differences between the different ethnic groups in their responses concerning mental health services may be due to their differential service experience and histories as well as different ways such experiences are understood and articulated. On the basis of these data, it is difficult to assess whether, for example, Chinese people are less likely to experience racial discrimination within mental health services, or whether the discourse (not the experience) of discrimination has tended to overlook or exclude Chinese people, which in turn is reflected in how experiences are described (an issue also for Irish people who are commonly excluded from discussions around 'race', racial discrimination *and* cultural sensitivity). Experiences of discrimination

are painful and cultural issues are often difficult to articulate, so sensitive, culturally responsive interviews may provide a more appropriate environment within which to explore these nuanced experiences and understandings.

It is possible that there may be different community preferences for methods to research some of these issues, and that perhaps a questionnaire might have prohibited comments from some people. There were age differences and a range of language competencies in the sample, and therefore it is possible that even within communities, some people might have preferred the use of other research methods. However, it is also possible, as was often re-iterated, that as mental illness is clearly stigmatised, that the use of an anonymous survey such as this, gave people greater freedom to express views which they might feel less inclined to voice in an interview or focus group situation.

Conclusion

The views analysed here of Asian, Black, Irish and Chinese respondents on their experiences of mental health services and their views on how services might be changed to effectively deal with a multi-cultural population, mirror the evidence and proposals for change detailed in the Inside Outside report. Cultural insensitivity and racial discrimination are linked and regarded as both causes and effects of service inequality for people from BME communities. The solutions proposed towards improving the care of people from BME communities with mental health problems challenge the practices of mental health professionals. There is general acknowledgement that improvement in services would not be possible without greater community capacity building, empowerment, partnership and ownership over mental health. Training of staff within services and developing communities outside statutory services were therefore endorsed by all communities as inter-dependent goals towards reducing mental health service inequalities for BME groups, and essential to responding to the needs of a multi-cultural population.

Appendix 1

Community Consultation Questionnaire

Here are some questions about your views of current mental health services and of the 'Inside/Outside' report that sets out the plans to improve mental health services for Black and Minority Ethnic communities in England

This questionnaire is confidential. The purpose of it is to find out what members of different minority ethnic communities feel about mental health services and how the current services may be improved. Your name is not required.

General

Q1. To what ethnic group or community do you feel you belong? [Please tick ✔]

- ☐ Asian
- ☐ Black
- ☐ Chinese
- ☐ Irish
- ☐ Other [please describe]

Q2. Are you Male ☐ Female ☐ [Please tick ✔]

Q3. What age group do you belong to? [Please tick ✔]

- ☐ 19 years and under
- ☐ 20-29 years
- ☐ 30-39 years
- ☐ 40-49 years
- ☐ 50-59 years
- ☐ 60 years and over

Q4. Which community event are you attending?

- ☐ Asian
- ☐ Black

☐Chinese
☐Irish

Q5. In which city is the event taking place (e.g., London, Bradford)? Please write in……..

Q6. How did you first hear about today's event? [Please tick ✔ as many as apply]

☐Media (includes radio, newspapers)
☐Through friends
☐At work
☐Though community organisations and networks
☐Other [please describe]

<u>Your views and experiences of current mental health services</u>

Q7. Have you had any personal experience of mental health services? [Please tick ✔]

☐Yes
☐No

If you have answered No, please move to Q12

Q8. Is your experience from

a) ☐using services yourself
b) ☐caring for a friend or relative who has used mental health services
c) ☐working in mental health
d) ☐Other [please describe]

[Please tick ✔ as many as apply]

Q9) In which setting did you come into contact with mental health services

a) ☐primary care (for example, GPs, etc?)
b) ☐hospital care
c) ☐specialist mental health services (for example psychiatric hospital or out-patient clinic
d) ☐Other [please describe]

[Please tick ✔ as many as apply]

Q10) Overall, how would you rate the quality of your experience? [Please tick ✔]

☐very poor
☐poor
☐good
☐very good
☐excellent
☐don't know

Q11) Have you experienced racial discrimination in mental health services? [Please tick ✔]

☐Yes
☐No
☐Don't know

If you have answered Yes, please describe here your experience(s)

Q12. Do you think that mental health services are sufficiently sensitive to the needs of people from your ethnic background? [Please tick ✔]

☐Yes
☐No
☐Don’t know

If you have answered No, explain why you think this…

Q13. Do you think that any of the following is a problem in getting better mental health services for people from ethnic minority communities? [Please tick ✔ as appropriate]

a) No interest in mental health services within ethnic minority communities

☐Yes ☐No ☐Don’t know

b) Too few mental health staff from ethnic minority communities

☐Yes ☐No ☐Don’t know

c) Language problems such as no unterpreters

☐Yes ☐No ☐Don’t know

d) Racism of staff

☐Yes ☐No ☐Don’t know

e) Lack of cultural awareness amongst staff

☐Yes ☐No ☐Don’t know

f) General lack of interest by government in improving services for people from ethnic minority communities

☐Yes ☐No ☐Don’t know

Q14. How do you rate the following as problems for people from ethnic minority communities? [Please tick.

a) Getting access to services

☐A big problem ☐A problem ☐Not a problem
☐Don't know

Your views on the Inside Outside Report

Q15 The Inside/Outside report proposes a number of changes to current mental health services. These are meant to improve the services available for people from minority ethnic groups. Three of the main proposals are described below. Could you tick how important these proposals are in improving services

a) The plan proposes that training of staff on cultural awareness and competency is an important goal. How do you rate this goal? [Please tick ✔]

☐Not important
☐Fairly important
☐Important
☐Very important
☐Don't know

b) The plan proposes a number of changes to reduce ethnic differences in the care and delivery services. How important do you feel these changes are? [Please tick ✔]

☐Not important
☐Fairly important
☐Important
☐Very important
☐Don't know

c) The plan proposes that black and minority ethnic communities themselves need further help and assistance in dealing with mental health issues in their own communities alongside existing mental health services. How important do you feel is such community development for improving mental health in the community [Please tick ✔]

☐Not important
☐Fairly important
☐Important
☐Very important
☐Don’t know

Q16. Overall, do you feel that the plans, if put in action, will improve mental health services for people from ethnic minority groups? [Please tick ✔]

☐Yes
☐No
☐Don’t know

Q17a. Are there any other actions or issues not mentioned in the plan today which would benefit people from ethnic minorities who have mental health problems?

☐Yes
☐No
☐Don’t know

Q17b. If you have answered Yes, please describe here what else you feel could be done……..

Appendix 2: Methodology

From the questionnaire, a variable list, consisting of a total of 35 variables, was created, and analysis of the data was undertaken for descriptive and comparison purposes. Sometimes questionnaires were only partially completed, and in some cases demographic information such as age and gender were missing. If any questions on a questionnaire were completed, these questionnaires were taken as representing cases for analysis. The majority of the questionnaires were completed in English (78%), but quite a number were completed in Cantonese (13%) and a number of south Asian languages (9%). Most Chinese people filled in questionnaires in Cantonese (86%) whereas most Asian people filled in questionnaires in English (80%). Of the questionnaires completed in south Asian languages, 62% were completed in Gujarati, and the rest in Urdu, Hindi, Punjabi and Bengali. Written comments in south Asian languages and Cantonese were translated into English and included in the qualitative analysis. Both Chinese and Irish communities held two events in London. For the purposes of this analysis, questionnaires from both London events for each of these communities are amalgamated.

Cases were coded both by how people defined their ethnic background (Q1), and by which ethnic community event they were attending (Q4). The former led to some missing data, as some people did not tick any box, whereas data for the latter variable ('bmeevent') were complete as questionnaires were carefully collated at each event and kept separately. As expected, the vast majority of people attending any given community event belonged to that community (98% Irish and Chinese people attended their community events, 95% Asian people attended Asian events, and 93% Black people attended the Black community events), but there were occasional cases of Irish people attending non-Irish events, Asian people attending Black community events and White British people ('other') attending any of the events. For the purposes of this analysis, ethnicity is based on how people assigned their ethnicity (ethnic variable – Q1), rather than which community event they attended.

The ethnic variable was not without it problems. Some people objected that 'Black' for example, was not an ethnic group, while others offered self-definitions such as Sri Lankan, Indian, etc, in addition to ticking a box within the given list such as the Asian category. For purposes of this report only the pre-defined ethnic categories are used in the quantitative analysis. Throughout the report 'Asian' refers to people of south Asian origin and 'Black' refers to people of African Caribbean origin, although the questionnaire responses may have included self-assigned ethnic descriptions such as Indian, British Indian, Black British, Black Caribbean, African-Caribbean, etc.

Overall, there were 41 (41 out of 526 cases or 7.8 per cent) cases outside of the four main ethnic minority categories used, who ticked the 'other' ethnic category. They were excluded from quantitative analysis using ethnic minority as the main variable. Fourteen of this group provided no further information, 6 gave information which defined them as having the following 'dual identities' – 'Pakistani/Irish', 'Irish/Indian Punjabi', 'Mixed race Indian/English', 'White/African Caribbean', 'Mixed race' and 'African Asian'. Twenty described themselves as white British, English, etc (therefore of the majority ethnic community), and one person defined herself as Turkish. If more than one box was ticked where only one was required, these answers were regarded as invalid. Additionally unless a box was ticked, even if comments

suggested what should have been a ticked response, such responses were entered as missing data.

Analysis using SPSS (version 11.5) broadly compared responses of the different ethnic communities on all the key variables. Two new variables – 'exper' (whether a carer/worker/user of mental health services) and 'mhcare' (whether service experience was of hospital and/or specialist mental health services) were created from the responses and in one case (quality), responses were recoded to capture negative and positive perceptions of care.

All variables were initially analysed by ethnic group. Basic cross tabulations were done and column percentages and totals are reported in tables, which also show the distribution of responses within each ethnic group for each variable. In order to ascertain whether the two different variables were related, that is, if there were differences between ethnic groups in relation to each variable, the chi-based Cramer's V (V) statistic was computed. This is commonly used with nominal variables in tables of any dimension, and similar to the Phi statistic if the number of rows or columns is 2. This informs us of the strength of any association.

Due to the difficulty in reading the relationship directly from the tables, for simplicity's sake, the ethnic variable was recoded so that each ethnic group was compared with all others (for example, Black compared with Asian/Irish/Chinese others, etc – tables not reported here) for each variable and where significant differences were found these are reported in the text. For example, there was a strong relationship (V=.399) between being Chinese and age group which was significant ($p<.0005$). It is therefore apparent that age group in this sample significantly differs according to Chinese ethnicity when compared to others (Black/Asian/Irish). From reading the relevant table it is clear that this statistically significant difference is that the majority of Chinese respondents were aged 60+ and this varied from the other ethnic minority groups. This analysis was repeated for all variables, but only cases of significant differences ($p<.05$) are reported in the text. Analysis was also carried out on each variable by sex, age and service user status and significant differences are reported in the text.

Qualitative analysis involved coding the answers to the three open-ended questions on racial discrimination, culturally sensitive services and actions to improve services, as free nodes in Nud*ist4. All other written comments were collated under a general umbrella node. That done, more fine-tuned analysis was done to record exhaustively the themes which emerged under each heading and to explore the extent to which these themes varied by ethnic group, service experience, gender and age. All quotes relevant to particular issues were therefore amassed and initial summaries of the data were written up. These were then shortened by retaining fewer quotes illustrating the same themes, although some allowance was made for repetition in order to illustrate that people from different ethnic backgrounds, of different ages, with different experiences of services and of different genders broadly agreed on issues of importance. Quotes are unaltered except for occasional cases of spelling correction. Comments on the issues of racism, cultural sensitivity and service improvements needed were not discrete. As a result, there was some overlap of comments in the three areas of analysis. These linkages are discussed in the Discussion section of the report.