



**Equalities in
Mental Health**



**National Mental Health
Development Unit**

**DELIVERING
RACE EQUALITY
IN MENTAL
HEALTH CARE**

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Race Equality Action Plan: a five year review

**Melba Wilson, National Programme Lead,
Mental Health Equalities Programme,
National Mental Health Development Unit**

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Introduction

DRE – Summary Report (December 2009)

A summary report setting out the key areas of this longer report was published in December 2009. It is available at www.nmhdu.org.uk. The Delivering Race Equality in Mental Health Care action plan for reform inside and outside of services (DRE) was published in January 2005.

Who is covered?

DRE was a five-year plan to improve services for people from Black and minority ethnic (BME) communities. The DRE action plan extended its coverage to 'all people of minority ethnic status in England... [and] does not only refer to skin colour, but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, Mediterranean origin and East European migrants¹'. In addition, the DRE action plan also covers specific populations, including refugees and asylum seekers, older people, and children and young people.

In short, the DRE action plan was designed to reduce inequalities in how people from a range of communities access, experience and achieve outcomes from mental health services.

The DRE action plan was published simultaneously with the previous Government's response to the independent inquiry into the death of David Bennett. David Bennett was a 38 year-old African Caribbean patient who died in October 1998 in a medium secure psychiatric unit after being restrained by staff. The action plan and response can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

The DRE programme reached its planned end date in January 2010. In its five years of existence, the landscape in mental health policy implementation has changed. Amongst the significant changes are;

- The ending of the National Service Framework for Mental Health (1999);
- The development of the previous government's mental health strategy (New Horizons) (2009);
- The publication of the NHS White Paper: Equity and excellence: Liberating the NHS (July 2010)
- The development of a new mental health strategy – expected in 2011;
- The passage of The Equality Act 2010; AND
- "Big Society"

This report:

- Discusses the environment and context in which DRE operated;
- Sets out and assesses progress, learning and achievements of the DRE programme;
- Discusses progress and measurement in relation to experience, access and outcomes for people from BME communities; and
- Sets out proposals for how the work of the DRE programme can inform current and future work in health and social care to address inequalities in mental health.

¹ DRE action plan, 2005, p.9

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DRE – Background and context

The impact and progress of the DRE action plan must be set within the context of two other key areas of policy:

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

This document preceded the DRE action plan. It included published responses to a consultation which sought to identify issues and concerns within mental health care in relation to Black and minority ethnic communities. It identified three key objectives:

- To reduce and eliminate ethnic inequalities in mental health service experience and outcome;
- To develop the cultural capability of mental health services; and
- To engage the community and build capacity through Community Development Workers (CDWs).

Each of these objectives was embedded within the DRE Action plan.

2 The previous government's response to the independent inquiry into the death of David Bennett (DH 2005)

The inquiry response was published simultaneously with the DRE action plan and made a number of recommendations. These were broadly accepted in principle. They focused on:

- Workforce issues – including the need for training in cultural competency and for recruitment of a culturally diverse workforce;
- The need to address issues of racism and discrimination;
- The need for appropriate policies – e.g. in relation to harassment and abuse, patient care, control and restraint;
- The importance of good information and record-keeping;
- The importance of good and appropriate clinical care and treatment – including assessment, diagnosis, medication, timely care, care in secure settings, and the importance of after care in the community;
- The importance of involving families and linkage with communities; and
- The importance of linkage across the spectrum of health and social care.

The DRE programme set out to address these issues in its implementation.

DRE – The vision and action plan

The DRE action plan was developed on the basis that people from BME communities in England do not always get the quality of mental health care to which they are entitled. It was also developed within a context that acknowledged that some patients from BME communities are more likely than their White British counterparts to be detained compulsorily, to be admitted to hospital rather than treated in the community, to be subject to measures like seclusion in hospital, and to come into contact with services through the criminal justice system.

A widely held view then (and to some extent now) amongst some within BME communities was that 'this fuels a vicious circle that can deter BME people from seeking care early in their illness²'.

There continue to be differing and contentious perceptions about BME communities' readiness to engage with services, and the ability of services to appropriately address their needs. Evidence gained through the DRE programme suggests a mixed picture – with some people expressing satisfaction; others not. Responses also differ between communities. Other evidence, e.g., the mental health inpatient survey³ consistently reports broadly similar rates of satisfaction for BME and White populations when engaging with services. The position remains complex and will ultimately require a public health based approach in assessing and meeting mental health need based on good information and data.

The belief in setting up the programme was that a comprehensive framework of action – on many fronts – would enable change to occur in how services were configured and provided. The aim was to develop a systemic approach to change.

The programme's first national director, Lord Kamlesh Patel, noted at the time of the action plan's publication:

"DRE is not about separate mental health services for BME communities. As the case of David Bennett demonstrates, it is not possible to adequately address improvements in access, experiences and outcomes for BME service users without taking a comprehensive mainstream approach. We need equality for all ages, from childhood through to old age; we need it for women and men, and for particular groups such as refugees and asylum seekers⁴".

² DRE: A summary, DH 2005, P.2

³ www.cqc.org.uk/guidanceforprofessionals/healthcare/nhsstaff/annualhealthcheck2008/09/qualityofservices/exis/experienceofthepatients.cfm

⁴ DRE action plan, 2005, p.9

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This would involve developing enabling and supportive mechanisms for change, while, at the same time, identifying opportunities for service improvement. It meant having a focus on:

- The role of clinicians and other aspects of workforce development;
- The part that communities could play in informing systems and processes; and
- Data capture to build an evidence base.

These became the three building blocks for change on which the programme was based.

Building Blocks

The DRE action plan aimed to tackle discrimination in NHS and local authority mental health services, and was set up as a key component of the Department of Health's (DH's) wider equality and human rights strategy. The action plan was based on three building blocks:

- Better, more responsive services;
- Better engagement of services with their local communities; and
- Better information.

12 characteristics

The goal and vision for the DRE action plan was that by 2010, mental health services would be characterised by:

- Less fear of services among BME communities;
- Increased satisfaction with services;
- A reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units;
- A reduction in the disproportionate rates of compulsory detention of BME users in inpatient units;
- Fewer violent incidents secondary to inadequate treatment of mental illness;
- A reduction in the use of seclusion in BME groups;
- The prevention of deaths in mental health services following physical intervention;
- An increase in the proportion of BME service users who feel they have recovered from their illness;
- A reduction in the proportion of prisoners from BME communities;
- A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;

- A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy and in the planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

78 Actions

As part of implementation, a series of 78 actions (see [Appendix 1](#)) were identified as criteria to help organisations identify specific approaches to bring about successful delivery.

The actions covered a range of agencies and organisations – some of whom went out of existence during the course of the action plan's life span.

A significant number of actions involved a lead role for the National Institute for Mental Health in England (NIMHE) in facilitating the actions. Some of the actions were strategic; others operational. Accountabilities for monitoring and reviewing progress overall, however, were unclear. Examples of actions for specific organisations include:

- All organisations e.g. Mental Health (MH) trusts, Primary Care Trusts, NIMHE having in place a race equality scheme and cultural capability framework;
- Department of Health (DH) to implement the national action plan on leadership and race equality;
- DH to encourage research that considers BME issues as an integral part of planning and delivery;
- NIMHE race equality leads to provide regional leadership;
- NIMHE, Care Services Improvement Partnership (CSIP), Sainsbury Centre for Mental Health (SCMH) – to identify training needs;
- NIMHE, the Mental Health Act Commission and Healthcare Commission – to carry out a national mental health inpatient census;
- NIMHE to work with the Prison Service, the National Association for the Care and Resettlement of Offenders (NACRO) and National Offender Management Scheme;
- DH to commission an independent evaluation of DRE;
- PCTs and Local Authorities (LAs) to review their implementation of Standard 7 of the National Service Frameworks (NSF) for older people;
- PCTs to develop and agree plans for early diversion from the criminal justice system;
- PCTs/Strategic Health Authorities (SHAs)/ LAs to identify training needs of their staff;
- Professional and government bodies to plan and manage individuals' progress towards cultural capability;

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- PCTs to recruit 500 CDWs;
- PCTs and social services departments to identify senior managers to liaise with CDWs;
- Mental health services to record patient ethnicity and other relevant data, e.g. religion and language, for planning care;
- National Patient Safety Agency to publish thematic reviews based on data from the Confidential Inquiry into Suicides;
- NHS Direct to provide a national interpretation service;
- NHS University to develop a race equality and cultural capability programme; and
- Healthcare Commission to promote safer inpatient and therapeutic environment.

Feedback from those with responsibility for implementation indicated that the sheer volume of actions made it difficult for organisations to focus on all of the actions involved, as well as how to link effectively with relevant agencies, or to understand the ‘fit’ in terms of delivering a whole systems approach.

There has been progress in many of these areas. However, the ability of the DRE programme to monitor such a huge swathe of activity has been affected by variable data availability, quality and collection, as well as variable understanding about the programme itself amongst some of the organisations included in the 78 actions.

Nevertheless, the existence of the DRE programme, and the attendant expectations on differing agencies did lead to a range of activities and initiatives aimed at addressing and improving equality of access for people from BME communities.

Effectively, the DRE action plan set out to achieve organisational, attitudinal and behavioural change across health and social care in England within five years.

Key learning

Future work to improve access, experiences and outcomes should be directed by the use of relevant and focused indicators. These should be locally and regionally owned and determined, with clear mechanisms of accountability for delivery.

DRE – Implementation – An overview

The mechanisms identified for implementing the DRE action plan were to:

- 1 Work towards more appropriate services through a national system of Focused Implementation Sites (FIS). The aim of the FIS was to demonstrate a whole systems approach to improving care;

- 2 Develop and support a national process of engaging communities through:
 - Supporting the recruitment of 500 community development workers by PCTs; and
 - Developing and supporting community infrastructures through Community Engagement (CE) projects.
- 3 Develop systems and processes for better information through research, evaluation and identifying good practice.

Governance and national leadership

The DRE action plan had specific governance arrangements. It was sited within the National Institute for Mental Health in England (NIMHE) and accountable to the Department of Health (DH). Reporting was to the Department of Health’s BME Mental Health Programme Board. This included ministerial accountability.

This board had the remit of driving the development and delivery of the action plan, and the response to the inquiry into the death of David Bennett, in a co-ordinated BME Mental Health Programme, through the leadership of a national director.

Throughout its existence, the DRE programme has had overlapping accountabilities which have included:

- A National Programme Board – to oversee development and implementation (jointly chaired by Lord Kamlesh Patel and a DH representative);
- A National Steering Group – with internal (DH) and external representation (jointly chaired by Lord Victor Adebawale & the Health Minister);
- The NIMHE Programme Board⁵;
- The Care Services Improvement Partnership Management Team (an overarching partnership established in 2006 which included NIMHE and regional development centres);
- The Department of Health Mental Health Programme Delivery Board (MHPDB); and
- The DRE Programme Board.

The DRE programme has had a number of changes in leadership, personnel and structure since its inception. In addition, it has been affected by structural and organisational changes in health and social care.

Regional Roles

The primary focus for the implementation of the DRE programme was through regional development centres (RDCs), initially within NIMHE, and later the CSIP. The RDCs’ remit was to incorporate and integrate the DRE programme work with the other NIMHE workstreams for which they were responsible.

⁵ The programme is now within the National Mental Health Development Unit which replaced NIMHE on 1 April 2009

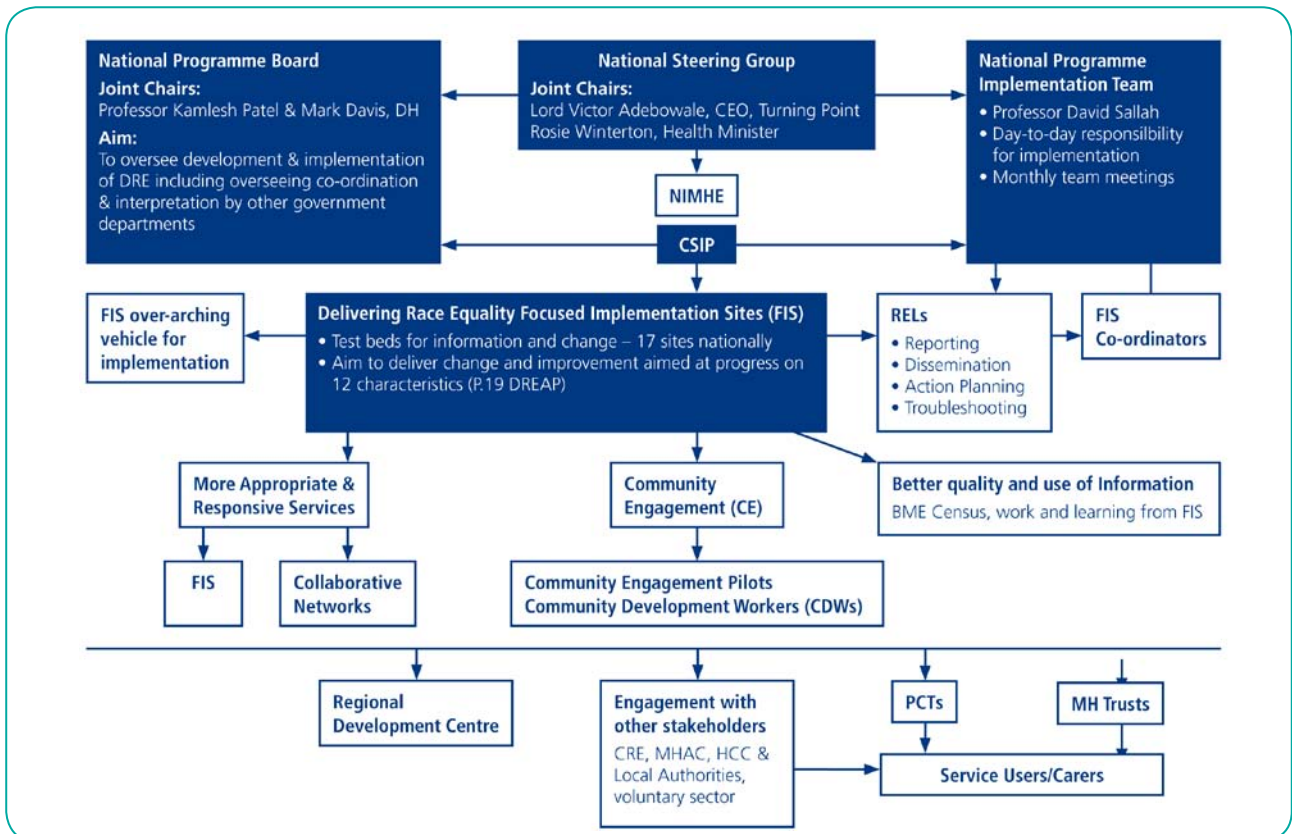
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Race Equality Leads

The DRE programme created new regional race equality leads (RELs). Their role was to provide ‘local leadership’ within the NIMHE development centres – working with communities and through regional and national accountabilities. Key aspects of the RELs’ role included:

- 1 Membership of a national team of eight Regional Race Equality Leads, which contributed to national development and implementation;
- 2 Leading on and contributing to a wide range of national, regional and local projects;
- 3 Leading and developing areas of race equality and CE in regional development centres to promote the mainstreaming of race equality;
- 4 Leading on the development of NIMHE’s Race Equality Scheme and the implementation of its Race Equality Action Plan at national, regional and local levels;
- 5 Developing strategies and providing leadership to enable mental health services to mainstream race equality and better meet their obligations under the Race Relations (Amendment) Act 2000 and human rights legislation;
- 6 Managing and overseeing a wide range of locally based CE projects, including recruitment, retention, training and support of community groups. This included providing them with strategic guidance on budgetary, human resource, research and mental health issues;
- 7 Providing leadership and guidance on the recruitment, retention and career development of the regional proportion of 500 CDWs;
- 8 Providing mentorship and leadership to CDWs;
- 9 Influencing the development and nurturing of local and regional partnerships between the BME voluntary sector and statutory agencies in mental health and related fields and supporting networks of voluntary sector agencies in mental health;
- 10 Engaging with the business sector, academia and regional bodies relating to social exclusion and race equality in an effort to raise awareness of mental health issues, contribute to the evidence base and secure funding for future CE work;
- 11 Supporting networking and the dissemination of good practice among statutory sector organisations in relation to BME mental health; and
- 12 Providing leadership and facilitating the development of a strategic response to the needs of BME service users through the establishment of a service user network.

DRE Structural & Reporting Framework (2005)



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This meant that RELs had a significant – indeed lynchpin – role in helping to set up and maintain an active watching brief on Focused Implementation Sites. RELs were accountable to the director of their NIMHE regional development centre, and to the national director of the BME Mental Health Programme. There were eight NIMHE regions, each of which (with the exception of London) employed a REL. London had two RELs.

The chart on the previous page illustrates the structure and reporting lines established at the outset of the programme.

Practicalities of implementation

- The DRE action plan was launched through inviting expressions of interest from strategic health authorities (SHAs) to bid for monies (£50k per site) to establish FIS in their regions. Consortia which included primary care trusts, mental health trusts, voluntary sector agencies and others were encouraged to set up FIS in regional localities.
- Criteria for becoming a FIS included linkage across the building blocks (services, community engagement, better information); relevance to the 12 characteristics for change; and ability to generate partnership arrangements, including with communities and the voluntary sector.

The aim was to produce a rich mix which would identify opportunities and leverage for change.

Early considerations

The DRE programme was established within a climate of heightened concern about the inequalities and barriers faced by BME in mental health services. Its aim was to proactively improve the status quo.

DRE's existence was governed by:

- A significant commitment of resources: £2m national annual budget and £16.5 million allocations to PCT baselines in 2005 to fund CDWs. This is on a recurring basis;
- A profile which involved ministerial and civil service commitment;
- High expectations of service users and carers and professionals from Black and minority ethnic communities; and
- Wide-ranging interest and good will for it to succeed.

The programme was also subject to:

- Differing interpretations by stakeholders – including users, carers and professionals, about how it should deliver;
- Complexity and changing landscapes within health and social care; and
- Competing priorities from a range of stakeholders.

Other contributing factors affecting the programme's development included:

- **Internal environment** – changes in leadership; significant organisational change within its host organisations – National Institute for Mental Health in England (NIMHE) and the Care Services Improvement Partnership (CSIP) – both of which no longer exist. In addition, there were changes in accountabilities and governance, including devolved decision-making and resources to strategic health authorities and regional development centres, which were the primary agencies charged with steering the work.
- **External environment** – The setting up of the DRE programme coincided with major structural change in the NHS through the re-configuration of strategic health authorities and PCTs. Financial imperatives for the NHS were also a factor.
- **Complexities of basic principles** – The programme's strong emphasis on experimentation and innovation, e.g. in relation to community development; and the degree to which this needed to be clarified and explained in a statutory sector context.

One of the most significant aspects to emerge was the need for greater clarity about the differing ways in which people from different BME communities experience services. For example, the findings of the report⁶ on the national CE projects illustrate the complexities in how different communities express and experience fears in relation to mental ill-health (which is this first DRE characteristic):

“It is clear from the study reports that fears differed according to the level of participants' experiences of mental health problems and treatments. Community members with no or little experience of mental illness reported that their biggest fear was not what might happen to them at mental health services if they sought help there, but rather the stigma, shame and the repercussions of these (such as negative effect on marriage prospects).”

⁶ Fountain, J. & Hicks, J. (2010), Delivering Race Equality in Mental Health Care: Report on the findings and outcomes of the community engagement programme 2005-2008. P.33 (UCLAN)

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The report notes that:

“it should be stressed that not all participants who were asked expressed a fear of mental health services. There is some evidence that fear may not be a major issue for many Arabic-speaking, Kurdish, Turkish and Yemeni study participants... particularly males”.

The report also notes, however, that:

“Nevertheless, fear as a barrier to service access facing members of Black and minority communities was a recurring theme in the majority of the study reports, with a significant number – including service providers – reporting this.”

and that:

“A fear of mental health services – whether based on experience or perception – was rarely reported in isolation. Multiple fears, with complex connections to other issues were the norm. These were strongly related to experiences and perceptions of services’ cultural competence, especially in relation to language and faith.”

This illustrates the degree of complexity within which the DRE programme operated. It meant the programme had to:

- Incorporate continuing flexibility, while remaining focused on the task set for it;
- Constantly re-make ground and re-establish itself in the face of changing circumstances, personnel and priorities;
- Develop ways of working which promote understanding, enable delivery and measurement of change and progress; while keeping communities informed and engaged; and
- Seek to understand and inculcate differing perspectives in relation to different communities in all aspects of the work of the programme.

The DRE programme generated a huge range and depth of work relating to activity, initiatives and development. It has made a significant contribution to the evidence base on the demography of communities – their needs; how they access services; how they wish to access services; and what commissioners and providers can do to improve that interface. The systematic engagement of the programme in evaluation, knowledge generation and research has helped to foster a better understanding of inequalities issues, in relation to care pathways as a means to improving services.

Arguably one of the most significant outcomes of the programme has been to help shift opinion and practice about the need to fundamentally address issues of service development and improvement in terms of how people from Black and minority ethnic communities access and experience services.

Format

The format of this report will follow that set out within the DRE action plan.

We report on progress and developments in relation to:

- The three building blocks; and
- The 12 DRE characteristics.

For each section discussed we will:

- Set out the **intended aim** of the building block or characteristic;
- Cite the **evidence developed** through the work; and
- Set out **key learning and other messages**.

The aim is to capture the interlinked evidence base for future learning, development and sustainability.

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DRE action plan – The evidence base

The DRE programme achieved a great deal in its five years. A summary of achievements at regional, national and local levels is set out below:

During its five years, the DRE programme:

- Recruited a cohort of nine regional Race Equality Leads (REs) who operated at strategic and operational levels to deliver on the aims and objectives of the programme;
- Instituted regional programmes of work through NIMHE and CSIP regional development centres;
- Developed and supported partnerships with users and carers at local, regional and national levels, including the setting up of a national DRE Ambassadors workstream to inform and influence how the work is developed. The work of the DRE Ambassadors will be discussed in more detail later on in the report;
- Worked with NHS and social care partners to establish 17 focused implementation sites (FIS) to look at the needs of local communities and to test out new and innovative ways of working. In the course of the programme an 18th FIS – from the private sector (Partnerships in Care) came on board as part of the programme;
- Supported the development of 79 CE projects nationally to forge partnerships with the voluntary and community sectors (VCS) and to develop the skills base of people involved with small BME VCS organisations. Available at iscioffice@UCLAN.ac.uk;
- Supported the recruitment and development of more than 450 CDWs nationally;
- Introduced and implemented an annual census – Count Me In – to aid better understanding of the pathways for mental health patients. This work was in partnership with the then Healthcare Commission and the Mental Health Act Commission (since replaced by the Care Quality Commission).
- Developed a programme of race equality training, including the setting up of a national training team (NTT);
- Funded 20 clinical trailblazer sites within the NHS to test out new ways of working with clinicians and managers (further information on this work is available at www.nmhd.org.uk/our-work/mhep/delivering-race-equality/dre-archive. A list of clinical trailblazers is attached at [Appendix 3](#));
- Commissioned a robust body of research which focuses on pathways, outcomes and experiences of BME communities. (Components of this work will be discussed later in this report. An overview of research and knowledge generated by the programme is attached at [Appendix 4](#);
- Organised annual conferences which showcased the work and brought together stakeholders at regional and national levels;
- Contributed to the development of a comprehensive mental health equalities website and supporting systems for knowledge management (www.nmhd.org.uk/our-work/mhep/);
- Developed a set of performance indicators to enable measurement and review⁷; and
- Integrated the work and learning of DRE into a broader equalities programme which now reflects the protected characteristics of the Equality Act 2010 (race, gender, age, sexual orientation, disability and religion/faith).

Involvement of users and carers

The involvement of people who use services and their carers was a key principle underpinning work within DRE. This continues to be a key focus and area of development. The DRE programme significantly involved users and carers in contributing to the decision-making process at times of review and direction setting. In September 2007, for example, users and carers were actively involved in framing performance indicators to steer the programme.

This report discusses these and other achievements in more detail in the context of the three building blocks, the 12 characteristics and the work to develop key performance indicators to measure change.

⁷ Glover, G. & Evison, F. (2009) Use of new mental health services by minority ethnic groups in England, www.nepho.org.uk (This study was originally referred to as the DRE Dashboard study)

Building Block 1 – Appropriate and responsive services

A range of inter-related initiatives and projects were incorporated within the appropriate and responsive services building block.

Some of the areas which we include here are:

- Organisational engagement (Focused Implementation Sites);
- Clinical engagement (Enhanced Pathways into Care (EPICs) sites, Clinical trailblazers); and
- Workforce development (Race Equality Cultural Capability (RECC) training/Race Equality Cultural Awareness Programme (RECAP)

Organisational engagement – Focused Implementation Sites

As noted in the introduction earlier, workforce and organisational development were key components of this building block. The FIS were set up to provide the overarching framework within which to take forward areas of service improvement. They were established as time-limited test bed mechanisms for developing innovative practice and utilising whole systems approaches. The aim was to identify good practice and barriers to good practice, and to lever the learning into wider health and social care commissioning, planning and provision intentions.

FIS, in the main, operated over a three year period (April 2005 – March 2008). Their purpose was to:

- Help demonstrate that change can be achieved;
- Demonstrate the efficacy of a whole systems approach in improving services for BME populations, drawing on and adapting a collaborative approach used in other areas of healthcare;
- Provide leadership and raise the profile of the DRE programme;
- Develop strategic partnerships between key organisations to lever investment and build capacity;
- Directly and quickly improve mental health services for BME populations; and
- Build capacity and intelligence that could lead to further change.

Intended outputs were:

- Good and practical information to help improve services;
- Better dissemination of information;
- Strengthening capacity and capabilities; and
- Promoting more co-ordinated approaches to care, which looked across the whole of the organisation⁸.

Regional leadership

Race equality leads (RELs) provided local leadership for the DRE programme, through work with NIMHE, and regional and local services, agencies and stakeholders. Their role included providing leadership and mentoring to CDWs in their areas.

Racism, discrimination and harassment

The DRE action plan also set out the importance to organisations of tackling racism, discrimination and harassment. In particular, it identified the need for compliance with race relations legislation, identified the need for an active race equality and cultural capability framework and plans; highlighted the importance of key performance indicators to assess progress, and identified the role of the (then) Healthcare Commission and Commission for Social Care Inspection in supporting assessment of progress. (Note: On 1 April 2009 the Healthcare Commission and the Commission for Social Care Inspection became part of the new Care Quality Commission.)

In this discussion, there will inevitably be overlap across the three building blocks and the characteristics. The aim, however, is to demonstrate how specific aspects of what was always intended as an integrated programme of work contributed to the aims and objectives.

The Evidence – FIS

Initially, seventeen focused implementation sites were set up. They helped identify and spread best practice by developing the evidence base and facilitating the roll out of the DRE action plan. FIS acted as 'hothouses of reform'. The aim was to demonstrate the government's commitment through the DRE programme to provide a valuable source of best practice and support for the rest of the NHS.

The 17 focused implementation sites were:

- 1 Bedfordshire & Luton
- 2 Birmingham & the Black Country
- 3 Bradford (West Yorkshire)
- 4 Country Durham & Tees Valley
- 5 Dorset & Somerset
- 6 Greater Manchester
- 7 Hampshire & Isle of Wight
- 8 Leicestershire, Northamptonshire & Rutland
- 9 Northumberland, Tyne & Wear
- 10 North Central London
- 11 North East London
- 12 North West London
- 13 South East London
- 14 South West Peninsula
- 15 South Yorkshire
- 16 Surrey & Borders
- 17 Trent

⁸ DRE: December 2005, Guidance for NIMHE Regional Directors and strategic health authorities on the selection of focused implementation sites

Building Block 1 – Appropriate and responsive services

Focused implementation sites – Coverage, volume, outcomes

The tables set out at [Appendix 2](#) illustrate the coverage, volume and outcomes of the work of the FIS. The information contained in these tables was supplied and validated by regional race equality leads and others, based on their knowledge and awareness of the work. It is also based on available final reports of FIS. We have tried to compile as complete a picture as possible.

A private sector FIS

One outgrowth from the FIS work was the request from a private sector organisation – Partnerships in Care (PiC) to become part of the DRE framework. (See below).

The rationale behind its participation was to reinforce the organisation's "commitment to equality of opportunity for its patients and staff". PiC's affiliation to the programme was also an acknowledgement that it recognised "the importance of DRE and equality in the provision of its services".

PiC's involvement in the DRE programme was on a different basis to the other 17 FIS. It did not, for example, receive funding through the programme. The company was, however, represented on the DRE Programme Delivery Board. PiC's affiliation helped to benefit the programme by:

- Promoting access to private sector forums;
- Enabling information sharing and learning across the public and private sectors; and
- Promoting the programme's ability to create change.

Partnerships in Care progress as a FIS Steven Woolgar, Director of Policy and Regulation July 2009

"In 2007 Partnerships in Care (PiC) became a Focused Implementation Site (FIS) as part of the Delivering Race Equality (DRE) programme sponsored by the Department of Health. PiC is the largest independent provider of secure mental health facilities with over 1,200 beds across the UK. We have over 20 years of experience in caring for men and women with complex mental health needs and specialise in the areas of:

- Mental illness
- Personality disorders
- Learning disabilities
- Brain injury rehabilitation

PiC provides specialist assessment, treatment and rehabilitation services to help prepare patients for their return to community services or alternative residential accommodation. PiC wanted to consolidate its existing work in equalities by being part of a nationally recognised programme, becoming more integrated into the healthcare system and to give PiC a wider perspective of work in this field.

PiC developed an action plan to take this work forward in a structured way and as a means of monitoring progress.

PiC has approached becoming a FIS as an ongoing project, not a time limited project.

Where we have made progress

Areas where PiC has made progress since becoming a FIS include:

- All Human Resource (HR) policies have been reviewed against the DRE agenda and the diversity policy has been updated and includes a plan for future action and monitoring;
- In some PiC services patients are now involved in staff induction training and tours of the unit;

- Patients are involved in councils, audit and clinical governance within all regions;
- Patient satisfaction surveys have been carried out at all PiC sites. Some sites have involved patients in the redesign of questionnaires;
- Easy Read clip art is now available to all PiC services to assist in communication;
- Updated information on sourcing interpreters has been collated and circulated to PiC services;
- Carer surveys and carer workshops are carried out throughout hospitals;
- The new PiC CPA framework has been introduced for all patients within PiC services and includes a more comprehensive 'patients' views' section;
- The PiC Accident and Incident reporting now includes analysis by ethnicity and gender;
- The PiC Patient Population report includes analysis by ethnicity, gender and religion; and
- Other PiC reporting is being reviewed for feasibility of ethnic monitoring.

Areas we have found difficult to progress and which are identified as our current priorities:

- Identifying an equality impact assessment process that we find appropriate and beneficial;
- Analysing data in a way that is meaningful and can initiate change; and
- Building equality aspects into our audit tools.

Current and future impact on PiC

PiC has always focused on providing individualised care. Involvement in the DRE programme has helped move forward that work in a more structured and focused way. The PiC approach has been to integrate any DRE influenced changes into the way that we work and not as additions. This has given us a sustainable programme that is not reliant on PiC being a FIS."

Building Block 1 – Appropriate and responsive services

FIS Peer Review (2006)

A national peer review of the original 17 FIS sites was carried out in 2006: <http://www.nmhd.org.uk/our-work/mhep/delivering-race-equality/dre-archive/dre-focused-implementation-site-reports/> Its aims were to discuss progress, share ideas and reflect on actions for the future.

The national FIS project manager devised a review process based on lessons learned from the Race for Health⁹ peer reviews, the national Positively Diverse evaluation and the Improving Working Lives assessment processes. The five questions used for the review process were taken directly from the NIMHE Review of Regional Development Centres (2005 to 2006) so that, where relevant, links between FIS and the RDCs which supported their work could be further enhanced.

FIS Peer Review Questions

- What has the FIS project done particularly well?
- What examples are there of innovative or good practice that could contribute to CSIP's wider development?
- What could the FIS project do to improve its effectiveness?
- What are the main challenges facing the FIS project over the next twelve months?
- What support mechanisms will help with these issues?

The review took place between October and December 2006. It involved more than 32 review panel members, including users and carers, and an estimated 450 stakeholders across the (then) eight Care Services Improvement Partnership (CSIP) regions. The review included evidence from project managers, service users, statutory and non-statutory sector staff, race equality leads and senior managers. The review provided a snapshot review of what was working well, as well as insights into the challenges faced, and made suggestions about areas for improvement at national, regional and local levels.

The review highlighted good practice in a range of areas. Some of these are included below, alongside the relevant DRE building blocks.

More appropriate and responsive services

Enhanced Pathways into Care (EPIC) pilot sites

EPIC sites were felt to be well placed to deliver changes in patient outcomes. The processes followed made sense to people, promoted close involvement of clinical staff and reached the core issues that staff and patients wanted to improve. Many of the sites had adopted a whole systems approach, bringing together different parts of the

organisation to deliver on and learn from the process. In some cases tools developed for tracking pathways for BME patients, were also used more widely.

Spirituality, religion and belief

A number of FIS were exploring how an improved understanding of faith issues and appropriate involvement of faith leaders could improve recovery for mental health patients. For example, Bradford FIS led a Jinn project which expanded the care package offered to male Muslim patients, to include spiritual therapy, thus providing a holistic approach to care. Hampshire and Isle of Wight developed this further and supported a training package on Islam Awareness to suit the information needs of mental health professionals, including setting up a series of meetings between Imams and groups of trained professionals.

Criminal Justice

One of the 12 DRE characteristics focused on “a reduction in the ethnic disparities found in prison populations”. The peer review found a number of good practices in the area of criminal justice. One example was a project within Morton Hall Prison in the East Midlands, where BME researchers were recruited from the prison community. The aim was to focus research on culturally appropriate assessment, communication and translation needs. The project aimed to create less fear of MH services, a more balanced range of services and to support compliance with the Race Relations Amendment Act.

Community Engagement (CE)

BME non statutory sector

The peer review found a number of examples of good practice in the non-statutory sector across the country, highlighting innovation, cost effectiveness and a high level of service user involvement. When the West Midlands FIS presented the work of the Pattigift African Centered counselling service, the first Healthcare Commission registered acute psychiatric hospital with a holistic focus on supporting people of African descent, a service user commented that people would be prepared to move to the West Midlands if it meant that they could access services offered by Pattigift.

Commissioning sensitive services

The peer review identified a number of emerging models of good commissioning practice. For example, in Manchester the FIS worked to ensure that as practice based commissioning developed, it would provide an opportunity to ensure that specific requirements for communities were addressed as part of the new arrangements. In addition the FIS became involved with contracting and procurement processes to ensure that issues relating to equality and diversity were addressed.

⁹ The Race for Health programme is a separate Department of Health initiative. It was set up in 2002 to work with primary care trusts. It works to improve health services for BME communities in three key areas – workforce, commissioning and service improvement

Building Block 1 – Appropriate and responsive services

Better Information

Data collection and analysis

The peer review identified the difficulties of achieving robust data collection; however some good practice did emerge. For example The London Development Centre commissioned the London Health Observatory to analyse census data, clarify data trends, compare with the national census and make recommendations for addressing the issues arising from the data. The report provided a breakdown of data in relation to individual trusts and helped to establish baseline data to set targets for improvement.

The Executive Summary of the FIS Peer Review identified 12 recommendations for improving the work of and processes associated with the FIS. These included the need to:

- 1 **Identify priorities** and more directly relate the work to the 12 DRE characteristics;
- 2 Revisit **governance and structures**;
- 3 **Improve communication**;
- 4 **Measure success**;
- 5 **Identify early implementer sites** in order to establish priorities relating to the results of the Count Me In census;
- 6 **Provide professional development and support** to FIS project managers;
- 7 **Strengthen service user and carer involvement**;
- 8 **Assess the effectiveness of partnerships and networks**;
- 9 **Strengthen the understanding of and support for CDWs**;
- 10 **Explore a rural delivery model for DRE**;
- 11 **Identify and assess the themes emerging from CE projects**; and
- 12 **Mainstream the work of the FIS to ensure its sustainability beyond 2010**.

Recommendations of the report were taken forward in the context of:

- Addressing the major issue of health inequalities;
- Sharing existing good practice; and
- Influencing new and emerging performance and planning frameworks.

Specific work resulting from the recommendations included:

- **Improved business planning** to reflect emerging regional issues (e.g., development of service level agreements and clear objectives with regional development centres to address local circumstances; revamping internal structures, e.g. setting up a Programme Review Team for regular review and tracking of the work);
- **Improved communication** – through developing and implementing a communications strategy which built on existing work within NIMHE and externally;
- **Establishing indicators** to measure success (e.g. developing the DRE Dashboard);
- **Aligning the work of FIS project managers** more closely with the work of race equality leads and others through improved networks and opportunities for development (e.g. Birmingham FIS);
- **Enabling and supporting service user and carer involvement** through establishment of the DRE Ambassador Programme;
- **Developing regional partnerships**, which included a wide range of stakeholders (NHS, social care, voluntary sector, faith groups, police);
- **Reviewing how the role of CDWs** was understood and being implemented; and provision of guidance and communications support to CDWs, for example through a specialist website, newsletter, toolkits and practical training sessions. The aim was to help CDWs develop the skills necessary to reach and communicate with BME groups, and to develop partnerships with stakeholders;
- **Distilling and disseminating the learning from CE projects**; and
- **Seeking to mainstream the work** of DRE through linkage with public sector agreement targets (PSA); the NHS Planning and Performance Framework; development of the DRE Dashboard; supporting the development of transition plans from stand alone FIS to incorporation within PCT commissioning intentions (e.g. NE FIS, Yorkshire & the Humber FIS).

Building Block 1 – Appropriate and responsive services

Key learning FIS Evaluation

A national evaluation of the FIS¹⁰, based on selected sites, identified a number of themes in relation to the FIS.

The work involved a two-stage, qualitative evaluation comprising three waves of data collection. Eight sites were chosen for Phase I, from which four areas were recruited to take part in Phase II. Areas were chosen to provide geographical spread across England, and to include areas with contrasting densities and distributions of BME populations. Urban areas with the largest BME populations were over-represented, although areas with rural and semi-rural populations were also included.

Phase I involved in-depth interviews with Race Equality Leads (RELS) and FIS Programme Leads in each area, followed by a thematic questionnaire survey of a wider stakeholder community drawn from statutory (NHS and local authority) and community and voluntary sector (CVS) agencies. Phase II, which took place approximately 18 months after the initial Phase I interviews, comprised focus groups with service users and representatives from CVS agencies. The aim of Phase II was to elicit and describe views on perceived changes in the experiences of mental health care among those from BME communities.

Data was analysed using a Framework approach.

Key conclusions were:

- DRE and the FIS programme took place against a background of entrenched, long-standing ethnic inequalities in mental health care in England. Study participants, and especially service users who took part in the focus groups, articulated dissatisfaction with existing service provision very eloquently;
- The energy and commitment behind the programme was widely acknowledged. Many service users spoke of the credible changes they had observed. Trust in services, absent for so long, was beginning to emerge. Service users, by no means uncritical, welcomed evidence that statutory services were becoming more culturally sensitive and accessible. Two of the most demonstrable improvements were the employment of CDWs, and the great availability of interpreting services;
- There had been some improvement in partnership and joint working between agencies, though representatives from the VCS were less positive about the impact, largely due to short term funding arrangements; and
- At every stage of the project, participants noted two key considerations. First, that change takes time, and two years (or even five years) is just not long enough for real change to occur; second, the real challenge is not effecting change but rather sustaining it.

BME Inpatient Review

Appropriate and Responsive Services – BME Inpatient Review – Royal College of Psychiatrists (2010)

In February 2009 the DRE programme collaborated with the Royal College of Psychiatrists to convene a BME expert panel to undertake a review of BME inpatient services.

The aims were to:

- 1 Review standards used by the College Centre for Quality Improvement in three inpatient accreditation networks; and
- 2 Make recommendations for improvement to existing standards; for issues to be formulated into new standards; and for guidance or information to accompany existing or new standards.

The resulting report, *'Improving inpatient psychiatric services for Black and minority ethnic patients' (2010)*¹¹ includes recommendations to the College Centre for Quality Improvement (CCQI) to inform accreditation standards. These focus on:

- Staff skills in discussing and understanding the needs of BME patients;
- The Patient Journey;
- Admission;
- Initial assessment and care planning;
- Continuing assessment;
- Medication;
- Activities, therapies and links;
- Discharge;
- The ward environment: violence, abuse and other issues;
- Ethnicity data collection;
- Other issues – such as self care, relationships, legal issues, issues affecting women, recovery, identity, outcomes and power; and
- Staff needs: including education, training and support.

The report was formally submitted to the CCQI. It has been agreed that the report's recommendations will be incorporated into a core set of universal standards currently being developed by the CCQI. These standards will apply to all CCQI networks.

¹⁰ Weich, S., Bhui, K, et.al., *Evaluation of the Focused Implementation Site Programme (in press)*

¹¹ *Royal College of Psychiatrists 2010, Occasional Paper OP71*

Building Block 1 – Appropriate and responsive services

Racism, discrimination and harassment

The work of the DRE programme emphasised the provision of services (focused on the whole pathway, rather than individual service points along it) which promote equality and reduce inequalities in access, experiences and outcomes. Key areas of work have included:

- Development of race equality cultural capability training – RECC and RECAP (see below);
- Leading on race equality impact assessments internally within NIMHE and CSIP, and promoting their use externally; and
- Commissioning and supporting research.

Racism – impact

Recent research¹² comprising interviews with 40 service users (of whom 24 were of non-white ethnicity), 13 carers and 24 mental health professionals in one very diverse city indicated that:

“Above all, service users value competent, professional care combined with personal attention and humanity [and] perhaps the strongest finding to emerge from this research was the universal dislike of inpatient treatment...”

The report also notes:

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

Other related work¹³ was “unable to find evidence that involuntarily detained people from ethnic minorities reported or experienced more coercion than the ethnic majority”. It noted, however:

“It is, nevertheless, important to be cautious before drawing reassuring conclusions about racism in mental health services. This study has only focused on one aspect of potential institutional racism in mental health services, namely the use of coercive measures in involuntarily detained patients. We also recognise that some of our results had low power so may have been compatible with clinically important differences in the use of coercion. It remains of concern though that levels of inpatient coercion were generally high, with more than half the patients reporting the use of a coercive measure during the first 4 weeks of their hospital stay. Though detention under the Mental Health Act implies that some degree of coercion is inevitable, it appears that there is still room for an improvement in the way users of mental health services experience this process, among both people of Black and ethnic minorities and those of the ethnic majority.”

Key learning

Evidence to date does not suggest the absence of discrimination within services. However, it does point – as does much of the learning which has emerged within, through and as a result of the DRE programme – to a complexity of experience. This further points to a need to develop a more sophisticated approach to better understand what contributes to differing experiences in relation to different communities in order that outcomes and experiences are improved.

Race, faith, ethnicity and culture all affect how mental illness and health are experienced, and therefore consideration of all these aspects should be part of the solution for addressing needs effectively. Sewell¹⁴ (2009)) notes that:

“The term ‘minority ethnic groups’ does not describe a homogenous collective. A Japanese woman and a West African man are so ethnically different that it is not possible to develop a service response supposedly tailored to universally meet the needs of people from BME groups.” [He notes that] “effective practitioners in mental health will need to inform their assessment and practice with detailed information from the service user point of view.”

¹² Weich, S., et al. (personal communication) with reference to Users', Carers' & Mental Health Professionals' experiences of receiving and providing acute mental health care in a diverse inner city setting, (in press)

¹³ Bennewith, O., et al. (2010) Ethnicity and coercion among involuntarily detained psychiatric inpatients in England, British Journal of Psychiatry 196: 75-76

¹⁴ Sewell, H. Working with Ethnicity, Race and Culture in Mental Health, a handbook for practitioners, (Jessica Kingsley Publishers (2009)

Building Block 1 – Appropriate and responsive services

Workforce development – Training in race and culture

The DRE programme devoted a significant amount of resource towards developing the cultural competency skills of the mental health workforce. The cornerstone of this work was the commissioning of the learning materials which became known as the Race Equality Cultural Capability training. An independent consultancy, Ferns Associates, developed the original Race Equality and Cultural Capability (RECC) training material for mental health staff under contract to the National Institute for Mental Health in England.

The RECC were commissioned through the University of Lincoln's Centre for Clinical and Academic Workforce Innovation (CCAWI) in 2005, by NIMHE on behalf of the DRE programme.

This commission resulted in training materials which were developed and piloted by Ferns Associates, a training consultancy with a track record in race equality training. The RECC training consists of 12 modules to be taught over a period of four months. The first stage of the work was piloted in four localities.

The learning materials resulting from this work include:

- A participant's reader – a set of pre-course reading materials;
- A practice development workbook – a series of work task templates; and
- Materials that support the teaching of 12 RECC sessions.

Race Equality Cultural Awareness Programme (RECAP)

Building on the original RECC materials (namely, the participant's reader and practice development workbook) and supporting materials, as well as learning from this work, the DRE programme developed a training the trainer course through the Race Equality Cultural Awareness Programme (RECAP). This included developing and establishing a national training team of 18 people who were responsible for rolling out the RECAP training the trainer course in 2009/10.

The RECAP course was developed in response to feedback and requests from mental health organisations across the country. This focused on the need for an accessible, high quality race equality training package.

The focus of RECAP was to help ensure that the aims set out in the DRE action plan, i.e., for training based on the ten essential shared capabilities, were integral to the dissemination and rollout of the work.

The ten capabilities are:

- Working in partnership;
- Understanding and respecting diversity;
- Practising ethically;
- Challenging inequality;
- Promoting recovery;
- Identifying people's needs and strengths;
- Providing service user centred care;
- Making a difference;
- Promoting safety and positive risk-taking; and
- Personal development and learning.

What is the RECAP?

The DRE programme developed a 12 hour training course, the Race Equality Cultural Awareness Programme (RECAP), and a national training team of 18 people responsible for rolling out the train the trainer package for this course in 2009/10. The training consists of:

- 1 **Participants' course:** a two-day programme which aims to enable individuals to:
 - develop an individual's knowledge and understanding of racism;
 - develop knowledge and understanding of cultural difference and recognise and understand the impact of discrimination;
 - promote race equality; and
 - work more positively with cultural difference and effectively deal with the impact of discrimination on an individual and institutional level.
- 2 **RECAP – Regional Facilitator course:** a five-day programme which:
 - equips individuals to deliver RECAP training to participants;
 - is funded and supported regionally, and is based on:
 - A participant's reader – a set of pre-course reading materials;
 - A practice development workbook – a series of work task templates; and
 - Handouts – materials that support the teaching of the RECAP sessions.

Building Block 1 – Appropriate and responsive services

Key learning from Race Equality Cultural Capability (RECC) training

The conclusions of an independent evaluation¹⁵ of the RECC training, which was based on the pilot of the learning materials in four NHS trusts, points to a mixed picture in relation to the original training. The evaluation notes that:

“overall the conclusions that can be drawn from this study are that while training participants’ overall ratings of the RECC training programme were positive, the content was too theoretical on three of the five days of training and that there was insufficient opportunity for the participants to achieve competency and develop practice”.

The evaluation also notes that:

“Although the RECC training was shown to be effective in improving self assessed knowledge and competency of participants directly after the training, a large proportion of these gains were lost by the three-month follow-up assessment.

The study found that the training:

“appears to have had the least sustainable impact on the development of knowledge and competencies in significant areas such as ‘knowledge of DRE in MH’, ‘empowerment of BME groups’, judging (and the importance of) cultural appropriateness’, ‘anti-discriminatory risk work’ and assessment, including ‘holistic approach’ and ‘whole systems approach’”.

In addition, it was found that the training had a limited impact on changing organisational processes or individual practitioner behaviour, though major changes in processes may have been unlikely in the follow-up time after training in the report.

The report notes that sustained changes in knowledge, organisational processes and behaviour are complex and inter-related and expecting evidence of them to rest on the RECC training is ambitious, to say the least.

The study concludes that:

“It has been recognised that, to be effective, cultural competency training in mental health services should focus on specific areas of inequality and the emphasis must be on the improvement of professional practice and not merely the acquisition of knowledge (Bennett, et.al. 2007). Further Vega (2005) suggests that only by making cultural competence training more operationally valid for clinical care will its value as a means of addressing disparities in care be fully acknowledged”.

A further evaluation (McGonagle 2009)¹⁶ focused on a pilot of the original materials (developed by Ferns Associates) and provides the evaluation of the initial national ‘Train the Trainer’ programme across ten sites in England. These ten programmes were completed over a period of one year, running from January 2008 – January 2009. The courses were facilitated by a range of RECC facilitators, with just over half delivered by the original author of the RECC materials (Ferns Associates).

Amongst the study’s findings are:

- The scope of the RECC materials represents a challenge for most trainers and to counter this it is proposed that careful selection and support for all trainers is important;
- RECC presents a significant commitment on the part of facilitators. This commitment is in delivery of the programme, but also to manage challenging situations in the training context;
- RECC facilitators need to provide flexible learning opportunities for organisations facing real difficulties to release personnel for training;
- The cohorts of participants/trainees in the study were highly motivated and working in services which took race equality seriously; and
- The RECC programme appears to have been successful in maintaining engagement of the participants in the subject over time. Their mean scores for motivation, learning, self efficacy etc. remained high after training. However a more systematic review of the RECC programme on learners may require an evaluation which examines results from a less highly selective sample group.

Both the RECC and RECAP courses, however, have received positive feedback from participants. CDWs in the South West have succeeded in the successful mandatory roll out of RECC in Cornwall (see below); while the RECAP course has received very positive feedback on national rollout. Ongoing work will need to take account of the RECC evaluation and other information which will flow from implementing this training to inform its evolution, and consider the interaction of the training with other interventions to build sustained organisational and behavioural change where needed.

¹⁵ Bennett, J., An Evaluation of Race Equality and Cultural Capability Training in Mental Health Services, Sainsbury Centre for Mental Health (in press)

¹⁶ McGonagle, I., Evaluation Report on Race Equality & Cultural Capability (RECC) Training, University of Lincoln (www.lincoln.ac.uk/ccawi/ESC.htm)

Building Block 1 – Appropriate and responsive services

Delivering Race Equality in Mental Health Care in Cornwall and Isles of Scilly

Joe McEvoy, Deputy Director of Partnership Commissioning, NHS Cornwall & Isles of Scilly

“The PCT/LA commissioners took the view that Delivering Race Equality in Mental Health Care (DRE) in Cornwall and Isles of Scilly would take significant combined efforts if it was to deliver its aims fully. The main reason for this was a prevailing sense among communities that a small number of people from BME backgrounds represented ‘less of an issue’, and that the things that went on elsewhere didn’t happen in Cornwall.

DRE is led by the PCT on behalf of the partners and the first step in delivering our aims was to establish a multi-agency group of partners to agree ways of working. Within this we designed and procured a new community development worker service. With this new service in place the DRE group expanded its membership to include criminal justice partners, primary care and other third sector partners.

Together, this group devised the DRE action plan and set up a performance management regime to monitor progress which is reported at the bi-monthly DRE group and also through the PCT’s Equality and Diversity Sub Committee. The DRE group is chaired by one of the PCT’s Non-Executive board members. The DRE group has participated in Race Equality and Cultural Capability Training (RECC).

The difference to service users is marked and we anticipate further significant improvements. The group agreed that RECC training would be mandatory for all mental health services and in September 2009 the first train the trainers programme began. Roll out across all in-patient areas is underway with 25% of staff trained so far. This rollout has been enabled by providing backfill for staff costs.

The group has prioritised the production of mental health directories in Polish, Russian and Portuguese and the development of resources to help people access and understand services, and development of improved ethnicity monitoring that goes beyond the statutory requirements. Commissioners have built DRE into the Commissioning for Quality Incentive (CQIN) payments of the local mental health trust and have also set clear targets for the number of people from BME backgrounds to receive psychological therapy in primary care. This has led to the development of stress control groups for both Polish and Portuguese speakers.

The Community Development Worker (CDW) service has impacted tremendously on previously held perceptions within the community, and have improved access to services through the developing of the “Colourful Women’s Network”, and by holding weekly clinics on inpatient units. The workers themselves are integrated members of the PCT’s Equality and Diversity Sub Committee and play an active part in the wider work of the PCT.

Clinical trailblazers

The aim of the Clinical trailblazers programme (2007-2009) was to tackle the challenging clinically related service change characteristics of the DRE action plan.

These related specifically to:

- Characteristic 3 – disproportionate admission;
- Characteristic 4 – disproportionate detention;
- Characteristic 10 – a more balanced range of therapies;
- Characteristic 11 – more active involvement of BME communities; and
- Characteristic 12 – developing a more capable workforce and organisations.

(See [Section 5](#) for a fuller discussion of the work in relation to the 12 characteristics.)

Method

The DRE programme funded 20 organisations to run a range of projects that looked at how they could change and improve the clinical services they provided to patients from BME backgrounds. These ranged from an audit and interventions within a Home Treatment team to development of a Wellness Recovery Action Plan (WRAP) for BME communities.

Within the first year sites met regularly for networking and support, and during the second year, seven of the 20 original sites received further and variable sums of sustainability funding from the DRE programme. This enabled them to develop their original work further.

A complete list of clinical trailblazers is attached at [Appendix 3](#). Information about the work and outcomes is available at www.nmhd.org.uk/our-work/mhpe/delivering-race-equality/dre-archive/

Building Block 1 – Appropriate and responsive services

Enhancing Pathways into Care (EPIC) sites

The Enhancing Pathways Into Care (EPIC) project www.wolfson.qmul.ac.uk/psychiatry/epic/ aimed to demonstrate how pathways to mental health care could be improved for BME groups. The project was developed because people from BME backgrounds can have different, sometimes more coercive, pathways into mental healthcare, compared to their White British peers. There was a lack of evidence about why this happens and how it can be improved. EPIC set out to document knowledge, skills, and change processes needed to implement improved pathways.

The first phase of the project was implemented between January 2006 and March 2007. The four original EPIC sites and their aims and outcomes are described below:

Sheffield

Aim – to formalise partnerships between statutory and NGO services

In Sheffield, the local acute care team developed the EPIC project having identified that there was patchy cultural awareness in mainstream mental health services and mistrust of mainstream mental health by BME communities. The EPIC aims were to be realized through partnership working between the Crisis at Home Service and the local Pakistani Muslim Centre (PMC). In May 2006 Sheffield Care Trust funded an NHS-employed link worker at the PMC for 20 hours a week. Sheffield currently has two further EPIC projects (see further work below). EPIC 2 was applied to African Caribbean people. EPIC 2 began by training eight African Caribbean staff from Sheffield African Caribbean Mental Health Association (SACMHA) and examining leadership. EPIC 2 is also evaluating the experience of service users. At the same time, audit data are being analysed in more depth for EPIC2 than for EPIC1. EPIC3 uses the same model but adapted to be specific to the Somali and Arab community. Progress was sustained through awareness raising and data collection and dissemination of knowledge.

EPIC data reports are sent regularly to senior management. There is shared ownership across the trust and also within the SHA. The organisation recognises the development of staff competencies and cultural awareness as a lever to promote quality in care and to sustain change. Additional funding was secured for the trust – voluntary sector partnership. The PMC link worker role has been mainstreamed and is now PCT funded as a permanent post. The development and dissemination of an EPIC manual, formalisation of the EPIC steering group and adaptation so that CDWs provide capacity building in the community are evidence of sustained progress. Funding from the Health Foundation has enabled the clinical team to develop a corporate brand identity that emphasises the continued presence of EPIC in Sheffield. In their 2009 Race Equality Impact Assessment (REIA), Sheffield focus on EPIC2 rather than EPIC1: (see p.21) they have good detailed information on ethnicity and diversity, and note that patients prefer to remain at home once assessed. However, referral

processes remained potentially disadvantageous to people from BME groups.

Durham (Easington)

Aim: a rural site with the aim to improve access for an isolated ethnic group (Chinese)

Easington is a rural site with many micro-cultures located within isolated rural communities, as well as a small BME population. Their EPIC project was designed to facilitate access to services for local Chinese people suffering from any mental illness or distress and to improve staff cultural awareness so that, once services were accessed, a Chinese person's journey to recovery was smooth and effective. The expected result was an improvement in pathways outside formal care services, or into, through or out of mental health care for Chinese people and for other isolated rural communities.

As of 2008, information on interpreting services and community groups was readily available at the single point of access. The staff Directory of Resources was being finalised in 2009. During 2008 and early 2009 a website was developed as a stand-alone site linked into the regional NHS site, at www.cmh-easington.org.uk (originally it was to be contained within the NHS site). It houses information in both Cantonese and English and a leaflet has been developed to promote it. A single point of access team has now been established for the whole of Durham. This was achieved for Easington itself during EPIC facilitation. The website will be updated annually. All clinical and managerial staff are involved in the update and development of the directory. The team considered that the sustainability of the EPIC resources was assured. Cultural awareness training was planned (initial training took place at the time of the original EPIC facilitation). This has resulted in significant cultural shifts in ways of working with BME groups. Equality and diversity is now also on the trust induction programme also.

The model developed for Easington has now been applied to the whole of Durham and other BME communities in the region (in particular the website, and achieved by expanding the cultural awareness work through community staff involvement). The model was also considered transferable to all patients, especially isolated rural communities, irrespective of ethnicity and as a general model of good practice. The team working on the project have become local equality and diversity champions and this has led to lateral diffusion of their newly developed skills and cultural awareness. A Race Equality Impact Assessment (REIA) completed in June 2009 showed continued improvements in that a flexible approach and cultural awareness had been introduced to the new services referral team, which was set up in June 2009. The services have been extended to cover the whole of Durham and the staff were receiving training around cultural awareness and assessment that it was hoped would bring them 'up to scratch' with the EPIC Easington team members. However it was noted that there were gaps in knowledge that remained to be addressed for Durham.

Building Block 1 – Appropriate and responsive services

Birmingham

Aim – to move patients of Black African or Black Caribbean origin from containment to discharge through assertive outreach team (AOT)

The Birmingham EPIC project was undertaken by the Handsworth Assertive Outreach Team (AOT). The team developed a methodology of collecting patient life stories, once preliminary profiling questionnaires had been administered, then reviewing the life stories and modifying care plans to make these more individualised. The questionnaire was used to obtain data from the service users in 2008. As of June 2009, the team had been unable to undertake fuller life story narrative sessions on a routine basis with the service users. Despite looking for someone with the right skills, no-one has yet come forward.

However, the project team has collaborated with the team at Barts and the London to develop a proposal for a project based around such narrative work and this has been submitted for a “National Institute for Health Research (NIHR) for Patient Benefits” project to progress this work. The team also reported that the use of narratives in clinical care enthused them, and helped them begin to think positively about their patients again, some of whom had been in the team for a long time. Assessing sustainability was not possible given that the intervention was only partially implemented, but the conditions for radical change and commitment remain. This is evidenced by the development of a training and a research project on the subject, to be hosted by the team, and supported by the trust R&D department. The approach that now aims to avoid retention in AOT unnecessarily is a major shift and is sustained.

Manchester

Aim: a whole systems approach for change

The Manchester EPIC team decided on a different approach to the other three teams by bringing together a strategic planning group for three NHS Trusts¹⁷. The main aim of EPIC in Manchester was to undertake a total systems change. They undertook a baseline audit to explore the nature of the pathways into, through and out of mental health care taken by BME individuals. This was to help provide information to support appropriate service improvement, and to enhance the experience of BME individuals who accessed these services. Existing relationships with service users facilitated consultation.

Following agreement at executive level, clinical intervention teams were set up within each of the trusts to use the EPIC process to develop action plans which, along with learning experiences, were shared with the other trusts where appropriate. The detail of the approaches used for the action plans differed between trusts. Thus, for Manchester Health and Social Care it is possible to measure the sustainability of their original objectives. For Bolton, these were only short term objectives that have led on to other things as defined in

their recent action plan. However, if we consider sustainability of the process, which broadly followed the Plan Do Study Act (PDSA) cycle, this seemed assured since there had been organisational and structural changes in the ways that the trusts worked. The small steps that had been taken could be built upon as a result. Transferability into specific areas of mental health and social care, such as elderly services, has taken place. Both the race equality impact assessment (REIA) and action plan, and the top-down approach, and small bottom-up projects have developed in different departments and geographical areas.

Similarly, changes in the way that voluntary sector work is commissioned have also been transferred onto other projects, which have been successfully implemented as a result. There have been several spin-off projects. The REIA filled in for 2009 for Manchester represented services at only one of the three trusts. This stated that good information was collected on ethnicity and diversity but was not routinely sent out to the person concerned. Assessment was person-centred and considered needs, wishes and aspirations, but there was thought to be more need for cultural competence training for staff. Also the staff spoke English only, which was highlighted as a problem. These two areas were selected as actions for the next year but would require further funding. Services were considered to avoid an adverse impact on BME groups, by opening up opportunities for self-help groups, since these were offered free space, resources and support. This was evidently successful since a wide range of groups were said to be using the resource centre that the services provided.

EPIC – further work

EPIC sites in Yorkshire & Humber

As noted earlier, one of the outcomes of the EPIC work was to create interest in extending the approach beyond the original four EPIC sites. This resulted in three additional areas of EPIC work /developments in Yorkshire and the Humber. These focused on:

- **EPIC 1 (Sheffield)** – Mainstreamed original Sheffield site described above through permanent employment of a worker from the Pakistani community.
- **EPIC 2 (Sheffield)** – Sheffield Health and Social Care NHS Foundation Trust established a working group involving staff from SACMHA (Sheffield African Caribbean Mental Health Association), the Crisis Resolution Home Treatment Team and the Yorkshire & Humber Improvement Partnership to put in place actions to help to improve services to people from BME communities. The aims are to use data to measure the impact on the length of stay for African and Caribbean service users (with the aim being to reduce this in line with the average); to work with wards and clinicians to better understand referral strategies and patient experience; to work to improve access to the full range of services, including voluntary provision and crisis intervention; and to offer support to staff across the trust to enable greater competency and confidence in their roles.

¹⁷ The three trusts were Bolton, Salford & Trafford Mental Health NHS Trust; Manchester Joint Mental Health & Social Care Partnership Trust; and Pennine Care NHS Trust

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- **Epic 3 (Sheffield) – Enhancing Pathways into Care for the Somali Community** – The aims for EPIC 3 are to improve the service experiences of Somali mental health service users; to assist the Somali community to access services when they need them; to ensure the health and social care needs of Somali service users and their families are met; and to ensure partnerships with community organisations to enable a timely and responsive service.

EPIC Evaluation¹⁸

An evaluation of the original EPIC project was commissioned by the DRE programme. Key learning is set out below.

Key learning

The EPIC project showed that clinical leadership can work effectively with all layers of an organisation to effect service improvement projects within existing resources and by securing additional resources. The evaluation data show frank statements about the challenges, benefits, and processes by which services can be improved for BME groups, and by which care pathways were evolved, modified, or limited to improve quality of care.

Maybe EPIC is an opportunity for those organisations to... look again at the way that they're working, because that to me has been an opportunity and one of the best things that's happened with EPIC is... the collaborative working that has happened with the wards and [voluntary sector] organisations, you know, the beginnings of those conversations about how that could be put on a better basis. (32)

I just thought it's another token research thing; there won't be any involvement and that was it – a one-off research! We've ticked the box and that was it, we're going to move on and we're not going to hear, but it was nothing like that, to be honest. There's been communication, there's been input, there's been I think support from both sides. Issues that we've brought up, things have been addressed and I just feel a massive part of it. I just feel that, you know, it's been really positive, for us anyway as an organisation definitely, I'm really happy to be part of it. (164-166)

And I think what the EPIC research did was actually give us opportunities to bring to the forefront the issues that these service users do come across, like BME service users say, right – or even the carer – right, these are the issues that we've got; like these are the gaps, how are we going to meet them? And we can actually see them, and this is an opportunity where, like you're saying, this is what I'm doing, this is what so and so is doing, how can we bring it together? So you can see the changes. (109-110)

I'm quite proud of what we've done, I think it's, we do a good service, and carers have given good feedback too. (456-457)

Cultural Confidence

Staff expressed 'cultural confidence' training as a key issue in line with one of the DRE recommendations. There was consensus among participants that the cultural confidence to ask informed questions was only just beginning and needed to evolve to full cultural competence. Providers said it was important to ask questions and engage in face to face work with individuals to develop full competence but they were sometimes limited in being able to do so, due to resource issues, or, in one area, a minimally ethnically diverse population. There was little evidence of the roll out of culturally competent training to the mainstream workforce; even when there was, it was not considered to be locally relevant. Training was a term that was liberally used but it was unclear what it meant in the detail and this could not be unpacked for this evaluation. EPIC delivered in-service experiences which improved cultural confidence of direct local relevance.

The idea of cultural confidence is an important one that obviates the need for ethnic minority representation in teams to match the ethnicities of potential service users. Such matching, it was noted, does not necessarily achieve what it is meant to do since ethnic origin is only one part of a person's identity. Moreover, as Ramsden¹⁹ points out, "as diversity increases – as diversity becomes more diverse – it will become increasingly difficult to 'slot' people into particular ethnic groups," so that matching becomes ever more unattainable. However, where teams do not have BME representation, the learning curve may be steeper.

Local Impacts & Clinical Leadership

The local focus of EPIC projects and local ownership were considered important and empowering aspects of the model. This elevated beyond a simple catalyst of equality and diversity work that the Trust might be expected to roll out eventually anyway. Staff were empowered to deal with issues, and involved the Trust as necessary.

Teams showed that such problems could be tackled by creativity and reflection. Some participants stated that EPIC had led to a climate conducive to discussing cultural and inequality work and partnership issues, and better communication in turn led to successful problem-solving. In relation to the Darzi recommendations, the projects were successfully led by clinical teams and this should not be underestimated. Some leads were also equality and diversity leads but others were not, rather being departmental or service leads. Teams all reported some successes and some increased recognition by the organisation. Teams generally succeeded in obtaining funding for their local projects but all considered it a serious problem that EPIC did not come with at least some funding attached and that funding would motivate other people to do an EPIC.

¹⁸ Carol Rivas & Kamaldeep Bhui, *EPIC II – Evaluation of outcomes and sustainability, Barts & The London, Queen Mary's School of Medicine & Dentistry (in press).*

¹⁹ Ramsden, S., January 2007, *Delivering Race Equality in Mental Healthcare, Progress Review of Focused Implementation Sites, National Summary*

Building Block 1 – Appropriate and responsive services

Transformational Leadership

The national EPIC facilitation had a long term impact, in that it built teams, and enhanced the confidence of teams and individuals. This in turn led teams to develop and extend and transfer EPIC projects of enhanced culturally appropriate services, thus ensuring at least sustainability. That this occurred despite huge changes within the organisations in the recent NHS reforms is testament to the embedding of EPIC by those involved. It is likely that longer term effects will be associable with EPIC but will diffuse outwards.

Forensic services

The DRE action plan also set out to develop workstreams to influence and improve BME engagement with the criminal justice system. The aim was to look at training, differing pathways into care, including diversion from the criminal justice system and to work with the Prison Service. Some examples of this work are listed below:

Pathways to Forensic Care Project – Lambeth

Guilaine Kinouani, former Lambeth CDW

This project, which was carried out by a CDW, “aimed to understand the life events that preceded a sample of African and African Caribbean service users’ incarceration and mental health detention.” A sample of 17 patients were recruited from two South London and the Maudsley (SLaM) medium secure units – Bridge House and Cane Hill. The project used semi-structured interviews with a view to:

- Hear service users’ perspectives;
- Explore unmet needs;
- Document service users, narratives and personal stories; and
- Propose improvements to pathways.

The project identified a number of themes and factors affecting pathways. These included:

- Significant life events (e.g. family breakdown; homelessness and/or unstable housing conditions);
- Mental health awareness – (i.e., the need to have greater awareness on issues ranging from knowledge of the biomedical framework of mental illness and issues related to identity and power; to insight into their conditions and factors facilitating recovery);
- Participants’ attributions – e.g., regarding reasons for offending; and experience of mental health services; and
- Participants’ views on pathways to care – which focused on issues of educational achievement; and lack of supportive networks.

Court Diversion Project – Central North West London

David Truswell, August 2009

Mainstreaming the FIS work in a mental health trust

In 2005 CNWL was chosen to be a Focused Implementation Site (FIS) for delivering racial equality across its services. Delivering an equitable mental health service to defendants seen by the Trust’s court diversion schemes became one of five key project areas for CNWL.

FIS Court Diversion Project Aims

The aims of this particular project were:

- To monitor the activity of CNWL’s court diversion schemes (in Brent and Harrow) and determine how effective court diversion can be at helping BME defendants with mental health difficulties to be diverted into appropriate treatment;
- To identify, promote and disseminate good practice in court diversion;
- To develop a business case for a model court diversion service in North West London serving Brent, Hillingdon and Harrow Magistrates’ Courts based on this evidence; and
- To develop alliances with other agencies to raise the profile of services providing alternatives to prison for BME defendants and prisoners with mental health difficulties.

These aims were aligned with CNWL’s commitment to tackling the DRE objective of ‘a reduction in the proportion of prisoners from BME communities’.

Outcomes

The Monitoring Report (April 2007 – March 2008)

- 67% of referrals to the Brent Court Diversion Scheme were assessed as having severe mental health difficulties. Of those diverted, 46% belonged to the White group, 7% were Asian and 46% were from the Black African and African Caribbean group.
- 76% of referrals to the Harrow Court Diversion Scheme were assessed as having severe mental health difficulties. Of those diverted, 14% belonged to the White group, 14% were Asian and 57% were from the Mixed Black African and African-Caribbean group.

Taking into account the limitations of the ethnic monitoring by the courts, the Brent and Harrow Court Diversion services proportionally provide substantial transfers of Black African, Black Caribbean and Other Black defendants out of custodial outcomes within the criminal justice system as these groups are more likely to be diverted when they are referred than the White group.

Building Block 1 – Appropriate and responsive services

Promoting and Disseminating Good Practice

- The FIS Project was significantly involved in successful lobbying for CNWL to be a National Court Report Service Level Agreement Pilot Site. It featured as a national example of good practice in the 2006 National FIS Peer Review and the 2008 DRE national conference.
- The FIS project manager participated in the Nacro Steering Group for research on cultural needs assessment for Court Reports. Nacro has recently published guidance on assessment of cultural needs for Court Diversion based on this research.
- The FIS project manager and the CNWL Court Scheme project manager have submitted evidence to Lord Bradley's review of diversion from the criminal justice system. Chair of the CNWL FIS Steering Group, Ruth Runciman also submitted evidence to Lord Bradley based on the Trust's FIS work.
- The FIS Project has recently completed work with CSIP South East developing guidance for CDWs to be linked with Court Diversion teams.
- In partnership with PLIAS (Prison Liaison and Advice Service), a local community-based organisation in Brent, the FIS Clinical Trailblazer researched the experience of people from BME backgrounds living in the community who had used mental health services and also been through the Criminal Justice System.

Developing CNWL Court Diversion Services

- The Pilot Project for the North West London Court Diversion Scheme involving Brent, Hillingdon and Harrow Mental Health Services and Her Majesty's Court Service (HMCS) was set up in 2007 to pilot assessments and report writing for defendants with a view to referral, timeliness in the context of the agreement contract, appropriateness and diversion. This project is addressing many of the issues highlighted in the Lord Bradley Report.
- The Court Diversion Scheme has also produced research on the experience of BME offenders who been diverted through the Brent Court Diversion Scheme.
- Due to the high proportion of Black African and African Caribbean Offenders appearing before magistrates' courts, improvements in the effectiveness, appropriateness and capacity of CNWL Court Diversion schemes will produce greater referral of Black African and African Caribbean defendants to Court Diversion than any other ethnic group. Mainstream service improvements in Court Diversion will have a significant impact in increasing number of diversions from prison in these groups.

Developing Alliances

- As a result of both the FIS work and the link with the North West London Court Diversion Scheme, CNWL has forged much closer working links with the Sainsbury Centre for Mental Health, Nacro, the Prison Reform Trust, PLIAS and CSIP South East to help raise the issue of effective and appropriate services for BME offenders with mental health problems.

Improving services for specific populations

Delivering race equality in refugee and asylum seeker communities

A large proportion of the work which took place within the DRE programme – in particular within the CE strand – concerned specific communities. This was the intention as set out in the action plan. Highlighted below are examples of some of the work. A consistent strand is the involvement of CDWs. Findings from the CE report²⁰ indicated that:

"The trauma that leads to asylum seekers leaving their home countries was reported to include war, genocide, torture, persecution, rape, imprisonment and witnessing family members being killed. These experiences, the process of seeking asylum in the UK and overt racism, were reported to have a negative effect on the mental health of both females and males."

Regarding access to primary care the CE report notes:

"Many of the asylum seekers were unsatisfied with their GP and there were instances where this had led to disengagement with mental health services. The problems were partly due to lack of clarity among staff in GP surgeries about the rights of asylum seekers to treatment, but also to GPs' lack of sensitivity regarding their situation".

The following, from a study of 60 asylum-seeking men in Plymouth, describes one such incident:

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

Primary care guidelines

The Department of Health is currently finalising guidelines to primary care aimed at promoting more effective working with refugees and asylum seekers. The Mental Health Equalities Programme and Mind are contributing to this work.

²⁰ *Op.cit.* Section 2

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Plymouth

Razaw Fatah, CDW, Plymouth

“Plymouth is a dispersal site for asylum seekers, so the BME community here has grown enormously in recent years. I myself came here as an asylum seeker initially, so I have first hand experience of some the issues faced by the community. I became involved in the CE project because I was accessing a service within Child and Adolescent Mental Health Services (CAMHS) in Plymouth called Kew 5. The service was supporting my son who had some behaviour problems at that time, and through my contact with Kew 5, I was invited to get involved in the CE project, which was focussing on the experiences and needs of asylum seeker and refugee women and families in Plymouth... I learned a lot from the project. It was a big opportunity for me and opened a door for me to understand more and gain new skills and knowledge. As well as learning about different aspects of mental health, my communication skills and confidence levels improved. This, in turn, has had a big impact on me getting the CDW job, which I was offered in August 2008. From my role in the CE project I now have a wealth of knowledge to use every day in my work.”

Delivering race equality for older people

The DRE action plan called for greater collaboration between PCTs, NIMHE and agencies and organisations specifically focusing on the needs of older people. Currently about 3 million older people in the UK suffer from a mental health problem and this is expected to rise by one third over the next 15 years. Depression is the most common condition and affects three times as many older people as dementia. Delirium, schizophrenia, bipolar affective disorder, alcohol misuse, anxiety, agoraphobia and adjustment disorders will make up most of the remainder.

Amongst the developments in the past five years was the drawing up of a national Consensus Statement through the NIMHE older people’s mental health programme (now Mental Health in Later Life programme). The Consensus statement signatories included a range of voluntary sector agencies, Royal Colleges, clinicians and academics. The statement set out the evidence base in relation to older people’s mental health and called for a range of actions including:

- More person centred care;
- Development of better clinical pathways;
- Improved access to services;
- A more socially inclusive approach to developing services;
- Support for carers; and
- Improved skills training for staff.

Other work within the Mental Health and Later Life Programme has been the development of guidance for commissioning mental health services for BME elders: www.nmhdu.org.uk/our-work/mhlep/

A key development has been the linkage of the Mental Health & Later Life, DRE and Gender Equality programmes into the MH Equalities Programme. This was formed in April 2008. Work is currently underway to ensure greater integration across all programmes, including work on age equality in relation to the Equality Act 2010.

Delivering race equality for children and young people

The DRE action plan called for improved working to improve services for children and young people through more collaborative working between child and adolescent mental health services (CAMHS), NIMHE and others. A key role was envisaged for CDWs “to help bridge the gap between local CAMHS and BME communities”. (p.53)

A range of work has taken place around the country.

DRE in CAMHS in the North West

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

- In Lancashire, cultural competency training was organised and rolled out. The aim was to help staff identify how to improve mental health services for children and young people. As well as informing Lancashire’s commissioning cycle, the results will be shared across the region;
- In Manchester, a mental health and well being toolkit to help young people support each other was rolled out. Staff and parents also received training around the toolkit and it is hoped that the referral process and care pathway will be enhanced;
- In Wigan, a community arts project in schools has targeted young asylum seekers and refugees, BME children and the mainstream population of children to express how they feel. A creative writing project has also enabled young people to explore mental health and well being;
- In Liverpool, the CDW helped to establish an agreement that CAMHS Cultural Competency Training will be incorporated in all contracts for staff, and service delivery roll-out will take place shortly. The Bridges Project, a drop in service for young BME children, adolescents and parents has developed as well as services to meet the needs of young BME adolescents facing forced marriage;

Building Block 1 – Appropriate and responsive services

- In the Wirral, Merseyside, clinical staff are supporting the development of a local young people's forum that addresses mental health issues experienced by children and young people from BME communities; and
- CAMHS Cultural Competency train the trainer training has been delivered to CAMHS staff and CDWs across the North West., as well as to other staff – for example medical staff in Lancashire.

'Keeping families strong,' Lewisham, South London

In Lewisham, South London, the community development worker is based within the Mental Health Promotion team in the South London and the Maudsley (SLaM) NHS Foundation Trust. One of the areas of development with the local communities is the CAMHS keeping families strong work. This involves work with local schools and families to promote greater mental health awareness and identify ways of promoting and developing initiatives for mental well being. This includes delivering training, workshops and seminars. The aim is to work on number of fronts – individual, family, community, structural.

Other activities include a support group for African Caribbean fathers, again exploring issues of parenting, self-awareness and the implications for better mental health and well being.

Key learning

There has been good progress in developing appropriate and responsive services. A number of organisations and partnerships have engaged with local communities and developed innovative services across England. In addition, DRE has raised awareness about the needs of people from BME communities; and the need to tackle inequalities is increasingly being considered at a commissioning level. However, much remains to be done.

Some of the key learning in relation to the appropriate and responsive services strand includes:

- A key area for improvement is in how PCTs and other commissioners address the particular and differing needs of BME communities;
- The success of projects such as the Sheffield EPIC has shown that services can meet communities' needs, but they need to take the time to engage with them in a meaningful way. This engagement needs to inform all levels – from commissioning through to the delivery and promotion of services;
- Mental health problems can have a complex range of causes and a wide range of factors need to be taken into account when treating people. Services need to be flexible enough to address many issues and staff need to have appropriate cultural and other competency skills; and
- As with most public health transformations, change takes time. However, the prerequisites to improved outcomes are now beginning to take root.

Building Block 2 – Engaged communities

The second building block of the DRE action plan was concerned with improving and enhancing the role of people from Black and minority ethnic communities to help improve services. The two main strands for this work were:

- 1 Recruitment of 500 CDWs nationally; and
- 2 Building upon the skills already existing in communities through supporting community engagement (CE) projects.

The impetus and rationale for the CE strand is clear in the DRE action plan. It noted that:

“Any initiative aimed at improving the healthcare experience of BME groups must recognise the leading role that BME communities themselves can play. [and that] All communities have a role in preventing mental health problems and providing an environment where people who have become ill can recover and prosper.”

A significant proportion of the DRE action plan work, including that of the CE strand occurred through the focused implementation sites in:

- 1 Work within the regional development centres; and
- 2 Work with users and carers.

It was led by regional race equality leads. This section discusses the evidence base provided by the work of CDWs and the CE projects.

The CE strand of the DRE programme was, arguably, the most ambitious and experimental aspect of the action plan. The aim was to help build healthier communities and to engage communities.

The idea was to integrate “the experience, values, approaches and knowledge of the non-statutory sector into the whole system” to “help development both inside the mental health system and outside.” The model for the DRE CE strand was imported from a similar model of community engagement developed through the University of Central Lancashire’s Centre for Ethnicity and Health²¹.

The community engagement model was intended to create an environment in which communities (individuals and organisations) and agencies could work equitably together to address an issue of mutual concern.

Community development as a process

The process of community engagement/development has been identified as a strength of the DRE programme. It is useful, therefore, to explore a number of key issues

which directly affect the implementation of a community engagement process within the context of statutory sector service commissioning and provision.

Community development (CD) has been defined as “a set of values and practices which plays a special role in overcoming poverty and disadvantage, knitting society together at the grass roots and deepening democracy²²”.

This report also notes that:

“Attempts to define CD often become muddled because of an assumption that a community is a fixed entity and that the aim is to develop it as such. A community is a group of people with some important common characteristics or concerns and a network of relationships which endure over a long period. However, these same people also have other relationships and networks and belong to other communities, and it is not the purpose of CD to limit this essential freedom and fluidity.”

It could be argued that incorporating the “freedom and fluidity” inherent in communities within a context of statutory service provision was the task of the community engagement work which took place within the DRE programme. This gave rise to overlapping priorities. In their report, ‘Organisational frameworks for implementing the community development approach within Delivering Race Equality (DRE) in mental healthcare,’ Walker and Craig²³ (2009) note:

“The CDWs’ role in helping to improve service provision for minority groups cannot be carried out in isolation from other service development functions. Whether working in PCTs, Mental Health Trusts, Local Authorities or Voluntary & Community Organisations, there are designated processes for reviewing and making changes to services and pathways, and for consulting with other agencies about such matters. Similarly, there are designated processes for drawing up or revising Service Level Agreements, for carrying out Equality Impact Assessments, for having inputs to staff training, and so on.

It follows that CDWs can only perform their role in this regard by forming links with people who have more say about such matters and by working through the appropriate systems and processes for getting policies reviewed and for changing ways of working. So, people managing CDWs need to clear the lines for those links to be developed and need to pave the way for CDWs to have some impact within the various processes mentioned, based on their understanding of service improvement possibilities from BME perspectives.”

²¹ The Centre for Ethnicity and Health was succeeded by the International School for Communities, Rights and Inclusion (ISCRI)

²² Craig, G. & Walker, R. (2009) Organisational frameworks for implementing the community development approach within Delivering Race Equality (DRE) in mental health care, P8 www.communities.gov.uk/publications/communities/communitydevelopment

²³ Chacksfield, D. et al (2006) The Community Development Challenge, P13 www.mentalhealthequalities.org.uk/equalities/news-/community-development-workers-for-bme-mental-health

Building Block 2 – Engaged communities

One CDW described needing to “meet the challenges of working strategically across disciplines, directorates and services, while at the same time raising awareness of and explaining the role of community development”. The problem, she noted, is that “people don’t know what to expect”.

The impact of the community engagement work will continue to be felt in the long term. Its strengths included its innovation and the willingness of voluntary sector organisations to engage with the process. The task now is to build on that work. One of the commentators in the Community Engagement report described it this way:

Marcel Vige, Manager of Diverse Minds, Mind

“DRE has been successful in generating an array of local projects that engage communities in novel ways. Also, within some PCTs DRE has underpinned a shift in consciousness around responding to the mental health needs of diverse communities. One telling discussion I had with a local Mind service provider in Oxford revealed how DRE had concentrated priorities of the local PCT onto responding to BME issues within mental health provision. This was reflected in both the allocation of resources and a general climate amongst commissioners and others. A critical aspect of this was the willingness by the PCT to take risks – supporting projects to engage with communities in creative ways. Though it’s hard to quantify such effects, it’s fair to say that the extent to which DRE has facilitated improvements in understanding of and response to BME mental health issues at the juncture between local strategy, implementation and service provision is indicative of its overall success.

“Clearly, a critical element in its success has been a willingness of stakeholders within particular localities to engage. This probably reflects a pre-existing desire to respond to such issues, which DRE conveniently tapped into. Fermenting such zeal across all local stakeholders – particularly gatekeepers such as commissioners – is an important lesson for future engagement/service improvement strategies. This would be assisted by addressing the other deficit of DRE, namely an overemphasis on local determination at the expense of a centrally driven strategy. Whilst by no means suggesting that local contextualisation isn’t essential, the consistency of DRE’s successes could certainly have been increased by a more thorough interweaving into the accountability systems of those responsible for its roll-out. Referring back to my Oxford example, location of DRE objectives into the monitoring systems of the PCT was acknowledged to have concentrated minds, securing buy-in from key personnel.”

Community Development Workers (CDWs)

The recruitment of 500 CDWs nationally by primary care trusts (PCTs) was the only hard target of the DRE action plan. The interim guidance (DH 2004) on their recruitment stated that:

“The aim of introducing CDWs is to enable greater understanding and ownership of the issues facing people from BME communities so that real improvement takes place in the commissioning and provision of mental health services across the full age range. CDWs will work to ensure full participation and greater ownership in the development of effective health and social care with BME communities themselves, recognising their experiences and reflecting their aspirations.

Funding was put into PCT baselines (£5 million in 2004-05, rising to £16.3 million in 2005/06 and each year afterwards) to fund CDWs. The original target for CDW recruitment was that the 500 workers would be in post by December 2006. This was revised to December 2007, with a new interim milestone of at least 50% of CDWs in post within each SHA by March 2007²⁴.

The role

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

- To bring about changes to the way that services were commissioned, delivered and perceived. This included identifying gaps in services, improving mental health needs assessments and improving communication between BME community services and statutory services;
- To identify and remove barriers to accessing services;
- To improve services and develop joint working between statutory and community services; and
- To work with BME communities to help develop grass roots solutions and community resources for mental health. They also helped to build relationships with local groups and networks so that they could have a more effective role within local partnerships.

²⁴ October 2006, Department of Health letter to SHA Chief Executives, Gateway 7049

Building Block 2 – Engaged communities

Four key roles were identified for CDWs:

Change Agent:

- To raise levels of understanding of the mental health needs of BME population groups;
- To improve the quality of mental health needs assessment for such groups;
- To identify gaps in services;
- To work towards more inclusive commissioning of mainstream services and more effective commissioning of services for BME population groups; and
- To improve communication between BME community services and statutory services.

Access Facilitator:

- To identify and help to resolve access barriers for BME population groups at service design and delivery levels, and in BME uptake of services.

Service Developer:

- To help services to become more responsive to the needs of BME population groups and to develop more effective services for them;
- To develop joint working between statutory and community services; and
- To help to evaluate and sustain improvements in service provision.

Community People Capacity-builder:

- Where possible, to help BME population groups to develop grassroots solutions to mental health issues;
- To support the development of BME community resources for mental health; and
- To help local groups and networks to develop the relationships and know-how which will enable them to make their views known and play an effective role in local partnerships for mental health.

The Evidence

CDWs had and continue to have a key role in engaging and working with local communities. The role was developed to help bridge the gap between BME communities and health and social care services. CDWs worked strategically across NHS directorates and services but also directly with BME communities. The importance of the CDW role must be particularly noted. They have been the focus and lead for exemplary work in many aspects of the DRE programme. CDWs have:

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

Through the DRE programme, 450 CDWs had been recruited at the last count. DRE research was commissioned, which we believe shows the positive impact CDWs have had. National and regional networks were set up to support their work. Many continue to be employed within PCTs.

In addition, a support programme for CDWs was set up to assist them in developing the skills necessary to reach and communicate with BME groups. The programme included a specialist website for CDWs with best practice case studies and updates on national programme activity, a bi-monthly e-newsletter and bespoke toolkits looking at topics ranging from how to engage stakeholder partners to running events and working with the media. More than 150 CDWs took part in this process.

Currently, a national evaluation of the work of CDWs has been commissioned and is expected to report in January 2011.

Building Block 2 – Engaged communities

Key learning

CDWs – implementing the role

A report²⁵ on how the CDW role is identified a number of key issues. These included:

- Slow progress towards achieving the full complement of CDWs;
- Shortfall in expenditure on employing CDWs, given that funding continues to go into PCT baselines;
- Pay levels and disparities;
- The need for concerted and ongoing intervention to support CDWs; and
- The importance of sustaining the intent of the DRE programme's objectives through incorporation into New Horizons.

The report also identified key areas for sustaining the role. These include:

- Ensuring partnership infrastructures – to enable CDWs to work across agency boundaries and to be in a position to better influence statutory services;
- Development of organisational frameworks – to better enable organisations to implement the role fully and build capacity;
- Education and training – for CDWs, and the maintenance of a national CDW network; and
- Developing the evidence base to document, disseminate and raise awareness about the wide range of work of CDWs.

One outcome of this was a further commissioned report²⁶ to support implementation. This identified the importance of:

- Integrating the role into the organisation – including the need for basic resources to do the job;
- Clarity about the basis of employment;

- Commissioners understanding the basis on which the role would be integrated;
- A managerial approach that enables better and more across-the-board understanding of the role within organisations;
- Partnership working – to promote work across agency and geographical boundaries;
- Mapping minority groups and their needs to better understand the diversity of local populations;
- Understanding how community development processes can enhance statutory sector working;
- Understanding the CDW role in improving service provision;
- Measuring progress, e.g., through the DRE Dashboard; and
- Ensuring continuity for the work.

The full reports are available on the mental health equalities website – www.nmhdu.org.uk/our-work/mhep/delivering-race-equality/dre-archive/

Other work carried out by Seebohm²⁷ looked at CDWs' performance. It noted:

"CDWs have to identify priorities within their work programme... and how they relate to dimensions of CD [community development], race equality and mental health... whatever their priorities, if CDWs are to gain the trust of diverse communities it is important they understand why people from BME groups might find statutory services alienating and oppressive, and why the help that services offer might not be valued. Taking a critical approach to psychiatry and respecting traditional non-medical approaches to distress may help. Above all, CDWs need to be aware of the increasing body of evidence that shows the mental health of BME groups can only be improved by reducing the impact of injustice and inequality: more is required than improved access to medical care."

²⁵ Walker, R. & Craig, G., (2009) Community Development Workers for BME mental health: Embedding Sustainable Change, DRE/NIMHE www.nmhdu.org.uk/our-work/mhep/delivering-race-equality/dre-archive/

²⁶ Walker, R. & Craig, G., (2009) Organisational frameworks for implementing the community development approach within Delivering Race Equality (DRE)

²⁷ Seebohm, P., (2009) A study to explore if and how community development workers and groups of people with mental health problems work together to promote racial equality in mental health services, PhD Thesis

Building Block 2 – Engaged communities

Doncaster

Curtis Henry, CDW, Doncaster PCT

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

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

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

On a strategic level, Curtis is leading on a Doncaster PCT project to evaluate the equality framework for commissioners. The framework is a checklist to ensure BME mental health needs are being met by services that are commissioned by the PCT. Additionally, Curtis is working with the Improving Access to Psychological Therapies (IAPT) programme which seeks to provide improved access to psychological therapies for people who require the help of mental health services. It also responds to service users' requests for more personalised services based around their individual needs. Doncaster PCT was a pilot for this programme, and Curtis now sits on the steering group in an advisory role to raise awareness about how IAPT relates to BME services and how to effectively engage BME communities about mental health issues.

Curtis also works with Tier 3 professionals in the Child and Adolescent Mental Health Services (CAMHS) in Doncaster to raise awareness of adolescent mental health issues and to develop community-based pathways of care for children and families from BME communities in the area. After a year-long process of infiltrating the CAMHS service through credibility and engagement building, Curtis now works alongside the team, liaising closely with health practitioners and family therapists to establish, identify and widen access to BME specific mental health services.

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

Although Curtis has been involved with many BME community mental health projects, he admits that engaging younger people hasn't been easy.

He explains, “Making young people aware of BME mental health issues and services has been challenging, particularly in terms of access, so we are keen to target schools with young people engagement work. Ideally, we would like to gain access to schools and talk to teachers about targeting BME children around mental health issues. I think it's incredibly important to reach children at an early age to demystify mental health and create awareness around services available to BME groups”.

Over the months Curtis has set up a series of meetings with young BME people to consult with them about mental health issues. He says, “To engage young people you need to get out into the communities and find out first-hand what they need.

From here I hope to develop a better idea about how we can establish services which meet the needs of a variety of BME communities.”

Building Block 2 – Engaged communities

Community engagement (CE) projects

The DRE action plan identified a £2 million investment scheme for 80 projects to be run by non-statutory organisations across England over two years. The aim was “to help to build capacity in the non-statutory sector, develop partnerships between the non-statutory and statutory sectors; and to offer new and innovative services to meet need.”

The aim was also “to improve pathways to care and recovery, mental health awareness and satisfaction with care.” In addition to funding, projects received support and training to enhance the work.

The evidence

Between 2005 and 2008, 79 CE projects were carried out by non-statutory community organisations across England. The projects engaged people from BME backgrounds to find out their views and opinions. The aim was to build capacity, through developing skills and competencies of people and groups in the non-statutory sector; to develop partnerships between the non-statutory and statutory sectors and to help providers offer new and innovative services to meet needs.

A DRE-commissioned report²⁸ has examined work of the local projects. It provides a comprehensive overview of the issues explored by the studies in relation to BME populations and mental wellbeing, mental health problems, mental health services and the vision of service characteristics for 2010 set out in DRE. The report also documents some of the project's outcomes for individuals, communities and mental health service development.

The report locates this work in the context of current mental health policy, practice and service provision, and includes commentaries from a number of mental health experts.

It contains a number of key messages relevant to the DRE characteristics. These highlight ways of working to help ensure less fear of services; access to a balanced range of therapies; development of more culturally appropriate treatments and interventions, delivered by a workforce and organisation capable of delivering appropriate and responsive services; more self reports of recovery amongst BME service users; information about what is needed to help ensure increased satisfaction with services; and information about how BME communities can have a more active role in training professionals.

A community engagement approach was developed by the University of Central Lancashire (UCLan). It involved training and supporting BME organisations to carry out research among their communities and supporting them to connect with local services by setting up steering groups. These groups typically included local mental health service planners, commissioners

and providers. This engagement ensured that the studies were compatible with local priorities and strategies, provided a mechanism for implementing the recommendations, and made it more likely that the community organisations' work would be sustained in the long term.

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

Each project focused on one or more of the 12 DRE characteristics for 2010 (see section 5 for the full list of characteristics). The findings for six of the characteristics have been summarised in UCLan's report on the process, findings and outcomes of the CE project.

Outcomes

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

- **Outcomes for individuals**

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

- **Outcomes for community organisations**

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

- **Outcomes for BME communities**

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

²⁸ Fountain, J & Hicks, J. (2010) *Op.cit.*, Section 2

Building Block 2 – Engaged communities

Derbyshire Gypsy Liaison Group (DGLG)

Derbyshire Gypsy Liaison Group provides assistance and information to the Gypsy community in and around Derbyshire. Their 2007 community engagement study explored the emotional and well-being needs of Romany Gypsies and Irish Travellers. A team of five, including two CDWs, interviewed 50 Irish Travellers and 100 Romany Gypsies. The study's recommendations have been progressed as follows:

- A further study was commissioned by West Midlands CSIP to explore the emotional well-being and mental health needs of older people. Its final report was *Shoon te o Puri Folki* (Listen to the Elders);
- Through outreach work and improved inter-agency working, there have been improvements to primary health care for people from Gypsy and Traveller communities;
- A swipe card system is being investigated to help Travellers provide information about their health at GP surgeries. The cards would hold their patient records in a protected format;
- DGLG are working with a Leeds-based organisation to provide a DVD package of information following the study's recommendation to provide information not just in written formats. Information is also provided through two leaflets as part of the older people's project; and
- DGLG send out reports to agencies and offer training seminars on cultural aspects of life of Romany Gypsies and Irish Travellers. These have been picked up on by agencies outside Derbyshire, including those in Devon, Sussex, Kent and the North East.

DRE Ambassadors

The DRE Ambassadors programme was established to involve users and carers strategically in the DRE programme. Thirty-three (33) ambassadors were recruited across nine English regions. They included carers, former mental health service users and ex-offenders who have had mental health problems.

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

Their role helped to shape the implementation of the DRE action plan, both regionally and locally. Ambassadors worked with RELs and CDWs as well as health, social care and other professionals. Ambassadors received training and other support to help inform their work at both local and central government levels.

Currently, a national evaluation of the work of the DRE Ambassadors is being commissioned, and is expected to report in January 2011.

Key learning about community engagement

CE projects and day to day work of CDWs have successfully engaged BME communities. This work has informed policy at regional and national levels and has helped to improve services. It includes:

- The majority of the CE projects recommended vastly increased BME community members' and service users' involvement in the planning, commissioning and delivery of mental health services;
- Community organisations recommended a number of ways of reducing fear of mental health services including:
 - education about mental health disorders;
 - addressing the negative connotations of some terminology, for example, the word 'mental';
 - community based services rather than mainstream services;
 - culturally sensitive support groups; and
 - partnerships with other organisations.
- One of the key challenges for community engagement is the fluidity of the term 'communities'. Communities are not static or fixed and people may identify with a number of communities. Work at a local level is important. For example, it would address the diversity of 'the South Asian communities', within which there are differences between genders, generations (especially between those who were born in and outside the UK), faiths and religions, and languages and dialects, as well as between those of Bangladeshi, Indian, Pakistani and Sri Lankan heritage. What works for any one of these – or for any other BME population – may be inappropriate for another; and
- CDWs need to be supported to work across disciplines, directorates and services so they are better placed to influence statutory services. Organisations need a better understanding of the role and should develop frameworks that allow CDWs to work strategically.

Building Block 3 – Information, research, evaluation

Better quality, more intelligently used information was the key third building block of the DRE action plan. Research and evaluation formed a main strand within this, with the focus being to emphasise the need for improved ethnicity monitoring, identification of good practice and provision of better information to patients. Analysis and dissemination of information to inform strategic and operational planning was also a significant aspect.

In a recent article²⁹, Michael Clark, former CSIP research manager, noted that:

“From the beginning DRE had a close relationship with research evidence. Such knowledge was significant in the origins of the programme, being used to present a case of injustice.”

He identified two points of importance about this relationship.

“First, it was a diversity of research evidence being valued and used to understand the inequalities, and second, such evidence was one form of knowledge used alongside others”.

The DRE action plan emphasised that ‘better quality, more intelligently used information is vital to improve services and equity in outcomes and to develop new strategies and services for mental health problems’.

The programme has aimed, through the range of work undertaken within it, to strengthen the evidence base in relation to:

- Monitoring ethnicity and service use;
- Analysing and disseminating information; and in
- Making knowledge available.

“From inception, the programme has maintained a commitment to a ‘sustained interaction’ across policy and practice development with research and evidence, in the spirit of genuinely seeking learning to inform the evolution of DRE. Fundamental to the sustained interaction was for the programme itself to commission research and evaluate its work.”

Overview of the DRE research programme

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

- **Original research** that in some way addressed one or more of the 12 characteristics) – e.g., focusing on prescribing; adaptability of cognitive behavioural therapy to BME communities; looking at the experiences of users and carers; and cultural consultation in forensic settings;
- **Evaluative research** – of DRE work, e.g., FIS, implementation of the CDW role, review of the EPIC work; review of CE projects, evaluation of the RECC; and

- **Programme-specific research** – e.g., 79 CE project reports; research related to data collection and measurement.

The Evidence

The body of work which has resulted represents a significant contribution to the quantitative and qualitative evidence base of literature. Full details on the DRE research and knowledge generation programme is attached at [Appendix 4](#). Two key aspects of DRE-led information gathering are the Count Me In census and the DRE Dashboard.

The Count Me In census

The Count Me In census has been a key plank of the DRE information building block.

The census is a headcount of all mental health inpatients on 31 March each year (from 2006 it was extended to cover learning disabled inpatients). It records ethnicity, related factors like first language and faith, and some information about patients’ care pathways prior to admission.

The census is funded by the Department of Health and was undertaken by the Healthcare Commission. The final Count Me In census was conducted in March 2010. The Healthcare Commission was replaced on 1 April 2009 by the Care Quality Commission (CQC), and the CQC undertook the 2009 Count Me In census.

The census has been very successful in securing an almost complete response from providers, and in improving the quality of ethnic monitoring in the Mental Health Minimum Data Set. Ultimately, the aim is to ensure that routine data sources will then be able to provide information.

Information provided by the census has been consistent across the four year period 2005-2008. Most inpatients continue to be treated within the NHS, although a slightly higher proportion of inpatients received services from independent providers.

The vast majority of BME inpatients came from 23 of the 238 healthcare organisations that took part in the census. The census records the ethnicity of almost all patients. This shows that healthcare providers can fulfil their statutory obligation to record the ethnicity of patients when asked to do so on a one-off basis.

2005 – 2007 results: admission and detention

The first census was seen to confirm the need for DRE. It showed that people from Black African or Caribbean communities were three times more likely to be admitted to hospital than the population as a whole, and 44% more likely to be detained. The same groups were also about twice as likely to be referred to hospital through the police or the courts. Results in 2006 and 2007 were broadly similar. The White British, Indian and Chinese groups have consistently shown below average admission rates.

²⁹ Clark, M. (2008) ‘Research evidence and delivering race equality in mental health,’ *International Journal of Psychiatry*, 1-5

Building Block 3 – Information, research, evaluation

2005 – 2007 results: mixed sex accommodation

The census asked about mixed sex accommodation, in part to compare BME patients' experience and also in an attempt to gain maximum value from the census as a general monitoring tool. In defining 'mixed sex' it applied DH guidelines, i.e., anyone without access to single sex day areas is counted as not in a single sex ward. DH guidance is that single sex accommodation – separate sleeping, toilet and bathing facilities – is mandatory, but single sex wards – separate day areas as well – are not. The 2005 census reported that 78% of patients were not in single sex wards (the figure was actually slightly lower for BME patients). In 2006 it was 55% (although the question was asked in a different way). In 2007 the Healthcare Commission reverted to the 2005 question and reported that 68% of patients weren't in single sex wards.

2008 results: admission and detention

The 2008 report showed detention rates for BME groups at levels similar to those in previous years, and admission rates that were slightly higher than in 2007 for most of the Black groups. It has been noted that the increase may be a statistical phenomenon – the rate for people classifying themselves as 'Other Black' has dropped, suggesting that there could have been some redistribution of self-classification from that group to the rest of the Black groups. The proportion of 'Other White' (i.e. not White British or White Irish) inpatients rose from 3% in 2005 to 4.5% in 2008. There is a perception that Black inpatients are more likely to be subject to measures like physical restraint and seclusion. However, the four census reports do not confirm this – the groups most likely to be restrained or secluded change from year to year, and the Healthcare Commission view was that this represents 'regression to the mean'. The exception is the Other Black group, who have shown high rates of seclusion in all four reports.

2008 results: mixed sex accommodation

The census report showed that 68% of patients were not in single sex wards, unchanged since 2007. This year the census asked for the specifics: whether patients had single sex sleeping accommodation, toilet and bathing facilities, and day areas.

2009 results: admission and detention

Patterns in the 2009 report show detention rates broadly similar to those reported in previous censuses. Detention rates were higher than average among the Black Caribbean, Black African and Other Black groups in all five censuses. Detention rates were higher than average among the Other White group in the three most recent censuses.

2009 results: seclusion and restraint

There is a perception that Black inpatients are more likely to be subject to measures like physical restraint and seclusion. However, the census results do not confirm this. The report shows that although seclusion rates were higher than average among the Other White and White/Black Caribbean Mixed groups. The high rates evident for Black groups in some previous censuses were not apparent in 2009.

2009 results: Community Treatment Orders

Numbers are relatively small, and some data is missing, but the findings suggest that inpatients from some ethnic minority groups (including Black Caribbean and Black Others) are more likely than average to be discharged onto a Community Treatment Orders (CTOs). These groups are also more likely to be detained in the first place (only patients who have been detained can be discharged to CTOs). It is not possible to tell from this report whether detained patients from any ethnic groups are more or less likely to be discharged onto CTOs than other groups. (Note: a further report, published by the Mental Health Alliance (Briefing Paper 2, Lawton-Smith, S., Supervised Community Treatment, (August 2010 (slatwon-smith@mhf.org.uk)) noted concern "about the disproportionate use of CTOs for people from black and minority ethnic communities."

2009 results: Mixed sex accommodation

The 2009 report shows that 67% of patients were not in single sex wards, (similar to 2007 and 2008). As in 2008, the census asked for the specifics: whether patients had single sex sleeping accommodation, toilet and bathing facilities, and day areas. Overall 19% of men and 24% of women were reported as not having access to toilet and bathing facilities designated for single sex use, and about half of all patients were reported as not having access to a lounge and day space designated for single sex use. These proportions were generally lower among minority ethnic groups than among the White British group.

West London Mental Health Trust

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

The findings indicated a disproportional rate of admissions of the BME patient group when compared to the White patient group. The findings also suggested that Black patient groups "are also disproportionately admitted to the service when examined in relation to the local population census."

In addition, in some services the rate of seclusion and incidence of restraint was higher in the BME patient group. The report identified three DRE service characteristics as key performance indicators from which the trust can benchmark improvements year on year:

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

Building Block 3 – Information, research, evaluation

2009 Care Quality Commission

Count Me In Recommendations

- “1 Health and social care organisations should work with other statutory bodies (including police, courts, housing and education), non-statutory or voluntary agencies, and with minority ethnic communities, towards achieving the goals of DRE and the vision of mental wellbeing set out in New Horizons.
- 2 Statutory bodies, working in partnership with others, should understand the demographic and clinical needs of their local populations, and commission and deliver fair, personalised and effective services that reduce mental ill-health among Black and minority ethnic groups, improve pathways to healthcare for those who become mentally unwell, and improve the experience of those who are admitted to hospital.
- 3 Those who commission and provide mental health and learning disability services should make renewed and strenuous efforts to improve the provision of single sex accommodation for inpatients.
- 4 Those who commission and provide mental health and learning disability services, in both the NHS and the independent sector, should have fully comprehensive systems to record and monitor ethnicity.

We recommend to the Department of Health and the Information Centre for Health and Social Care that:

- 5 Submission of the Mental Health Minimum Data Set (MHMDS) and Hospital Episode Statistics (HES) is made mandatory for all independent providers of mental health and learning disability services, especially in view of the growing number and proportion of all mental health and learning disability inpatients cared for in these establishments. Submission of these data sets should be a requirement in the mental health standard contract that is being developed by the Department of Health.
- 6 The Information Centre should routinely monitor and publish reports on the quality of MHMDS data submitted by all providers of mental health services, including those in the independent sector. These data quality assessments should include the quality of data on community treatment orders.
- 7 The Information Centre should routinely publish data on all admissions, detentions and community treatment orders under the Mental Health Act in England (in both NHS and independent healthcare providers) by the ethnicity of patients, with the longer term aim of the MHMDS being the definitive source of information about mental health patients, including use of the Mental Health Act.

High quality, appropriate data is essential for monitoring the way that patients gain access to healthcare, the quality of care they receive and the outcomes of that care. This applies to all patients with mental health problems and learning disabilities, including those from Black and minority ethnic groups. Such information is also vital for the effective regulation of mental health and learning disability services by CQC.”

The DRE Dashboard

The DRE Dashboard³⁰ was developed to support measurement of progress in the DRE programme. It was published and disseminated in September 2008 and was intended for use as a detailed set of indicators to support and guide strategic health authorities (SHAs), primary care trusts (PCTs) and mental health trusts in better understanding how to use the work generated through the DRE programme, and service delivery generally to improve access, outcomes and experiences for people from BME groups. The DRE Dashboard reflected the DRE programme's commitment to working with statutory sector agencies through regional race equality leads (RELs), service users and carers, voluntary and community sector agencies and others.

The DRE Dashboard identified six headline priorities to support local, regional and national monitoring of outcomes for BME communities.

These were:

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

These areas overlapped with the overall DRE programme priorities of:

- 1 Continued recruitment of CDWs;
- 2 Continuing work to ensure access to appropriate services; and
- 3 Continuing work to increase satisfaction and confidence of people from BME communities in mental health services.

The rationale for the DRE Dashboard was to focus on co-ordinated information gathering and analysis to aid service improvement.

³⁰ www.nmhd.org.uk/our-work/mhdp/delivering-race-equality/dre-dashboard/

Building Block 3 – Information, research, evaluation

Data collection

Work to progress understanding and use of the DRE Dashboard was led centrally through the DRE programme. This resulted in a data collection (Quarter 4 2008-09) on the six headline indicators. The full DRE Dashboard contains 26 indicators, which are aimed at helping SHAs and PCTs to better understand and meet the needs of their local populations.

For the longer term, the aim is that the information and indicators identified through the Dashboard will be collected through existing data capture mechanisms – the Mental Health Minimum Dataset and the annual collection of mental health statistics (KP 90) to inform commissioning understanding and processes in order to improve services to diverse populations.

The report – *Use of new mental health services by ethnic minorities in England* prepared by Glover & Evison (2009) analyses and discusses the results of the Q4 data collection. This included the responses of 152 PCTs. (North East Public Health Observatory,) www.nepho.org.uk

The DRE Dashboard was also intended as a tool for gathering detailed **narrative information** on the range of work undertaken within the DRE programme since its inception in 2005. The aim was to support service improvement and policy implementation to address the 12 characteristics for service change set out in the DRE action plan.

Key learning – information, research, evaluation

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

The DRE 12 characteristics – a discussion on context and measurability

As noted earlier, the DRE 12 characteristics were the vision set for the programme in relation to service development and improvement by 2010. As such, the characteristics have been the starting point for much of the work carried out within the DRE programme. This report looks at progress through the mechanisms identified for implementation – the FIS, CE projects, CDWs and other information and initiatives.

The DRE characteristics are discussed throughout this document. This section attempts to take an objective view of the indicators and progress towards them based on available evidence, not previously cited in this report:

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

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

2 Increased satisfaction with services

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

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

The Count Me In census shows that there has been little change in the numbers of BME patients on inpatient wards. The fifth national census, published in January 2010, showed that admission rates for BME communities are not falling and that some BME groups are three or more times more likely than average to be admitted. Rates of admission were lower than the national average among the White British, Indian and Chinese groups, and were average for the Pakistani and Bangladeshi groups. They were higher than average among other minority ethnic groups – particularly in the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups – with rates over three times higher than average, and nine times higher in the Other Black group. These patterns are similar to those observed in previous censuses, with no evidence of a decline in admission rates among Black and minority ethnic groups. It is important to note independent research (see Fearon, et.al.³¹ and Singh, et.al.³²) that indicates higher rates of mental illness in some BME groups.

³¹ Fearon, P., et al., 2006 Incidence of schizophrenia and other psychoses in ethnic minority groups: results from MRC AESOP study, *Psychological Medicine*; 36(11) Cambridge University Press, pp.1541-1550

³² Singh, S., Greenwood, N., White, S. Churchill, R. (2007) 'Ethnicity and the Mental Health Act 1983.' *British Journal of Psychiatry* 191, 99-105

Building Block 3 – Information, research, evaluation

However, the discussion below highlights that compulsory detention rates alone may not be a good indicator of quality in mental health services, though they are an important reflection of the experience of BME service users.

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

Results from the 2009 Count Me In census show that detention rates for BME communities are not falling. 46% of all patients were detained under the Mental Health Act on admission, an increase from 40% in 2005. Overall rates of patients subject to the Mental Health Act (including CTOs) were higher than average among the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups, and in the Other White group. Detention rates have remained higher than average among the Black Caribbean, Black African and Other Black groups in the four annual censuses conducted from 2005 to 2008; the same pattern was seen in the 2009 census in terms of overall use of the Mental Health Act, including CTOs.

As previously noted, higher rates of mental illness in some BME groups means that compulsory detention rates alone may not be a good indicator of quality in mental health services, though they are an important reflection of the experience of BME service users.

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

The Count Me In census shows there is no disparity between BME and White British inpatients in the incidence of physical assault, accidents and self-harm. The Department of Health funded a study of over 700 psychiatric inpatients in general adult psychiatric units across eight mental health trusts in England³³. They had been admitted on sections 2,3, or 4 of the Mental Health Act 1983 or became involuntary patients within the first seven days from admission. The study found no association between ethnicity and the use of coercion in psychiatric inpatient units.

6 A reduction in the use of seclusion in BME groups

The fifth national census showed that although seclusion rates were higher than average among the Other White and White/Black Caribbean Mixed groups, the high rates that were evident for Black groups in some previous censuses were not apparent in 2009.

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

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

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

Research shows there is no disparity between BME and White British groups in the proportion of service users who feel they have recovered from their illness. The Bennewith, O., et. al (2010) study indicated that those from ethnic minorities have better outcomes on symptom improvement scales and scales rating 'satisfaction with life in general and different life domains' one year after admission. Healthcare Commission community patient surveys also show no disparity between BME and White British service users when asked about their feelings about their own mental health.

9 A reduction in the proportion of prisoners from BME communities

Home Office and Ministry of Justice figures show there was a slight decrease in the proportion of prisoners from White backgrounds between 2005 and 2007 (from 82% to 81% of total British national prisoners and from 75% to 73% of the total prison population). The Black or Black British proportion of the British national prison population increased from 10% to 11% in the same period, while the proportion in the total prison population stayed the same at 15%. The Asian or Asian British proportion of the British national prison population increased from 4% to 5% in the same period, while the proportion in the total prison population also increased, from 6% to 7%. A consistent pattern across all five annual Count Me In censuses was the higher than average detention rate under section 37/41 for the Black Caribbean and Other Black groups.

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

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

- Mistrust of services/practitioners;
- Worries about confidentiality;
- Poor availability of information; and
- Language issues³⁴.

Learning from the DRE programme is being incorporated into the rollout of the Increasing Access Psychological Therapies (IAPT) programme.

³³ Bennewith, O., et. al (2010) 'Ethnicity and Coercion among involuntarily detained psychiatric inpatients in England', British Journal of Psychiatry 196, 75-76

³⁴ For more information visit: www.nmhd.org.uk/our-work/mhep/delivering-race-equality/dre-archive

Building Block 3 – Information, research, evaluation

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

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

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

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

Race equality training, clinical trailblazers, CDWs and the development of the DRE Dashboard have helped

to improve the skills of the mental health workforce and measuring progress in relation to these interventions. Evaluation and research, however, indicate that the understanding and impact of some of these initiatives has been variable.

Developing the characteristics

Concerns about the characteristics themselves have been raised both by clinicians and service users. There are also concerns from an analytical point of view. This suggests that there may be scope to develop the characteristics further, or to consider assessing the DRE programme against a wider set of success factors.

The above notwithstanding, a degree of measurement of the impact of the work in the DRE programme – as evidenced by the DRE Dashboard, continuing work to influence data capture through the Mental Health Minimum Data Set, and in specific work with PCTs and strategic health authorities has led to improved awareness and the need for further work in this important area.

Key learning

The 12 characteristics were not all measurable indicators; and a significant part of the DRE programme's work has been to identify ways that the programme can measure its success and effectiveness. The DRE Dashboard was the practical response to this.

Questions have been raised about the characteristics and a wider set of success factors may be needed going forward. Some of the key learning around the 12 characteristics has been:

1 Timescale

We need to collect data for longer if we are to measure ongoing trends rather than year on year fluctuations. The majority of data are available only once a year. While there may be differences between one year and the previous year, it is impossible to say whether these are part of an ongoing trend or simply fluctuations. It is probable that there will be potential for a full assessment of the impact of DRE only after several years of efficient data capture and analysis.

2 Regional variation

Development of indicators should incorporate trust-level data, where appropriate. However, local-level data may sometimes concern numbers of service users or survey respondents that are too small to be meaningful. Data could be usefully analysed on a regional basis through strategic health authorities, linking with public health observatories. This can be augmented by national data collection – e.g. The Mental Health Minimum Data Set.

3 Gaps in the data being collected

Some characteristics cannot currently be measured. Furthermore, even where characteristics can be measured, data may not be complete, which will limit the conclusions that can be drawn. For example, data on NHS and private sector providers are, in some cases, not comparable.

4 Complexity

Some of the characteristics are complex – for example, one of the characteristics raises the question of causality while three raise questions of what is clinically appropriate. Such characteristics will always need to be explained and assessed within the appropriate context.

5 Ethnicity variation

It is not straightforward to use surveys to make comparisons between the experiences and views of different ethnic groups. For example, factors such as age and levels of self-reported health have a significant impact on how individuals answer survey questions. Different ethnic groups may have different mixes of age, or levels of self-reported health. So it would be misleading simply to look at differences between different ethnic groups in survey questions, because the difference may be due to these other factors. This means that a (sometimes complex) process of “standardising” the data to remove differences caused by these other factors is needed. However it is vital to consider different BME groups separately, rather than looking at all groups together as a whole.

Building Block 3 – Information, research, evaluation

Key learning

Work on the DRE action plan has indicated the importance of robust and measurable project and data management. Future work must build on this and continue to address how to develop metrics which better quantify and measure progress. Key areas include good ethnic monitoring; developing a range of ways of improving demographic information; ensuring good links between informatics, audit and equality and diversity leads within trusts in order to effectively use the information to inform service development, monitoring and review at board, management, ward and community levels.

DRE and partnerships

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

The DRE action plan's aim to promote greater access to a more balanced range of therapies for people from BME communities fitted, e.g., with IAPT's aim to promote access to psychological therapies. Consequently, DRE's work has informed and influenced the IAPT programme. A significant aspect was the appointment of a joint IAPT/Equalities project manager who is working across both programmes to address issues of inequality and access. We have been involved at a strategic level, contributing to equality impact assessments and at a local level through the work of CDWs. See the IAPT case study for how IAPT is improving access to therapies in Newham.

DRE worked with other NMH DU programmes to support the implementation of the Mental Health Act 2007, including the Three Keys initiative of adopting a shared, values-based approach in mental health assessment. This involved training a national cohort of CDW champions to develop the Three Keys approach to help improve the skills of mental health practitioners in working with diverse communities. The report on the work of the CDW Champions will be available in January 2011.

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

Shift is a DH funded initiative to tackle stigma and discrimination surrounding mental health issues in England. We jointly commissioned a number of projects, including a film, *Open Secrets*, a photographic exhibition, a research project into the coverage of mental health stories in the African and Caribbean media and a BME media resources library.

The DRE programme also undertook a successful collaboration with Shift through the Breaking Through Barriers project. This involved CDWs, working regionally, to improve mental health awareness in BME communities.

Improving Access to Psychological Therapies

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

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

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

DRE action plan – Narratives and feedback

Throughout its existence the DRE programme has generated wide-ranging comment and feedback. The goal of the DRE programme – to deliver the vision contained in the 12 characteristics – was ultimately about managing a range of uncertainties and complexities, perhaps mirroring exactly what clinicians face on a daily basis. This was evident at the outset of the programme and continued to be the case throughout its existence.

The DRE programme has undoubtedly made a major impact given the level of debate, discussion and at times, controversy it has generated. The DRE programme has been regarded as a huge catalyst for change by people from Black and minority ethnic communities – users, carers, professionals, communities. That has made it a repository for the hopes and aspirations (for successful delivery) of many who have been involved with it. With such a large investment and engagement, it is perhaps inevitable there would be differing views about the programme's performance and legacy.

Building Block 3 – Information, research, evaluation

This section discusses the complexities with which the programme has had to contend; sets out a number of views from stakeholders about the performance and achievements of the programme; and draws on other views which identify specific ways in which the accomplishments of the programme can be built upon and embedded.

Managing complexity

The degree of complexity which has governed the work of the DRE programme can be described in terms of:

- The complexities of **understanding personal identity** in terms of **race, culture, ethnicity, geography, sexuality, faith** – these must come into play in any discussion about mental health;
- The complexity of how personal identity interacts with social systems and organisations and the inequalities which can result;
- The **complexity of participation** represented by **users and carers**, working to achieve change; and
- The complexity of **approach** – which includes working inside and outside the system to bring about change.

Understanding the person

People from BME communities who use mental health services have long said that it is necessary to see the person, not the stereotype: to see the person, not the diagnosis. To do so requires active engagement to understand some of the complexity of what is contained in the acronym BME.

There is, for example, a big difference between the position of an elderly Asian woman, whose first language does not have a name for depressive illness; and her grandson, born in the UK. They are different again from a young African Caribbean man, who is afraid to engage with services because of fears about what might happen to him. He is different again to someone from a refugee or asylum seeking community, who may be traumatised by previous experiences.

The work of the DRE programme has been about helping to address these issues of complexity, by working with commissioners and providers to better enable their understanding of race, culture and ethnicity within a context of equality as well as inequality. This requires commitment, courage, and consistency.

Complexity of participation – users and carers

There is a long and historic tradition of developing and building the mental health service user movement in Britain. The legacy of those who developed and campaigned for advocacy and involvement, and who took direct, as well as indirect action to try and achieve change has created a position whereby “engaging people who use mental health services in developing those services... [or user involvement] ...is now an intrinsic part of policy³⁵”.

The DRE Ambassadors programme, Catch-a-Fiya, and the work of the National Survivor User Network (NSUN) are recipients of that legacy. In terms of Black and minority ethnic service user involvement, the case for understanding the complexity and the need for greater inclusivity within the service user movement was set out eloquently by service users in a report³⁶ published in 2008. It noted:

“While user involvement is generally seen as enabling, some groups, for example, people from Black and minority ethnic communities, are not as ‘involved’ as others in mainstream user involvement activities.”

The DRE Ambassadors programme, working with other user and carer groups has helped to change the face of participation and involvement.

Complexity regarding approach

There is a diversity of opinion across the ideological spectrum about the work of the DRE programme itself.

The DRE programme has been subject to some criticism that it would never fully meet expectations; that the scale of the challenge was too large; that the strength of commitment was too small; and that consequently, in the years of its existence, it could not meet the challenges set out for it. The work of the programme had to – necessarily – be transformational and to take the long term view of attempting to change the culture of health and social care, through work to influence, work to promote understanding about equality and inequality, and work to continue to identify opportunities and levers for change.

The end of the DRE programme does not mean the end of the work or of the need for it; and the programme has laid a good foundation upon which to build.

The views and assessments of a number of stakeholders set out below provide indications of how this might occur.

³⁵ Department of Health 1999, 2005; National Institute for Mental Health in England 2003

³⁶ Kalathil, J. (2008) Dancing to our own tunes: Reassessing Black and minority ethnic mental health service user involvement. National Service User Network in collaboration with Catch-a-Fiya. www.nsun.org.uk/WebPageFiles/65/NSUN_Report.pdf

Building Block 3 – Information, research, evaluation

DRE – The stakeholders' view

The outcome of a ministerial discussion meeting in May 2009, to assess the work of the programme raised a number of points which are outlined below:

Key messages

DRE at the outset

- It was felt that the vision of the DRE programme was very comprehensive, but the work had been hampered by ineffective communication in its early stages.
- It was thought that the programme's original objectives needed more focus and greater clarity about ways of measuring progress.
- Governance of the programme at the outset could have been clearer.
- Community engagement was a strength of the programme (particularly CDWs working at a community level) and there were good outcomes at a community level.
- The debate about DRE and what it meant to different people (racism, institutional racism, shift in practice) affected some people's willingness to cooperate with the programme.
- It was important to make the link between understanding and learning about community engagement with e-designing services.

Key issues for DRE

- There is not a consensus on issues surrounding mental health amongst BME groups, for example how much of an influence poverty and lifestyle factors have on mental health.
- The public health agenda relating to BME mental healthcare should focus on service change as well as prevention through raising awareness of mental health conditions. BME communities had an important role to play within this.
- Concerns were expressed that the vision of DRE should be retained under a new mental health strategy. The issue now is to establish what parts of the programme are sustainable and how to ensure proper resourcing within community organisations.
- CDWs needed greater support and clarification about expectations within their localities.

Key achievements of DRE

Key points of success were felt to be:

- DRE's CE programme; and
- The culture change that has occurred as a result of DRE – people now think very differently about race equality than they did five years ago. There is greater awareness of the need to actively address meeting the needs of people from BME communities. Also, as a result of DRE, more systems are in place, and there is a greater evidence base upon which to build.

The programme going forward

- It was felt that there should be ongoing investment in targeting communities.
- It was felt that the NHS should send out clear anti-racist messages.
- A more sophisticated approach is needed to developing a more capable workforce. Skills training and training in cultural awareness are an integral part of achieving this.
- It was felt that a new mental health strategy should:
 - look at the different levels and understanding of mental health problems amongst the public;
 - encourage more self-referrals;
 - link departments and agencies across government to address issues of equality and inequality; and
 - tackle health inequalities and link up community cohesion with health inequalities.
- Views were expressed that equality should run through all mental healthcare, not just race equality.
- It was suggested that once common ground is established on the role of stigma, trust and confidence of BME groups in the system, progress will be made.

Building Block 3 – Information, research, evaluation

DRE – A clinician's view

The following points were made by Professor Kamaldeep Bhui at a conference³⁷ in June 2009.

DRE programme lesson:

- The landscape is totally different, and DRE has had a major part to play in promoting this shift in the culture of organisations and care practices.
- Generic health policies had mentioned BME groups and ethnic inequalities without actions for decades.
- Separate policy development to tackle ethnic inequalities began in 1999 with Inside Outside, and then DRE in 2005.
- The David Bennett response was linked with DRE by DH but was not the only motivation for DRE. The later disagreement about whether institutional racism exists and what form it takes was therefore de-stabilising for DRE, as the foundations were already based on a particular paradigm that was generally accepted by the public and professionals. Therefore, the linkage, although important, proved to not be helpful to the wider ambitions of DRE and alienated those who did not believe in institutional racism.
- At the time of DRE, there was a clearly stated culture of 'no targets' and only aspirations. Despite this the 12 outcome indicators emerged without adequate provision or scoping of information systems suited to provide high quality data for all 12 indicators.
- The information strategy seemed to be lacking to monitor change against all 12 indicators.
- There was limited understanding and investment in workforce development and service development and re-design, called the appropriate and responsive services block; this was the least resourced component yet the most demanding of local providers and systems change.
- There was an over-emphasis on CE and appointment of CDWs as magical mantras, whilst not supporting CDWs with the right skills and leadership support to act at a sufficiently senior level in order to implement the very ambitious programme.
- What was needed was real and sustainable growth in capacity and skills, and not to again engage those communities that complain of being over-engaged; nonetheless building capacity in the NGO sector to truly build social capital in the community may have permitted local people to determine pathways choices about mental health care.

And the future?

Lessons for the future:

- Leadership: acknowledge success and realistic plans for change of 'culture' and specific deliverables;
- Remove contradictions in DH, programme, local policy;
- Isolate from political response to crises;
- Ensure clinical relevance and engagement;
- Maintain focus on quality improvement;
- Engage with knowledge rather than dismiss expertise in favour of politically quieter/expedient solutions;
- Objectives consistent and sustained over time;
- Don't get derailed by conceptual issues around institutional racism or by polarized caricatures of the problem – level up not down!;
- Information strategy and communications and programme management; and
- Resources: people, knowledge and financial.

³⁷ 25 June 2009, DRE in Mental Healthcare – Implementing Preventing and Proactive Measures, The House Magazine, Westminster Briefing

Building Block 3 – Information, research, evaluation

DRE – A manager's view

Hari Sewell was a director of Camden & Islington (C & I) NHS Foundation Trust through much of the lifespan of the DRE programme. C & I was the recipient of a DRE grant, and carried out work which was sited within the North West London FIS. In his recent book³⁸, he describes the Changing Outcomes initiative which resulted.

Camden and Islington NHS Foundation Trust Changing Outcomes is currently being implemented. It is an example of trying to establish a causal relationship between service inputs and improved service user outcomes.

Aims

Changing Outcomes strives towards the following outcomes:

- A reduction in the number of people from African and African Caribbean backgrounds admitted to psychiatric intensive care units;
- A reduction in the number of people admitted under section 3 of the Mental Health Act 1983; and
- A reduction in the proportion of people readmitted within 120 days.

Description

Changing Outcomes is an approach rather than a service. It is based on the principle of beginning with the end in mind (Covey, S. (1989) *The 7 Habits of Highly Effective People: Powerful Lessons in Personal Change*. New York: Fireside.). Team and delivery systems set targets for closing the gap on variations in service utilization by people of African and African Caribbean backgrounds. The term 'delivery systems' relates to a network of sector-based services that have an interdependent impact on outcomes. For example, use of psychiatric intensive care units (PICUs) may be affected by the actions of both the community mental health team and the acute psychiatric wards. Length of stay may be affected by the decisions of inpatient staff but also by the responsiveness of community staff to enable discharge.

Approach

Changing Outcomes therefore has no staff team but is an approach throughout the organization based on three principles:

- Begin with the end in mind – identify what needs to change and set targets;
- Make a working assumption that services have the ability to help change outcomes for Black African and Black African Caribbean people; and
- Invest in the possibility that the relationship between worker and service user is the primary vehicle for change (where pharmacology and other models of intervention have failed).

DRE action plan – Next Steps

The DRE programme was located within the mental health equality programme (MHEP). The MHEP is one of the NHMDU workstreams. The MHEP formed into one programme in April 2008. Initially it covered mental health in later life, delivering race equality and gender equality. The closer working relationship between the existing three programmes has brought about many benefits, with an increase in collaborative working being the most evident. As previously stated, MHEP's work now focuses on the six protected characteristic areas of the Equality Act 2010.

Underpinning Principles of the Mental Health Equalities Programme

- Person centred – dignity, respect, safety.
- Supporting improvements in health & social care within a human rights framework for legislative compliance.
- Reducing inequalities.
- Valuing and celebrating diversity.
- Promoting organisational/attitudinal change and development.

National drivers for the work of MHE

- The new mental health strategy
- NHS White Paper: Equity and excellence: Liberating the NHS (July 2010)
- Liberating the NHS: Local democratic legitimacy in health
- QIPP – *NHS 2010-2015 – From good to great*.
- Equality Delivery System (NHS)
- The Equality Act 2010 – including Equalities Impact Assessments, work on age equality and supporting development of single equality schemes.

³⁸ Working with Ethnicity, Race and Culture in Mental Health – a handbook for practitioners (Jessica Kingsley 2009)

Building Block 3 – Information, research, evaluation

The National Mental Health Development Unit (NMHDU)

The National Mental Health Development Unit (NMHDU) was established in April 2009. It has developed its work through co-production between the Department of Health (DH) and the ten Strategic Health Authorities (SHAs); and through strategic partnerships with other groups and agencies such as the NHS Confederation, the Association of Directors of Adult Social Services (ADASS) and the major mental health third sector organisations.

NMHDU assumed some of the national activities previously carried out by the National Institute for Mental Health in England (NIMHE). The Mental Health Equalities Programme is a key programme area of NMHDU.

The future

The existence of the DRE programme has led to an important shift in attitudes which acknowledges the need to promote equality and reduce inequalities through a cohesive programme of planning, action, monitoring and review. It has contributed to and focused a national, critical discussion to help better understand the nature of inequalities and of a means of addressing them. The work of the DRE programme provides a good foundation upon which the new mental health strategy can build.

It has become increasingly evident that there is a need to consider all strands of equality as these areas cross cut all aspects of mental health. It is important to ensure there is an integrated approach to tackling inequalities. The work of the DRE programme has been subsumed within the 'race' strand of the MHEP. This has led to a richer and more integrated way of working which provides an ideal platform for further work.

Key outcome areas to promote equality and reduce inequalities within the new mental health strategy should include:

- Consolidating the DRE work within a wider mental health equalities and human rights context, while ensuring a continued focus on race, ethnicity and culture. This will enable greater understanding of the complexity of diverse communities;
- Promoting social inclusion and social justice through co-production, including integrating a person-centred approach to ongoing work, including better data capture. This will involve continued strengthening of user and carer involvement; and developing sustainable leadership and relationships across sectors, disciplines and government departments; and
- Incorporating a public health approach to working with diverse communities through ensuring greater understanding of communities' needs.

This will require better data capture and analysis at local level through, e.g. joint strategic needs assessments (JSNAs) and local measures to understand need; and better coordination of community based initiatives in order to drive and incorporate new models of provision:

- Ensuring a systemic, cross-government, cross-agency approach to recording information, monitoring outcomes and reviewing strategy and operations;
- Promoting greater clinical ownership and leadership for change; and
- Acknowledging and addressing the dilemma of public health versus specialist care, e.g. there will be a continuing need to care for people with complex and enduring mental health problems, balanced against a need for prevention and early intervention.

New mental health strategy

In announcing the advent of the new mental health strategy, the care services minister signaled the coalition government's intention of "drawing on a broader canvas" in taking a public health approach to improving mental health. This included:

- Involving other public services
- Empowering neighbourhoods; and
- Galvanizing charities and grassroots community groups

The work of the DRE programme has played a significant part in developing an evidence base for community involvement, with diverse communities. It will be important to build on this legacy as part of a continuing commitment to promoting equality and reducing inequality.

Conclusion

The DRE action plan represented an ambitious experiment. It aimed to create change in organisational systems, and (as a consequence) in societal attitudes in relation to people from BME communities who experience mental health problems.

Arguably, if it were being drafted today, the starting point would be different. The issue at hand is the improvement of services; but that cannot be done in isolation from a range of other considerations – to do with people's experiences, aspirations, hopes, resiliencies, opportunities and roadblocks. Some of this is the territory of services – for people who have mental health problems, but much of it is to do with how they navigate their lives in a context of discrimination, indifference and resistance to change.

That is not the whole picture, however. In the context of service improvement – which is the day-to-day systemic way of creating order and parameters in working with people and their vulnerabilities, there is, on the whole, a desire to do what is good and workable for people in helping them to negotiate the realities of mental ill-health. The desire for service improvement combined with helping to shape societal change is now to be framed in the further context of the new mental health strategy.

This gives us the different starting point.

The DRE programme has, over the course of its existence, produced a wide range of evidence which addresses the concerns of people from Black and minority ethnic communities about their engagement with mental health services. This documents the innovation and interventions which have been developed to address those concerns. The information contained in this report is the picture five years on.

It was, indeed, an ambitious undertaking.

There is much that is very good that has come out of the DRE programme – some of the work has had an impact (e.g. the CNWL court diversion project, work with fathers in Lambeth, work with Imams in Yorkshire, numerous examples of the work of CDWs, and the strengthened research and knowledge base). For those who have been closely involved with the work of the programme, it is difficult to escape the palpable and almost overwhelming sense of frustration – notwithstanding that work – which is felt to be due to the inadequacy of a coordinated, systemic response.

The reasons for the inadequacy of response have been set out within this report. They do not provide easy answers. They relate to:

- The complexities inherent in responding to the huge range of diversity encapsulated in the phrase 'Black and minority ethnic communities';
- The difficulties of grasping – in purely service delivery terms – what was intended through the DRE action plan;
- The difficulties of translating innovatory projects into long-term commissioning and provision intentions; and
- The difficulty inherent in expecting societal change through a service delivery mechanism.

That said, the work of the DRE programme is pivotally placed in the context of the new mental health strategy. This can provide the future framework for the learning which has taken place with the DRE programme. The experience and outcome of the DRE programme means that there is a wealth of knowledge about how to make practical steps, guided by critical thinking. The road to a better world – in mental health terms – is not about getting bogged down in an overwhelming sense of injustice, or about getting lost in abstract discussion about what it all means and how to address it; or about being daunted by the huge challenge.

The new mental health strategy is an opportunity to build upon the direct evidence offered up through the DRE programme; by proactively aiding understanding and taking practical steps to inculcate that evidence; and finding ways of acknowledging that this must be done in concert with users, carers and communities.

Specifically it will involve:

1 Making sure that existing learning continues to be sustained and used in policy development and implementation

This means – in service delivery terms – better monitoring and collection of information on ethnicity and culture; and better use of data to inform commissioning and provision intentions in health and social care. In other words, the focus is on outcomes – what works for which communities, and how it can be captured in or change existing systems and processes. One example of how this could be done is through the Care Quality Commission. It could, for example, as part of its regulation of health and adult social care services for people with mental health problems, include a focus on equality of access and experience of services for people from black and minority ethnic groups. A measure of DRE's success is that the CQC has strongly signalled this is an approach which it will take. The learning from the DRE programme provides evidence of the importance of building in and building upon the evidence base it has created.

Conclusion

2 Taking a single equalities approach

People do not experience mental ill-health in a vacuum of race alone. A solution which addresses all aspects of people's lived lives is what is required. The DRE programme, of necessity, had to accommodate an approach which addressed race, gender, age, disability and sexual orientation. All of these will impact on health and mental health. Taking a single equalities approach promotes, as well, a socially inclusive and human rights approach to mental health. A Black, gay man, for example, who has mental health problems, wants a solution which does not stigmatise either his sexual preference, nor one which pigeon-holes him into a box which is affixed with a stereotypical diagnosis, and a one-sized, off-the-shelf response. This, again, requires good information and good use of information to allow working with people from their individual starting points. It also requires working across organisational, departmental and professional boundaries to effect change. Such an approach can also signal greater flex and interplay between promoting equalities and reducing inequalities. It could also form part of the thinking which informs commissioning intentions, including strengthening the joint strategic needs assessment (JSNA) process.

3 Re-thinking workforce development

There will need to be staff with skills and capabilities which inherently incorporate an approach to understanding diversity, from a position which reflects a willingness to listen, learn and be open to finding new patterns and routes into achieving mental health in ways which people find helpful and relevant. This is not simply the domain of race equality training – though that is part of it – but is more to do with creating new paradigms for working with people; and for helping to effect organisational change.

Evidence coming through the DRE programme, for example, points to the importance of early intervention in its widest sense – working with parents, teachers and local communities to circumvent negative pathways. One model which also has merit is the explanatory model of working with service users and carers. It takes a more level playing field approach between users, carers and professionals. Efforts which reflect such an approach – which, by definition, is interactive, learning, reflective, enquiring – may be better suited to helping to create greater job satisfaction, and, in turn, improved outcomes for patients.

4 Better understanding and involving users and carers

This is the bedrock for creating change. Provision for incorporating and making use of the diversity of user and carer voices and experiences must be at the centre of mental health strategy and policy implementation. This is about looking, in the first place, at what users and carers need to support their engagement – at a practical as well as a philosophical level. It also involves different ways of thinking about engagement – for example, use of narratives in informing treatment options and training initiatives; taking practical steps to drill down into satisfaction levels in terms of outcomes; better documentation of the patient experience (views, fears, sensibilities, mores, choices) to inform responses; and about developing a basis for more equitable relationship (in systemic terms) with users, carers, communities. The learning from the DRE programme – though experimental and experiential – does point to the value of good community engagement (including that of the voluntary sector).

The DRE action plan was a good starting point. Much has been learned as a result of its existence. One of its strengths has been to aid the identification of opportunities and possibilities for change and improvement. It has also served to highlight good practice, where it has been found. It was not and could not, however, be a panacea – or a once and for all remedy for all of the gaps and shortcomings identified by people from diverse communities.

From that starting point, and taking account of all of the learning and development over the past five years, the time is right to pass the mantle on so that the work can develop in the next stage of mental health strategy development and implementation.

Appendices

Appendix 1: 78 Actions

Appendix 2: FIS List

Appendix 3: National (Executive) Summary – Clinical Trailblazers

Appendix 4: Research and knowledge generation overview

Appendix 1: 78 Actions

Delivering race equality in mental healthcare

Organisation	Action	Service change characteristics	BUILDING BLOCKS		
			Responsive services	Community engagement	Better information
All Organisations	Race Equality Scheme Cultural Capability Framework Harassment Policy				
All Mental Health Providers	Updated race equality schemes to be ready for publishing by May 2005				✓
National Director NIMHE and	Manage NIMHE BME programme	12			
National Director of BME	Will lead reform for BME programme	12			
NIMHE	NIMHE Race Equality Leads to provide regional leadership	12			
NIMHE	Develop a common skills set for mental health practitioners	11			
NIMHE, CSIP, SCMH	Will identify training needs and good practice	11			✓
NIMHE, MHAC, Health Care	Carry out a national census of mental health inpatients in 2005. From 2006 it will be extended to other patient groups and carried out annually by HC	3	✓	✓	✓
NIMHE, Association of Chief Police Officers	NIMHE will support ACPO in its review of training in mental health	11	✓		
NIMHE and Inspection Agencies	Will appraise local procedures and practice			✓	
NIMHE and Training Organisation for Personal Social Services (TOPSS)	NIMHE and TOPSS to improve the understanding of BME issues among all involved professions	12			
NIMHE, Social Care Institute for Excellence	NIMHE and SCIE will disseminate guidance on direct payments for BME service users				
NIMHE, PCT Development Team	Disseminate good practice in access to PCT mental health services		✓		
NIMHE Prison Service	NIMHE will work with the Prison Service on modernising mental health care in prisons	9			
NIMHE, National Offender Management Service, Home Office, NACRO	NIMHE will work with NOMS, HO and NACRO to review arrangements for releasing mentally disordered offenders	9			

Appendix 1: 78 Actions

Delivering race equality in mental healthcare

Organisation	Action	Service change characteristics	BUILDING BLOCKS		
			Responsive services	Community engagement	Better information
NIMHE	NIMHE is commissioning a project on improving BME mental health care pathways		✓		
Department of Health NIMHE	Commissioned an independent evaluation of DRE				✓
NIMHE	NIMHE will work with Royal Colleges and others to ensure that patients receive care in the least restrictive environment that is consistent with their needs		✓		
NIMHE, HARP	NIMHE and HARP will encourage use of the new mental health and well-being web site				✓
NIMHE, National Council for Social Studies	NIMHE and NCSS will promote good practice within BME CAMHS, and will identify community development “early implementation” sites to bridge the gap between CAMHS and BME communities			✓	
NIMHE	NIMHE has published “Celebrating our Cultures” and will provide training workshops on mental health promotion within BME communities	11			✓
NIMHE	NIMHE has commissioned research on suicides in BME communities that will contribute to the national suicide prevention strategy	7			✓
NIMHE	NIMHE is co-ordinating a five year action plan to tackle stigma and discrimination	1	✓		
NIMHE	NIMHE will invest £2 million in a National Community Engagement Scheme			✓	
NIMHE	NIMHE will commission evaluations of the community engagement scheme and the work of CDWs			✓	
NIMHE	NIMHE is implementing a Knowledge Community project to disseminate evaluated good practice		✓		✓
NIMHE	NIMHE has convened a national group to develop best practice guidance on interpreting and communication support in mental health settings and will disseminate existing guidance to mental health service		✓	✓	✓

Appendix 1: 78 Actions

Delivering race equality in mental healthcare

Organisation	Action	Service change characteristics	BUILDING BLOCKS		
			Responsive services	Community engagement	Better information
NIMHE	NIMHE will continue to increase the evidence base by commissioning research and evaluation				✓
NIMHE, PRAIE	Will work with organisations such as Policy Research institute on Ageing and Ethnicity to disseminate good practice in caring for older BME people		✓		✓
NHS Equality and Human Rights Director	National Director for MH and NHS Equality and Human Rights Director to collaborate	12			
Patient Advice and Liaison Service	PALS to ensure they are linguistically and culturally equipped		✓		
PCTs	PCTs to develop agreed plans for early diversion from the criminal justice system				
PCTs LAs	PCTs and LAs to review their implementation of standard 7 of the NSF for Older People		✓		
PCTs	To enhance and encourage earlier access to care		✓		
PCTs	To provide opportunities for BME involvement on wards, e.g. by befriending and advising patients		✓		
PCTs	To ensure that mental health in-reach services are available in all prisons	9	✓		
PCTs	To consider how their commissioning and inspection processes reflect mental health modernisation objectives		✓		
PCTs	PCTs to seek new pathways to referral from BME communities		✓		
PCTs Service Providers	Service providers and PCTs to ensure that BME inpatients have access to culturally appropriate facilities and services		✓		
PCTs Service Providers	Service providers and PCTs to ensure adequate provision of culturally appropriate independent advocacy		✓		
PCTs and mental health trusts	To ensure that services users and carers are aware of their options in seeking a second clinical opinion		✓		
PCTs, LAs, Community Mental Health Teams	To involve CMHTs in discharge planning, in partnership with families and other agencies	8			
PCTs, mental health trusts	To ensure that carers, families and advocates are involved in care planning that is centred on the patient's needs	2	✓		

Appendix 1: 78 Actions

Delivering race equality in mental healthcare

Organisation	Action	Service change characteristics	BUILDING BLOCKS		
			Responsive services	Community engagement	Better information
PCTs, SHAs, Local Authorities	PCTs to ensure that service providers identify the training needs of their staff	11			
Service Planners and Providers	To receive training in cultural sensitivity, religious and linguistic needs, care and recovery planning, needs assessment and community engagement	11		✓	✓
DH	DH to implement the national action plan on leadership and race equality	11			
DH	DH to disseminate good practice on the employment of refugees and overseas workers	12			
DH	DH to review exclusion from direct payments of people away from hospital on leave	6			
DH	DH will encourage research that considers BME issues as an integral part of planning and delivery				✓
DH	DH is developing resource pack on the needs of refugees and asylum seekers				✓
DH	DH will publish "Choosing Health", reiterating its commitment to reducing health inequalities	10			
PCTs LAs	PCTs and LAs to ensure that services reflect the particular linguistic needs of older people from BME groups	1		✓	✓
PCTs LAs	PCTs and LAs should provide directories of local services to help BME children and their families get access to support		✓		
PCTs LAs	PCTs and LAs need to use local demographic data				✓
PCTs	PCTs will recruit 500 CDWs	11, 12		✓	
PCTs LAs	PCTs and LAs should identify potential BME independent sector partners and learn from their experience and expertise			✓	
PCTs LAs	PCTs and LAs should make sure that planning processes and groups represent and involve the BME independent sector and BME service users and carers			✓	

Appendix 1: 78 Actions

Delivering race equality in mental healthcare

Organisation	Action	Service change characteristics	BUILDING BLOCKS		
			Responsive services	Community engagement	Better information
PCTs	PCTs should ensure a multi-agency approach and integrate projects into local implementation teams, local strategic partnerships and other local activity			✓	
PCTs Service Providers	PCTs and service providers need specific arrangements to meet the needs of refugees and asylum seeking families, including children and young people	1			
PCTs	PCTs should ensure that appropriate support is available to BME community organisations			✓	
PCTs Social Services Departments	PCTs and social services departments should nominate a senior manager with whom CDWs will liaise			✓	
Professional Bodies, Government bodies	Plan and manage individuals' progress towards cultural capability	11			
BME service users	BME service users' experience will be surveyed annually and used to inform service change				
Community Engagement Pilot Projects Team	Community engagement pilot projects will include refugees and asylum seekers				
Confidential Inquiry Team	Confidential inquiry into suicide and homicide by people with a mental illness will publish its second five year report in 2006	7			✓
Department for Constitutional Affairs, Legal Services Commission	Legal Services Commission to pilot new arrangements for legal advice for people with mental health problems	1, 4		✓	
Local Health Agencies	Local health agencies should form partnerships with diverse faith communities			✓	
Local Health Agencies	Local health agencies should meet the existing requirement to make information accessible to all groups within the community			✓	✓
Mental Health	Draft Mental Health Bill to provide for independent advocacy to be available to everyone treated under powers of compulsory detention				
Mental Health Services	Mental Health services should record users' ethnicity, and other relevant data such as religion and language, for planning care				✓

Appendix 1: 78 Actions

Delivering race equality in mental healthcare

Organisation	Action	Service change characteristics	BUILDING BLOCKS		
			Responsive services	Community engagement	Better information
MHAC NIMHE HC	The MHAC, NIMHE and HC will carry out a national census of mental health inpatients in 2005. From 2006 it will be extended to other patient groups and carried out annually by HC				✓
National Patient Safety Agency	NPSA will publish thematic reviews based on data from the Confidential Inquiry	7		✓	✓
National Patient Safety Agency	issue advice on safer acute psychiatric wards		✓		
NHS Direct	Provide a national interpretation service				✓
NHSU	NHSU will develop a race equality and cultural capability programme				
NICE	Will publish an annual table recording the number of deaths, including information on ethnicity	7			✓
NIMHE CSIP SCMH	NIMHE, CSIP and SCMH will identify training needs and good practice				
The Healthcare Commission	Promote safer inpatient and therapeutic environment	10	✓		

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
EASTERN	BL BEDFORDSHIRE & LUTON	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Learning Disability and Mental Health (SPLD) • Initial assessment / Care Plan / implementation • Share training (mental health specific and cultural competence). • Update policies • Risk Assessment Tool for challenging behaviour • Inter-agency forums • The role of faith organisations • Data collection • More strategic approach for provision of services • Engagement of clinical staff • Joint working • Disseminate findings • Cultural Capability Training • Clinical Networks • Value Added Grants • Address stigma • Community Engagement amongst BME community services / BME Service User and Carer Involvement • Recruit CDWs <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Leadership priorities • The role of carers and service users in research. • The role of faith communities • Research topics: Health Service Needs of the African Caribbean Community / African Heritage People Affected by HIV/Aids / Carers of dementia sufferers /Asian women from Indian, Pakistani, Sri Lankan and Bangladeshi / understanding about mental well being; views about the accessibility and appropriateness of local mental health services. • Specialist Community Support: increased sustainable support. • Baseline data collection: increased awareness about local populations / action plans prioritised / clinical data analysed / rates of compulsory detention & seclusion addressed at Trust level / clinical areas where there is greatest need identified / advised objectives & targets for improvement set / impact of initiatives measured / racial inequalities addressed. • BME Service User and Carer Involvement: a process for BME users' expenses to be paid promptly / information and support to enable involvement / culturally sensitive respite care to carers who wish to participate in forums / ethnic monitor of BME representatives involved / links developed with BME user involvement leads / training and support provided for service users and carers • Develop strategic approaches: provided clear roles and responsibilities for all members / Used levers to ensure DRE work is core to all organisations' performance management process / built on existing resources / involved external partners e.g. police, education, housing, local authority. <p>NEXT STEPS:</p> <ul style="list-style-type: none"> • Use evidence from Count Me In census to benchmark services • Use knowledge about populations to prioritise action plans and target the work of FIS for maximum impact • Analyse clinical data to address rates of compulsory detention, seclusion even at NHS Trust level • Use findings to identify greatest need in clinical areas • Improve / measure impact of initiatives to address racial inequalities • BME Service User and Carer involvement • Staff training for NHS Knowledge and Skills Framework • Improve (i) Access to psychological therapies (through the IAPT programme); (ii) Access to early intervention services; (iii) Access to crisis resolution/home treatment services; (iv) use of assertive outreach services; (v) Community Treatment

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FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
EAST MIDLANDS	LNR Leicestershire Northampton & Rutland TRENT	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Reach out to the community e.g. Address needs of changing population; Interpret and translate; develop family centred approach • Develop commissioning strategy including evidence based commissioning; Value Added grants • Review governance and reporting structures • Establish BME Network & Community Engagement; showcase events targeting BME communities; disseminate and analyse BME census; consult biennially with BME communities for service development and provision. • Share information • Maximise potential for sustainability • Support FIS leads • Develop organisational wide approach to equality and diversity; Produce yearly equality and diversity action plan; work with reference to national equalities agenda; clarify links to DRE characteristics • CDW target: Fund a minimum of 2 CDWs including recruitment of a CAMHS CDW • Improve Cultural Awareness for front line staff including providing all staff with Islamic Awareness (IA) training & disability awareness training & Assess impact of existing policies/practices on any minority group where adverse impact is identified • Develop process for monitoring incidents of control and restraint on patients; Investigate causes / take immediate remedial action <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Excellent models for working with BME third sector , DRE and recovery • Engaged wide range of strategic, policy making, grass roots, and community based agendas • One stop BME health and wellbeing centre • Prison Project in rural area • South Asian women resettling following domestic violence • CE project access to secondary care services in mental health for South Asians in Nottinghamshire • Irish Support Group for first generation Irish community and their experiences of mental health and mental health services • Caribbean men make use of Mental Health services prior to crisis • Exploring experiences and attitudes of young people from BME communities • Emotional Health and Well-being Needs of Romany Gypsies and Irish Travellers • Report on Post Traumatic Stress in Somali Community and experiences of Health Services. <p>NEXT STEPS:</p> <ul style="list-style-type: none"> • CDWs in more parts of the region • More activities on collection of data in line with 12 characteristics of DRE • Access to information regarding prison population for BME groups. • Effective intervention, counselling treatment and intervention • Cultural awareness for front line staff • Use value added grant appropriately • Improve (i) Access to psychological therapies (through the IAPT programme); (ii) Access to early intervention services; (iii) Access to crisis resolution / home treatment services; (iv) the use of assertive outreach services; (v) Community Treatment (vi) Access to information regarding prison population for BME groups. • Effective intervention, counselling treatment and intervention • Interpreting and translation • Appropriate sharing of information.

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
SOUTH WEST	<p>DS Dorset & Somerset</p> <p>SWP South West Peninsula Cornwall & Devon</p>	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Create celebratory cultural project to promote health professionals' engagement with religious diversity • Acknowledge importance of spiritual and faith needs within BME cultures • Implement community engagement pilot projects • Provide information for users and carers about mental health and mental health services • Sustain knowledge and training reference for staff in mental health services • Improve insights, knowledge and intelligence of Black and minority ethnic communities in local areas • Build on and extend existing training and awareness • Raise opportunities to make race equality part of mainstream training for all staff in mental health services • Involve service users in training • Local Authority Race Equality leads to present to Area Action Groups • CDW programmes to strengthen local insights and intelligence. <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Good practice models: CDWs working in prisons and Criminal Justice / DVD with BME Carers / CDWs in CAMHS / RECC cohorts on training the trainers • Implementation • Meeting CDW targets: more appropriate and responsive services for BME individuals to reduce fear and increase involvement by BME communities in mental health service delivery • Identifying experiences, needs and aspirations of BME individuals with regards to mental health • Better engagement of BME groups in shaping mental health services • Exploring drug use/misuse • Addressing issues of fear and cultural barriers • Exploring current mental health service availability • Researching appropriateness of services and perceived barriers to access • Measuring a range of presenting problems connected with mental health • Identifying mental health needs of Eastern Europeans from the A8 Accession countries • Exploring the mental health needs of Somali 11 to 18 year olds • BME views on mental health provision • Exploring the mental health needs of the Bangladeshi community • Investigating the extent and impact of isolation and loneliness amongst ex-service users and carers • Exploring the mental health needs of people from Chinese, Vietnamese and Sikh communities aged 50 and over • Research into the mental health of lone male refugees and of those seeking asylum.

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
<p>NORTH EAST</p>	<p>NTW Northumber- Land Tyne & Wear</p> <p>CDTV County Durham & Tees Valley</p>	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Children, young people, families • Offender partnerships – working with BME people in the criminal justice system • Social care, health and well-being • Recruitment • Guidance packs for local and national use including templates and tools • Leadership support at a CEO level across FIS sites to negotiate with SHAs and identify project management arrangements • Governance structure to support implementation • Action plan to implement findings from Count Me In census incl. pilot ethnic monitoring of service uptake and use outcome measures tools. • Create ownership and identify priorities • Share good practice • Undertake a cultural capability audit of 22 prisons across the North East Yorkshire and Humber Region • Work with commissioners to identify standard criteria for commissioning mental health care for BME communities • Develop faith and spirituality networks • Adopt EPIC • Look at the key challenges for the rural sites (e.g. Sedgefield, Durham Dales, Easington and Northumberland) in delivering the DRE action plan and reduce the fear and isolation experienced in a rural community • Make service users feel more comfortable in accessing services earlier • Provide accessible information within the communities (in support of generating extra information on practical steps towards delivering appropriate and responsive services) and build trust in the communities e.g. increase knowledge and skills of the Chinese community to assist recognition of mental ill health in Chinese community and facilitate one to one consultation with BME groups • Engagement with clinical staff to improve individual skills, organisational cultural competence, advice on how care and recovery pathways for BME groups can be diversified and developed • Base line assessments, developing local structures, putting in governance and performance management frameworks to deliver the 20/10 vision • Identify key partners in the delivery of effective community engagement participation in the collaborative programme. <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Good practice in rural areas • RECC training completed by 30 people – cultural awareness training for the multi-disciplinary team • Two Mental Health DRE Partnership Groups established • NTW Directory of Information about BME organisations, groups, activities, events and services jointly produced by the Newcastle CDW Team and the Patients Information Centre, with input from the other NTW CDW teams Reform mental health and learning disability services to deliver appropriate care to BME communities • Involvement of service users and carers • Strong links with the newly established branch of the Medical Foundation based in Newcastle • First meeting of the Northumberland Tyne and Wear DRE Management Group • Region-wide event aimed at establishing how to take forward DRE within rural areas, Sedgefield, Durham Dales and Northumberland • The Newcastle Advocacy Centre surveys members about current service provision • NTW CDW Network launched • Three training courses delivered • Loop – a monthly e-bulletin about the DRE programme sent to interested people across the region.

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
NORTH EAST	<p>NTW Northumber- Land Tyne & Wear</p> <p>CDTV County Durham & Tees Valley</p>	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Message on a Mug campaign launched at Newcastle Health and Race Equality Forum • Report on 10th Chinese Mental Health Conference in Newcastle published • Training sessions arranged for interpreters on key points of Mental Capacity Act and Mental Health Bill • DRE in MH training course developed, piloted & launched by North Tyneside CDW Team • Essential Shared Capabilities training for BME CDWs • Medical Foundation set up trials on workshop for interpreters on how to deal with stress • Service User and Carer Coordinator from NTW NHS Trust produce report based on young people's experiences of mental health and mental health services across Newcastle and North Tyneside. 'Feel Good' Women's Group starts weekly meetings in Bensham Community Centre • NE conference on DRE in MH in rural areas held in Northumberland • Sunderland DRE CDW team fully recruited & formally launched • STAR (Sunderland Together against Racism) event co-ordinated by the Sunderland CDWs working with The Sunderland Partnership and Show Racism the Red Card • South Tyneside PCT produce a mental health Desk Top calendar aimed at members of local BME communities giving details of local mental health services • CSIP run 2 x 2 day programme of Cultural Competency Training specifically for staff working in CAMHS • CDWs in Newcastle held an initial Mental Health Consultation event with members of the African community at ACANE (African Community Advice North East) which attracted over 25 people • Frontline community staff and religious leaders from Gateshead complete a 10 week Active Listening Talk Therapy training course run by two Counselors from MIND. The Active Listening service is now being rolled out to support residents in both Gateshead and Newcastle • A spirituality, religion and mental health conference of over 160 representatives from the North East's main recognised faiths along with service users and carers, and mental health care professionals, to discuss spirituality and mental health • Publication of conference report, 'Making Space for Spirituality' • North East Spirituality Network formed • Making it Better report is published, based on two events • Spotlight Sahara for older South Asian women from the Pakistani, Bangladeshi and Indian communities within Middlesbrough, to maintain health well being to relieve isolation. Encouraging South Asian women to access services • Darwen Community Links Limited: Exploring The Needs, Views And Experiences Of South Asian Mental Health Carers • Research On The Mental Health Need And Experiences Of African Men Living In The Tees Valley by Tees Valley Voice For Justice (TVVFJ) Community Organisation In Middlesbrough • Faith Community Project (FACOP): Report of the community led research project focusing on The Effective use of Faith in Alleviating Mental Health Problems Amongst Asylum Seekers and Refugees • A Study of the Accommodation and Support Needs of Gypsies and Travellers in County Durham • Independent Health & Social Care Advocacy Service for BME People. • Newcastle Interpreting Service trains 30 mental health workers to improve working with interpreters • Ethnic Minority Wellbeing Project.

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
<p>NORTH EAST</p>	<p>NTW Northumber- Land Tyne and Wear</p> <p>CDTV County Durham and Tees Valley</p>	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Enhancing Pathways into Care (EPIC) for BME Communities • Awareness-Raising Workshops on mental health issues affecting asylum seekers and refugees • Research into the mental health needs of the Chinese community in E asington • Website to promote BME group’s Mental Health in developing capacity to drive change across England • Knowledge research: measures that demonstrate the benefits of information on practical steps towards delivering appropriate services • Developed outcome measures tools for monitoring ethnicity and BME groups. <p>NEXT STEPS:</p> <ul style="list-style-type: none"> • Proper supervision of home treatment team through accessing BME information for older people • Robust analysis of the results of the Count Me In census for BME users in the FIS • Improve clinical practice • Identify standard criteria for commissioning mental health care for BME communities • Access to psychological therapies on shared good practice identified from the Census via the Acute Services Network • Service users accessing services earlier • Cultural capability audit of 22 prisons across the North East Yorkshire and Humber Region by the assertive outreach team. Keep proper records on alcohol and drugs • Implement mental health needs regarding crisis resolution home treatment • Mechanism for reducing fear and isolation experienced in a rural community • Proper research on BME issues regarding the 12 characteristics • Appropriate ethnic monitoring of service uptake in specific speciality areas to inform commissioning of services • Record total number of BME users receiving home treatment properly • Embed DRE work in the Early Intervention Psychosis Team • Record information on young people, children and family of BME groups are properly • Improve current knowledge areas sufficiently as gaps show in analysis exercises. Knowledge Management (KM) across the region will be required to fill these gaps in reaching the communities • CDWs fully engaged with BME groups and commissioners • Equality staff fully engaged with commissioners, GPs and most BME communities to identify standard criteria for commissioning MH care for BME groups to monitor ethnicity data.

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
YORKSHIRE & THE HUMBER	SY South Yorkshire BRADFORD (West Yorkshire)	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Develop integrated model of treatment for those with alcohol problems coming into contact with the Criminal Justice System within the region • Recruit and implement DRE via FIS Sites • Develop guidance packs for FIS sites for both local and national use and develop templates and tools as part of the guidance packs • Identify leadership support at CEO level across each of the FIS sites and negotiate with SHAs and FIS sites to identify project management arrangements • Develop a governance structure and support the implementation at a local level and facilitate multi-stakeholder days to create ownership and identify priorities • Develop outcome measures tools including Performance Management, Internal communications, Values Based Practice network and measure commissioning outcomes • Use Sharing the Vision to improve services; Develop Clinical and Community Engagement Project capable of delivering responsive services and use Data Collection to inform Service redesign. Use and develop Ethnicity and Health's model for this. • Users and carers able to access services; promote needs of carers' spirituality • Support from the National Team • Communicate success • Continue to make the scheme part of the culture of work • Develop capacity building of individuals, BME voluntary sector and communities involved in the project • Discuss any culturally specific explanations of their mental health • Ensure there are proper arrangements in place for effective implementation of all schemes • Identify barriers to accessing mental health services e.g. make sure the public have access to information • Identify and assess functions and policies for the relevance in meeting the General Duty and assess and consult on the likely effects of proposed policies on meeting the duty • Monitor policies for any adverse impact on different racial groups and explore interventions needed and types of community resources that could be developed to facilitate culturally appropriate intervention e.g. expand care package offered to male Muslim patients, to including spiritual therapy, a holistic approach (Jinn Project), promote to local Pakistani community in Sheffield with support of advocacy worker working with Crisis and Home Treatment team (CAHT), Commission research into the location and needs of the East European Migrant Community • Monitor specified areas of employment by racial group in line with the specific duty for employers • Publish the results of assessments, consultations and monitoring • Adopt EPIC. <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Sheffield Care Trust has developed an inpatient culturally appropriate care form for all patients which incorporate race and ethnicity data collection. • CDWs employed to deliver appropriate and responsible services <p>Excellent practice in South Yorkshire FIS:</p> <ul style="list-style-type: none"> – Working with mosques – Meeting CDW target and models in CVS – EPIC 1, 2, 3 – Working with BME carers – Working with BME communities and spirituality – Developed audit tools which staff use to monitor inpatients needs including ethnicity and cultural needs.

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
<p>YORKSHIRE & THE HUMBER</p>	<p>SY South Yorkshire</p> <p>BRADFORD (West Yorkshire)</p>	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Models in intelligently using the data from the Count Me In census • YWCA (Doncaster): working with women facing poverty, discrimination and abuse • BBEMI (Barnsley): To look at what mental health problems are present within Black and ethnic minority populations in Barnsley, and how statutory organisations need to work in order to provide a service which fully meets the needs of these communities • Sharing Voices (Bradford): Research Focusing on Self Defined Mental Health Needs of the Muslim BBEMI: Research on whether mental health services are appropriate and responsive to the needs of the Gypsy and Traveller communities of South Yorkshire • RYCA: Research on Exploring the Mental Health Needs of The Yemeni Community By the Rotherham Yemeni Community Association • Khidmat: Research on the Mental Health Needs of Older People from South Asian Communities in Bradford • Doncaster national demonstration sites, tested the effectiveness of providing significant increases in evidence based psychological therapy services to people with ‘common’ mental health problems such as anxiety and depression, in providing improvements in health, well-being, and in maintaining people or supporting people to return to employment and community participation • Sheffield Care Trust developed an inpatient culturally appropriate care form for all patients which incorporate race and ethnicity data collection • Cultural awareness self assessment audit tool produced by the Nurse Consultant leading EPIC • Community Engagement Projects in evaluation areas will support the practical application of changes in commissioning • Carers conference to promote BME Enhanced Pathways Into Care (EPIC) by offering support and advise on recovery pathways for BME groups can be diversified and developed <p>NEXT STEPS:</p> <ul style="list-style-type: none"> • Cultural Awareness to improve individual skills (clinical service) • Leadership to raise the profile of the BME programme • Communicating success to build intelligent data for national census • Establish mental health service needs of older South Asian communities living in Bradford

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FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
NORTH WEST	GM Greater Manchester	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Adopt EPIC with three mental health trusts, focus race equality impact assessment, engagement with service users and staff re service provision audit of current training and review of contracts with BME voluntary sector • Develop work around prisons • Look at patient safety • Develop a local evaluation tool for the site • Value added grant to provide locally tailored BME Leadership Course in partnership with Common Purpose • Develop capacity of the BME Voluntary Sector • Recruit CDWs • Establish regional CDWs network • Commission CE projects • Build capacity of the BME voluntary sector. <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <p>Good practice: CE Projects with: Oldham – BME elders Pakistani, Bangladeshi, Indian, Polish and Ukrainian. Liverpool – ICCM, three community groups involved Irish, Chinese and Asylum Seekers and Refugees, BME MH service inequalities & cultural needs Preston – Nguzo Saba, MH needs & access for young BME males African, Caribbean, South Asian And Mixed Heritage Backgrounds within Preston Manchester – Wai Yin, needs of older Chinese people with dementia and their carers in the Manchester area</p> <ul style="list-style-type: none"> • Research to improve services for women with no recourse to public funds. Excellent outcomes frontline staff trained to meet the needs of women and drop in service developed for women • Produced DVD to support building the capacity of the BME Voluntary Sector and report on the needs of groups • Established a regional CDW network and other regions adopted this approach • Supported and developed a Post Graduate Masters level programme in Community Development with Salford University and offered CDWs from Greater Manchester funds to access the course as well as other workers in the region, two cohorts received training • Addressed the needs of Black and minority ethnic offenders with mental health problems, partnership working with Secure Commissioning and voluntary sector developing a communication tool increased access to services for BME older people with dementia • Supported the IAPT programme. <p>Blackburn with Darwen Community Links: education, employment and equality Asian, African, Caribbean and other minority ethnic communities BAND (Bolton): access to and cultural appropriateness of specialist mental health services, Asian and refugee asylum seeking individuals BINOH (Manchester): work to improve educational provision, quality of life, social awareness, youth and family support advocacy and empowerment within the Jewish community POPS (Manchester): supporting someone in prison. 3 key areas: family support, equality of access and outcome for Black prisoners Saheli (Manchester): temporary safe refuge accommodation for women and children from South Asian backgrounds who have experienced domestic violence Big Life Services (Liverpool): Why Black and Muslim women in Liverpool do not access mental health services HARP: the mental health needs of refugees and asylum seekers in Manchester</p>

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FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
NORTH WEST	GM Greater Manchester	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS: Excellent practice on working with engaging BME Third Sector work on building capacity is being taken forward by Association of Greater Manchester PCTS and the Greater Manchester Association of the Voluntary Sector, work will be extended across the region. Excellent work on mainstreaming the work of the CEP work into commissioning structures</p> <p>OUTCOMES: The site has successfully developed a number of national and regional projects including:</p> <ul style="list-style-type: none"> • Enhancing Pathways in to Care across the three provider mental health trusts has led to a befriending service being developed in one trust, improved contracting and partnership working with the voluntary sector and better information for communities being produced in one trust • Pilot for National Race Equality Cultural Capability Training • Establish Clinical Trailblazer with a provider mental health trust • Utilised a Value Added Grant to provide a leadership programme and support group for Black and minority ethnic staff working across greater Manchester; resulting in a number of staff breaking through • Established a buddy FIS in Lancashire and Cumbria • Equality Impact Assessed access to IAPT services • Improved service provision for women with no recourse to public funds • Secured a two year post for a Race Equality Co-ordinator for BME Offender Health. Post recruited to • Communication tool aimed at BME communities to increase access to older peoples mental health services developed • CDWs have been recruited across the whole of the region apart from one PCT where a working group has been established to work with BME communities • Work to support delivering race equality in CAMHS has resulted in a baseline of CAMHS partnerships progress and increased capacity through needs assessment, well being and prevention work and good regional presence of CDWS leading on CAMHS • Asylum Seeker and Refugee Conference held to disseminate key policy, share good practice and promote partnerships. <p>NEXT STEPS:</p> <ul style="list-style-type: none"> • Interpreters for BME groups • Equal access to services for people from BME to improve therapies and early interventions and home treatment • BME and other ethnic groups need better (i) Access to psychological therapies (through the IAPT programme); (ii) Access to early intervention services; (iii) Access to crisis resolution/home treatment services; (iv) the use of assertive outreach services; (v) Community Treatment • Prioritise Work with Partners of Prisoners after slower uptake due to temporary cover for governor and change in governor during this period • Communications tool needed to increase access • Information on supervised community treatment • In Oldham, joined up approach in improving the mental health and wellbeing of BME groups needs to be taken including a whole systems approach in all key areas such as Housing, Education, Employment and Social Care that will help develop strategic partnerships between key organisations to lever investment and build capacity • Better information from the Salford IAPT service • In Cheshire, increase data monitoring by ethnicity and usage of data • In Cumbria, information needed on how to improve access to maintain a focus on early intervention to manage the pathways of care of people from Black and minority ethnic communities.

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FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
SOUTH CENTRAL	HIW Hampshire & Isle Of Wight (IoW)	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Carry out spirituality pilots • Support Imams in Southampton • Encourage use of Direct Payments and support staying in community • Develop partnerships with Winchester City Council, the Police, other statutory agencies and voluntary sector and improve their knowledge of and links with BME communities. This included a Muslim Cultural support group, a Portuguese support network, migrant workers, faith groups, a travelers and gypsies forum • Data: Build on the success of collecting inpatient data by progressing and piloting collection of data in community service • Faith: Develop outcome measures for the Faith project and share learning from project with the DRE Communication Company (Forster Company) • CDW target: Commissioners and Local Implementation Teams to develop a coherent strategy to meet remainder of CDW target • CDW Network: Prioritise development of CDW Network and provide two representatives for national network • Engage wider groups: Engage existing FIS champions in discussions about how the FIS could involve people who have not engaged with the FIS. Use this information to produce an influencing strategy which will engage and involve wider groups, particularly front line staff • Steering group membership: support the development of and review attendance of the FIS steering group • User Involvement: develop links between Service User lead and the FIS site, to ensure a clear strategy and action plan around user involvement • Asylum Seekers and Refugees: Set up systems to support development of Community Engagement Project for Asylum Seekers • BME User Network: Identify timescales for setting up BME user network and involve FI sites in developing this further • Community Engagement: Address the flexibility of the core questions within the Community Engagement questionnaire. Highlight community concerns around balancing respect for religious needs against prejudice against sexuality issues <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <p>Examples of good practice in a rural area. Excellent Models in:</p> <ul style="list-style-type: none"> – Intelligently using the Count Me In census data and links to clinical governance and relevant committees in the Trust to initiate change – Transferable models of work to other regions – Meeting CDW target • Brunswick Community Development Project (BCDP): provides community and social welfare facilities, addresses diversity and disadvantage to improve the inhabitants of Brunswick district of Hove and the wider Brighton and Hove Area. Access to mental health services and treatment for the Arabic speaking community in Brighton and Hove and whether these services are culturally appropriate • James Wiltshire Trust (JWT): Examined issues of isolation and loneliness experienced by mental health service users from BME communities in Southampton and to determine ways to address and prevent these. • Bangladesh Welfare Association (BWA): a partnership between BWA and Culture Works (CW) which is a local BME mental health service to rebuild the capacity of the organisation • SHIFA: Why people over the age of 50 from Pakistani, Bengali, Indian, Nepalese and Chinese communities who are living in the North and West Surrey areas do not access mental health services provided by the NHS Trust in North West Surrey and part of North East Hampshire

Appendix 2: FIS List

FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
SOUTH CENTRAL	HIW Hampshire & Isle Of Wight (IoW)	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Oppressed Voices Kent: the effects of Domestic Violence for South Asian Women • FOREST: Research on mental health, equality and wellbeing of Gypsies and Travellers in Hampshire • POWER to PARENTS: Power to Parents: work by a local school to enable South Asian parents to foster their children's mental well being • NHCAN: Mental health, equality and wellbeing of Black Caribbean and Black African men in Hampshire

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
SOUTH EAST COAST	SB Surrey & Borders	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Identify the needs of BME ex-service-users and carers so that their experience of using mental health services can be improved • Reduce rate of admission of people from BME communities to psychiatric inpatient units • Reduce disproportionate rates of compulsory detention of BME service users in the inpatients units • Research, analyse and collate data and disseminate report on findings and recommendations • Leadership and governance • Emerging community work • Vision and Values • Governance • CDW recruitment • Communication • Co-ordination <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Action Plan developed <ul style="list-style-type: none"> – key CEO to incorporate the FIS work into the Surrey and Borders Partnership Trust's Equality and Diversity Group • Excellent models on working with CDW/DRE in Prisons and Criminal Justice system • Excellent work with CE projects working with BME older people in rural areas • Trusts developed partnership work with local BME CVS around building capacity through partnership funding as a result of the FIS

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FIS sites by region, name and trust, aims and outcomes

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
WEST MIDLANDS	BBC Birmingham & The Black Country	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <ul style="list-style-type: none"> • Membership of the FIS • Health and Social Care Voluntary Sector forum • CE projects • Addressing spiritual needs within Birmingham South Mental Health Trust • Street Pastors • CDWs • Airwaves Media – Value Added Grant • Better Information Group • Restructuring of FIS location • Address instability of the change in role • Reaching service users and carers • Communication with stakeholders • Data to be able to track improvements in services • Adopt EPIC in the Health and Social Care in Criminal Justice Programme e.g. at Reaside Forensic Unit, HMP Birmingham and a Young Offenders institution • Deliver organisational change throughout the whole system to produce and sustain the desired outcomes in mental health • Focus streams of work across the main building blocks outlined in DRE • Strategically develop and build sustainability into the programme • Ensure leadership, commitment and sustainability of the DRE programme within/ MH Trust at Board level • Develop BME User/Survivor and Carer Involvement / development programmes. Success criteria against DRE service reform characteristics. • Improve the quality and effective use of the ethnic monitoring data across the BBC • Inform staff training and workforce and organisational equity • Local evaluation of the BBC FIS Programme, strategic development of FIS work programme • Carry out spirituality pilots • Develop and promote the inclusion of spirituality, spiritual care and support for patients • Link spiritual care into CPA • Carefully track the pathways to care and the obstacles which arise throughout the patient journey <p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <p>Key outcomes and examples of good work:</p> <ul style="list-style-type: none"> – Produced DVD/ Multimedia tool on DRE/FIS – CDW regional Network – CDW target met – Clinical Effectiveness Programmes – 11 mainstreaming in the region – Development programme with NHS Boards and Mental Health Commissioners on mainstreaming DRE – Development Tools for Commissioners – Implementation of two RECC Training the Trainer cohorts • African Caribbean Citizens Initiative (Wolverhampton): To look at the pathways of African Caribbean women into Mental Health services, the causes and experiences, and the appropriateness of services, and make recommendations for the improvement of these services • Irish Welfare and Information Centre (Birmingham): To gain insight into the current issues facing older Irish adults in terms of mental health issues and access to services. Specifically the group will focus on the ability of the target group to access available services and in turn what factors may improve or hinder the quality and availability of service

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FIS sites by region, name and trust, aims and outcomes

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WEST MIDLANDS	BBC Birmingham & The Black Country	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS:</p> <ul style="list-style-type: none"> • Rethink (Birmingham): The research will target, service users, carers, service providers and the general community. The group aims to place their findings within the context of DRE • Smethwick Bangladeshi Youth Forum (Smethwick): SBYF was founded in 1997 by young Bangladeshis to improve the prospect of their community to overcome isolation and disadvantage. The forum was set up to address the social and economic deprivation experienced by the Bangladeshi community in North Smethwick • ACCI AND NYELA (Birmingham): The Mental Health Service Needs of African and African Caribbean Women • Irish Welfare & Information Centre The Mental Health Needs of Older Irish Adults Community in Birmingham • Bangladeshi Youth Forum Sandwell Bangladeshi Mental Health Needs Analysis Research Smethwick • BCHA: Report of The Community Led Research Project Focusing on The Mental Health Needs of BME Young People by Black Country Holistic Approach in Walsall • FOCUS: Report of The Community Led Research Project Focusing on The Mental Health Needs of Irish Women In Birmingham BY 'Éirim Mná 'Midland Heart • Interaction – Worcestershire Report of The Community Research Project Focusing on The Level of Interaction between Black and Minority Ethnic Individuals Aged 50 and over and Service Providers in Relation to Mental Well Being in Worcestershire • IWIC Report on The Community Led Research Project Focussing on the Mental Health Needs of The Older Irish Adult Community In Birmingham By 'Irish Welfare & Information Centre' • MYTIME Report of The Community Led Research Project Focussing on Mental Health Needs of Asylum Seeker And Refugee Men And Women By New Communities Team, My Time Community in Small Heath, Birmingham <p>NEXT STEPS:</p> <ul style="list-style-type: none"> • Impact of BME population on statistics such as compulsory detention rates for BME patients • Better and more intelligent use of information • Proper documentation on people accessing the services • Improve & enhance BBC observatory • Promote more intelligent use of existing data and its relevance to the experience of BME service users particularly within the acute settings of secondary services • Monitor and develop mental health services through collaboration, to accurately and efficiently help improve outcomes for BME communities who come into contact with mental health services • Census data to be properly recorded for BME users to demonstrate improvements in services • CDWs to engage more effectively with partners to pull information • Record examples of self harm and suicide prevention in a more robust way • Leadership and sustainability

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Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
WEST MIDLANDS	BBC Birmingham & The Black Country	<p>NEXT STEPS:</p> <ul style="list-style-type: none"> • More appropriate and responsive services • More robust monitoring of organisations and Trusts is required to ensure delivery of improvement • Information held on BME suffering from depression and anxiety depression across communities • Information needed on IAPT pathfinders • Information needed on BME people suffering from depression and anxiety disorders in a statistical or narrative format • Information on response to choice; and better accessibility to clinically effective evidence base • An oversight group accreditation for IAPT training (OGAIT) • BME and other ethnic groups need better (i) Access to psychological therapies (through the IAPT programme); (ii) Access to early intervention services; (iii) Access to crisis resolution/home treatment services; (iv) the use of assertive outreach services; (v) Community Treatment • Different challenges presented within rural communities where there is a huge geographical spread, smaller percentages of BME populations and comparatively less organised BME communities

Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
LONDON	SEL South East London NEL North East London NWL North West London NCL North Central London	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <p>SEL:</p> <ul style="list-style-type: none"> • Engage BME users, carers and communities in commissioning mental health services in Lambeth and Southwark PCTs. FIS to ensure these are inclusive and contribute to the development of an independent BME voice specifically within commissioning; that BME service survivors build their capacity to influence and directly participate in development, improvement and delivery of local inpatient mental health services that are culturally sensitive and appropriate • Make recommendations for improving care by identifying which aspects of public services need to be capacity built in order to engage and work effectively with diverse communities • Data Collection to benchmark services • Build on the CDW network to ensure that CDWs are able to feed back their issues to the central team and the DRE programme board

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LONDON	<p>SEL South East London</p> <p>NEL North East London</p> <p>NWL North West London</p> <p>NCL North Central London</p>	<p>AIMS, OBJECTIVES, PRIORITIES:</p> <p>NEL:</p> <ul style="list-style-type: none"> • A pilot site for the RECC training programme • Look at the experience of BME acute care patients in MH wards • Develop a common dataset to measure progress • Look at pathways to care for African Caribbean men in seclusion • Governance structure in developing and planning of services • Community Engagement • Value added grants to support dissemination of projects • Review and develop existing services run by the East London NHS Foundation Trust and other mental health providers e.g. Adult Services; Newham PCT etc., in the community and in institutions to ensure that they meet the needs of Asian elders referred there, taking into consideration gender, diet, language and dialect, interests, religion etc • Develop a partnership programme with local community groups, voluntary organisations and faith groups (places of worship) to highlight issues of mental health • Ensure access to universal services to ensure social inclusion of Asian elders and their family carers • Develop mental health information that is targeted at the BME community • Develop pilot site in Newham <p>NWL aims:</p> <ul style="list-style-type: none"> • Disseminate good practice in court diversion, use evidence gathered to develop a business case for a model court diversion service in NW London to better divert African Caribbean men from aversive pathways to mental health care • Alliances with other agencies to highlight the need to provide alternatives to prison for BME defendants and prisoners with mental health problems • Collate and analyse data to be available for the steering group discussions and cross referenced with routine data from the courts • Tackle the needs of BME Prisoners with MH needs • Build DRE indicators into the whole criminal justice system • Devise a minimum dataset to track the progress they are making • Carry out review of commissioning work with the Prison Reform Trust to research the pathway of Black African patients <p>NCL aims:</p> <ul style="list-style-type: none"> • A national pilot site for National Court Diversion • CDW Resources – develop more capacity to drive change • Communication • Community Engagement to support services • Networks with CDWs, partners and users to lever investment and build capacity <p>Camden & Islington:</p> <ul style="list-style-type: none"> • Carry out a scoping exercise to seek to develop a new service for African Caribbean men to prevent their admissions to acute care wards and their experience of mental health services <p>Barnet, Enfield and Haringey:</p> <ul style="list-style-type: none"> • Look at the creation of a mentoring scheme for BME inpatients whereby previous successful survivors are trained up as mentors and paired with mentors to offer various types of support • Talking Matters Association: Identify the Mental Health needs of Orthodox Jewish Community in Stamford Hill area

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LONDON	<p>SEL South East London</p> <p>NEL North East London</p> <p>NWL North West London</p> <p>NCL North Central London</p>	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS</p> <p>Excellent and transferable models emerging:</p> <ul style="list-style-type: none"> • Alternative pathways report by East London NHS Foundation Trust • DRE and forensic pathways work • Intelligently using data • DRE and CPA project • DRE and access to psychological therapies • Capacity building of BME users and carers • Toolkit for commissioners on implementing race equality • Project on mapping positive practice on DRE in mental health care in London • DRE and Court Diversion • Pilots on reducing ethnic disparities of prison population • Regional CDW network • Talking Matters Association (TMA): A needs analysis in mental health in the Orthodox Jewish Community in Stamford Hill • Chinese Mental Health Association (CMHA): Explores the need for mental health care in the Chinese community in Barnet • Mind in Tower Hamlets (MiTH): Improves the mental health of the community through direct provision of services, partnership-working and campaigning on issues pertinent to the quality of life of service-users • QALB Mental Health Centre: Provides counselling, day care and respite care for the South Asian community in the borough of Waltham Forest • UK Coalition of People Living With HIV/Aids (UKC): Identifies the key mental health concerns of African people living with HIV • Redbridge User Network and User Pressure Group: (RUN-UP UK): Run-up UK gives SU voice in local service development and delivery meetings. To look at the experience of service users from the BME and refugee and asylum-seeker communities in the mental health sector • Social Action for Health (SAfH): based in Hackney focuses on reducing health inequalities working alongside local people and service-users with the aims of both to promote community-led initiatives and to influence policy • BigLife Lewisham, South London: Refugees and Asylum Seekers • Research into Male African and African Caribbean perspectives on “Recovery” is due in part to the NIMHE (National Institute for Mental Health in England) CE project • CMHA Chinese Mental Health Association Hackney: Research on ‘Investigating The Barriers And Difficulties Faced By The Older Chinese People In Tower Hamlets And Hackney in Coping With Mental Health Issues’ • CNHLC Central London: Research On: The Mental Health Service Needs Of Chinese Elders in Westminster, Kensington & Chelsea and Brent by the Chinese National Healthy Living Centre London • TWSG: Research Project On The Mental Health Needs Of Turkish Speaking Children/Young Persons By Turkish Women’s Support Group Community In Enfield, Barnet And Haringey-London • Subco research on Asian elders and carers access to mental health services

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Region	FIS site	THEMES: Aims, Objectives, Priorities; Outcomes, Good Practices, Key Achievements; Next Steps
LONDON	<p>SEL South East London</p> <p>NEL North East London</p> <p>NWL North West London</p> <p>NCL North Central London</p>	<p>OUTCOMES, GOOD PRACTICE, KEY ACHIEVEMENTS</p> <ul style="list-style-type: none"> • Derman Voice of Men: Mental health needs assessment of Turkish/ Kurdish and Cypriot/Turkish Men in Hackney • Healing Waters, Croydon – Research on: the Aftercare Mental Health Services In Croydon For African, African-Caribbean And Black British Male Mental Health Service Users Aged Between 18-45 Years • Hopscotch Camden: Research on The Mental Health Needs Of Young People From a Bangladeshi Background • Mind in Harrow: Research on Gujarati-Speaking Asian Elders’ Experiences/Views and Attitudes of Mental Health and Mental Health Services in Harrow • Peer Mentoring Scheme for BME Mental Health Service Users in Barnet, Enfield and Haringey to identify and disseminate good practice in Court Diversion Evidence gathered used to develop a business case for a model Court Diversion service in North West London <p>NEXT STEPS:</p> <p>SEL:</p> <ul style="list-style-type: none"> • Measure outcomes in an appropriate way to improve experience of BME users • Full involvement of BME service users in the Pan London data collection made more robust • Proper engagement in order to work effectively with diverse communities • Interpreting services affects communication between patients and health care workers and is likely to impact on the quality of service received by patients from the Somali community where language barrier is a major issue • Alternative Pathways project – reducing compulsory detention rates for BME users • Establish an implementation group to monitor progress of actions identified • BME and other ethnic groups need better (i) Access to psychological therapies (through the IAPT programme); (ii) Access to early intervention services; (iii) Access to crisis resolution/home treatment services; (iv) use of assertive outreach services; (v) community treatment <p>NEL:</p> <ul style="list-style-type: none"> • Training received in-house with separate arrangements • Review development of existing services run by the East London NHS Foundation Trust and others • Appropriate monitoring of ethnicity data • Monitor progress • Mental health providers for Adult Services • Improve REL cover for London and impact on the level of support offered <p>NCL:</p> <ul style="list-style-type: none"> • Improve communication across sites • Improve evidence base from existing research and activity monitoring of court diversion schemes • BME information to deliver appropriate and responsive services for people accessing MH services • Peer support services, home treatment as well as pharmacological intervention in some areas • BME and other ethnic groups need better (i) Access to psychological therapies (through the IAPT programme); (ii) Access to early intervention services; (iii) Access to crisis resolution/home treatment services; (iv) the use of assertive outreach services; (v) Community Treatment • Improve knowledge base system • Improve population data of BME in a robust way

Appendix 3: National (Executive) Summary – Clinical Trailblazers

National support – 20 sites recruited

CT Site	CSIP Region	Brief Summary of project
1. Central and North West London NHS Foundation Trust	Ldn	Court Diversion supported with good practice guidance and training package for Cultural Needs Assessment in CNWL Home Treatment and Assertive Outreach Teams
2. East London and City University Mental Health NHS Trust	Ldn	Home Treatment Team Audit and In reach mentoring
3. Camden and Islington Mental Health and Social Care Trust	Ldn	Training for managers to support front line staff in improving responses and actions relating to race and ethnicity issues
4. South London and Maudsley	Ldn	Service user led review of CPA programme in relation to BME Communities. Provision of a holistic model of CPA with supporting documents from a BME perspective
5. Wandsworth PCT	Ldn	CBT based counselling skills and other low intensity psychosocial interventions for non English speaking groups
6. West London MH Trust	Ldn	Research into what causes or influences ethnic disparities seen at different stages of the care pathway with actions to improve on existing data
7. Bedfordshire and Luton NHS Partnership Trust	Esn	Cultural Competence training to a wider audience – Primary Care (GPs) and A&E staff. Support the role of Equality Champions within secondary mental health settings
8. Hertfordshire Partnership NHS Foundation Trust	Esn	Identify individual users and carers from BME communities or organisations to develop them into 'Experts by Experience'
9. Avon and Wiltshire Mental Health Partnership NHS Trust	SW	Research into information needs of the Somalian community and culturally appropriate means of delivering that information and development of specific training packages created with service user and community involvement to be included in existing staff training
10. Northumberland Tyne and Wear	NE	Analysis of statistics by ethnicity Discovery Interviews*carried out with Asian BME service users focusing upon adult acute inpatient settings across NTW NHS Trust Deliver training initiatives to enable staff to provide more culturally sensitive services
11. County Durham and Tees Valley	NE	Race equality service improvements projects will be identified through the use of an audit cycle and prioritised The course will identify clinical champions and key influencers for race equality Develop a service approach to carrying out consultations, in particular consulting with relevant community groups and individuals Identifying and removing service barriers to information and services, especially for individuals and groups Carrying out race equality monitoring and impact assessment–ensuring that policies and practices comply with relevant legislation
12. Hampshire and Isle of Wight	SE	Culturally adapted evidenced based CBT manual

* Discovery Interview process as described (Modernisation Agency 2003) which was adopted to meet the needs of BME participants (Ali and Gray 2006).

Appendix 3: National (Executive) Summary – Clinical Trailblazers

National support – 20 sites recruited

CT Site	CSIP Region	Brief Summary of project
13. Lancashire Care Trust	Ldn	Carry out mapping exercise to inform broader DRE funded project Identify phase 2 of project in terms of information needed to be gathered to provide ongoing information for the broader DRE project
14. Bolton, Salford and Trafford Mental Health NHS Trust	Ldn	More culturally appropriate environments on acute admission and forensic admission wards
15. Leicester, Leicestershire and Rutland	Ldn	Commission satisfaction surveys with BME Voluntary Sector and utilise Mental Health Act Commission Ethnicity Data to support service improvement
16. Birmingham and Solihull Mental Health NHS Trust	Ldn	20 senior clinicians, including the Medical Director and Director of Nursing to complete RECC training and to form a core clinical group driving improvements in clinical practice in relation to BME communities
17. Sandwell Mental Health NHS and Social Care Trust	Ldn	1. Looking at Data analysis and intelligently using the data 2. Implement Race Equality Cultural Competency training for up to 16 staff, service users and carers participating in the RECC Training the Trainer Course
18. North Staffordshire Combined Healthcare NHS Trust	Esn	RECC training rollout. Delivering a range of workshops individual clinical teams. Prioritise workshops around the feedback received through recent Trust audit of the BME service user experience (additional to the Count me in Census)
19. Coventry and Warwickshire Partnership Trust	SW	5 Trailblazer themes: Data, workforce improving service delivery, capacity and leadership, monitoring and evaluation of outcomes
20. Northamptonshire Healthcare NHS Trust (in partnership with Black Wellness Initiative and Northamptonshire PCT)	NE	WRAP training provided to BME inpatient service users and users who are close to discharge/recently been discharged from inpatient services and to provide WRAP facilitated sessions with inpatients using the trained WRAP facilitators/trainers as above

Appendix 4: Research and knowledge generation overview

This is an overview of research and knowledge generated by the DRE programme; and of related research. References and websites for accessing the more detailed studies are included.

CDWs

Community Development Workers for BME mental health: Embedding Sustainable Change

Dr Reg Walker and Professor Gary Craig
Elliott Walker Consultancy
Reported March 2009

This report presents the findings of research into how the role is being implemented in practice and issues affecting its sustainability.

Some of the findings were:

- Slow progress on the recruitment of CDWs nationally;
- Levels of pay disparity;
- The need for better organisational understanding of the role for long term sustainability; and
- The need for better training and support of CDWs.

www.nmhd.org.uk.our-work/mhep/delivering-race-equality/dre-archive/

Community Development Workers for Mental Healthcare in Black and Minority Ethnic (BME) Communities – Organisational frameworks for implementing the community development approach within Delivering Race Equality (DRE) in mental healthcare

Dr Reg Walker and Professor Gary Craig
Elliott Walker Consultancy
Reported April 2009

This report was commissioned as a follow-on to the CDW sustainability report. It offered guidance to strategic health authorities and primary care trusts aimed at improving organisational understanding of the CDW role.

www.nmhd.org.uk.our-work/mhep/delivering-race-equality/dre-archive/

Community Engagement

Evaluation of Eleven Community Engagement Mental Health Pilot Projects

Helen Killaspy, Nika Fuchkan & Kwame McKenzie
Department of Mental Health Sciences, Hampstead Campus
University College London
Start Date – April 2005
Final Report – October 2006

This project examined the experiences and progress made by 11 Community Engagement pilot projects (Phase One) within voluntary sector organisations across England. The study aimed to describe and assess the process of using the Community Engagement model devised by the University of Central Lancashire and to compare mental health needs assessments carried out as part of the Community Engagement model with a standardised mental health need assessment tool.

The project had three phases: 1) initial detailed description of each project, their target population and their aims; 2) quantitative comparison of each pilot project's own mental health needs assessment with a standardised mental health needs assessment of their target population; 3) in-depth qualitative interviews with project managers and volunteers from each pilot project regarding their experiences and telephone interviews with local mental health commissioners regarding their views and commissioning intentions subsequent to receipt of a final report from each pilot project.

www.nmhd.org.uk.our-work/mhep/delivering-race-equality/dre-archive/

www.uclan.ac.uk

Delivering race equality in mental health care: report on the findings and outcomes from the Community Engagement Programme 2005-2008

Jane Fountain & Joanna Hicks, with Jez Buffin, et.al
International School of Communities, Rights & Inclusion (ISCRI), University of Central Lancashire
Publication date: 2010

This report analyses the quantitative and qualitative data from 79 studies which resulted from the work of the 75 participating community organisations. It provides a comprehensive overview of the issues that were explored by the studies in relation to BME populations and mental wellbeing, mental health problems, mental health services and the vision of service characteristics for 2010 set out in DRE. The report also documents some of the project's outcomes for individuals, communities and mental health service development. The full report is available at

iscrionce@uclan.ac.uk

Appendix 4: Research and knowledge generation overview

Count Me In Census

The Count Me In census began as a joint initiative between the National Institute for Mental Health in England, the Healthcare Commission and the Mental Health Act Commission. The census is funded by the Department of Health.

The census is a headcount of all mental health inpatients on 31 March each year (from 2006 it was extended to cover learning disabled inpatients). It records ethnicity, related factors like first language and faith, and some information about patients' care pathways prior to admission.

The census has been very successful in securing an almost complete response from providers, and in improving the quality of ethnic monitoring in the Mental Health Minimum Data Set. The final Count Me In census was carried out in March 2010. Ultimately, the aim is to ensure that routine data sources will then be able to provide information.

Information provided by the census has been consistent across the four year period 2005-2008. Most inpatients continue to be treated within the NHS, although a slightly higher proportion of inpatients received services from independent providers.

The vast majority of BME inpatients came from 23 of the 238 healthcare organisations that take part in the census. The census records the ethnicity of almost all patients. This shows that healthcare providers can fulfil their statutory obligation to record the ethnicity of patients when asked to do so on a one-off basis.

Full details of the findings of each census can be found at: www.cqc.org.uk

Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions

**Shanaya Rathod, David Kingdon, Peter Phiri and Mary Gobbi, University of Southampton School of Medicine/ Hampshire Partnership NHS Trust
Reported February 2009**

The main aims of the study of 114 participants was to produce a culturally sensitive adaption of an existing Cognitive Behaviour Therapy (CBT) manual that (a) was more reflective of the needs of people with psychosis from the specified ethnic minority communities (Black Caribbean, Bangladeshi and Pakistani); and (b) to develop guidance for health professionals to enable them to deliver CBT that is culturally sensitive and responsive to clients with psychosis from these communities.

The study looked at the needs of and aspects of BME mental health 'in the round.' It had a number of objectives which were:

- 1 To gain meaningful understanding concerning the way members (lay and service users) of the three communities concerned typically view psychosis, its origin, and management;
- 2 To elicit those cultural influences, values and attitudes that shape a client's degree of participation and response to CBT;
- 3 To elicit from CBT therapists and mental health practitioners (MHP) from these communities their experiences and interpretations of the way a client's culture influences their attitude and response to CBT;
- 4 To identify those strategies that CBT therapists and other mental health practitioners identify as being supportive or non-supportive with clients from the above ethnic communities; and
- 5 To analyse these data to make culturally specific adaptations to the existing Kingdon and Turkington manual (2005). This will include an accompanying good practice guide and recommendations for the training of therapists delivering CBT to clients from the ethnic communities.

www.nmhdu.org.uk/our-work/mhdp/delivering-race-equality/dre-archive/

Appendix 4: Research and knowledge generation overview

Prescribing

Antipsychotic prescribing in Black and White hospitalised patients: A cross sectional study

Anne Connolly, David Taylor, et.al.
South London & Maudsley Trust
Interim report July 2009

The aim of the project was to determine if ethnicity of patients affects total dose of antipsychotic used (high dose (> 100% of dose), antipsychotic use, total numbers of antipsychotics prescribed and type of antipsychotic used) after controlling for more than 20 factors affecting dose e.g. age, weight etc. Ten (10) sites were approached to provide data with only two not being able to participate. Data on over 900 patients has been collected. The study found there were no differences in any outcome by ethnicity, but that 'prescribed polypharmacy was significantly higher for Blacks than Whites.'

Prison Count Me In Census

Health & Social Care Criminal Justice Team
South East Region 2008

The DRE programme did not specifically commission the SE pilot census scheme, outlined below, but has commissioned follow-up work in relation to BME offenders and court diversion (see next page).

The South East Pilot

The South-East Health and Social Care in Criminal Justice (HSCCJ) Team piloted the Count Me in Census in twenty-seven (27) establishments across the South East. The aim of the pilot 'Count Me In' in prisons was to test the census' transferability to the prison service nationally. The scope was the 32 prisons in the South East. The work was led by the Care Services Improvement Partnership (CSIP) South East region. Analysis was undertaken by the North East Public Health Observatory (NEPHO). Links were established with the CMI Census and several joint meetings held to explore the extent to which the two can work to the same criteria.

Specific aims of the project were:

- To obtain robust baseline figures of all prisoners using mental health services on a specified date in 2008 with full details of ethnicity;
- To encourage all mental health providers of services within prisons to have accurate and comprehensive sustainable ethnic monitoring and ethnic record keeping procedures in place that will provide the basis for high quality data on the ethnicity of patients in all future data gathering exercises; and
- To provide information that will help providers of mental health services in prisons take practical steps to achieve the government's five-year plan to tackle discrimination in mental health services (Delivering Race Equality DH Jan 2005), and within services as a whole.

Conducted over a week in April 2008, the Census used a modified dataset to meet different circumstances in prisons, recording offenders on prison mental health in-reach teams' case loads, those in mental health beds in prisons and those awaiting transfer to Mental Health Unit in that week. On census day all those offenders no longer fulfilling the three categories were removed and those left were counted.

Evaluation and analysis, conducted by Kate Saffin from the Public Health Resource Unit (PHRU) and North East Public Health Observatory (NEPHO) via Professor John Wilkinson and Marianne Law, provided us with important feedback and recommendations for 2009's national roll-out.

Appendix 4: Research and knowledge generation overview

National Roll-Out

Following the successful pilot the decision was made to roll-out the census nationally in all custodial establishments in England and Wales in 2009. The census was undertaken by the Department of Health's South East Health and Social Care in Criminal Justice Team with support from other regional teams as well as colleagues from the Healthcare Commission.

Court Diversion Pilot London and South East

Health & Social Care Criminal Justice Team South East Region 2009

In December 2007, Lord Keith Bradley was asked by the Secretary of State for Justice, Jack Straw, to lead an independent inquiry into the diversion of offenders with mental health problems or learning disabilities away from prison and into more appropriate services. This independent review was commissioned to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion. The review had a broad remit and incorporated the range of mental health problems and learning disabilities across the whole of the criminal justice system, and made recommendations to government.

- The review was published in April 2009 with over 80 recommendations including one which stated that schemes should also consider how they can best serve the interests of particular groups within the offender population, for example: people with learning disabilities, women, children and young people, and people from Black and minority ethnic groups.

Funding from the DRE programme assisted in piloting an approach known as the CDW plus model, whereby offenders in the community post release could be supported by CDWs as part of the general community. The premise was that CDWs could also link into court diversion schemes to support teams to understand the specific needs of BME offenders and thereby contribute to developing culturally appropriate services.

The project intended to meet the following outcomes:

- Implementation across London and the South East;
- To undertake desktop research of BME pathways of care into secondary mental health services to identify the main issues and concerns;
- Undertake a stakeholder analysis exercise to identify key stakeholders for involvement as part of the steering group;
- Identification of best practice models for diversion schemes;
- Identify current work best practice models in the London, the South East and Liverpool;
- Develop best practice guide for BME court diversion schemes; and
- As part of action research exercise work with selected court diversion schemes to improve and embed good practice approach.

The work was evaluated by the then Sainsbury Centre for Mental Health – now the Centre for Mental Health.

Key learning included:

- Insufficient data and information about best practice approaches for BME groups.
- Lack of standardised commissioning of the diversion schemes and no central guidelines detailing operational practice.
- Accountability and governance of the schemes is non-existent with the majority of the schemes.
- No consistency in the data recording and monitoring of schemes and where ethnicity is recorded there seems to be a lack of knowledge of the 16 plus 1 system.
- Timescales of the project were not conducive to undertaking an in depth evaluation to determine the before and after effect.
- The project was limited by its dependence on utilising the already overstretched capacity of CDWs and court diversion scheme practitioners.

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'Use of new mental health services by ethnic minorities in England'

Gyles Glover, Felicity Evison
North East Public Health Observatory
Publication date: December 2009

The DRE Dashboard was developed to support measurement of progress in the DRE programme. It was published and disseminated in September 2008 and was intended for use in the following context:

As a detailed set of indicators to support and guide strategic health authorities (SHAs), primary care trusts (PCTs) and mental health trusts in better understanding how to use the work generated through the DRE programme, and service delivery generally to improve access, outcomes and experiences for people from BME groups.

The DRE Dashboard reflected the DRE programme's commitment to working with statutory sector agencies through regional race equality leads (RELs); service users and carers; voluntary and community sector agencies and others.

The DRE Dashboard identified six headline priorities to support local, regional and national monitoring of outcomes for BME communities. These were:

- 1 access to early intervention;
- 2 access to crisis resolution/home treatment;
- 3 use of assertive outreach services;
- 4 access to psychological therapies;
- 5 implementation of Supervised Community Treatment (under the Mental Health Act 2007); and
- 6 recruitment and impact of CDWs.

The Dashboard report focuses on the first four – access to community services. The findings point to variable access to community services across communities; and, though it reflects interim findings in relation to the Improving Access to Psychological Therapies (IAPT) programme, the findings point to low rates of access to the services.

www.nepho.org.uk

Current research relating to minority ethnic groups and mental health: Analysis from the Department of Health's National Research Register April 2006

Neil Moreland
Dementiplus West Midlands
Start Date – April 2005
Final report May 2006

This was a review of BME mental health research projects registered on the National Research Register (NRR). The aim was to provide a strategic overview of the research in this area and key gaps. The NRR was the system used to collate a national overview of all research in health care in England, but it is no longer used. The full report is available on www.nmhd.org.uk/our-work/mhep/delivering-race-equality/dre-archive/

Economic Modelling of Early Intervention in Psychosis: Phase III Report

Paul McCrone, Martin Knapp & Ramon Sabes-Figuera
Centre for the Economics of Mental Health,
Institute of Psychiatry, King's College London
Personal Social Services Research Unit, London School of Economics & Political Science
Interim Report July 2009

The report is based on Phase III of a programme of work to assess the economic impact of early intervention (EI) services. In Phase I a general model was developed while Phase II consisted of a scoping exercise to determine how the model could be developed and adapted for different patient groups, including the impact for BME patients; children and adolescents; and offenders.

The model used to assess the impact on costs of services for BME patients focused on reduced admission and re-admission rates, and also included data on employment.

Some of the findings in relation to BME patients were that 'savings of over 30% were estimated compared to usual care.'

The study also concluded that 'other variables not incorporated into the model re BME groups indicate additional savings for this patient group because of reduced duration of untreated psychosis (DUP) and shorter hospital stays.'

Appendix 4: Research and knowledge generation overview

Enhanced pathways into care (EPIC) for Black and Minority Ethnic (BME) populations:

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

The EPIC work gave rise to further EPIC initiatives (these are detailed in the EPIC section of the DRE full report). The work of the EPIC sites has also been evaluated. Further reading and referencing of the EPIC research is set out below:

www.wolfson.qmul.ac.uk/psychiatry/epic/

Publications from EPIC

Bhui, K. (2009). Enhancing pathways into care & recovery: From specialist services to healthy minds. *International Review of Psychiatry*, 21(5), 425-426. doi:10.1080/09540260903190187

Brett, M., Wiggins, J. & Bowman, B. (2009). The EPIC project in Easington. *International Review of Psychiatry*, 21(5), 460-464. doi:10.1080/09540260802204014

Clark, M. (2009). Research evidence and delivering race equality in mental health. *International Review of Psychiatry*, 21(5), 482-485. doi:10.1080/09540260802211050

Hackett, R., Nicholson, J., Mullins, S., Farrington, T., Ward, S., Pritchard, G., et al. (2009). Enhancing Pathways Into Care (EPIC): Community development working with the Pakistani community to improve patient pathways within a crisis resolution and home treatment service. *International Review of Psychiatry*, 21(5), 465-471. doi:10.1080/09540260903163366

Moffat, J., Sass, B., Mckenzie, K. & Bhui, K. (2009). Enhancing pathways & mental healthcare for BME groups: Learning between the ideological and operational. *International Review of Psychiatry*, 21(5), 450-459. doi:10.1080/09540260802202075

Sass, B., Moffat, J., Mckenzie, K. & Bhui, K. (2009). A learning and action manual to improve care pathways for mental health and recovery among BME groups. *International Review of Psychiatry*, 21(5), 472-481. doi:10.1080/09540260802204089

Wilson, M., Ramsden, S. & Clark, M. (2009). Delivering Race Equality in Mental Health in England: The importance of pathways. *International Review of Psychiatry*, 21(5), 427-429. doi:10.1080/09540260802211043

Moffat, J., Sass, B., Mckenzie, K. & Bhui, K. (2009). Improving pathways into mental health care for Black and ethnic minority groups: A systematic review of the grey literature. *International Review of Psychiatry*, 21(5), 439-449. doi:10.1080/09540260802204105

Sass, B., Moffat, J., Bhui, K. & Mckenzie, K. (2009). Enhancing pathways to care for Black and minority ethnic populations: A systematic review. *International Review of Psychiatry*, 21(5), 430-438. doi:10.1080/09540260802204121

Evaluation of the Focused Implementation Site Programme

Scott Weich, Kamaldeep Bhui, et.al.

University of Warwick

Start Date – October 2006

Reported January 2010

This report describes a two-year evaluation of the Focused Implementation Site (FIS) programme, which ran in 17 demonstration areas from 2005 to 2008.

The work involved a two-stage, qualitative evaluation comprising three waves of data collection. Eight sites were chosen for Phase I, from which 4 areas were recruited to take part in Phase II. Areas were chosen to provide geographical spread across England, and to include areas with contrasting densities and distributions of BME populations. Urban areas with the largest BME populations were over-represented, although areas with rural and semi-rural populations were also included.

Phase I involved in-depth interviews with Race Equality Leads (RELs) and FIS Programme Leads in each area, followed by a thematic questionnaire survey of a wider stakeholder community drawn from statutory (NHS and local authority) and community and voluntary sector (CVS) agencies. Phase II, which took place approximately 18 months after the initial Phase I interviews, comprised focus groups with service users and representatives from CVS agencies. The aim of Phase II was to elicit and describe views on perceived changes in the experiences of mental health care among those from BME communities.

Appendix 4: Research and knowledge generation overview

Data were analysed using a Framework approach.

Key conclusions were:

- DRE and the FIS programme took place against a background of entrenched, long-standing ethnic inequalities in mental health care in England. Study participants, and especially service users who took part in the focus groups, articulated dissatisfaction with existing service provision very eloquently;
- The energy and commitment behind the programme was widely acknowledged. Many service users spoke of the credible changes they had observed. Trust in services, absent for so long, was beginning to emerge. Service users, by no means uncritical, welcomed evidence that statutory services were becoming more culturally sensitive and accessible. Two of the most demonstrable improvements were the employment of CDWs, and the great availability of interpreting services;
- Some improvement in partnership and joint working between agencies, though representatives from the VCS were less positive about the impact they have been able to have, largely due to short term funding arrangements; and
- At every stage of the project participants noted two key considerations. First, that change takes time, and two years (or even five years) is just not long enough for real change to occur; second, the real challenge is not effecting change but rather sustaining it.

An Evaluation of Race Equality and Cultural Capability Training in Mental Health Services

Joanna Bennett
Sainsbury Centre for Mental Health
Reported June 2009

This report provided an independent evaluation of the original RECC training. The aim was to assess the effectiveness of the training programme in providing mental health staff with the knowledge, skills, attitudes and behaviours to deliver equitable and effective care to Black and minority ethnic groups. Some of the findings were:

- Overall conclusion that while training participants' overall ratings of the RECC training programme were positive, the content was too theoretical on three of the five days of training and there was insufficient opportunity for participants to achieve competency and develop practice;

- The RECC training was shown to be effective in improving self-assessed knowledge and competency of participants directly after the training, but a large proportion of these gains were lost by the three-month follow up assessment;
- The training appeared to have had the least sustainable impact on the development of knowledge and competencies in significant areas such as 'knowledge of DRE in MH', 'empowerment of BME groups', 'judging (and the importance of) cultural appropriateness,' anti-discriminatory risk work' and assessment, including 'holistic approach', and 'whole systems approach'; and
- The RECC training had a limited impact on changing organisational processes or individual practitioner behaviour.

Evaluation of Race Equality & Cultural Capability (RECC) Training

Ian McGonagle,
University of Lincoln
Reported: August 2009

This report analyses the RECC 'Train the Trainer' programme across 10 sites in England. These ran for a year – from January 2008 – January 2009. The courses were facilitated by a range of RECC facilitators, with just over half delivered by the original author of the RECC materials (Ferns Associates).

The report concludes that: the RECC materials are challenging for most trainers; that trainers need careful selection and support; that RECC facilitators need to provide flexible learning opportunities for organisations who find it difficult to release staff for training; that participants/trainees in the cohort of trainers were highly motivated and already working in services which took race equality seriously, and therefore, showed little significant change after the training had been completed. Other points: stylistic issues with the published materials (either too long or too clinically focused); nearly half of cohort not from statutory services; and of the 57% that were from statutory services only 34% had a clinical or practice background qualification. The report notes:

"The RECC programme appears to have been successful in maintaining engagement of the participants in the subject over time. Their mean scores for motivation, learning, and self efficacy remained high after training. However a more systematic review of the RECC programme on learners may require an evaluation which examines results from a less highly selective sample group."

www.lincoln.ac.uk/ccawi/ESC.htm

Appendix 4: Research and knowledge generation overview

'Recovery Star model and cultural competency' pilot project report

Third Sector Providers Forum
Imoniore, O & Okonkwo, N.
Reported June 2009

In April 2008, the DRE programme commissioned the Third Sector Providers Forum to undertake an assessment of the adaptability of its Recovery Star model for use with people from Black and minority ethnic communities.

The Recovery Star model is a keyworking and outcomes measurement tool, produced by Mental Health Providers Forum (MHPF). It identifies and visually represents the different dimensions of life that people may often want to focus on as part of a journey of recovery. It provides:

- A jointly agreed assessment of the current position;
- Understanding of the journey of change;
- Guides to the next steps towards recovery; and
- Visual and numerical indicators of progress over time

Okonkwo, N. & Weleminsky, J., Implementing the Mental Health Recovery Star with Southside Partnership, Mental Health Providers Forum, (2009).

The Recovery Star looks at and maps change across ten areas:

- 1 Managing mental health;
- 2 Self care;
- 3 Living skills;
- 4 Social networks;
- 5 Work;
- 6 Relationships;
- 7 Addictive behaviour;
- 8 Responsibilities;
- 9 Identify and self-esteem; and
- 10 Trust and hope.

The aim of the work was to evaluate the Recovery Star's appropriateness, develop potential adaptations and make recommendations for its use in BME contexts. Key issues explored included:

- Whether it met the needs of people from minority ethnic backgrounds who access mental health services;
- The appropriateness of the outcome areas – and ideas for modification to reflect cultural parameters; and
- Whether the visual presentation of the model was suitable.

The findings indicated that:

- On the whole, using the Recovery Star as part of the key working session is considered to be a valuable experience for service users who took part in the pilot;
- A significant number of respondents, however, found the Recovery Star confusing and the user guide difficult to read; pointing to the language barriers that the guides pose for services users who may have limited English language skills. Of those who had difficulties in accessing the materials, many said that their key-worker was able to adequately explain the things they didn't understand. This highlights the importance of staff training around the tool; and
- Over half of respondents who used the original Recovery Star felt that it failed to address issues of cultural importance to them.

The key recommendation of the BME study was:

Good training is the key to enabling staff to use the Recovery Star in a way that acknowledges the impact of race and culture on mental health and wellbeing. It is crucial that adequate cultural competency and key-working training is provided for front-line staff. This will give them a sense of awareness of the cultural issues that impact on the lived experiences of the people with whom they work. The Recovery Star encourages clients to talk about issues that they may otherwise not have the confidence to. In this way, issues relating to race/culture and health/wellbeing can be brought up, and worked through.

Other recommendations included:

- 1 The need for full translation of some of the resources into a range of languages;
- 2 A DVD or CD ROM version of the Recovery Star in a range of languages would be helpful for those service users who don't read or write their first language; and
- 3 The need for an easy read version of the user guide.

The full report is available at:

www.mentalhealthprovidersforum.org.uk/

Appendix 4: Research and knowledge generation overview

SPEKTRA – Cultural consultation in forensic settings

David Ndegwa
Consultant Forensic Psychiatrist
Clinical Director, Lambeth Forensic Services & South
London Maudsley NHS Foundation Trust Medium
Secure Services
July 2009 – July 2010

This work is undertaking a stakeholder analysis of the feasibility of adapting cultural consultation in forensic settings. The aim is to develop a forensic model, based on investigation of explanatory models and cultural formulations in diagnostic practice.

The work is being jointly funded by the DRE programme and NHS London.

Suicide Prevention for BME groups in England, Report from the BME Suicide Prevention Project

Kamaldeep Bhui & Kwame McKenzie, et.al.
Centre for Health Improvement and Minority Ethnic
Services (CHIMES), Barts and the London, School of Medicine
and Dentistry, QMUL & UCL
Reported March 2007

There were three components to the work:

- 1 Assessing the evidence – reviews of the evidence on comparative risk and preventive factors for suicide and Deliberate Self Harm (DSH) amongst BME groups in England and Wales;
- 2 Secondary analysis of other data sets, such as from the EMPIRIC and UK700 research projects and national data sets; and
- 3 Expert panel – the findings of parts 1 and 2 were presented to an expert panel for views about implications and possibilities for ways forward to address suicide and DSH amongst BME groups.

Publications

McKenzie K, Bhui K, Nanchahal K, Blizard B. *Suicide rates in people of South Asian origin in England and Wales: 1993-2003*. Br J Psychiatry. 2008 Nov;193(5):406-9.

Bhui KS, McKenzie K. *Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales*. Psychiatric Services. 2008 Apr; 59(4):414-20.

Bhui K, McKenzie K, Rasul F. *Rates, risk factors and methods of self harm among minority ethnic groups in the UK: a systematic review*. BMC Public Health. 2007 Nov 19;7:336. Review

Some of the findings were:

- 1 We know surprisingly little about the rates of or risk factor for suicide in BME groups in England and Wales. This is mainly because of a lack of good quality data;
- 2 A total of 16 058 people committed suicide within 12 months of contact with services during the five year study period 1996-2001: 10882 of the suicides were of White men and 478 were of men from the three other ethnic groups (112 South Asian, 74 Black Caribbean and 53 Black African men); 4514 of the suicides were of White women and 184 were of women from the three other ethnic groups (54 South Asian, 23 Black Caribbean and 15 Black African women);
- 3 New analyses demonstrated that suicides in South Asian groups are decreasing but there remain high risk groups such as some adult inpatient groups. However, it was not possible to analyse whether particular sub-groups had different risks. *Future research should ensure adequate sampling of sub-groups, and that routine data includes sub-group information;*
- 4 Black Caribbean young men were three times more likely to have been in contact with mental health services in the year before they committed suicide and their suicides were more likely to be considered preventable. They are a possible high risk target group for prevention. *Improving general psychiatric care to detect symptoms of depression in psychosis and ensure compliance with treatment may decrease suicidal behaviour in Black Caribbean people;*
- 5 In the Black African group compared to Whites, men under the age of 25 are 2.5 times and women between the ages of 25 and 39 are three times more likely to be in contact with services in the year before they commit suicide. Male Black African inpatients are twice as likely to commit suicide as Whites. *Investigating reasons for this, including which sub-groups (asylum seekers, specific countries of origin etc) are at high risk should be a preventive and R&D priority;*

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- 6 There were very few data on other BME groups, in particular a lack of data on White minority ethnic groups. There are concerns about high rates of suicide in Irish and Scottish people in London. The data on higher risk among White minorities and sub-cultural groups needs synthesis; future studies should account for these groups;
- 7 The fact that place of birth not ethnicity is recorded on death certificates is a major obstacle to improving the evidence and understanding changes in trends. We recommend that ethnicity not place of birth is recorded on death certificates and official records dealing with suicide;
- 8 Follow up studies using validated measures of mental distress and self harm are necessary for better prediction of risk of distinct ethnic groups. Population based studies that follow individuals to evaluate their pathways into care are necessary to fully discern whether ethnic variations of help seeking or access account of the ethnic variations in rates and prevalence in service based studies;
- 9 There is next to no evidence based literature on suicide prevention initiatives in BME groups in England and Wales. R&D commissioners should ensure that this is given some priority in future research;
- 10 The mapping exercise found that there were no projects whose primary activity was BME suicide prevention. Existing projects should review their aims and objectives to ensure BME suicide prevention is included and adequately resourced;
- 11 The expert panel concluded that there was sufficient information from specialists in cross cultural mental health and from the suicide prevention project to develop practice development, learning and teaching materials;
- 12 There was agreement about the need for BME specific public awareness campaign which would produce targeted accessible public awareness as well as capacity building (community networks of groups interested in BME suicide prevention). Initial pilots were envisaged to test the model perhaps linking with existing national stigma projects;
- 13 The expert panels concluded that much more information was needed. The three most important areas of research were: mixed methods research into suicide in adolescence, research into hidden groups such as refugee and asylum seekers, and work on Young African and Caribbean people in contact with mental health services; and
- 14 Future efforts might be directed at targeting prevention at young people in contact with mental health services and by developing culturally appropriate and effective strategies to assess risk and engage in treatment. Specific groups at risk include Black Caribbean and Black African men (aged 13-24), and women (aged 25-39). Future research will need to investigate South Asian sub-groups, specifically young women and those not in contact with services, in order to evaluate whether rates of suicide are actually decreasing in this group, or whether there is a selection bias in our sample. Although unlikely, if this does explain our findings the suggestion is of under reporting of suicides in the community. Specific investigation of cultural sub-groups should also include White sub-groups such as the Irish. Ultimately, suicide statistics should include more detailed ethnic codes. Specific risk factors of interest include religious practice, levels of mental illness, help-seeking and illness perceptions, socioeconomic status, self-harm behaviours and life events including racism.

Users', Carers', and Mental Health Professionals' Experiences of Receiving and Providing Acute Mental Health Care in a Diverse Inner City Setting

Scott Weich, Laura Griffith, Sashi Sashidharan, et.al.
Health Sciences Research Institute
Warwick Medical School
University of Warwick
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This project explored – from new perspectives – the issues of the over-representation in mental health in-patient services of people from BME communities. A multi-disciplinary and in-depth, qualitative analysis of the experiences of people from BME communities with regard to mental health inpatient care explored the interaction between individual factors and experiences and community and socio-geographical factors.