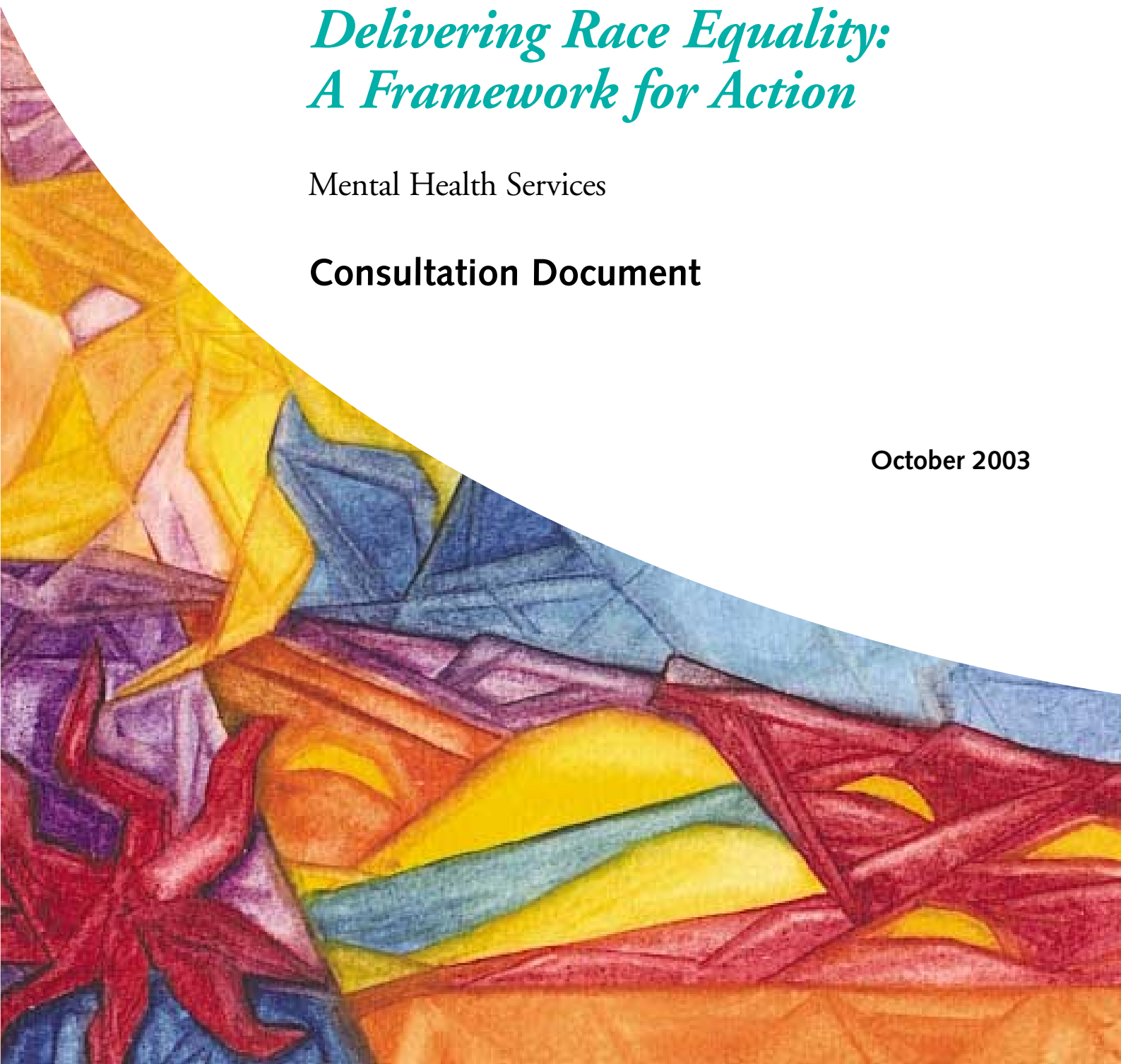# *Delivering Race Equality: A Framework for Action*

Mental Health Services

Consultation Document

October 2003

Delivering Race Equality: A Framework for Action

Mental Health Services

Consultation Document

CONTENTS

Executive Summary

This draft framework, which is being issued for consultation, sets out what those planning, delivering and monitoring local primary care and mental health services need to do to improve services for users experiencing mental illness and distress, and their relatives and carers, from Black and minority ethnic communities[1]. There is clear evidence that these users and their relatives and carers experience inequitable services and outcomes.

The document asks for views on what needs to be done at national level to provide support and leadership to those carrying out this work. The results of the consultation, including details of the work to be carried out at national level, will be published in the final version of this document in early 2004.

The framework should be taken forward by health and social care bodies and local authorities as part of the process of implementing, reviewing and improving their race equality strategies. Responsibility for monitoring health and social care bodies' compliance with the Race Relations Amendment Act lies with the national inspectorates, the Commission for Health Improvement (CHI) and the Social Services Inspectorate (SSI).

The document focuses on achieving improvements in three generic aspects of delivery (information, appropriate and responsive services and community engagement). These are termed the 'building blocks' as they are fundamental to delivering improvements in the outcomes and experiences of Black and minority ethnic users and their carers and relatives. The document then looks in detail at three specialist areas (suicide, pathways to care and acute inpatient care) of particular concern. Actions needed to be taken to comply with statutory obligations and assist in meeting existing national targets and other standards and commitments are set out for each 'building block' and for each specialist area.

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1   The term Black and minority ethnic is used throughout this document. This reflects that the focus of this document is not only on those for whom 'Black' is a political term, denoting those who identify around a basis of skin colour distinction or who may face discrimination because of this or their culture: 'Black and minority ethnic' also acknowledges the diversity that exists within these communities, and includes a wider range of those who may not consider their identity to be 'Black,' but who nevertheless constitute a distinct ethnic group.

Foreword by the Secretary of State for Health

In my first speech as Secretary of State I set out four principles or 'compass points' that will guide my way in leading implementation of the NHS Plan[2]:

- Services which are provided equally to those who need it, free at the point of need

- Offering to the public a personal service which is truly patient-centred

- Achieving sufficient increases in capacity to enable choice and diversity to be offered to patients

- Providing equity of access to care and a fair system.

Equity and fairness are key elements of these 'compass points'. We cannot provide a truly patient-centred and responsive service if we do not provide equal access to, and design services in partnership with, all sections of the community. Further, services are already under a statutory duty not only under the Health and Social Care Act 2001 to consult and involve patients and the public in their work, but also under the amended Race Relations Act to ensure that they consult all racial groups. These key pieces of legislation are consistent with the Government's wider drive to strengthen patient and public involvement. This major programme of initiatives will enable patients and their carers to be as involved as they want to be in decisions about their care and enable communities to be involved in their local health service.

Creating a diverse workforce that reflects and capitalises on the strengths and skills of *all* people, and designing and delivering services in partnership with all groups, are vital if we are to increase capacity within the system. If we do not achieve that increased capacity we will be unable to offer real choice and diversity of provision to patients. And merely offering choice of provision will not be enough – if equity is to be achieved we need to ensure that all groups within society are in a position to exercise that choice in a meaningful way.

Improving the provision of services to Black and minority ethnic communities, and ensuring that those communities are not only informed, but also willing and able to work in partnership with services, are not merely matters of fulfilling statutory obligations, important though those are. They are essential if we are to achieve our overall goals in modernising the health and social care system. While this holds true for all services, there has been particular concern for a number of years that adequate services and health outcomes have not been delivered to people from Black and minority ethnic communities experiencing mental illness and distress. There is clear evidence of the need to transform the services and outcomes experienced by these users and their relatives and carers.

The current situation is unacceptable and unsustainable since it contradicts the basic value of equity that is a cornerstone of the NHS. It is no good us pretending to have these values and failing to recognise we need to change in order to live up to them. We cannot both support the NHS principle of equity and allow the existing situation to continue.

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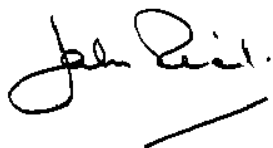
2   www.doh.gov.uk/speeches/jun03reidnhs.htm

This draft framework, which is being issued for consultation, sets out recommendations about what needs to be done to achieve the necessary improvements in primary care and mental health services. However the principles and approach of the framework have a wider applicability than the mental health field. I therefore commend this framework to all those responsible for planning, delivering and monitoring health and social care services.

I have appointed Professor Kamlesh Patel OBE, Chair of the Mental Health Act Commission and Director of the Centre of Ethnicity and Health at the University of Central Lancashire, to act as National Strategic Director of this work, working within the National Institute for Mental Health in England.

This consultation document asks for views on what needs to be done at national level to provide support and leadership to those carrying out this essential work. The results of the consultation, including details of the work to be carried out at national level, will be published in 2004.

It is vital those responsible for and working within primary care and mental health services carry out these improvements, so that we may meet our obligations not only to the law but equally importantly to the public we serve. In so doing they will be playing a key part in delivering our overall goal of a modern and equitable health and social care system.

JOHN REID
SECRETARY OF STATE FOR HEALTH

Foreword by the National Strategic Director

It was with mixed feelings that I accepted the post of acting National Strategic Director, charged with developing and implementing the Government's plans to improve mental health services for people from Black and minority ethnic communities. On the one hand I was honoured to have been asked, on the other, I was almost overwhelmed by the responsibility of effecting far-reaching changes in an area where there has been only sporadic progress for some 30 years. This early apprehension, however, was rapidly quelled by an enormous sense of excitement and enthusiasm, which I hope I will be able to share with you during the coming consultation period.

The over-arching vision of this framework is one of achieving changes both within mental health services and within the communities they serve – there is a strong emphasis on communities and services working together to achieve that change. The framework aims to:

- enhance the quality of life and challenge the exclusion of users and carers by delivering improved mental health services and health outcomes to people from Black and minority ethnic communities;

- support staff by providing them with appropriate training and guidance to deliver culturally competent services with confidence; and

- ensure services comply with statutory obligations under the Race Relations (Amendment) Act 2000 and the Human Rights Act 1998.

This document is intended to be a practical and useful tool that will help those involved in the design, development and delivery of mental health services to achieve the aims highlighted above. Support and leadership will be available at national level and the consultation period will gather views on the level and nature of the support required. However, the changes that are envisaged locally are also necessary at national level and therefore the consultation, further development and implementation of this framework will take place in conjunction with the development and implementation of a new Race Equality Scheme for the National Institute for Mental Health in England (NIMHE).

The approach to race equality and improving community relations that we are taking in NIMHE is one of mainstreaming; firmly embedded within the modernising government policy agenda. A 'tick box' approach is not acceptable under the monitoring arrangements for the Race Relations (Amendment) Act. The duty to promote race equality and good community relations is a positive duty. The Amendment Act seeks to drive up standards and create organisations that are pro-active rather than solely responding to complaints and acting defensively out of ignorance and fear. Race equality and improving community relations must and will be core components of NIMHE and embedded in all of the organisation's mainstream activities.

In the short time that I have been in post I have already had the opportunity of meeting many people that will be involved in implementing the final version of this framework – in the not too distant future I hope to meet many more. I have already been impressed by the commitment and enthusiasm that this vision is being received with. My commitment to you is to help you in whatever way I can, to listen to your views on this draft framework and to work pro-actively with you to make race equality and improved community relations a reality in mental health services.

Professor Kamlesh Patel, OBE
(Acting) National Strategic Director

1. Introduction

1.1 Providing equitable services that are designed around and responsive to the needs and wishes of individuals, reflecting the rich diversity of modern British society, is at the heart of the Government programme of public service reform. This includes the NHS Plan[3] and the Mental Health Modernisation Programme (MHMP). Since publication of the Mental Health National Service Framework (MHNSF)[4] in 1999, with its requirement in Standard 1 for the promotion of health and social inclusion, the introduction of the Human Rights Act 1998[5] and the Race Relations (Amendment) Act 2000[6] have provided a statutory framework setting out the obligations of health and social care services in relation to equality and human rights.

Case for action

1.2 Concerns have been expressed over a number of years that services are not being delivered to people from Black and minority ethnic (BME) communities experiencing mental illness and distress in a way that meets these obligations. The Mental Health Taskforce therefore commissioned Professor S P Sashidharan to look in detail at this area. *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*[7] was published in March 2003. Twelve consultations took place with the Black and African-Caribbean, South Asian, Chinese and Irish communities between December 2002 and March 2003. These consultations and the evidence set out in Inside Outside and other research, such as that undertaken by the University of Central Lancashire[8] and the Sainsbury Centre for Mental Health (SCMH)[9], and the Mental Health Act Commission[10] have shown that Black and minority ethnic people are more likely to experience:

- problems in accessing services;

- lower satisfaction with services;

- cultural and language barriers in assessments;

- lower GP involvement in care;

- inadequate community-based crisis care;

- lower involvement of service users, family and carers;

- inadequate support for Black community initiatives;

- an aversive pathway into mental health services:
  - higher compulsory admission rates to hospital;
  - higher involvement in legal system and forensic settings;
  - higher rates of transfer to medium and high secure facilities;

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3   www.doh.gov.uk/nhsplan/
4   NHS Plan – National Service Framework for Mental Health www.doh.gov.uk/nsf/mentalhealth.htm
5   Human Rights Act – www.humanrights.gov.uk/, http://www.doh.gov.uk/humanrights
6   Race Relations (Amendment) Act 2000 – www.homeoffice.gov.uk/comrace/race/raceact/index.html & www.cre.gov.uk/legaladv/rra_amend.html
7   Inside Outside (2003) NIMHE; www.nimhe.org.uk
8   Patel, Winters, Bashford & Bingley; Engaging & Changing (2003), NIMHE
9   Breaking the Circles of Fear (2002) Sainsbury Centre for Mental Health
10 Mental Health Act Commission 9th Biennial Report (2001)

- higher voluntary admission rates to hospital;

- lower satisfaction with hospital care;

- lower effectiveness of hospital treatment;

- longer stays in hospital;

- higher rates of readmission to hospital;

- less likelihood of having social care/psychological needs addressed within care planning/treatments processes;

- more severe and coercive treatments;

- lower access to talking treatments.

1.3   What the SCMH has termed 'circles of fear' have been created so that:

- many people, particularly in the Black African and Caribbean communities, do not believe that mainstream mental health services can offer positive help, so they delay seeking help;

- they therefore are not engaging with services at an early point in the cycle when they could receive less coercive and more appropriate services, coming instead to services in crisis when they face a range of risks including over and misdiagnosis, police intervention and use of the Mental Health Act;

- these aversive care pathways further influence both the nature and outcome of treatment and the willingness of communities to engage with mainstream services.

1.4   This situation is clearly unacceptable and unsustainable. Further, it constitutes an adverse and unjustifiable impact under the RR(A)A 2000 and as such there is a statutory obligation for remedial action to be taken. The main body of this document sets out the actions those responsible for and working in primary care and mental health services need to take to meet their statutory obligations and will help them to meet national targets and other standards and commitments. These actions are summarised at Annex A. The remaining annexes set out pointers for achieving improvements to services and examples of notable developments that have already taken place locally.

1.5   Successful delivery of the framework will require action by all responsible for planning, commissioning, delivering and monitoring primary care and mental health services. This work should not be seen as 'specialist' or separate. It is central to the modernisation of mainstream services. Implementation of this framework should help planners, commissioners and providers meet their national mental health delivery targets. It will be more difficult to meet national targets if the need of Black and minority ethnic groups are unmet, given their over-representation in certain aspects of mental health services (and their under-representation in others). For example, Black and minority ethnic patients are currently over-represented in both voluntary and compulsory hospital admissions, on average staying longer in hospital, and are more likely to be readmitted. Services, including those set up under the Mental Health Modernisation Programme such as early intervention, crisis services and assertive outreach teams, will need to take full account of the needs of these groups if they are to be as effective as possible in meeting their acute care targets.

1.6   This draft framework focuses on adults of working age, as does the overarching MHNSF. The needs of particular groups such as older people, children and adolescents, refugee and asylum seekers and prisoners are at present being dealt with elsewhere. The ultimate aim will be to ensure that these policies are fully integrated into a coherent programme[11].

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11   Older people – www.doh.gov.uk/nsf/olderpeople/index.htm; Children and adolescents – www.doh.gov.uk/nsf/children.htm
Refugee and asylum seekers – www.doh.gov.uk/asylumseekers/resourcepack.htm; Prisoners – www.doh.gov.uk/prisonhealth/ and
www.doh.gov.uk/prisonhealth/pdf/mhstrategy.pdf for strategy

1.7 The Department of Health (DH) is also publishing implementation guidance on gender and women's mental health. Both these documents will provide essential guidance on understanding and addressing the interplay between gender, race and cultural inequalities: a vital prerequisite to meeting the needs of women from Black and minority ethnic communities[12].

Consultation

1.8 The findings of *Inside Outside* have already been the subject of significant consultation with Black and minority ethnic communities, the results of which have fed into the development of this draft framework[13]. The Department of Health would now welcome comments not only from communities but also from service planners, commissioners and providers, and other key stakeholders, on this draft framework and its implementation. Details of the consultation process and a summary of the consultation questions are set out at Annexes H and I of this document. The document also asks for views on what needs to be done at national level to provide support and leadership to services implementing this guidance. Details of the work to be carried out at national level will be published in the final version of this document, in 2004.

1.9 The findings of the independent inquiry into the death of David Bennett[14] will also inform policy and practice developments.

Monitoring

1.10 Both services and populations vary greatly across the country. Positive practice undoubtedly exists and often results from the enthusiasm, hard work and commitment of health and social care staff, not least staff from Black and minority ethnic communities.

1.11 Examples of notable development are highlighted in the annexes to this document. Systems also, however need to be in place at both national and local level to ensure that bad practice is identified and rooted out.

1.12 Effective monitoring along with action where appropriate are essential components of the obligations placed on public bodies by the RR(A)A 2000. This framework for services should be taken forward by health and social care bodies and local councils as part of the process of implementing, reviewing and improving their race equality strategies and associated action plans formulated under the RR(A)A 2000. DH is working with a core group of Strategic Health Authorities to develop a template to assist monitoring progress on compliance with RR(A)A 2000 among NHS bodies, and to develop benchmark standards to assess progress of race equality in localities.

1.13 Responsibility for monitoring health and social care bodies' compliance with the RR(A)A 2000 lies with the national inspectorates, the Commission for Health Improvement (CHI) and the Social Services Inspectorate (SSI). Local councils also have a responsibility to focus on addressing inequalities and improving the access to services of their whole population. Responsibility for performance management of local councils lies with the Office of the Deputy Prime Minister (ODPM) and that of monitoring their compliance with the RR(A)A 2000 with the Audit Commission.

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12 Available from www.doh.gov.uk/mentalhealth/women.htm

13 Findings will be available from www.nimhe.org

14 David Bennett, a young Black man, died whilst an inpatient in Norfolk Mental Care NHS Trust in October 1998. His death followed a period of physical restraint. At the inquest the Coroner found that the cause of death was "accidental" aggravated by "neglect". An independent inquiry into his death is currently underway and findings are expected to be published later in 2003. Health Ministers have made a commitment that the inquiry findings will help shape future national policy and practice in mental health services.

1.14   Local Implementation Teams (LITs) will also continue to play a critical role at the centre of mental health services in bringing together key stakeholders in planning and reviewing services to deliver National Service Framework Standards and NHS Plan commitments. Increasingly, both to respond to the particular needs of the most deprived communities and ensure the development of neighbourhood level support systems, this will be achieved through linking LITs closely with partner organisations beyond mental health by way of the Local Strategic Partnership.

1.15   To ensure that we are on track to achieving the necessary improvements a full review of implementation of this framework for services, and progress on implementation of the national level action plan, will take place three years after this framework is finalised. The Department of Health will discuss with the national inspectorates how to take this forward. A full reassessment of the impact of mental health services on Black and minority ethnic communities, including public consultation, will be carried out in six years. The results of both will be published.

1.16   The rest of this document sets out the actions those responsible for and working in primary care and mental health services need to take to meet their statutory obligations and help them in meeting national targets and other standards and commitments.

2. The 'Building Blocks'

2.1   While recognising the broad range of potential issues that this framework could deal with, this document focuses on achieving improvements in three generic aspects of delivery. These are termed the 'building blocks' as they are fundamental to delivering improvements in the outcomes and experiences of Black and minority ethnic people using mental health services. The document then looks in detail at three specific areas (suicide, pathways to care and acute inpatient facilities) of particular concern. Action which needs to be taken to comply with statutory obligations and which can help to meet national targets and other standards and commitments are set out for each 'building block' and for each specialist area. They are summarised at Annex A. Pointers for improvements and notable development sites are set out in the remaining annexes.

2.2   The three generic 'building blocks' fundamental to the successful delivery of improved outcomes and experiences are:

- Better quality and more intelligently used information;

- More appropriate and responsive services;

- Increased community engagement.

2.3   These are complementary and all are necessary if the required improvements are to be made. Without **community engagement**[15] it will not be possible for individual care plans/treatments, and local services, to be designed around and capable of meeting the needs and aspirations of all racial and cultural groups within the local community. Community engagement will also improve the quality of the **information** available to commissioners and providers. This will enable them in turn to make services more **appropriate and responsive** to Black and minority ethnic communities, thus making the latter more willing to engage with services. Action to improve information, make services more appropriate and responsive and increase community engagement should create a virtuous circle capable of replacing the 'circles of fear'.

2.4   A range of mechanisms make up the Government's general drive to strengthen patient and public involvement. At a local level patients forums are being established to collect the views of service users and feed them directly into the local health decision-making process. At the national level the Commission for Patient and Public Involvement in Health will promote the greater involvement of the public in matters affecting their health and will report on the major trends and issues emerging from greater public involvement. Section 11 of the Health and Social Care Act 2001 places a duty on NHS bodies to involve and consult patients and the public in the planning and development of services and in decisions affecting the operation of services.

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15 See definition of community engagement in Winters, M. & Patel, K. (2003) 'The Department of Health Black and Minority Ethnic Drug Misuse, Needs Assessment Project Community Engagement Report 1'; University of Central Lancashire and Department of Health

Better quality and more intelligently used information

2.5   The identification of both good and bad practice, and the achievement of service improvements, require **good quality and intelligently used information**. This is a vital element of meeting the specific duty under the RR(A)A 2000 of monitoring the effect of services on different racial groups. Without comprehensive and good quality ethnic data, the bodies responsible for performance management and monitoring, such as Strategic Health Authorities (SHAs) will be unable to measure the success of efforts made at improving services for Black and minority ethnic people.

2.6   It is therefore essential that better quality ethnic data is comprehensively collected in both primary and secondary care[16]. It is vital that this is then used to inform the planning and commissioning of:

- culturally capable individual care plans and treatment;

- services capable of meeting the needs of all local communities (planned and commissioned by Primary Care Trusts, Mental Health Trusts, social care and local councils in partnership with local communities).

2.7   The Department of Health has issued guidance and training material on "Collecting Ethnic Category Data" to assist implementation of the new 2001 census ethnic categories[17]. The Chair of the Mental Health Act Commission was commissioned by the Department to provide a follow-up report to the Commission's National Visit No 2. One of the areas of focus in the report is best practice and recommendations on the collection of ethnic data in mental health services[18]. The mental health performance rating indicators for 2002-3 include an indicator on the quality of HES (hospital) data. HES data includes ethnic coding which should be improved as part of this process. The gender of the service user, as well as ethnicity (and other relevant data e.g. religion and language), should be identified so that any disparities in provision or access between men and women from individual ethnic categories can also be explored.

Action for services

2.8   **Those responsible for planning, delivering and monitoring services, both to individuals and collectively, need to ensure that good quality data on ethnicity is comprehensively collected and intelligently used. This is considered essential if services are to be able to meet their legal obligation under the RR(A)A 2000 to monitor the impact of services on all racial groups.**

2.9   The following actions should help achieve services achieve improvements in data:

Actions	Outcomes	Local Stakeholders
Identify and record patients' ethnicity[19] (and gender and other relevant data) Ensure staff, patients and their relatives/carers understand the importance of ethnicity data for improving services Map ethnic information throughout care pathways to inform decisions about appropriate treatment/services Trust Boards monitor and review collection and use of ethnic information as part of the Clinical Governance process	Compliance with RR(A)A 2000 requirements on monitoring Ethnicity taken into account in planning and delivery of services to individuals.	Commissioners, planners and providers of primary care and specialist mental health services and social care

16 SSI Modernising Mental Health Services: Inspection of Mental Health Services 2002; also see Warner et al (2000) MHAC National Visit no 2: The Sainsbury Centre for Mental Health and Mental Health Commission and University of Central Lancashire

17 www.doh.gov.uk/ethnicity2001guidance

18 See Engaging and Changing (2003)

19 see Departmental guidance www.doh.gov.uk/ethnicity2001guidance

Actions	Outcomes	Local Stakeholders
Gather local demographic data and conduct with communities needs assessments, including understanding how different cultures within the area regard mental ill health Use ethnic data strategically to map representation and plan services designed around these different needs/understandings	Compliance with RR(A)A 2000 requirements on monitoring and consultation Compliance with local councils' responsibility to address health inequalities and to consider the well being of residents Ethnicity taken into account in collective planning and delivery of services.	Local council planners and primary care trust commissioners
Monitor collection and use of ethnic data Monitor local services for impact on different racial groups using outcome and performance indicator data. Mechanisms might include monitoring of local delivery plans, SSD annual user surveys and development of local benchmarking. Look for outliers and take action as appropriate.	Compliance with RR(A)A 2000 requirement on monitoring impact of services.	Strategic Health Authorities, local councils.

2.10   Examples of notable developments relating to information in local areas are set out in Annex B.

> *Consultation questions*
>
> *1. Are there any barriers to services meeting their obligations in relation to the collection and use of ethnicity data? Please give any examples of plans to overcome these barriers or how they have already been overcome.*

Appropriate and responsive services

2.11   There is evidence that mental health services need to become more **appropriate and responsive** to the needs and wishes of Black and minority ethnic communities[20]. Health and social care bodies need to develop a better understanding of their organisational culture and how it interacts with the cultures of the local population they serve, and to identify learning needs on both an organisational and individual level. Staff need to be given the tools to enable them to deliver services to and in partnership with the various groups within the local population with confidence and sensitivity. This will help them meet DH's Public Service Agreement (PSA) target to secure sustained national improvements to patient experience. Improving patient experience is one of the priorities set out in the Planning and Priorities Framework[21].

2.12   DH has already highlighted the importance of achieving a culturally capable workforce, stating that cultural and racial issues will be an integral part of pre-qualification training for all health care workers, and services will be expected to be staffed by people who represent the community they serve[22].

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20 Social Services Inspectorate Inspection Report (2002) Modernising Mental Health Services; Inside Outside (2003), NIMHE; National Visit 2 (2000) The Sainsbury Centre for Mental Health & Mental Health Act Commission & University of Central Lancashire; Engaging and Changing (2003)

21 Improvement, Expansion and Reform: the next three years (www.doh.gov.uk/planning2003-2006)

22 www.doh.gov.uk/mentalhealth/journeytorecovery.pdf

2.13   DH promotes equality in the NHS through the national programme *Improving Working Lives* (IWL)[23], and supports NHS employers to achieve IWL standards and national equality targets through the *Positively Diverse* programme[24]. The Modernisation Agency's Leadership Centre is running a major programme of leadership development for Black and minority ethnic staff. The *Breaking Through Programme*, which was announced as part of the NHS *Managing for Excellence* initiative last year, is targeted at aspiring directors and senior managers and will be launched later this year. The aim of the programme is to provide a national leadership development programme for Black and minority ethnic staff across the NHS and to increase the number of BME staff at executive level. In addition, the Leadership Centre runs *Getting on Against the Odds*, a pilot project aimed at promoting more diverse and representative nurse leadership.

2.14   SSI collects data on performance indicators of the cultural sensitivity of assessment processes and services as part of its annual performance assessment round relating to social services.

2.15   DH is sponsoring a transformational change programme in race and health that brings together PCTs to pioneer and model inclusive ways of partnership working with Black and minority ethnic communities, to improve the cultural appropriateness of primary care services and deliver a wider choice for service users.

2.16   The National Visit 2 follow up report sets out best practice and recommendations around interpreting services and training in mental health services[25]. Specific guidance has been issued to services:

- on cultural sensitivity in *The Mental Health Policy Implementation Guide* (2001)[26];

- NIMHE *Cases for Change* summary 2003 of recent research on anti-discriminatory practice in mental health services[27].

2.17   The Department is currently developing guidance on:

- how to provide services that are appropriate and responsive to women service users, including those from Black and minority ethnic communities[28];

- the value of spirituality in the treatment of mental health problems (a particular important issue for understanding and aiding the recovery of many Black and minority ethnic patients).

2.18   Assessment of the extent to which mental health services are appropriate and responsive to Black and minority ethnic communities needs to be undertaken to meet the RR(A)A 2000 requirement of assessing and monitoring the impact of services on different racial groups, with appropriate action taken where improvements need to be made. Training will be an important component of this work. This will also help services meet their obligation under the RR(A)A 2000 to train staff on general duty to:

- promote equality of opportunity;

- promote good relations between people of different racial groups;

- eliminate unlawful racial discrimination.

23 www.doh.gov.uk/iwl
24 www.doh.gov.uk/positivelydiverse
25 See Engaging and Changing (2003)
26 www.dog.gov.uk/mentalhealth/implementationguide.htm
27 www.nimhe.org.uk/whatshapp/publications.asp
28 Mainstreaming Gender and Women's Mental Health: Implementation Guidance (2003); [www.doh.gov.uk/mentalhealth/women.htm]

Action for services

2.19   **It is a legal requirement that staff be trained on the general duty under the RR(A)A 2000 to promote race equality and good race relations and to eliminate unlawful racial discrimination. It is considered essential that the extent to which mental health services are appropriate and responsive to the needs and wishes of Black and minority ethnic communities be considered as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups. The Act requires that remedial action be taken where adverse and unjustifiable impact is identified.**

2.20   The following actions will help achieve this:

Key Actions	Outcomes	Local Stakeholders
Make workforce representative of the community it serves.	Meet DH commitment on representative workforce. Increased willingness of Black and minority ethnic communities to engage with services.	Commissioners, planners and providers of primary care and specialist mental health services and social care
Assess individual and organisational learning/development needs. Promote and enable staff to undertake training on RR(A)A 2000 general duty.	Compliance with RR(A)A 2000 requirement on training. Staff have the knowledge and skills to enable them to deliver services to and in partnership with all groups in their community with confidence and sensitivity. Patient experience improved (PSA target). Communities feel more confident in services and readier to engage with them voluntarily.	Planners, commissioners and providers of mental health services, including GPs and primary care workers and the social care and independent sector Education commissioners Workforce Development Confederations
Develop benchmarks and monitor progress on appropriateness and responsiveness of services. Look for outliers and take action as appropriate.	Compliance with RR(A)A 2000 requirement to monitor impact of services. Those with monitoring responsibilities assured that services comply with RR(A)A 2000 requirements and are responsive to the needs and wishes of Black and minority ethnic communities.	Strategic Health Authorities and local councils.

2.21   Pointers to help services achieve these improvements, and examples of notable developments in local areas, are set out in Annex C.

> ***Consultation questions***
>
> 2.   *Are there any barriers to services meeting their obligations and commitments in relation to providing services that are appropriate and responsive to the needs and wishes of Black and minority ethnic communities? Please give any examples of plans to overcome these barriers or how they have already been overcome.*
>
> 3.   *What sort of support would services find helpful from other bodies (e.g. NIMHE Development Centres, Workforce Development Confederations) in this area?*
>
> 4.   *What do communities/voluntary and community sector (VCS) think they can contribute to helping services become more appropriate and responsive?*

Increased community engagement

2.22   While such internal improvements to services are necessary, they are not themselves sufficient to effect the necessary changes. These cannot be delivered without **community engagement**. Services designed around the needs and wishes of service users cannot be achieved without listening to what communities want and being able to act on this. Section 11 of the Health and Social Care Act 2001 requires Strategic Health Authorities, PCTs and NHS Trusts to make arrangements to involve and consult patients and the public. The departmental guidance on this duty highlights the need to design services "with local populations, not for them"; and the important role of local compacts between NHS and other public organisations and the voluntary and community sector[29]. Compacts are supported by national codes of good practice including a code on Black and minority ethnic voluntary and community groups[30].

2.23   In carrying out this duty, it is important that services are also mindful of their specific duty under the RR(A)A 2000 to consult with and make information on services available to all racial groups. The duties under s11 of the Health and Social Care Act 2001 and the RR(A)A 2000 are thus complementary. The Department's patient and public involvement programme to improve patient experience includes establishing Patients' Advice and Liaison Services in NHS and PCT Trusts locally and creating the Commission for Patient and Public Involvement in Health (CPPIH). CPPIH is a new national patient body that has a remit to establish Patients' Forums in every Trust, and monitor provision of new Independent Complaints Advocacy Services (ICAS)[31]. Services are further required under MHNSF Standard 1 to work with vulnerable groups and individuals at risk and to tackle social exclusion. Work to develop and engage with Black and minority ethnic communities also promotes the Government's overall aim to increase the role of the voluntary and community sector in service delivery, and to promote social cohesion and regeneration[32].

2.24   To meet the general duty of the RR(A)A 2000 of promoting equality of opportunity and good relations between racial groups, commissioners and providers need to recognise and proactively address the dissatisfaction with and disengagement from mental health services of some communities. To achieve this a partnership needs to be built with Black and minority ethnic communities who need to be fully involved in not only planning and designing but also, where appropriate, delivering services[33]. Through

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29 Strengthening Accountability: Involving Patients and the Public DH 2003; www.doh.gov.uk/involvingpatients/strengthaccountpolicy.pdf

30 www.thecompact.org.uk/PDFs/ BMEcode.pdf.

31 see www.doh.gov.uk/involvingpatients/ and www.cppih.org

32 See www.socialexclusionunit.gov.uk, www.homeoffice.gov.uk/comrace/cohesion/; www.neighbourhood.gov.uk/ and *The Role of the Voluntary and Community Sector in Service Delivery: A Cross Cutting Review* HM Treasury 2002.

33 Inside Outside (2003), NIMHE; Breaking the Circles of Fear (2002) SCMH; SSI Inspection of Mental Health Services 2002

such work the alienation from services of some communities may lessen, with fear and suspicion decreasing leading to increased willingness to engage voluntarily and early with services.

2.25   The Planning and Priorities Framework provides for 500 BME Community Development Workers (CDWs) to be recruited by 2006 to help services take forward this work with Black and minority ethnic communities[34]. NIMHE's chosen method for recruiting these workers is through the innovative and proven process of community engagement. The CDWs will be the catalysts for:

- providing the exchange of information, knowledge and skills between mental health services and the communities they serve;

- creating the environment where communities can have meaningful involvement in planning, and where possible delivery of, services;

- increasing community confidence in services;

- obtaining community endorsement for local mental health strategies.

2.26   Further details on the recruitment and role of the CDWs will be provided separately to services.

2.27   NIMHE is currently developing good practice models on:

- commissioning VCS groups to provide mental health services;

- community resilience;

- effective promotion of mental health with Black and minority ethnic communities.

2.28   NIMHE has also commissioned, jointly with the Voluntary and Community Sector (VCS) Mental Health Providers Forum, a report setting out choices in commissioning and how to maximise the involvement of the VCS in the provision of mental health services.

Action for services

2.29   **It is a legal requirement that services make information available to and consult all racial groups. Those responsible for planning and delivering services need therefore to involve and build a partnership with Black and minority ethnic communities, with progress assessed by those responsible for monitoring services.**

2.30   The following actions will help achieve this:

Key Actions	Outcomes	Local Stakeholders
Ensure information on services, including information for carers, is made accessible to the local community, in forms which take into account issues such as literacy levels	RR(A)A 2000 compliance (public access to information about services)	All providers of mental health services, including GPs and primary care workers

34 Improvement, Expansion and Reform: The Next Three Years – Priorities and Planning Framework 2003-2006 (www.doh.gov.uk/planning2003-2006)

Key Actions	Outcomes	Local Stakeholders
Support the community engagement process of recruiting and developing Black and minority ethnic Community Development Workers (further details to be issued separately).	Delivery of PPF target on CDWs. Better links and understanding between communities and statutory services.	Planners and commissioners.
Integrate consultation with and representation of Black and minority ethnic VCS specialist services, community and faith groups into the strategic planning process and key joint planning groups Put in place robust mechanisms to ensure this representation is underpinned by consultation and engagement with the wider local Black and minority ethnic community	Compliance with: • s11 Health and Social Care Act 2001 (involvement of and consultation with patients and the public) • MHNSF Standard 1 (work with vulnerable groups and individuals at risk and tackle social exclusion) • RR(A)A 2000 (consultation with all racial groups and promotion of good community relations). Services better reflect the needs and aspirations of Black and minority ethnic communities, making them more willing to engage voluntarily with services. Patient experience improved (PSA target).	Planners and commissioners, providers and local councils.
Develop benchmarks of and monitor progress on community engagement, referring to relevant local government targets/activity. Account should be taken of local councils' responsibility to maximise the impact of initiatives and synergy across activities. Look for outliers and take action as appropriate.	Assurance that services are complying with the above requirements and adequately engaging Black and minority ethnic communities with planning and delivery of services.	SHAs and local councils.

2.31   Pointers to help services engage local Black and minority ethnic communities, and examples of notable developments in local areas, are set out in Annex D.

> ***Consultation questions***
>
> 5. *Are there any barriers to services meeting their obligations and commitments in relation to working with Black and minority ethnic communities? Please give any examples of plans to overcome these barriers or how they have already been overcome.*
>
> 6. *What sort of support would services find helpful from other bodies (e.g. NIMHE Development Centres, Workforce Development Confederations) to help their organisations take forward this work, other than that described above?*
>
> 7. *What issues do communities and the VCS think are particularly important?*
>
> 8. *What do communities and VCS think they can contribute to helping create a partnership with services?*

3. Specific Areas of Concern

3.1   Having focused above on the three generic 'building block' processes, fundamental to delivering improved outcomes and experiences for people from Black and minority communities in all aspects of mental health services, this document now turns to three specific service areas that are of particular concern:

- suicide;

- pathways to care;

- acute in-patient facilities.

Suicide

3.2   The Case for Action in *Inside Outside* highlights the significantly raised risk of suicide and attempted suicide among young women born in India/East Africa and Irish-born men. Cutting the suicide rate by 20% by 2010 is a key national mental health target. Catering for the needs of the above high risks groups is a vital component of meeting this target.

Action for services

3.3   **It is considered essential that to meet the key national target on suicide reduction those responsible for planning and delivering services address the high suicide risk of vulnerable groups, including young women born in India/East Africa and Irish-born men.**

3.4   Catering for the needs of vulnerable groups is already being taken forward through the Suicide Prevention Strategy[35]. The Department is working towards collecting information on ethnicity by coroners. This work will also be significantly progressed by implementation of the 'building blocks' outlined earlier in this document. Progress in building partnership with communities will be particularly important as will taking into account issues relating to gender as set out in the Women's Implementation Strategy.

3.5   Those planning and delivering services need to be aware of the needs of vulnerable groups so that they may be factored into clinical practice. An example of notable practice development is given at Annex E.

> *Consultation questions*
>
> *9.   Are there any barriers to services taking forward the Suicide Prevention Strategy in relation to vulnerable Black and minority ethnic groups? Please give any examples of plans to overcome these barriers or how they have already been overcome.*
>
> *10. What support would communities and the VCS find helpful in relation to this area?*

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35   www.doh.gov.uk/mentalhealth/suicideprevention.htm

Pathways to care

3.6   The second area of particular concern relates to pathways to care. The issues highlighted have been as follows[36]:

- increased risk of following aversive pathways into specialist mental health care (treatment delay being a particularly significant factor for African and African-Caribbean patients);

- increased risk of GP not recognising mental health problems/wrongly attributing the nature of their presentation to mental illness (African and African-Caribbean and South Asian patients);

- GPs less likely to feel involved in the care of Black and minority ethnic patients with severe mental illness;

- some patients more likely to access GPs only after long delays;

- absence of GP involvement strongly associated with police involvement and compulsory admissions;

- increased risk of involvement in the legal system in both voluntary and compulsory admissions;

- increased risk of hospital admission (particularly African and African-Caribbean and Irish patients);

- increased risk of compulsory admission (particularly African and African-Caribbean patients);

- lower access to 'talking treatments' rather than medication;

- many African and African-Caribbean people do not believe that mainstream mental health services can offer positive help, so they delay in seeking help;

- they therefore are not engaging with services at an early point in the cycle when they could receive less coercive and more appropriate services, coming instead to services in crisis when they face a range of risks including over and misdiagnosis, police intervention and use of the Mental Health Act. Primary care involvement is limited and community-based crisis care lacking;

- the aversive care pathways of African and African-Caribbean users influence both the nature and outcome of treatment and the willingness of those communities to engage with mainstream services.

3.7   Action in this area is therefore vital to fulfil the RR(A)A 2000 general duty of promoting race equality in services and outcomes and to meet the PSA target concerning increased access to crisis services. Under the Mental Health Modernisation Programme DH has already made funding available for the recruitment of new workers – gateway workers, early intervention teams, assertive outreach teams, crisis resolution/home treatment teams and graduate primary care workers – with the potential significantly to improve users' pathways to care. DH's guidance on the role and recruitment of these workers highlighted the importance of cultural capability and of teams reflecting the local population, and of engaging Black and minority ethnic communities in their work. As noted above, the Department is also to make funding available for the recruitment of Black and minority ethnic Community Development Workers.

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36 Engaging and Changing (2003), MHAC National Visit no 2 (2000), Mental Health Act Commission (2001), Inside Outside (2003); Circles of Fear (2002)

Action for services

3.8 **It is considered essential that those responsible for monitoring local services monitor the pathways into and out of care of Black and minority ethnic groups, particularly African and African-Caribbean men, with the objective of making these less aversive in nature, as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups, with remedial action taken where adverse and unjustifiable impact is identified.**

3.9 Implementation of the 'building block' actions set out earlier in this document should achieve significant progress. Those with monitoring responsibilities in relation to health and social care should also develop benchmarks of and monitor progress on Black and minority ethnic pathways to care. They should look for outliers and take action as appropriate.

3.10 Pointers to help services achieve less aversive pathways, and examples of notable developments in local areas, are set out in Annex F.

Consultation questions

11. Are there any barriers to services creating a better pathway into and out of mental health services for Black and minority ethnic users, including relationships with other agencies? Please give any examples of plans to overcome these barriers or how they have already been overcome.

12. What sort of support would services find helpful from other bodies in this area?

13. What is the role of other agencies in helping achieve more acceptable pathways to care for Black and minority ethnic users?

14. What impact do services and communities/VCS think that the new workers/teams under the MH Modernisation Programme have had on this issue?

15. What do communities/VCS think they can contribute to helping services improve user pathways?

Acute in-patient facilities

3.11 The third area of particular concern relates to acute inpatient facilities. The issues highlighted have been[37]:

- acute care perceived as particularly negative and often does not aid recovery (African and African-Caribbean patients);

- increased risk of coercive care (particularly African and African-Caribbean and Irish patients);

- increased risk of transfer/admission to secure units, particularly medium secure facilities;

- increased risk of transfer/admission to high secure facilities (African and African-Caribbean patients);

- more time spent on average in hospital;

- less likely to have social care/psychological needs addressed within care planning/treatments processes;

- increased risk of readmission;

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37 Engaging & Changing (2003); MHAC National Visit no 2 (2000); Inside Outside (2003); Circles of Fear (2002); Mental Health Act Commission (2001)

- lack within many acute units of policies on:
  - recording and use of ethnic data, cultural capability training, and access to interpreters (for more on these issues see generic 'building blocks' recommendations earlier in this framework) and:
  - comprehensive policies on dealing with racism including patient to patient racism.

3.12 Action is needed to ensure services fulfil their statutory obligations under the Human Rights Act as well as the Race Relations Amendment Act. In meeting these obligations services will need to give consideration to the differing needs and wishes of women and men patients within acute inpatient facilities[38]. The Department has specified National Minimum Standards in Psychiatric Intensive Care Units (PICUs) and Low Secure Environments which stated that equal opportunity and racial harassment policies and monitoring systems should be in place and should cover both staff/patient and patient/patient harassment[39]. The follow up report to the MHAC National Visit no 2 – Engaging and Changing[40] – includes examples of best practice and recommendations on racial harassment policies. DH's guidance on Adult Acute Inpatient Care Provision[41] highlights the importance of sensitivity to gender and cultural needs and requires each NHS Trust to establish an Acute Care Forum involving service users and carers and highlights the role of Clinical Governance mechanisms. The Department will also be giving careful consideration to the recommendations of the Inquiry into the death of David Bennett once published.

Action for services

3.13 **It is considered essential that those responsible for planning and delivering acute services ensure they are appropriate and responsive to the needs and wishes of Black and minority ethnic patients and more effective in their treatment, with progress assessed by those responsible for monitoring services, as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups, with remedial action taken where adverse and unjustifiable impact is identified.**

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38 www.doh.gov.uk/mentalhealth/women.htm
39 www.doh.gov.uk/mentalhealth/dualdiagnosis.htm
40 Engaging and Changing (2003)
41 www.doh.gov.uk/mentalhealth/dualdiagnosis.htm

3.14   The following actions will help achieve this:

Key Actions	Outcomes	Local Stakeholders
Systematically review (through Clinical Governance mechanisms, and those created by implementation of the Adult Acute Inpatient Care Provision Guidance) in co-operation with Black and minority ethnic communities, the provision of acute inpatient care for male and female Black and minority ethnic mental health patients. Set up appropriate monitoring arrangements within Clinical Governance mechanisms. Make plans to reduce the re-admission rates of Black and minority ethnic patients, including consideration of the role of home treatment, assertive outreach and early intervention teams Ensure Black and minority ethnic involvement in the local Acute Care Forum, including the Black and minority ethnic VCS. Develop and implement racial harassment policies, covering patient/patient as well as staff/patient.	Compliance with Human Rights Act and Race Relations Amendment Act. Compliance with departmental guidance on PICUs and Adult Acute Inpatient Care Provision. Provision of care in acute inpatient facilities more appropriate to needs of male and female Black and minority ethnic patients. Treatment in acute inpatient care more effective in aiding recovery. Fear of acute inpatient care among some Black and minority ethnic communities lessened making them more willing to engage early with mental health services.	Providers of acute inpatient mental health care
Develop benchmarks of and monitor progress on provision of acute psychiatric care to Black and minority ethnic patients. Look for outliers and take action as appropriate. Ensure Black and minority ethnic involvement in the Acute Care service improvement and practice development network.	Assurance that acute facilities are: • capable of meeting the needs and aiding recovery of Black and minority ethnic patients • compliant with the Human Rights and Race Relations Acts.	Mental Health Trusts, SHAs and local councils

3.15   Pointers for achieving improved care are set out in Annex G, along with examples of notable development in local areas.

Consultation questions

16. Are there any barriers to services meeting their obligations and commitments in relation to improving acute inpatient facilities for Black and minority ethnic users? Please give any examples of plans to overcome these barriers or how they have already been overcome.

17. What do communities/VCS think are the main areas in which improvements should be made in acute inpatient facilities for Black and minority ethnic users and their relatives and carers?

18. What has been the impact of new structures such as the Acute Care Forums?

19. How else can communities/VCS contribute to helping services improve these facilities for Black and minority ethnic users and carers?

4. Conclusion

4.1   The goal of this draft framework is to achieve over the next decade services whose planning and delivery better reflect on both an individual and aggregate level the needs and aspirations of Black and minority ethnic people experiencing mental illness and distress, and their relatives and carers. Service provision needs to become appropriate and acceptable to Black and minority ethnic users and communities. Our aim is that their treatment will thus become more effective in aiding recovery, with users and carers feeling more confident in and satisfied with the service they receive. The fear of mental health services, especially acute inpatient care, currently felt by some communities will thereby lessen, leading to a greater readiness to engage early and voluntarily with services. The pathways to care of Black and minority ethnic users will thus re-align with the majority population, with fewer entering services compulsorily and/or via the criminal justice system.

4.2   These changes are significant and will not be delivered overnight. Tackling inequalities in mental health services is a complex and challenging task. This framework is designed to enable services to make step changes by focusing on three fundamental building block processes (information, appropriate and responsive services, and community engagement) and highlighting three priority areas where action is needed (suicide, pathways to care and acute inpatient facilities).

4.3   Implementation of this framework will help services achieve the following improvements:

Information/monitoring

- Compliance with RR(A)A 2000 duties relating to assessing/monitoring impact of services;

- Ethnicity taken into account in:
    – planning and delivery of services to individuals
    – collective planning and delivery of services
    – monitoring of services.

Appropriate and responsive services

- Compliance with RR(A)A 2000 training duty;

- Appropriateness and responsiveness of mental health services to Black and minority ethnic communities assessed and monitored, with action taken where appropriate;

- Staff given tools to enable them to deliver services to and in partnership with all groups in the local community with confidence and sensitivity;

- Patient experience thereby improved (PSA target).

Community engagement

- Compliance with statutory obligations under Health and Social Care Act 2001 and RR(A)A 2000 in relation to informing, involving and consulting with communities and promoting good community relations, and requirement under MHNSF Standard 1 to work with vulnerable groups and individuals at risk and to tackle social exclusion;

- Black and minority ethnic communities including VCS more effectively and sustainably involved in planning, designing, commissioning and delivery of services;

- Patient experience improved (PSA target).

Suicide prevention

- Help achieve PSA target on suicide reduction;

- Needs of high-risk groups taken into account in treatment and service planning.

Pathways to care

- Remedy adverse impact under RR(A)A 2000;

- Black and minority ethnic pathways to care monitored and action taken where appropriate.

Acute inpatient facilities

- Remedy adverse impact under RR(A)A 2000 and compliance with Human Rights Act;

- Provision of care in acute inpatient facilities more appropriate to needs of male and female Black and minority ethnic patients, and treatment more effective in aiding their recovery.

4.4 The process of implementing this framework will itself have wider benefits. It will act as a catalyst for significant individual and organisational learning and development within services. It will thus help achieve the culture change needed if health and social care organisations are to provide services that listen to, and improve the experience of, patients and communities. This framework will therefore assist the health and social care system not only to fulfil its statutory obligations in relation to race equality, community relations and human rights, but also to provide equitable services responsive to the needs and wishes of all individuals and communities within modern Britain.

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Annex A

Summary of Actions Considered Necessary to Meet Statutory Obligations and Assist in Achieving National Targets, Standards and Commitments

A.1   **Those responsible for planning, delivering and monitoring services, both to individuals and collectively, need to ensure that good quality data on ethnicity is comprehensively collected and intelligently used. This is considered essential if services are to be able to meet their legal obligation under the RR(A)A 2000 to monitor the impact of services on all racial groups.**

A.2   **It is a legal requirement that staff be trained on the general duty under the RR(A)A 2000 to promote race equality and good race relations and to eliminate unlawful racial discrimination. It is considered essential that the extent to which mental health services are appropriate and responsive to the needs and wishes of Black and minority ethnic communities be considered as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups. The Act requires that remedial action be taken where adverse and unjustifiable impact is identified.**

A.3   **It is a legal requirement that services make information available to and consult all racial groups and promote good community relations. Those responsible for planning and delivering services need therefore to involve and build a partnership with Black and minority ethnic communities, with progress assessed by those responsible for monitoring services.**

A.4   **It is considered essential that to meet the key national target on suicide reduction those responsible for planning and delivering services address the high suicide risk of vulnerable groups, including young women born in India/East Africa and Irish-born men.**

A.5   **It is considered essential that those responsible for monitoring local services monitor the pathways into and out of care of Black and minority ethnic groups, particularly African and African-Caribbean men, with the objective of making these less aversive in nature, as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups, with remedial action taken where adverse and unjustifiable impact is identified.**

A.6   **It is considered essential that those responsible for planning and delivering acute services ensure they are appropriate and responsive to the needs and wishes of Black and minority ethnic patients and more effective in their treatment, with progress assessed by those responsible for monitoring services, as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups, with remedial action taken where adverse and unjustifiable impact is identified.**

A.7   To achieve this:

Commissioners, planners and providers of primary care and specialist mental health services and social care should:

- Identify and record patients' ethnicity and gender (and other key data) (see Departmental guidance EL(94)77);

- Ensure staff, patients and their relatives/carers understand the importance of ethnicity data for improving services;

- Map ethnic information throughout care pathways to inform decisions about appropriate treatment/services;

- monitor and review collection and use of ethnic information as part of the Board level Clinical Governance process;

- Ensure information on services, including information for carers, is available in all languages spoken in local area, in forms that take into account issues such as literacy levels;

- Assess individual and organisational learning/development needs;

- Promote and enable staff to undertake training;

- Raise awareness of the needs of groups at high risk of suicide so that these may be taken into account in clinical practice.

Providers of acute mental health care should:

- Systematically review (through Clinical Governance mechanisms, and those created by implementation of the Adult Acute Inpatient Care Provision Guidance) in co-operation with the Black and minority ethnic community, the provision of acute inpatient care for male and female Black and minority ethnic mental health patients;

- Set up appropriate monitoring arrangements within Clinical Governance mechanisms;

- Make plans to reduce the re-admission rates of Black and minority ethnic patients, including consideration of the role of assertive outreach and early intervention teams;

- Ensure Black and minority ethnic involvement in the local Acute Care Forum, including the Black and minority ethnic VCS;

- Develop and implement racial harassment policies, covering patient/patient as well as staff/patient.

Local council planners and Primary Care Trust commissioners should:

- Gather local demographic data and conduct with communities needs assessments including understanding how different cultures within the area regard mental ill health;

- Use ethnic data strategically to map representation and plan services designed around these different needs/understandings;

- Support the community engagement process of recruiting and developing BME Community Development Workers (further details to be issued separately);

- Integrate consultation with and representation of Black and minority ethnic VCS specialist services, community and faith groups into the strategic planning process and key joint planning groups;

- Put in place robust mechanisms to ensure this representation is underpinned by consultation and engagement with the wider community;

- Raise awareness of the needs of groups at high risk of suicide.

Strategic Health Authorities and local councils should:

- Monitor collection and use within mental health services of ethnic data;

- Monitor local services for impact on different racial groups using outcome and performance indicator data. Look for outliers and take action as appropriate. Account should be taken of local councils' responsibility to maximise the impact of initiatives and synergy across activities. In particular develop benchmarks and monitor progress within mental health services, taking action where appropriate, on:
  - Appropriateness and responsiveness of services
  - community engagement, making reference to relevant local government targets/activity
  - pathways to care of Black and minority ethnic patients
  - provision of acute inpatient psychiatric care to Black and minority ethnic patients;

- Ensure involvement of people from Black and minority ethnic communities in the Acute Care service improvement and practice development network.

Annex B
Information

Notable Development Sites: Patient Profiling

Princes Park Health Centre, Liverpool serves approximately 8000 patients in a deprived area with a high proportion of Black and minority ethnic communities. It undertook a project in 1997 to take a fresh look at patient profiling having previously carried out such profiling opportunistically. A form was designed to collect self-ascribed ethnicity supplemented by questions exploring patients' family origins. Other relevant data were collected including access to a car and telephone, language spoken and written, and requirements for interpreting. Information was collected on specific illnesses and patient satisfaction. Forms were posted as well as given out opportunistically. Health link workers helped patients whose first language was not English. Practice staff and local community groups were involved throughout. A patient profile was produced. Differences in morbidity profiles and satisfaction for patient groups defined by ethnicity and socio-economic status were highlighted. Ethnicity profiling has become mainstream at the practice and brought about changes in service delivery. Patient profiling has since been extended to other local practices by Central Liverpool PCT and approximately 25,000 patients have so far been profiled.

Contact: See NW Public Health Observatory report on www.nwpho.org.uk (search under Ethnicity); or
www.centralliverpoolpct.nhs.uk/initiatives/diversity, or telephone the Health Inequalities
Resource 0151 285 2078.

Notable Development Site: Monitoring

SW London and St George's Mental Health Trust makes ethnicity recording of service users a regular part of its Clinical Governance report. Its top priorities include the improvement of data quality with a view to developing a clear set of performance indicators to monitor the impact of services on different racial groups as required under the RR(A)A 2000. It collects and monitors by ethnicity data on patients which through a sustained programme of improvement over 18 months has seen an increase from approx. 37% to 92% records having a valid code. Also collected and monitored by ethnicity is information on, workforce, critical incidents and complaints. These are all reported on regularly to the Trust Board. It uses this information to develop benchmarks and inform priorities. Similar efforts are now being developed for workforce information.

Contact: Julie Weston, Director of Workforce Development and Education
Angie Hammond, Positive Diversity Manager, 0208 682 6535
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Annex C
Appropriate and Responsive Services

Pointers for Improvement	Outcomes	Local Stakeholders
Record information about beliefs and practices in patients' notes Build up knowledge of and links with local religious organisations/support network Provide access to appropriately trained interpreters so that consultations may take place in the language that patients are most comfortable with – do not use family members Strive to ensure that patients have a choice regarding gender of practitioner where possible Require Board level reports on appropriateness and responsiveness of services to Black and minority ethnic communities as part of the Clinical Governance process	Staff have the knowledge, skills and tools to enable them to deliver services to and in partnership with all groups in their community with confidence and sensitivity. Communities feel more confident in those services and readier to engage with them voluntarily.	Planners, commissioners and providers of mental health services, including GPs and primary care workers and the social care and independent sector
Create mechanisms to ensure that joint learning takes place between health and social services. Undertake a whole service approach e.g. develop joint mental health workforce profiles, joint objectives/benchmarks, service-wide strategies on issues such as training, workforce planning, staff development, provision of interpreting/translating services Take account of relevant guidance on recognising and supporting diversity such as that issued by ODPM on the Supporting People programme[42] in relation to people: • from Black and minority ethnic communities; • experiencing mental health problems (when issued) • considering equality of opportunity and fair access at service review	Health and social services learn from each other and best practice approaches to achieving appropriate and responsive services are identified, replicated and built on under joint planning arrangements.	Planners and commissioners

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42 www.spkweb.org.uk

Notable Development Site: Increasing Representativeness of Workforce

The Mental Health Act Commission set a target of 20% Black and minority ethnic representation among Commissioners (slightly higher than the population of detained patients). Adverts were placed in both mainstream and the Black press with a clear message with respect to encouraging people from Black and minority ethnic communities to apply to become Commissioners. Flyers were mailed out to over 1000 key BME organisations to ensure the adverts received wider exposure within these communities. The MHAC's work programme included significant consultation with local groups in three regions which helped the recruitment drive. 24% of Commissioners are currently of Black and minority ethnic origin.

Contact: Matt Kinton; KintonM@mhac.trent.nhs.uk

Notable Development Site: Voluntary Sector

Rethink is a voluntary sector mental health provider organisation delivering mental health services across the UK, some of which are funded by DH and other public authorities and charitable trusts.

Rethinks Board of Trustees have made a commitment to tackle inequality within mental health. This applies to its public campaigns, and operational activities within its service delivery and in workforce planning. This commitment has been communicated through consultations, newsletters, seminars, workshops and public conferences.

This commitment was made in 2000 following the No Change Report, which was a comparative study of service user experiences. Following this report Rethink communicated its plans to improve its operations in 5 key areas: consultation, representation, service delivery, workforce planning and user satisfaction and as a consequence, has been inferred by further responsibilities in relation to the RR(A)A 2000 'duty to promote race equality'. This duty is delegated through contract compliance i.e. "contractually bound to provide culturally competent services on behalf of public authorities".

Rethink has developed a National Race and Ethnicity Equality Strategy and facilitates a BME Staff Network and a National Race and Mental Health Group chaired by its Chief Executive and has representation from senior staff from across the organisation. Rethink has appointed a National Lead on Race Equality who works alongside all Rethink functional departments and its 360 operational services across the UK. It is developing a Human Resource strategy to develop retention strategies and assist in the career progression of their Black and minority ethnic staff within the organisation and has set targets to ensure that its services are truly representative of local communities.

Work is being done to ensure that BME communities are represented on local and national Boards of Management, as well as increasing the number of service users, volunteers and paid staff from Black and minority ethnic communities. All 360-service managers have developed 3-year action plans that outline how they are intending to meet Rethinks Race Equality objectives and the requirements of the RR(A)A 2000. These plans will be in place by April 2004.

All services will soon have national access to a language line and it aims to have some of its information leaflets available in at least 6 languages. It has published policy documents on Race and Culture and on Meeting the Spiritual Needs of People with Severe Mental Illness. It has set targets for all 1600 paid staff and 900 volunteers to be trained in cultural competence and race equality and for 70% of its services to be culturally competent and responsive to user needs in respect of race and gender within three years. It has provided a Cultural Competence Checklist to all services and is developing a web page offering guidance on cultural competence and mental health, as well as undertaking a research project on the ability of its managers to deliver culturally competent services.

Contact: Claire Felix; claire.felix@ rethink.org; 0207 713 8984.

Notable Development Site: Training

North East London Mental Health Trust delivered Race and Cultural Awareness Workshops open to all staff, focusing on personal race and cultural awareness, interface with users and carers and workplace issues. One of the workshops was specifically directed to members of the NELMHT Trust Board. Further events will be held incorporating an outcome component.

Contact: Dr Annie Lau, Medical Director; annie.lau@nelmht.nhs.uk; 0208 970 4052

Notable Development Sites: Toolkits

Representatives of the Leeds statutory and voluntary sector developed a cultural competence toolkit to enable providers to undertake a quality assurance self-evaluation in this area. The standards were set at three levels and covered Respect, Information and Choice, Communication, Valuing Black and minority ethnic staff, Access and Partnership Working.

Contact: Diverse Minds on 020 8215 2220

Notable Development Sites: Toolkits

Bedfordshire Health Promotion Agency has developed a toolkit that includes manuals & audit materials and provides a mechanism to assess the cultural competency of services.

Its uses include:

*   helping users identify existing standards of services and common practice;

*   develop monitoring and evaluation mechanisms and tools to examine the impact of services on Black and minority ethnic communities;

*   improve access to health information and increase awareness amongst health and social care professionals of the barriers faced by people from BME communities when seeking to access services.

It can also be used to facilitate baseline studies, service review models, Cultural Competency training courses and community involvement.

Contact: Gina Felice, Race Equality Specialist, Bedford Primary Care Trust on 01234 792054; Gina.felice@bedford-pct.nhs.uk

Notable Development Sites: Access to Services

Merseyside Health Action Zone funded a research project on improving accessibility to mental health services for Chinese people. It produced in 2002 a pack for trainers to use when developing training programmes for staff working within a mental health context. The pack can also be of use to programme providers and planners designing health and social care courses, and as a resource pack for any health and social care staff working with people with mental health problems from the Chinese Community. Available from www.mhaz.org.uk/mhaz/achieving/fellowships.html

Contact: Echo Yeung, Merseyside HAZ Research Fellow; MHAZ phone is 0151 285 2169; echoyeung@ukonline.co.uk

Notable Development Site: Mediation and Cultural Consultancy

Lambeth, Southwark and Lewisham Health Action Zone funded a one year action research project 2001-2 offering a mediation/consultancy service to clinicians and Black mental health users to resolve conflict between them. The project is now funded by the local Trust. It aims to offer a structured and positive way to communicate their different explanatory models of illness/experience and to offer a service creating structured understanding between biomedical and non-medical cultural discourses. It uses the approach of medical anthropology to put a focus on cultural constructions of mental illness. Report of the project's first year are available on http://www.lho.org.uk/pubs/haz/pdf/Btwwrldsrpt.pdf

Contact: John Curran, South London and Maudsley NHS Trust
e-mail: John.Curran@slam.nhs.uk; Tel: 020 7411 6538

Contact: David Ndegwa, South London and Maudsley NHS Trust
e-mail: David.Ndegwa@slam.nhs.uk; Tel: 020 7411 6100

Notable Development Site: Making the RES Central to Service Delivery

In building on its work to date SW London and St George's Mental Health Trust has implemented a framework that requires all directorates to systematically assess for any adverse impact in service delivery and workforce on people from different racial groups. The emphasis is on developing local ownership of issues, critical appraisal, action planning, and implementation and reporting. Directorates are supported with guidance, developed in line with CRE good practice, which highlights the areas that need to be taken into account within their review. Each directorate is invited to discuss their plans with the RES steering group where they also present progress after six months. A RES logo has been developed as a means of helping to highlight RES developments. In addition, information on progress including good practices from directorates e.g,. Child and Adolescent Directorate model for integrating race equality into core business, is incorporated into the Trust wide magazine which is received by every employee. The framework has been supported by a series of road shows that have been carried out around the Trust which has helped to further raise awareness about the RES developments and been a useful mechanism for obtaining valuable feedback.

Contact: Melanie Walker Director Of Social Care and Modernisation 020 8682 6394

Angie Hammond, Positive Diversity Manager, 0208 682 6535
Angelina.Hammond@swlstg-tr.nhs.uk

Annex D
Community Engagement

Pointers for Improvement	Outcomes	Local Stakeholders
Provide local mental health promotion activity specifically aimed at Black and minority ethnic groups Form partnerships with faith communities (see *Faith and Community: a Good Practice Guide for Local Authorities*) Make connections with existing/ new initiatives/networks established by others e.g. local councils, Office of the Deputy Prime Minister. Establish linkage and responsibility for community engagement across whole health and social care system focussing particularly on the Local Strategic Partnership Ensure Black and minority ethnic VCS partners in planning process are clear on their role e.g. whether they are representing the Black and minority ethnic community or the independent sector or both Strive to ensure Black and minority ethnic VCS representatives are of a comparable seniority to representatives of main agencies Commission Black and minority ethnic specialist services on the basis of needs assessments and overall service strategy Identify local Black and minority ethnic VCS groups including faith groups which might be potential candidates for funding from the Treasury *futurebuilders* fund aimed at building up capacity within the VCS, or s64 grants, as well as from local budgets Practically support the capacity of local Black and minority ethnic VCS including faith groups to become involved in planning, designing and delivering services – e.g. information, training, joint working, access to support from a liaison officer. Put in place mechanisms to facilitate mutual learning between Black and minority ethnic VCS-delivered services and mainstream services.	Services better reflect the needs and aspirations of Black and minority ethnic communities, making them more willing to engage voluntarily with services. More effective and sustainable involvement of Black and minority ethnic VCS in planning, designing, commissioning and delivery of services.	Planners/commissioners and providers of mental health services, and local councils.

Notable Development Site: Community Engagement

The Cares of Life Project in Southwark (South London &Maudsley NHS Trust) is a community based model of care which aims to improve mental health services for African and Caribbean people by introducing graduate Community Health Workers to connect these communities with health care and other agencies such as housing, employment and education. The workers will belong to their local communities, be aware of the informal health and social support networks already available and will establish functional links between these communities and the formal health care service. As well as including user and community involvement in decisions relating to health care, the project aims to enable professionals to gain a better appreciation of African and Caribbean user-based explanatory models of mental illness, well being and appropriate interventions. It aims to build enduring local partnerships and social support networks to sustain people within their communities where satellite clinics will be located. It has to date mobilised the community and statutory stakeholders to determine the precise nature of intervention to be used by the Community Health Workers; undertaken a social network analysis of partner stakeholders which include barbers, hairdressers, Black businesses, faith groups and Black voluntary organisations. The Cares of Life Project will use the Time Bank economy to link service users and Lay Health Volunteers with partner businesses to encourage individual empowerment, social networking and community regeneration.

Contact: Dr Dele Olajide; Dele.Olajide@slam.nhs.uk; Tel: 0207 919 2951.

Annex E
Suicide

Notable Development Site: South Asian Women

Karma Nirvana is an Asian women's project in Derby funded by the National Lottery and others including the local PCT and Social Services. Its objectives are to support and promote the physical and emotional health of Asian women, provide a befriending/support service, empower Asian women to become active participants in promoting their own health and well-being and liaise with voluntary and statutory bodies to ensure the needs of Asian women are heard and met. It held a conference in 2000 on South Asian women self-harm and suicide that highlighted the significance of the GP role in early diagnosis and prevention, and the need for training/awareness raising on the risk factors leading to emotional distress in young Asian women. Karma Nirvana is conducting with Derby Mental Health Research Unit a local research project looking at factors of subordination, shame and entrapment and how these can affect the mental health of Asian women, particularly depression, and the implications for service delivery. It has identified the four main reasons for Asian women not accessing mental health services to be: 'Izzat' (a learnt complex set of rules an individual has to follow to protect the family honour and keep his/her position in the community); confidentiality; fear of being misunderstood; and unawareness of the available services.

Contact: Karma.Nirvana@btinternet.com; www.karmanirvana.freeserve.com; 01332 604098/299166.

Annex F
Pathways To Care

Implementation of the recommendations set out for the 'building blocks' earlier in this document above should help achieve significant progress. Additional pointers are set out in the table below.

Key Actions	Outcomes	Local Stakeholders
Increase access of Black and minority ethnic groups to 'talking treatments'. This may include: • Greater availability of appropriate counselling • awareness raising among Black and minority ethnic communities of its availability Follow NICE best practice guidelines on schizophrenia and those being developed on depression, generalised anxiety and self-harm.	Higher access of Black and minority ethnic groups to talking treatments.	All providers of mental health services, including GPs and primary care workers
Identify practical steps to encourage early and voluntary access to treatment. This may include: • building links with Black and minority ethnic communities, including faith organisations/support networks, and users/carers; • following NICE best practice guidelines	Higher voluntary and earlier access of Black and minority ethnic users and carers to mental health services	Graduate primary care and gateway workers, and early intervention, community mental health and assertive outreach teams
Liaise with local criminal justice agencies (e.g. through involvement in inter-agency training on the key issues in relation to mental health including aversive pathways of African and African–Caribbean males) to assist in identification and early diversion where appropriate of mentally disordered people into mental health services Provide treatment in non-hospital based settings where possible	Higher rate of identification and early diversion of Black and minority ethnic people from Criminal Justice System into mental health services. Lower entry rate of Black and minority ethnic people into mental health services via the legal system. Lower admission rate of people from Black and minority ethnic communities into hospital	Community mental health teams Criminal justice liaison teams Assertive outreach teams Crisis resolution/home treatment teams Local inter-agency steering groups

Key Actions	Outcomes	Local Stakeholders
Ensure adequate provision of • advocacy services for Black and minority ethnic service users • information in appropriate media/languages and active support for Black and minority ethnic carers Ensure adequate access by patients, especially African and African–Caribbean males, to primary care and home based treatments, rather than hospital based treatments; raise awareness of this issue among providers, including GPs Review potential to open up pathways to referral to mental health services Support development of culturally capable therapies/counselling services appropriate to needs of users from Black and minority ethnic communities	Higher access of Black and minority ethnic groups to primary care and home based treatments. Reduced admissions to hospital Higher voluntary and earlier access of Black and minority ethnic users and carers to mental health services	Planners, commissioners, and local councils

Notable Development Site: Assessment

The South Essex Community Care and Mental Health Trust has developed, in partnership with police, a Section 136 Suite. The development of the section 136 suite on hospital site will ensure assessment is carried out by staff who have been trained in line with the sensitivities of Black and minority ethnic patients. This will stop the patient being taken to the police station.

Contact: South Essex Community Care and Mental Health Trust, Unit 2 Dunton Court, Laindon, Basildon, Essex. Eunan MacIntrye, Tel: 01375 364660

Notable Development Site: Outreach Work with African and Caribbean Community

Antenna Outreach Service, a team funded by Barnet Enfield and Haringey Mental Health NHS Trust, targets 16-25 year old people of African and Caribbean origin with severe mental illness, who are hard to engage with traditional services or who have complex needs that CMHTs find difficult to meet. Antenna has been running for over three years and over 150 patients have been through the service. It was set up and monitored for its first two years by a steering group made up of community advisors in conjunction with health and social care advisers. It operates an open access referral scheme, which has meant that it has taken clients from non-traditional sources. This has allowed the service to offer earlier assessment and treatment.

Antenna promotes social inclusion for its clients and builds bridges with the health sector and the community including churches, the business communities, and youth teams. It trains young people who then become 'ambassadors' in the community. It has produced a video aiming to encourage young people to access help early. It operates a 360-degree appraisal system whereby relatives and carers are invited annually to appraise its service.

Contact: Dr Kwame McKenzie or Norma Johnson Antenna Outreach Service 312 Tottenham High Road London N15, 020 8365 9537

Notable Development Site: Criminal Justice System Links

The Revolving Doors Agency, supported by a variety of charitable trusts and statutory agencies including the Home Office Mental Health Unit and the Department of Health, has established community linkworker schemes to work with people with mental health problems who come into contact with the criminal justice system. The schemes include some specialist Black and minority ethnic workers who help raise the expertise of the whole team. For example a Bengali link worker in Tower Hamlets has radically improved the team's ability to engage with the local community.

Contact: Ethel Samkange, Director of Schemes, Revolving Doors Agency
      Units 28 & 29, The Turnmill, 63 Clerkenwell Road, London EC1M 5NP
      phone: 020 7253 4038, email: admin@revolving-doors.co.uk

Notable Development Site: Access to Talking Treatments

East London and the City Mental Health Trust has set up a psychology service for Bangladeshi clients with severe and enduring mental health problems, backed up by a specialist mental health interpreting service accessible by secondary care staff. It is in the process of translating information leaflets for clients and carers on mental health structures and processes and on specific mental health problems. The service is also committed to conducting research and evaluation projects, and is presently completing a needs assessment with staff relating to their work with Bangladeshi clients and a questionnaire study on the availability and accessibility of interpreters within the Trust.

Contact: Dr Alia Parvin @ St Clement's Hospital, Bow Rd, London E3 020 7377 7969

Notable Development Site: Access to Talking Treatments

Tower Hamlets Primary Care Trust has a Primary Care Psychology and Counselling Service. This includes a Bilingual Counselling Service staffed by Bangladeshi and Somali Counsellors, a Bengali-speaking Disability Counsellor and a Bengali-speaking Clinical Psychologist, who is developing tools for screening and management of post-natal depression among the Bangladeshi community. The service offers clinical work to a local population, many of whom are Bangladeshi.

The Somali Counselling Service has an advisory group made up of voluntary and statutory representatives, and has jointly recruited a Somali Assistant Psychologist with a voluntary sector organisation.

The service has developed an anxiety management pack about the team written in Bengali, and provided tailored information on mental health promotion available to the Somali and Bangladeshi communities.

It has also produced the following information for mental health promotion in the Bangladeshi and Somali communities:

•   Two videos – one about mental health issues in the Somali community, and one for the Bangladeshi community on disabilities and mental health.

•   Leaflets about the services and mental health. These have been translated for use by the Bangladeshi community and are in the process of being translated for the Somali community.

It has also provided training and consultation to professionals on Somali and Bangladeshi community mental health issues.

Contact: Aruna Mahtani, Steels Lane Health Centre – 020 7791 3667

Annex G
Acute Inpatient Facilities

Implementation of the recommendations set out for the 'building blocks' earlier in this document above should help achieve significant progress. Additional pointers are set out in the table below.

Pointers for Improvements	Outcomes	Local Stakeholders
Involve carers/advocates in care planning. Follow best practice such as the NICE guidelines in development on management of violence. Ensure patients have access to staff/practitioners of the gender of their choice, wherever possible. Ensure patients have access to accommodation, washing and living space facilities that take into account different cultural and gender definitions of 'normal' social behaviour, dignity and respect. Ensure patients have access to culturally appropriate facilities relating to, for example, diet and personal hygiene. Ensure that patients within inpatient units are able to have their spiritual and religious needs met and can draw on faith community support networks (see forthcoming DH guidance on spirituality and mental health).	Provision of care in acute inpatient facilities more appropriate to needs of Black and minority ethnic patients, women and men. Treatment in acute inpatient care more effective in aiding recovery. Fear of acute inpatient care among some Black and minority ethnic communities lessened making them more willing to engage voluntarily with mental health services.	Providers of acute inpatient mental health care.

Notable Development Site: Tackling Racial Harassment

South West London & St George's Mental Health Trust has outlined the procedure for staff to deal with racial harassment stating that all incidents are considered serious but differentiating two routes that a member of staff can take, by asking a series of questions that will lead to the matter being dealt with either formally or informally. Prompt action, sensitive support, clear communication and involvement of team managers and consultants in dealing with challenging behaviour are encouraged.

The Trust supports the policy through a training programme that raises awareness of the impact of race and culture on service delivery. The programme, which is mandatory for all staff, managers and leaders also, raises awareness of the RR(A)A 2000 requirements and has a strong practical focus, with action plans developed by participants as part of the programme.

In addition a network of Staff Support Advisors are available to offer support and confidential advice on the options available to help resolve concerns raised by individuals about any aspect of inappropriate behaviour experienced in the work place.

Contact: Angie Hammond, Positive Diversity Manager, 020 8682 6535
         Angelina.Hammond@swlstg-tr.nhs.uk

Notable Development Site: Meeting Spiritual Needs

Newham Community Health Services NHS Trust (now ELCMHT) established a department of spiritual, religious and cultural care. The department focused initially on providing a comprehensive service to mental health patients in acute wards. It then established and provided ongoing training to a team of committed volunteers reflecting the area's different faith communities to provide voluntary help both on the wards and in the context of the community. It thus aimed to involve communities in mental health care and promote social inclusion as well as providing a holistic service to users capable of meeting their spiritual needs.

Forward in Faith – Nigel Copsey, Sainsbury Centre for Mental Health, 2001
(E-Mail: N.Copsey@btopenworld.com)

Notable Practice Site: Mental Health & Islam

University College London and Camden & Islington Mental Health and Social Care Trust, London, undertook a research intervention project aimed at enhancing staff knowledge of Islamic cultures and religion, and translating this into culturally sensitive care for mental health users. Muslims, particularly from the Asian sub continent, form the second largest group of in-patients at the Huntley Centre, St Pancras Hospital. Issues under focus included prayer on the wards, hygiene, diet, gender & sexuality, dignity, fasting, working with the hospital *Imam*, possession by *jinns*, and relationship with other religions. A total of 135 mental health professionals and secretarial staff based at the Huntley Centre took part in this training. This is the first known intervention study world wide.

Contact Dr Sushrut Jadhav and Sue Salas
E mail: s.jadhav@ucl.ac.uk or sue.salas@candi.nhs.uk

Annex H
Consultation Process and Summary of Consultation Questions

Consultation process

Consultation will be undertaken in a number of ways:

- by written comments and information to DH directly (see below);

- through consultation events organised by the NIMHE Development Centres – more information will be available on the NIMHE website during October/December;

- by discussion and events co-ordinated by Mental Health Local Implementation Teams (LITs) (please contact your LIT to see if anything is planned);

- by the National Strategic Director, Professor Kamlesh Patel, meeting and consulting with a range of key stakeholders in the statutory and VCS sectors.

The web log address for giving comments is:

- www.nimhe.org.uk/dre

Please respond in writing or e-mail to:

Kevin Mantle
315 Wellington House
Department of Health
133-155 Waterloo House
London SE1 8UG
Tel: 020 7972 4364
Fax: 020 7972 4147
E-Mail: kevin.mantle@doh.gsi.gov.uk

PLEASE RESPOND BY FRIDAY 23RD JANUARY 2004.

Representative groups who respond to this consultation should provide a summary of the people and organisations they represent.

Responses will be made public unless confidentiality is specifically asked for.

If you have any comments or complaints about the consultation process please contact: Steve Wells (Consultations Co-ordinator) 020 7972 6073 – steve.wells@doh.gov.uk

The information you send to us may need to be passed to colleagues within the Department of Health and/or published in a summary of responses to this consultation. We will assume that you are content for us to do this and if you are replying by e-mail, that your consent overrides any confidentiality disclaimer that is generated by your organisation's IT system, unless you specifically include a request to the contrary in the main text of your submission to us.

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43 www.cabinet-office.gov.uk/regulation/Consultation/introduction.htm

This document conforms to the Cabinet Office Code of Practice on Written Consultation[41].

Code of Practice criteria

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage.

2. It should be clear who is being consulted, about what questions, in what time-scale and for what purpose.

3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.

4. Documents should be widely available, with the fullest use of electronic means (though not to the exclusion of others) and effectively be drawn to the attention of interested groups and individuals.

5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation.

6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed, and reasons for decisions finally taken.

7. Departments should monitor and evaluate consultations, designating a consultation co-ordinator who will ensure the lessons are disseminated.

Annex I
Summary of Consultation Questions

Information/monitoring

Aim: Compliance with RR(A)A 2000 duties relating to assessing/monitoring impact of services. Ethnicity taken into account in:

- planning and delivery of services to individuals;

- collective planning and delivery and monitoring of services.

1. *Are there any barriers to services meeting their obligations in relation to the collection and use of ethnicity data? Please give any examples of plans to overcome these barriers or how they have already been overcome.*

Appropriate and responsive services

Aims: Compliance with RR(A)A 2000 training duty. Appropriateness and responsiveness of mental health services to Black and minority ethnic communities assessed and monitored, with action taken where appropriate. Staff given tools to enable them to deliver services to and in partnership with all groups in the local community with confidence and sensitivity. Patient experience improved.

2. *Are there any barriers to services meeting their obligations and commitments in relation to providing services that are appropriate and responsive to the needs and wishes of Black and minority ethnic communities? Please give any examples of plans to overcome these barriers or how they have already been overcome.*

3. *What sort of support would services find helpful from other bodies (e.g. NIMHE Development Centres, Workforce Development Confederations) in this area?*

4. *What do communities/VCS think they can contribute to helping services become more appropriate and responsive?*

Community engagement

Aims: Compliance with statutory obligations under Health and Social Care Act 2001 and RR(A)A 2000 in relation to informing, involving and consulting with communities, and requirement under MHNSF Standard 1 to work with vulnerable groups and individuals at risk and to tackle social exclusion. Black and minority ethnic communities including VCS more effectively and sustainably involved in planning, designing, commissioning and delivery of services. Patient experience improved.

5. *Are there any barriers to services meeting their obligations and commitments in relation to working with Black and minority ethnic communities? Please give any examples of plans to overcome these barriers or how they have already been overcome.*

6. *What sort of support would services find helpful from other bodies (e.g. NIMHE Development Centres, Workforce Development Confederations) to help their organisations take forward this work, other than that described above?*

7. *What issues do communities and the VCS think are particularly important?*

8. *What do communities and VCS think they can contribute to helping create a partnership with services?*

Suicide prevention

Aims: Help achieve national target on suicide reduction. Needs of high-risk groups taken into account in treatment and service planning.

9. *Are there any barriers to services taking forward the Suicide Prevention Strategy in relation to vulnerable Black and minority ethnic groups? Please give any examples of plans to overcome these barriers or how they have already been overcome.*

10. *What support would communities and the VCS find helpful in relation to this area?*

Pathways to care

Aims: Remedy adverse impact under RR(A)A 2000. Black and minority ethnic pathways to care monitored and action taken where appropriate.

11. *Are there any barriers to services creating a better pathway into and out of mental health services for Black and minority ethnic users, including relationships with other agencies? Please give any examples of plans to overcome these barriers or how they have already been overcome.*

12. *What sort of support would services find helpful from other bodies in this area?*

13. *What is the role of other agencies in helping achieve more acceptable pathways to care for Black and minority ethnic users?*

14. *What impact do services and communities/VCS think that the new workers/teams under the MH Modernisation Programme have had on this issue?*

15. *What do communities/VCS think they can contribute to helping services improve user pathways?*

Acute inpatient facilities

Aims: Remedy adverse impact under RR(A)A 2000 and compliance with Human Rights Act Provision of care in acute inpatient facilities more appropriate to needs of male and female Black and minority ethnic patients, and treatment more effective in aiding their recovery.

16. *Are there any barriers to services meeting their obligations and commitments in relation to improving acute inpatient facilities for Black and minority ethnic users?*

17. *Please give any examples of plans to overcome these barriers or how they have already been overcome.*

18. *What do communities/VCS think are the main areas in which improvements should be made in acute inpatient facilities for Black and minority ethnic users and their relatives and carers?*

19. *What has been the impact of new structures such as the Acute Care Forums?*

20. *How else can communities/VCS contribute to helping services improve these facilities for Black and minority ethnic users and carers?*

DH *Department of Health*

Tropical Sun by Chris Bashford (1957–2002)