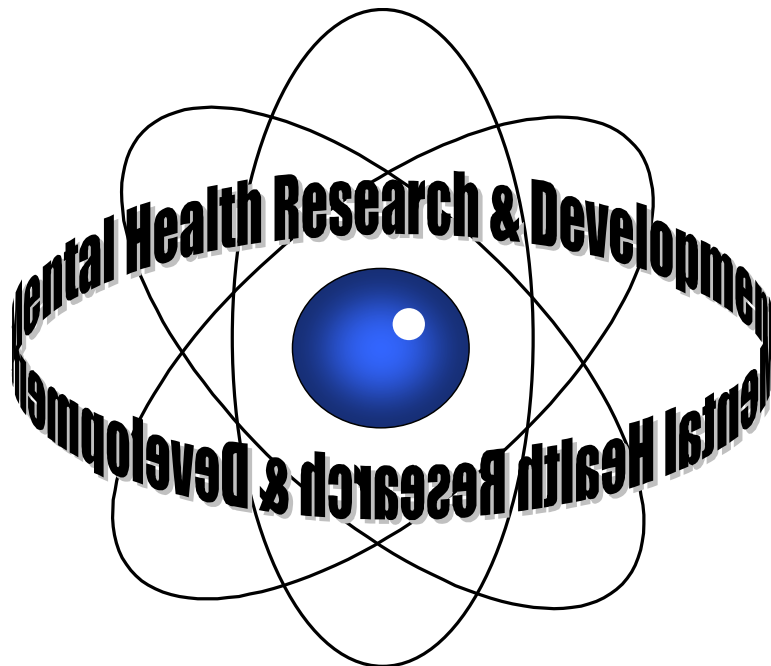


**Examining and improving the delivery of mental health care services to service users and carers from Black and Minority Ethnic (BME) groups in Central Bristol.**



Authors:	Janet Brandling, Researcher	Faiza Khaliq, Community Development Worker
	Mental Health Research & Development Unit	Inner City Mental Health
	School for Health	Brookland Hall
	University of Bath	Conduit Place
	Claverton Down	St Werburgh's
	Bath	Bristol
	BA2 7AY	BS2 9RU
Email:	<a href="mailto:J.Brandling@bath.ac.uk">J.Brandling@bath.ac.uk</a>	<a href="mailto:Faiza.Khaliq@awp.nhs.uk">Faiza.Khaliq@awp.nhs.uk</a>
Tel:	01225 383654	0117 9556098
Fax:	01225 383622	

<b>Introduction</b> .....	<b>3</b>
Table 1 Population percentage in Bristol central electoral wards Census 2001 taken from Bristol City Council ward profiles .....	4
Table 2 2006 Population Estimates by Ethnic Group in Bristol .....	6
<b>Principle Research Questions</b> .....	<b>7</b>
<b>Aims &amp; Objectives</b> .....	<b>7</b>
<b>Methods</b> .....	<b>8</b>
<b>Study Setting</b> .....	<b>8</b>
<b>Sample Group Size &amp; Description</b> .....	<b>8</b>
Table 3 Source of research participants .....	9
<b>Ethical approval</b> .....	<b>9</b>
<b>Project steering and implementation</b> .....	<b>9</b>
<b>Data analysis</b> .....	<b>10</b>
<b>Results</b> .....	<b>11</b>
<b>Quantitative data- service users</b> .....	<b>11</b>
Table 4 Number of service users on central Bristol team caseloads between research period 01.05.07-30.04.08 .....	11
Table 5 Distribution of caseload and ethnicity in central Bristol mental health teams .....	13
Table 6 Central Bristol mental health team caseload and language recorded .....	14
Table 7 Health professional contacts and service user ethnicity; .....	15
Table 8 Summary of service user contacts with therapeutic services and ethnicity. ....	16
Table 9 Summary of caseload and ethnicity .....	16
Table 10 Service users in combined central Bristol teams by electoral ward. ....	17
<b>Quantitative data- Health Professionals</b> .....	<b>18</b>
Table 11 Distribution of staff members in central Bristol teams by ethnicity .....	18
<b>Qualitative data</b> .....	<b>18</b>
Knowledge of services available .....	19
Range of services .....	19
Culturally diverse staff .....	19
<b>Discussion</b> .....	<b>21</b>
Demographic description of central Bristol mental health services .....	21
Interview data .....	22
Service User experience .....	22
Cultural competency .....	23
Health professional views .....	24
Local strategic considerations .....	24
<b>Conclusion</b> .....	<b>26</b>
<b>Recommendations</b> .....	<b>26</b>
<b>References</b> .....	<b>27</b>

## Introduction

It is thought that mental health is a particular issue of concern in diverse communities, especially where people are from Black and Minority ethnic (BME) backgrounds. It would appear that people from these groups are more likely to use mental health services but that their experience may not be equivalent to their white counterparts (Williams, 2006). Indeed, there has been an acknowledgement in government documents that mental health services have been discriminatory and must change (Department of Health, 2000, 2003, 2004, 2005, 2006). The National Institute for Mental Health in England have made a strong case for improving mental health services for people from black and minority ethnic backgrounds in England (Department of Health, 2003). By comprehensively reviewing the evidence it lays out the principles that there has been “an overemphasis on institutional and coercive models of care, that professional and organisational requirements are given priority over individual needs and rights and institutional racism exists within mental health care” experienced by BME groups (DH, 2003 p7). Furthermore, that people from BME backgrounds are “more likely to be prescribed drugs and ECT rather than talking treatments and counselling” (p13). This document goes on to make recommendations to drive change in the equity and distribution of mental health services. The strategic objectives are:

- “to reduce and eliminate ethnic inequalities in mental health service and outcome”
- “to develop a mental health work force that is capable of delivering effective mental health services to a multicultural population”
- “to enhance or build capacity within black and minority communities and the voluntary sector for dealing with mental health and mental ill health” (p19)

In a systematic review of detention under the mental health act and ethnicity, Singh et al (2007) found that BME status predicts psychiatric detention; although, it was not possible to propose a consistent cause for this. When examining distribution by ethnicity, the most recent quantitative evidence is provided via the Count Me In 2008 (CMI) census. This CMI census does not report the quality of care experienced by participants. However it has contributed to the DRE action plan to address the delivery of race equality within mental health services. CMI data indicate that in 2008 the number of service users from black and minority ethnic (BME) backgrounds was steady at 23% compared to the previous 3 years. Previous CMI censuses have suggested that this indicates an over-representation of service users from BME backgrounds compared to the general population. The 2008 census indicated that there was some continued variability by ethnicity in the referral source, detention and length of stay. The census considered other factors indicating varied cultural needs, including first language. Six percent did not have English as their first language. Local (central Bristol) CMI data (2008) shows that of the 25 inpatients in Silver Birch, 40% (N10), were from a minority background, while 12% (N3) did not have English as their first language.

This research has concentrated on central Bristol mental health services. Avon and Wiltshire Mental Health Partnership Trust provide services across a wide range of areas both rural and inner city, including central Bristol. In future service commissioners will be expecting appropriate, evidence based services that provide equality of opportunity (DH 2008) to meet the needs of all local communities. Therefore, it is important to examine the census and service monitoring data for services provided in the central Bristol area; in order to understand how many service users in this area are derived from a BME background, but also their access to therapeutic services and also perceptions of the services available to them.

Examining local data (table 2) indicates that in the 2001 national census data suggested that the population of the wards in the inner city area of central Bristol (Ashley, Easton, Eastville, Frome Vale, Hillfields, Lawrence Hill, St George East, St George West) had a non-white population of 11.6% (table 1). This was higher than figures across Bristol (8.2%) and also national (9.2%) data, indicating a concentration of non-white population in these inner city areas (ONS, 2001). In 2006, Bristol's Black and minority ethnic population estimates rose to 11.2%, and for the south west this was 4.3%. The population of Bristol has been estimated to have risen between 2001 and 2006 by 15,600 people; it is anticipated that 73% of this increase is derived of black and minority ethnic groups (Bristol City Population projections). One of the groups thought to be growing is the Somali population. In particular, Taharka (2007) suggest that there are approximately 18,000 Somali residents in Bristol, although this is unsubstantiated and does not match population estimates for Bristol's Black African population (table 2).

Ward	All White Population %	All BME population %
Ashley	74.4%	25.6%
Easton	75.1%	24.9%
Eastville	82.4%	17.6%
Frome Vale	92%	8%
Hillfields	92%	8%
Lawrence Hill	68.3%	31.7%
St George East	95.6%	4.4%
St George West	91.2%	8.8%

*Table 1 Population percentage in Bristol central electoral wards Census 2001 taken from Bristol City Council ward profiles.*

The current project is driven by the 'Delivering Race Equality (DRE) in Mental Health Care' action plan. This programme was designed to develop and sustain equality in access to services and therapies, the experiences of service users, for instance satisfaction and also outcomes, such as self perceived recovery. It is part of a much larger programme of creating equality in health and social care. Therefore funds have become available through a 'Clinical Trailblazer Network' to support service improvements and redesign. The building blocks of the programme are:

- Developing more appropriate and responsive services
- Community engagement
- Better information

This project responds to the programme objective 'better information'; to gauge what information is already known about the communities served by mental health services and understanding the local views of current service users. Service providers, such as Avon & Wiltshire Mental Health Partnership (AWP) are already obliged to record ethnicity, language and gender as part of the minimum data set and care planning. This quantitative information can aid health services understand the demographic distribution of the community they serve, monitor ethnicity and provide and enable access to services equally.

The more comprehensive DRE vision or 'action plan' for services is outlined in box 1. This outlines the specific actions and changes to mental health services envisioned for 2010, as a response to the evidence of inequity.

**Box 1- The vision for DRE is that by 2010 there will be a service characterised by:**

- less fear of mental health services among BME communities and service users;
- increased satisfaction with services;
- a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;
- a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;
- fewer violent incidents that are 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;
- more BME service users reaching self-reported states of recovery;
- a reduction in the ethnic disparities found in prison populations;
- a more balanced range of effective therapies, such as peer support services and 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.

(Delivering race equality in mental health care, DH, 2005)

Although it is very important to examine the statistical data regarding mental health service users, this does not provide insight into service user experience of mental health services. When examining reports of community engagement programmes funded by the DRE trailblazer work (<http://www.actiondre.org.uk/Reports/CommEng2007-08/research-projects07-08.html>) common themes are found in qualitative work. For instance, it is known that in times of distress, culturally competent professionals, sensitive to ethnicity, faith and gender are considered essential. This supports good practice and prevents disengagement from services. Communication of information and meanings of mental health across various languages, through translation and interpreting as well as advocacy is required. Also community involvement and community group training is important to bridge the gap between communities. These are key components to organisational and individual cultural competence.

Cultural competence is described in the literature as a dynamic process of understanding individuals and communities and operating; or behaving in such a way to avoid discrimination whilst meeting the needs of the people practitioners face. It is more than just cultural awareness or sensitivity. It is an appreciation of the underlying culture and belief system that surround the patient experience of mental distress and how this integrates with predominant models (Kastrup, 2008, Fernando, 2005). Cultural competence training is beginning to be disseminated to mental health professionals subsequent to the recommendations of the David Bennett inquiry (DH, 2005). In practice cultural competence and cultural capability are terms

often used interchangeably. In this document the term cultural competence will be used for consistency.

<b>Ethnic Group</b>	<b>Bristol</b>	<b>%</b>	<b>South West</b>	<b>%</b>	<b>England %</b>
White: British	342,800	83.5	4,744,400	92.6	84.2
White: Irish	4,200	1.0	35,700	0.7	1.1
White: Other White	17,400	4.2	124,000	2.4	3.3
Mixed: White and Black Caribbean	3,800	0.9	17,900	0.3	0.5
Mixed: White and Black African	1,200	0.3	6,600	0.1	0.2
Mixed: White and Asian	2,200	0.5	16,800	0.3	0.5
Mixed: Other Mixed	2,000	0.5	13,200	0.3	0.4
Asian or Asian British: Indian	8,500	2.1	37,500	0.7	2.5
Asian or Asian British: Pakistani	5,400	1.3	16,400	0.3	1.7
Asian or Asian British: Bangladeshi	1,600	0.4	8,300	0.2	0.7
Asian or Asian British: Other Asian	1,800	0.4	11,300	0.2	0.6
Black or Black British: Black Caribbean	5,400	1.3	18,600	0.4	1.2
Black or Black British: Black African	5,300	1.3	21,200	0.4	1.4
Black or Black British: Other Black	1,000	0.2	4,000	0.1	0.2
Chinese or Other Ethnic Group: Chinese	5,100	1.2	27,400	0.5	0.7
Chinese or Other Ethnic Group: Other	2,800	0.7	20,700	0.4	0.7
<b>White British</b>	<b>342,800</b>	<b>83.5</b>	<b>4,744,400</b>	<b>92.6</b>	<b>84.2</b>
<b>White Irish or White Other</b>	<b>21,600</b>	<b>5.3</b>	<b>159,700</b>	<b>3.1</b>	<b>4.5</b>
<b>Mixed</b>	<b>9,200</b>	<b>2.2</b>	<b>54,500</b>	<b>1.1</b>	<b>1.6</b>
<b>Asian or Asian British</b>	<b>17,300</b>	<b>4.2</b>	<b>73,500</b>	<b>1.4</b>	<b>5.5</b>
<b>Black or Black British</b>	<b>11,700</b>	<b>2.9</b>	<b>43,800</b>	<b>0.9</b>	<b>2.8</b>
<b>Chinese or Other Ethnic Group</b>	<b>7,900</b>	<b>1.9</b>	<b>48,100</b>	<b>0.9</b>	<b>1.4</b>
<b>Black and minority ethnic group</b>	<b>46,100</b>	<b>11.2</b>	<b>219,900</b>	<b>4.3</b>	<b>11.3</b>
<b>All People</b>	<b>410,500</b>	<b>100.0</b>	<b>5,124,100</b>	<b>100.0</b>	<b>100.0</b>

*Table 2 2006 Population Estimates by Ethnic Group in Bristol*

Source: Office for National Statistics, Crown Copyright 2008 (Experimental Statistics)  
 Provided by Strategic and Citywide Policy, Planning Transport and Sustainable Development, Bristol City Council

In order to meet the challenge of the DRE programme and to match mental health services in central Bristol to the diverse populations it serves the teams commissioned this research project. The research questions below reflect their desire to fulfil this challenge.

### **Principle Research Questions**

- 1, What is the distribution of mental health service provision in central Bristol teams according to ethnicity?
- 2, How can delivery of a range of psychological therapies to service users from black and minority ethnic backgrounds in central Bristol be improved?

### **Aims & Objectives**

- 1, Carry out a survey of service data collected for all service users in central Bristol
  - Examine and describe treatment and intervention data according to demographic categories including ethnicity and first spoken language
  - Compare results to local and national 'Count Me In' census and National Census data 2001.
- 2, Recruit service users to participate in semi-structured interviews
  - Service user participants should include those who have engaged with intervention services and those who have declined or opted out of intervention services after initial assessment
  - Interviews will examine the range of services offered, the acceptability and accessibility of those services, barriers to access and in the care pathway, gaps in provisions and suggested alternatives.
- 3, To provide evidence of current service provision and subsequently inform good practice development and service delivery improvement to match the needs of all service users.

Although not part of this current project it is hoped that this research can eventually be extended, subject to additional funding being made available and a favourable ethical application and R&D approval. The steering group are committed to this goal. This would include recruitment of health professionals from central Bristol teams and other mental health work stakeholders, to participate in semi-structured interviews regarding services for users from black and minority ethnic groups.

## Methods

### Study Setting

This study took place within the Avon and Wiltshire Mental Health Partnership NHS Trust, in 6 teams based in Central Bristol:

- Inpatient ward: Silver Birch
- Community Teams: East and Inner City support and recovery teams, Early Intervention team, Assertive Outreach team and the Central Assessment and Intervention team.

The electoral wards included are Frome Vale, Eastville, Hillfields, St George East, St George West, Easton, Ashley and Lawrence Hill. Participants were drawn from the teams and their caseloads. Interviews took place in venues of their choice, at home, in café's and in CMHT bases (Brookland Hall & Speedwell Centre).

### Sample Group Size & Description

The survey examined data collected by health professionals in initial and core assessments when service users are referred to and use mental health services. These data are collected in a central Trust database, MARACIS, and reports have been produced by the AWP information analysts.

The data collection examined all service users for the 6 central Bristol teams, who had been in contact with the teams over the period of 1 year 1<sup>st</sup> May 2007- 1<sup>st</sup> May 2008. The data set included:

- Ethnicity
- Electoral ward
- First language
- Contacts with health professionals specifically providing therapeutic services

No identifiable data, such as name or hospital number was provided to the research team.

The participants in service user interviews were recruited via the 6 Central Bristol teams. The community development worker was able to access MARACIS to identify a list of service users from black and minority ethnic backgrounds within the study period (01.05.07- 30.04.08). The teams were asked to exclude those who they felt should not be approached due to unstable health conditions. Then letters of invitation to participate were sent on behalf of the research team. Recruitment letters were sent in batches of 15-20. Responses to the invitation to participate were made directly to the research team using a tear off slip and freepost envelope. After presentation of the research to teams, direct approaches could also be made by the staff to follow up and explain the letters, as necessary. It was anticipated that between two and four service users per team would agree to participate.

In addition participants were recruited via the third sector and mental health support groups, specifically Two Way Street, Rethink, and MIND. Recruitment of participants was facilitated by the group leaders, who distributed invitations to participate to their group members. Responses were then be made directly to the research team. It was thought that these participants would have some experience of local NHS mental health as well as non-statutory services in order to provide an account of their needs and understanding of therapeutic services.

A total of 240 letters were sent and although 19 participants replied expressing interest in the research, 15 eventually participated in interviews. This is a response rate of 6.25%. It was hoped that maximum variation would be achieved, however with a protracted and limited response rate, interviews were conducted with those who offered. One participant required an interpreter for the interview. The remaining participants spoke English as their first language.

Team	Assertive Outreach	Central support & Recovery	Central Assessment Intervention	Silver Birch	Inner city support & recovery	Early Intervention	Voluntary sector
Responses	2	3	1	2	1	0	6

*Table 3 Source of research participants*

The interview schedule was anticipated to elicit a deeper understanding of the service users' previous experiences and perceptions of using mental health services in central Bristol; how this did or did not meet their needs and how they felt these services could be adapted and developed in the future. It did not include questions regarding measurable outcomes to treatments or therapies. The topic guide for the interview was used with all participants and focussed on the following areas:

- What do the service users understand about mental health services?
- Who have they seen and how often?
- Have they been offered a range of services?
- Are people able to access 'talking therapies' such as CBT, CAT, family interventions and psychotherapy or groups such as art therapy and music therapy?
- Why did they take up these services?
- Why did they decline services?
- What are the gaps in the service?
- What was good about the service they received?
- What services do these participants wish to have available?
- Is it important to see health professionals who are also from BME groups?

Interviews were held at mental health team premises and at service user homes.

### **Ethical approval**

Ethical approval for this study was sought from Bath Research Ethics Committee. This was given a favourable opinion on 25<sup>th</sup> July 2008. Research governance and sponsorship of this project was provided by Avon and Wiltshire Partnership NHS Trust.

### **Project steering and implementation**

The steering group comprised the research team, Bristol service manager, the central sector manager, a CSIP representative, clinical psychologist, consultant psychiatrist, community development worker, service user involvement worker, voluntary sector and service user and carer representatives.

The research data collection was carried out by Janet Brandling, researcher, MHRDU and Faiza Khaliq, Community Development Worker, AWP.

## Data analysis

The survey data were provided by the information analysts in the AWP NHS Trust, as descriptive statistics, in anonymous format. They were examined to identify trends in demographic distribution according to team as well as therapeutic services according to ethnicity and first spoken language. It became clear that it is very difficult to understand who is referred to whom or who uses and drops out of services, since the data collection system is created for Trust statistics purposes. It was only possible to examine how many contacts had been made with health professionals who deliver a solely therapeutic service. Contact with a CPN or other health professional may include therapeutic interventions such as CBT (Cognitive Behavioural Therapy) but this cannot be separated out from other work such as administration of depot medication or other types of visits. This provided a limited benchmark for current service uptake and delivery. In future further information could be sought from individual hard copy health records.

The qualitative data provided through one-to-one interviews was audio recorded (with permission) and notes taken. These notes were analysed using thematic analysis to identify the frequency, intensity and extensiveness of themes, which arose (Braun & Clarke, 2007).

1. Data are collected and transcribed in note form
2. The researcher immerses in the data, reading and re-reading interview notes and listening to audio recordings, making notes and identifying emerging patterns to form a coding framework.
3. The data are analysed using the coding framework, adding new themes to the framework as they emerge and linking related items into sub-themes.
4. A master list of themes is developed from this coding framework
5. Where possible the researcher obtains feedback from the participants to ensure that their true meaning has been captured in the interpretation (triangulation).

Themes that emerge were pieced together to form a comprehensive picture of collective experience; they were then compared to related policy and literature.

## Results

### Quantitative data- service users

The number of service users admitted to inpatient wards or on the caseload of the central Bristol sector teams in the period 01.05.07- 30.04.08 are shown in table 4 below.

<b>Team Name</b>	<b>Total caseload 01.05.07- 30.04.08</b>
Assertive Outreach Team	57
Central Assessment & Intervention Team	555
Early Intervention Team	106
East Support & Recovery Team	318
Inner City Support & Recovery Team	372
Silver Birch Ward	157
<b>Total</b>	<b>1565</b>

*Table 4 Number of service users on central Bristol team caseloads between research period 01.05.07- 30.04.08*

These admissions to the ward or caseload are further broken down in table 5 according to service user ethnicity, using ONS ethnicity categories.

Table 5 shows that all central Bristol teams had a diverse caseload for the period 01/05/07- 30/04/08. Teams with particularly high caseload rates of BME service users (over 5%) are highlighted in bold figures. This is likely to represent areas that have already high BME populations. The central assessment and intervention team had high numbers of service users who did not have their ethnicity recorded in the MARACIS database. The Silver Birch team updated service user ethnicity information within the duration of the project. These data should also be compared to the electoral ward data in table 10, which illustrate how service users are distributed in comparison to census data (ONS 2001). These tables clearly indicate the over-representation of BME service users in caseloads.

Table 6 shows the first languages spoken by service users. This indicates that the Central Assessment and Intervention team and the Inner City Support and Recovery team both work with individuals for whom English is not their first languages for which they may require translation and interpretation skills in order to carry out their daily work. It is evident that some teams have not yet successfully recorded the first language of service users. This gap in record keeping ranges between 5 and 34%.

It has been difficult to access data regarding the type of therapeutic intervention that service users have been offered or have taken up. This detailed information is likely to be recorded within the 'hard copy' health records but is not yet available through the MARACIS database. It was thought that by interrogating the database for the type of contacts, more understanding would be gained regarding this therapeutic contact. By asking which health professionals, service users have seen, it can be established that services such as Art therapy, Occupational therapy and Psychology have been used. However other health professionals such as nurses may be trained to conduct therapeutic interventions such as Cognitive Behavioural Therapy, but it is not possible to distinguish this type of contact from database entries. These data are summarised in table 8 and indicate that therapies are available to and taken up by a diverse range of service users. This balance of therapy take up is largely dependent upon the caseload

of the team and for some seems distributed unevenly. For instance, 55% of the Inner City Support and Recovery caseload are from a white British background; yet 78% of contacts with Psychology are with white British service users. Or in the Early Intervention team, the caseload is 39% minority background but 25% of Art therapy or 66% of Psychology contacts are derived from the same group.

In this case it is not clear why this imbalance may be the case. It could be that some service users are not offered information or referral to these therapeutic services so often. Alternatively, they may not take up the offer of these services due to perceived unsuitability or lack of information. It must be remembered that this shows the number of contacts rather than the number of people referred. Therefore it could be that service users who have more contacts with the Psychologists and other therapies, skew the results inflating the percentage of contacts overall. It would appear this issue needs to be investigated more thoroughly. Services may be able to conduct an audit of their own performance to identify any inequity and the reasons for this. Silver Birch ward are not included in this table as in patient contacts with health professionals are not recorded against the ward name. Contacts can be sought from the database using the dates of inpatient stay.

During the period considered within this research there were 1,565 service users counted on central Bristol team caseloads.

Where the ethnicity of service users is higher than the rate identified in the 2001 census, this could support the hypothesis that people from BME backgrounds are more frequently represented in mental health services. However, the numbers identified in the caseloads are small and therefore should be treated with caution. The overall percentages would change positively or negatively with the addition or removal of just one service user.

Ethnic grouping	Assertive Outreach		CAIT		Early Intervention		East Support & Recovery		Inner City Support & Recovery		Silver Birch Ward	
	N	%	N	%	N	%	N	%	N	%	N	%
Asian or British Asian- Other			12	2.2			2	0.6	2	0.5		
Asian or British Asian- Bangladeshi			2	0.4	2	1.9	1	0.3	8	2.2	3	1.9
Asian or British Asian- Indian	2	3.5	5	0.9	3	2.8	3	0.9	10	2.7	4	2.5
Asian or British Asian- Pakistani	3	<b>5.3</b>	10	1.8	3	2.8	6	1.9	22	<b>5.9</b>	6	3.8
Black or Black British- African	4	<b>7</b>	35	<b>6.3</b>	12	<b>11.3</b>	5	1.6	19	<b>5.1</b>	14	<b>8.9</b>
Black or Black British- Other	2	3.5	13	2.3	5	4.7	4	1.3	5	1.3	6	3.8
Black or Black British- Caribbean	18	<b>31.6</b>	30	<b>5.4</b>	1	0.9	11	3.5	58	<b>15.6</b>	22	<b>14</b>
Mixed- Other mixed background	1	1.8	3	0.5	1	0.9	3	0.9	2	0.5	2	1.3
Mixed- White & Asian	1	1.8	1	0.2	1	0.9	3	0.9	1	0.3	2	1.3
Mixed- White & Black African			2	0.4	2	1.9	3	0.9				
Mixed- White & Black Caribbean	3	<b>5.3</b>	11	2	2	1.9	5	1.6			6	3.8
White- British	20	35.1	256	46.1	61	57.5	259	81.1	212	57	86	54.8
White- Irish	1	1.8	3	0.5			2	0.6	4	1.1	1	0.6
Other- White	1	1.8	17	3.1	6	<b>5.7</b>	6	1.9	10	2.7	2	1.3
Chinese			2	0.4	3	2.8	1	0.3	5	1.3		
Other			11	2	1	0.9	2	0.6	2	0.5	3	1.9
Not known			6	1.1								
Not stated	1	1.8	136	24.5	3	2.8	2	0.6	1	0.3		
<b>Total</b>	<b>57</b>	<b>100%</b>	<b>555</b>	<b>100%</b>	<b>106</b>	<b>100%</b>	<b>318</b>	<b>100%</b>	<b>372</b>	<b>100%</b>	<b>157</b>	<b>100%</b>

Table 5 Distribution of caseload and ethnicity in central Bristol mental health teams  
(blank cells indicate nil in category, bold indicates rates over 5%)

Language spoken	Assertive Outreach		CAIT		Early Intervention		East Support & Recovery		Inner City Support & Recovery		Silver Birch Ward	
	N	%	N	%	N	%	N	%	N	%	N	%
Albanian			1	0.2								
Arabic	1	1.8	4	0.7					2	0.5		
Bengali			1	0.2					5	1.3	1	0.6
British Sign Language											1	0.6
Cantonese									1	0.3		
Chinese					1	0.9			1	0.3		
Dutch			1	0.2								
English	52	91.2	475	85.6	66	62.3	221	69.5	322	86.6	141	89.9
Farsi			6	1.1								
French			2	0.4					2	0.5		
German			1	0.2					1	0.3		
Hindi									1	0.3		
Iranian			1	0.2								
Japanese									1	0.3		
Kurdish							4	1.3			2	1.3
Non-verbal language			4	0.7					2	0.5		
Polish			2	0.4	2	1.9						
Portuguese	1	1.8									1	0.6
Punjabi			1	0.2					5	1.3		
Russian			1	0.2					1	0.3		
Somali			11	2	1	0.9	1	0.3	7	1.9	6	3.8
Spanish			1	0.2							1	0.6
Swahili			1	0.2								
Urdu			1	0.2					4	1.1		
Not entered	3	5.3	30	5.4	36	34	92	28.9	16	4.3	4	2.5
<b>Total</b>	<b>57</b>	<b>100</b>	<b>555</b>	<b>100</b>	<b>106</b>	<b>100</b>	<b>318</b>	<b>100</b>	<b>372</b>	<b>100</b>	<b>157</b>	<b>100</b>

Table 6 Central Bristol mental health team caseload and language recorded.  
(Blank cells indicate nil in category)

N. of Contacts & Ethnic grouping	Assertive Outreach		CAIT			Early Intervention		East Support & Recovery			I C Support & Recovery		
	AT	CP	AT	CP	OT	AT	CP	AT	CP	OT	AT	CP	OT
Asian or British Asian- Other				31 15.2%							1 0.7%		
Asian or British Asian- Bangladeshi							1 0.6%				2 1.4%		35 10.4%
Asian or British Asian- Indian					1 20%						4 2.7%	1 0.2%	
Asian or British Asian- Pakistani		20 6.6%		3 1.5%		9 25.7%			2 0.7%		6 4.1%	12 2.1%	1 0.3%
Black or Black British- African		44 14.6%		38 18.6%			12 7.5%		2 0.7%	1 10%		5 0.9%	35 10.4%
Black or Black British- Other		1 0.3%	1 8.3%	2 0.98%			32 19.9%				24 16.4%	17 3%	
Black or Black British- Caribbean	2 100%	58 19.2%		2 0.98%	1 20%						24 16.4%	72 12.8%	89 26.5%
Mixed- Other mixed background							12 7.5%		6 2.1%				2 0.6%
Mixed- White & Asian		14 4.6%							7 2.4%				
Mixed- White & Black African													
Mixed- White & Black Caribbean		20 6.6%		1 0.5%			18 11.2%	25 49%	19 6.6%		1 0.7%	3 0.5%	5 1.5%
White- British		144 47.7%	11 91.7%	86 42.2%	3 60%	26 74.3%	50 31.1%	26 51%	214 74.6%	8 80%	39 26.7%	439 78.1%	169 50.3%
White- Irish											21 14.4%		
Other- White		1 0.3%		1 0.5%					35 12.2%	1 10%	23 15.6%	13 2.3%	
Chinese				1 0.5%			31 19.3%						
Other				8 3.9%							1 0.7%		
Not entered				1 0.5%									
Not stated				30 14.7%			5 3.1%		2 0.7%				
<b>Total</b>	<b>2</b>	<b>302</b>	<b>12</b>	<b>204</b>	<b>5</b>	<b>35</b>	<b>161</b>	<b>51</b>	<b>287</b>	<b>10</b>	<b>146</b>	<b>562</b>	<b>336</b>

Table 7 Health professional contacts and service user ethnicity;

Key: AT- Art Therapy, CP- Clinical Psychology, OT- Occupational Therapy.

Contacts & ethnicity	Assertive Outreach		CAIT			Early Intervention		East Support & Recovery			Inner City Support & Recovery		
	AT	CP	AT	CP	OT	AT	CP	AT	CP	OT	AT	CP	OT
Non-white British White Irish & other	2 (100%)	158 (52.2%)	1 (8.3%)	87 (42.7%)	2 (40%)	9 (25.7%)	106 (66%)	25 (49%)	71 (24.4%)	2 (20%)	107 (73.1%)	123 (21.8%)	167 (49.7%)
White British	0	144 47.7%	11 (91.7%)	86 (42.2%)	3 (60%)	26 (74.3%)	50 (31%)	26 (51%)	214 (74.6%)	8 (80%)	39 (26.7%)	439 (78.1%)	169 (50.3%)
Not known/ stated	0	0	0	31 (15.2%)	0	0	5 (3%)	0	2 (0.7%)	0	0	0	0
<b>Total</b>	<b>2</b>	<b>302</b>	<b>12</b>	<b>204</b>	<b>5</b>	<b>35</b>	<b>161</b>	<b>51</b>	<b>287</b>	<b>10</b>	<b>146</b>	<b>562</b>	<b>336</b>

Table 8 Summary of service user contacts with therapeutic services and ethnicity.

Key: AT- Art Therapy, CP- Clinical Psychology, OT- Occupational Therapy.

Ethnic grouping	Assertive Outreach	CAIT	Early Int'ion	E Support & Recovery	I C Support & Recovery	Silver Birch Ward
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Non white British, Irish & other	36 (63.4%)	157 (28.4%)	42 (39.4%)	57 (17.8%)	148 (39.7%)	71 (45.1%)
White- British	20 (35.1%)	256 (46.1%)	61 (57.5%)	259 (81.1%)	212 (57%)	86 (54.8%)
Not known/ stated	1 (1.8%)	142 (25.6%)	3 (2.8)	2 (0.6%)	1 (0.3%)	0
<b>Total</b>	<b>57</b>	<b>555</b>	<b>106</b>	<b>318</b>	<b>372</b>	<b>157</b>

Table 9 Summary of caseload and ethnicity

	Ashley		Easton		Eastville		Frome Vale		Hillfields		Lawrence Hill		St George East		St George West	
	Caseload	Census	Caseload	Census	Caseload	Census	Caseload	Census	Caseload	Census	Caseload	Census	Caseload	Census	Caseload	Census
Asian or British Asian- Other	3 <b>1.8%</b>	0.6%	3 <b>2.6%</b>	0.8%	2 <b>1.9%</b>	0.5%	2 <b>1.4%</b>	0.3%		0.3%	5 <b>2.3%</b>	0.5%		0%		0.1%
Asian or British Asian- Bangladeshi		0.9%	3 <b>2.6%</b>	1.5%	2 <b>1.9%</b>	0.9%		0.4%	3 <b>2.4%</b>	0.4%	4 <b>1.8%</b>	2%	1 <b>1.3%</b>	0.3%		0.2%
Asian or British Asian- Indian	1 0.6%	1.5%	2 1.7%	2.7%	2 1.9%	3.1%	4 <b>2.8%</b>	1.1%	2 <b>1.6%</b>	1.1%	4 1.8%	3%		0.9%	4 <b>5.5%</b>	2.8%
Asian or British Asian- Pakistani	12 <b>7.1%</b>	3.1%	9 <b>7.7%</b>	5.5%	2 1.9%	3.7%	2 <b>1.4%</b>	1.2%	3 <b>2.4%</b>	1%	10 4.5%	4.7%		0.4%	1 1.4%	1.4%
Black or Black British- African	23 <b>13.7%</b>	2.7%	6 <b>5.1%</b>	1%	6 <b>5.7%</b>	0.9%	1 0.7%	0.7%	2 <b>1.6%</b>	0.4%	18 <b>8.1%</b>	4.3%		0.3%	1 <b>1.4%</b>	0.3%
Black or Black British- Other	5 <b>3%</b>	1.1%		1.1%	4 <b>3.8%</b>	0.5%	3 <b>2.1%</b>	0.2%	2 <b>1.6%</b>	0.4%	12 <b>5.4%</b>	1.8%		0.1%		0.2%
Black or Black British- Caribbean	25 <b>14.9%</b>	8.5%	6 5.1%	7%	4 3.8%	3.9%	4 <b>2.8%</b>	1.5%	1 0.8%	1.8%	33 <b>14.9%</b>	8.6%	4 <b>5%</b>	0.9%	5 <b>7%</b>	1.7%
Mixed- Other mixed background	3 <b>1.8%</b>	1.2%	2 <b>1.7%</b>	0.7%	4 <b>3.8%</b>	0.5%		0.3%		0.5%		0.9%		0.2%		0.2%
Mixed- White & Asian	1 0.6%	0.9%		0.7%		0.5%	3 <b>2.1%</b>	0.3%		0.3%	1 0.5%	0.5%		0.4%		0.3%
Mixed- White & Black African		0.6%	1 0.9%	0.3%		0.4%	2 <b>1.4%</b>	0.2%		0.3%	2 <b>0.9%</b>	0.6%		0.1%		0.2%
Mixed- White & Black Caribbean	4 2.4%	3.1%	1 0.9%	2.5%		1.7%	2 <b>1.4%</b>	1.1%	5 <b>4%</b>	1.1%	10 <b>4.5%</b>	3.7%		0.5%	1 <b>1.4%</b>	1%
White- British	62 36.9%	67.8%	66 56.4%	71.3%	64 61%	78.5%	98 67.6%	88.8%	84 67.2%	89.7%	98 44.1%	64.2%	56 70%	94%	47 64.4%	89%
White- Irish		1.5%		1.3%		1.4%		0.9%	3 <b>2.4%</b>	0.9%	1 0.5%	1.6%		0.5%	2 <b>2.7%</b>	1.1%
Other- White	7 4.7%	5.1%	1 0.9%	2.5%	1 0.95%	2.4%	2 1.4%	2.3%	5 <b>4%</b>	1.4%	7 <b>3.2%</b>	2.5%	1 <b>1.3%</b>	1.2%		1.5%
Chinese	4 <b>2.4%</b>	0.8%		0.3%		0.6%	2 <b>1.4%</b>	0.4%		0.3%	1 0.5%	0.7%		0.2%		0.3%
Other	3 <b>1.8%</b>	0.5%	2 <b>1.7%</b>	0.7%	3 <b>2.9%</b>	0.4%	2 <b>1.4%</b>	0.3%	2 <b>1.6%</b>	0.2%	2 <b>0.9%</b>	0.5%		0.1%		0.1%
Not stated	15 8.9%		15 12.8%		13 12.4%		17 11.7%		13 10.4%		13 5.9%		18 22.5%		12 16.4%	
Not known					1 0.95%		1 0.7%				1 0.5%					
<b>Total</b>	<b>168</b>		<b>117</b>		<b>105</b>		<b>145</b>		<b>125</b>		<b>222</b>		<b>80</b>		<b>73</b>	

Table 10 Service users in combined central Bristol teams by electoral ward.

Percentage comparisons related to prevalence indicated in 2001 census, bold where caseload higher than census.

### **Quantitative data- Health Professionals**

In 2003 it was known that 43 of 736 (5.8%) of AWP staff in Bristol were considered to be from a minority background. This fell short of representing the local community, as the 2001 census suggested this was over 8% (AWP Race Equality Scheme document, 2006); although the trust average was 4.4%. The current distribution of staff within the central sector teams is shown below in table 11. This shows considerable variability, but overall provides a mean representation of 22.6%. This is higher than the trust over all and is likely to be because staff are also derived from central Bristol areas. However it does not include staff employed in the teams by Bristol City Council, since these figures were not available during the project.

<b>Team name</b>	<b>Total number of staff</b>	<b>Number of BME staff</b>	<b>% BME staff</b>
Silver Birch	10	1	10%
Assertive Outreach	7	1	14.3%
Inner city support & recovery	18	6	33.3%
East support & recovery	7	1	14.3%
Early intervention	2	0	0%
Central assessment & intervention	11	7	63.6%

*Table 11 Distribution of staff members in central Bristol teams by ethnicity*

### **Qualitative data**

The research participants were sought from both statutory and non-statutory services. Six were referred via non-statutory services; the remainder were from the various central Bristol teams. The recruitment process was slow and unwieldy, since access could only be made via the teams. The community development worker was able to generate a list of potential candidates, randomly select a group of 15 and ask the team if any person should not be contacted. Letters of invitation were then sent with a freepost envelope for return to the researcher, who in turn made appointments. This method was chosen to satisfy the ethical considerations of researcher access to confidential information but also to attempt to eliminate risk to both researcher and service user. Several people indicated they would like to participate but later changed their minds. The group were predominantly male (9:6) and all but two had been a user of statutory services. One of these chose not to use secondary care services because of the perceived stigma of mental health difficulties and concerns about confidentiality and the other reported not having been considered entitled to these services at the time because of insecure status to remain in the UK. The participants were interviewed at home or in health centre premises. Most described enduring mental health difficulties that had included hospital admission. Some had explored their mental health problems in depth and had travelled a long way in their recovery, including a holistic approach to health. Others seemed to be resigned to the longevity of their mental health difficulties. In these cases, their motivation to pursue suggested activities was limited and they relied upon health professionals to remind them or encourage them to be proactive. For instance one young man had been offered contact with a

gym, but he was waiting for a professional to get back to him about it. He felt they had forgotten.

There are few themes evident in the interviews and this is because the participants demonstrated variable levels of knowledge and insight about the services available to them and also those provided by their mental health professionals. For instance some participants had been very eager to use psychological therapies or counselling type services, others were far more wary or lacked knowledge of what services were for. Most did not distinguish at all between supportive and therapeutic relationships. Those using the voluntary sector highly valued to their service.

### Knowledge of services available

Most of the service user participants who had used psychological therapies had been referred by health professionals. Until that point they had not known what was available or indeed what these services could do for them. Some said they had asserted their need for these services but found barriers such as waiting lists or limited funding. It was clear that the service users who did not know of psychological therapies could not request them and relied heavily upon health professionals presenting them with the potential referrals and discussing them.

### Range of services

Several of the participants expressed a desire for a holistic view, with a variety of services, ranging from psychological therapies to occupational activities such as the gym or dance or relaxation techniques, like massage. They also expressed the need for all the aspects of their lives to be addressed, recognising their commitment as parents and their family needs as well as their diagnosis. The researcher used descriptions of some types of therapies to illustrate points and a few of the participants expressed an interest in these, having never heard of them before. For instance, there does not appear to be any drama or music therapy available to these teams and service users in central Bristol. Some of the participants had been proactive in asking for services they had heard of both via statutory services and privately; whilst others had only taken up services they had been offered by health professionals.

### Culturally diverse staff

Overall, the majority of participants said they liked having a variety of people in the mental health teams and that the relationship they built with the health professional was of more importance than their ethnicity or background. The researcher described the schools of thought about having contact with health professionals who were also from Black and minority ethnic backgrounds, asking if this was important to them or not. They gave a range of responses. One participant felt that she did not want this at all, as she felt the local Black community was so small, she would be bound to know any such health professional. She did not want them to know her business and did not trust that confidentiality would be maintained. She expressed a need to access services in a different locality to avoid this. Another participant acknowledged he had been resistant to working with some members of staff and intimated that this was because they were white. He had since conceded that this had been a barrier to his progress. Several participants expressed disappointment in Black staff they had encountered, who had not acted or understood them as they had expected. One reported that she felt Black nurses treated her less well, compared to White nurses, and didn't take account of her requests. The reason for this was not clear but could indicate some level of complacency about diversity

issues in minority staff. On the other hand, having professionals from one's own cultural background made some of the participants feel that they didn't need to explain choices or beliefs and that they would understand particular needs. For instance, one woman described needing to visit a chemist for hair products to care for her Black hair and skin. She felt a woman with similar background would be sympathetic and would facilitate this kind of support. One person was expressly certain that it was the health professionals from a minority background who had treated her with most respect, understanding the particularities of her ethnicity and how discrimination had impacted upon her mental health. She felt she had been taken seriously and closer attention had been paid to her individual needs. She had particularly valued the culturally specific non-statutory services. It had taken some of the participants a long time to feel that the package of care was appropriate to their needs, due to a poor understanding of them as an individual and that this was muddled by their ethnicity. Clearly participants had a variety of needs that could not be addressed by one member of staff regardless of their background.

## Discussion

Outcomes of this project were predicted to be:

1. An understanding of the way services are used by people from BME backgrounds in central Bristol
2. Recommendations for improving service accessibility and acceptability for BME service users based on service user accounts
3. Secure funding, ethics and R&D approval for a third stage of this project, extending data collection to health professionals.

### Demographic description of central Bristol mental health services

The data retrieved for this research confirms that service users from Black and minority ethnic backgrounds form a large part of the team caseloads. For most teams this represents rates higher than the local population estimates (Table 5) and bears out the idea that service users from BME backgrounds are over-represented in mental health services (DH, 2003) but that they are, at times, underrepresented in other services such as Psychology (Williams, et al, 2006). Moreover, the central assessment and intervention and inner city support and recovery teams deal with a wide range of service users whose first language is not English. Although the numbers in each category are not large, there is considerable diversity. This has implications for translation and interpreting services required for information giving and consultations. An interpreter was used for one interview during this research. It was a successful interview and no difficulties were encountered making the arrangement. It would be important to know whether this experience is the same for staff booking appointments with service users.

It is clear from the research that the teams are able to access some demographic descriptions of their caseload and the service user contacts. This is in addition to the information available in the 'Count Me In' census, which concentrates upon inpatient data. It is important to note that NIMHE (DH, 2000) stressed the importance of monitoring service user ethnicity and preferred language, so that organisations can examine their performance and policies. This has become mandatory. Therefore, there is a top down imperative towards data collection. Some teams have yet to complete MARACIS records of ethnicity and language spoken for all service users and it important that this data is recorded. This may show reluctance for what is seen as a paper exercise, because the data is seen as being collected but not used by teams. It is therefore important that the teams become efficient in data collection, particularly in recording ethnicity. Data should be recorded in the HES (Hospital Episode Statistics and MHMDS (Mental Health Minimum Data Set). Where data is not recorded, Trusts will be penalised.

Team managers may ask for data, similar to that used in this study, directly from the information analysts and this may be used within teams to illustrate the purpose of data collection, illustrate trends as well as allow responsive teams to adapt services accordingly. Each team aims and outcomes vary widely and they will be able to concentrate on their own caseloads as well as making comparisons to other teams. However, although it is possible to look at many demographic variables in addition to those illustrated here, such as age and gender, there are still severe limitations in data illustrating access to therapeutic services. It was not possible to know what therapies services users had been offered or taken up; only the role of the health professionals they had had contact with. Psychology services in the central sector report that work with asylum seekers is not recorded in the central MARACIS system as contact with psychologists and therefore central data does not reflect this important work. It is

recorded as 'Asylum Clinic' rather by team. A more responsive data collection method could suit the needs of the teams, allowing them insight into the choices service users are given and take up and therefore access to therapies. If this data were available service design and planning could be based on evidence of need.

### Interview data

In discussing the services with service users, they had long histories of involvement in mental health services and they found it difficult to recall services they had used or frequently referred to particular people providing support, rather than types of therapeutic interventions. This was also problematic for at least one of the teams. They felt that the MARACIS database could not capture the wide variety of work they carried out with service users. For instance, one member of staff involves service users in music production yet this is not formal music therapy and would not be considered therapeutic. Although this intervention can be recorded in hard copy health records, no outcomes are measured and evidence of this creative working practice is not easily accessible. The community development worker plans to pursue data collection to illustrate this aspect of team working, in order that the teams can show evidence of their impact upon service users. In order to look at the referral to and uptake of therapeutic services teams are likely to have to collect their own audit data. They will need to consider how to categorise the data they collect, identifying what is considered to be a therapeutic intervention; as opposed to support and facilitation. There is also a need for the Trust wide data collection system to suit the needs of the health professionals too. If data collection has some impact at the service delivery level it will be easy to see why it is essential to collect information.

### Service User experience

Although this research was not examining satisfaction per se, service users were mostly positive about their current contact with health professionals when they were interviewed. However, some participants appeared to have limited insight into the wider view of mental health services, and the difference between therapy and support. Three main themes were identified from the interviews, 1, knowledge of services, 2, the range of services available and 3, culturally diverse staff.

It is not clear that service users have enough knowledge about the types of services they could engage with or what these services might provide. This is consistent with recent findings by Manthorpe et al, (2009), who found that more information and translation was required by older people from BME communities. The central Bristol participants often rely upon health professionals to offer them services as there is no menu, they do not know what is available. Furthermore, they may need some considerable explanation of what these services might be like or try to achieve. The more assertive and proactive service users appeared to seek out their own solutions but others relied heavily on health professionals for information and encouragement. Because the participants had limited insight into the wider perspective of mental health services it is difficult to draw any conclusions on how specific services could be improved to meet the needs of these service users. It is likely that where health professionals know that there is limited supply of such services they may act in a gate-keeping role (Williams et al, 2006), not giving information until they feel it is an acceptable or even an essential solution. This may be viewed a clinical decision, based upon experience of the success of mental health treatments. It is not clear how health professionals make the decision to offer psychological therapies and whether their view of cultural acceptance of such services impacts upon this. However, if health professionals do not offer a whole range of services, this does not

allow service users a level playing field of knowledge of potential services. Therefore it is very important to understand how health professionals view this aspect of their work, whether they feel able to offer any service and whether they feel as if they must limit entry to services due to cost or waiting times. One participant was very concerned about confidentiality, when consulting with a health professional from her own community. These issues of knowing what is available and whether the service is confidential chime with anecdotal feedback to local community development workers from community consultation. It is important to address these issues, as they may be easily dismissed yet create barriers to access for communities not used to British health systems and institutions.

### Cultural competency

It is likely that service users and communities expect to see that mental health services staff are representative of the communities they work within. Moreover, the DRE action plan and vision for the future includes 'a workforce and organisation capable of delivering appropriate and responsive mental health services for BME communities' (DH, 2005). This means having both a diverse and culturally competent workforce.

Participants in this study ranged in their views about the background of staff they had met. Many felt that it was not important to work with people from the same background because it is the relationship between them that is more important. But others were clear that working with staff from BME backgrounds had been advantageous. This both challenges and confirms the assumption that BME service users prefer to consult health professionals from BME backgrounds too. It is clear that the teams in central Bristol have considerable variability in staff diversity, although it has not been possible to identify the ethnicity of staff in order to see if this matches their service users. Subsequent to the David Bennett inquiry (DH, 2005) there has been an expectation that having a diverse workforce alone is not sufficient to stimulate culturally competent practice but that training is required (Bhui et al, 2007). There are limited evaluated models of training and practice and so there is yet little systematic understanding of the impact of training programmes. Bhui et al, (2007) suggest that cultural competency must be specific to the local context. Therefore, it is clear that central Bristol teams need to be able to meet the needs of all their service users, with well trained, multicultural teams that reflect communities in order to meet the needs of all service users. Where it is difficult to recruit a diverse workforce it is possible to use the Race Relations Act, (1976) to employ staff from BME backgrounds.

The central Bristol teams undertook Race Equality and Cultural Competency training between April and July 2008. This was delivered and evaluated by CSIP funded trainers, derived from service user survivors and carers as part of the DRE Clinical Trailblazers programme. Trainers were derived from the locality and were familiar with the local context. Two were service users, two were staff. There were 24 staff participants, who reported they found the programme relevant and useful but found it difficult to keep up the work tasks due to a lack of time. Recommendations arising from the evaluation (Barclay, 2008) were that workbook (AWP, 2006) use is continued, training is continued and time made available to study and that diversity policy is regularly reviewed within teams and at supervision. It is important to revisit the staff and gauge how helpful this type of training has been in the long term and whether they have adapted their practice as a consequence. It would also be interesting to note if training is taken up by all staff, regardless of role or ethnicity, since cultural competency can be improved by all. Managers need to understand the need for time to be made for this training and 'homework' to be completed, removing barriers to participation. It may be possible to examine

these issues if a further stage of this study is carried out, eliciting staff views of past training and also their future training requirements. Because training is a recommendation of the David Bennett inquiry (DH, 2005), it is important that the central Bristol teams and the Trust prioritise further cultural competency training to meet their obligations for a 'workforce capable of delivering appropriate and responsive services to BME communities'.

Other tools to disseminate supplementary information about cultural competency may be easily provided by the Trust through the intranet. For instance, a recent UK toolkit endorsed by the Department of Health's Race for Health programme, has been designed to improve cultural competence. It has been developed by the West London Mental Health Trust and is available online (<http://www.wlmht.nhs.uk/docs/general/CCTK.pdf>). This gives prescriptive guidance about ethnic groups in terms of language, religion and customs and should not be considered sufficient in terms of cultural competence training. It is simply a reference manual rather than context specific training.

### Health professional views

Some teams were very keen to have a data collection opportunity to demonstrate the innovative and responsive work they were conducting with their service users. When the research team approached the teams it became clear that the team members were also very keen to participate in research; to give their view of what services are accessible and acceptable to service users from BME backgrounds. Unfortunately, the resources available within this project were insufficient to include this aspect of data collection. However, it is recommended that this further stage would be beneficial to supplement knowledge of their service users needs but also provide evidence of areas suitable for service development. In the absence of funds it is possible a student could undertake the third stage of data collection, to triangulate the research project. This could include examining the ethnicity of staff in more depth, conducting interviews or focus groups with staff to identify barriers to practice, such as, interpretation and translation or availability of services such as art and drama therapy. It would also be interesting to examine whether the AWP Trust document Practice Governance and the Team- A modular workbook (AWP, 2006) for the team was still in use to both challenge and develop cultural diversity and whether there are other outstanding diversity training needs.

### Local strategic considerations

The 2008 CMI census findings from the Health Commission are very clear about how mental health services should move forward and they reiterate the DRE action plan (See box 1).

Avon and Wiltshire Mental Health services have already responded to the Delivering Race Equality programme in several ways. Community development workers have been appointed to engage with BME communities, to help reduce the stigma of mental health problems in these communities and also to identify gaps in service provision. It is hoped they will strengthen relationships between communities and health professionals as well as enhance cultural competence training for staff. These mandatory appointments have been stipulated to be:

- Change agents
- Service developers
- Capacity builders
- Access facilitators

Primary Care Trust commissioners are advised to work with existing community groups to raise awareness and promote engagement with services, as well as give feedback from the communities (DH, 2008). This might include working with faith groups and those with specialised linguistic and cultural knowledge. They are also asked to encourage providers of psychological therapies to engage staff from the local community, use translation and interpreting services as well self-referral routes into primary care level services (DH, 2008). Community development workers in secondary care are involved in promoting this kind of work locally. For instance with funding from the DRE, a Somali project has been established. Including several events held to consult with the Somali community. Also, a trust-wide conference was held, to demonstrate how equality and diversity is being addressed in the Trust. Central Bristol team members took an integral part by making presentations. These are good examples of positive attempts to address diversity issues at a Trust-wide level as well as in response to specific BME community's needs.

Fernando (2005) described successful projects that have served BME communities in the UK over the last 20 years and concludes that their success is usually due to strong leadership but also staff specific or matched to the cultural groups it seeks to serve. Moreover, the therapy it provides is not limited to the discussion of symptoms and diagnoses but extends to the social realm, with focus on dealing with racism. However, Fernando goes on to say that many of these have been non-statutory services and cannot be taken to represent widespread statutory multicultural practice. It is here that AWP can make some significant impact, promoting leadership activity within and outside of the Trust, to address specific community needs.

In central Bristol the local response to a need expressed by members of the black African and Caribbean community, has led to the evolution of 'The 2 Way Street'. This is in addition to other non-statutory services such as MIND and Rethink. This organisation has evolved out of a previous organisation 'Black Orchid' and been supported by AWP (Avon & Wiltshire Mental Health Partnership Trust), Bristol MIND, CSIP (Care Services Improvement Partnership), SURG (Service User Support Group) and the Bristol PCT (Primary Care Trust). Members of this group were keen to engage in this research, to have their voices heard about specific community needs whilst they continue to support individuals with mental health needs. This is evidence of positive strategic activity.

On a more cautionary note, Bhui & Sashidharan (2003), suggest that non-statutory organisations, such as the Bristol organisation '2 way street', flourish because statutory services are not taking their responsibilities to BME service users seriously enough with the provision of separate culturally competent care. Bhui & Sashidharan (2003) also suggest that there is little evidence that ethnic minority service user needs are different from anyone else or that different services are required. Instead, institutionalised practices (institutionalised racism and dominance of western psychiatry) are perpetuated, often for economic reasons. They go on to suggest that it is not until truly equitable services exist that all service user needs will be addressed. By relying on separate services means that mainstream services can feel that BME service users' needs are being met elsewhere. It may also be perceived that there is no need to develop cultural competence in all health professional groups, whether they are from BME groups or not. But if the care of BME service users is left only to non-statutory groups or BME staff, cultural competence is not developed equivalently, and it is at best ignored and at worst, ghettoised. These issues are important to understand in the local context. This can be done by engaging with the diverse range of staff who have high numbers of BME service users on their caseloads in central Bristol. To understand whether there truly is a difference in need or whether there remain institutional barriers.

## **Conclusion**

This local data indicates similarities to the national picture (CMI, 2008), where there is an over-representation of people from BME groups in mental health services. In this small sample it was not possible to gauge whether the experience of services is typical, nor whether it compares to the white service users experience. It is clear that staff should be both diverse and culturally competent and that in order to meet Department of Health recommendations, data collection and training should be high on the Trust agenda. It is now important to take the next step to understand the perspective of staff in central Bristol teams, in order to ascertain if they can indicate where services might be altered or improve to meet the needs of the diverse communities. Therefore the following recommendations arise from the data collected in this study.

## **Recommendations**

- 1, In the absence of additional funds to complete the third stages of this research, employ a student to investigate the health professional views of accessibility and suitability of mental health services to service users from BME backgrounds and barriers to service provision.
- 2, Teams should routinely examine the data they collect for the Trust but also audit their own referrals and caseloads for therapeutic services. For instance, nurse led CBT as well as referral to specialist services such as Psychology or Art therapy.
- 3, Revisit the workbook for cultural competence to understand its impact on practice. This means considering whether it continues to be useful or whether alternative training methods should be used.
- 4, Seek existing cultural competence toolkits available nationally as resources for central Bristol teams.
- 5, Responsive data collection methods need to be used in order to adapt to each teams requirement for data. Modifications of the Trust wide data collecting systems need to be considered in order that data can become increasingly useful at a service delivery level in service planning and design.
- 6, Provide more information about mental health services locally, so service users can make informed choices about which services are available and what they might do. This should include information about confidentiality.
- 7, Continued leadership support for voluntary sector groups working with BME communities

## References

Avon & Wiltshire Mental Health Partnership NHS Trust Race Equality Scheme – October 2006

Barclay, R. 2008, Evaluation of Bristol inner city mental health team delivery of RECC.

Bristol City Population projections:

<http://www.bristol.gov.uk/ccm/content/Council-Democracy/Statistics-Census-Information/population-estimates-and-projections.en>

Bhui, K. & Sashidharan, S.P. 2003, Should there be separate psychiatric services for ethnic minority groups? *British Journal of Psychiatry* 182, 10-12.

Bhui, K. Warfa, N. Edonya, P. McKenzie, K. & Bhugra, D. 2007 Cultural competence in mental health care: a review of model evaluations, *BMC Health Services Research* 7: 15.

Count Me In 2008 Census

[http://www.healthcarecommission.org.uk/db/documents/Count me in census 2008 Results of the national census of inpatients in mental health and learning disability services.pdf](http://www.healthcarecommission.org.uk/db/documents/Count%20me%20in%20census%202008%20Results%20of%20the%20national%20census%20of%20inpatients%20in%20mental%20health%20and%20learning%20disability%20services.pdf)

DH, 2000. National Service Framework for Mental Health: Modern Standards and Service Models, London.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009598](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598)

DH, 2003, Inside Outside- Improving Mental Health Services for Black and Minority Ethnic Communities in England

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4084558](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084558)

DH, 2004. The ten essential shared capabilities- a framework for the whole of the mental health workforce.

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4087169](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169)

DH, 2005. Delivering race equality in mental health care, an action plan for reform inside and outside services and the Governments response to the independent inquiry into the death of David Bennett

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4100773](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773)

DH, 2006. Our health, our care, our say: making it happen

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4139925](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139925)

DH, 2008. Commissioning IAPT for the whole community published 28<sup>th</sup> Nov

<http://www.iapt.nhs.uk/publications/>

Fernando, S. 2005 Multicultural Mental Health Services: Projects for Minority Ethnic Communities in England, *Transcultural Psychiatry* 42; 420.

Kastrup, M. 2008. Staff competence in dealing with traditional approaches, *European Psychiatry* 23 s59-s68.

Manthorpe, J. Iliffe, S. Moriarty, J. Cornes, M. Clough, R. Bright, L. Rapaport, J & OPRSI, 2009, 'We are not blaming anyone, but if we don't know about amenities, we cannot seek them out': black and minority older peoples views on the quality of local health and personal social services in England. *Ageing & Society*, 29, 93-113.

Office National Statistics, Census 2001  
<http://www.statistics.gov.uk/census/>

Singh, S. Greenwood, N. White, S & Churchill, R. 2007, Ethnicity and the Mental Health Act 1983- Systematic Review, *British Journal of Psychiatry*, 191, 99-105.

Taharka, End of Project Report 1996-2006.  
[http://www.bristolpct.nhs.uk/thetrust/Equality/publications/impact/taharka\\_final\\_report\\_april\\_2007.pdf](http://www.bristolpct.nhs.uk/thetrust/Equality/publications/impact/taharka_final_report_april_2007.pdf) Viewed 17/09/09

Williams, P, Turpin, G. & Hardy, G. 2006, Clinical Psychology Provision and Ethnic Diversity in the UK: A review of the literature, *Clinical Psychology and Psychotherapy*, 13, 324-338.