

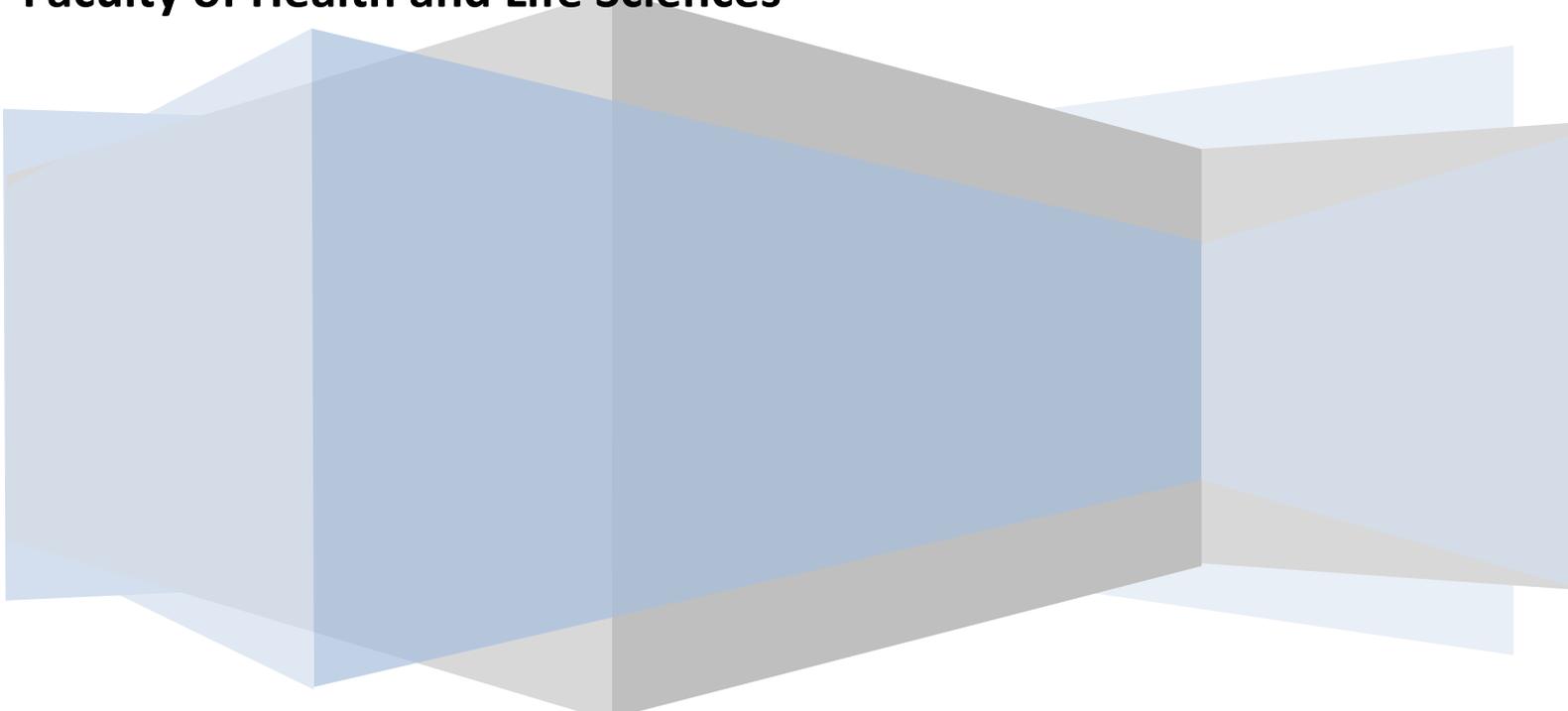


**Mental health services for Black and Minority  
Ethnic groups in Leicester, Leicestershire and Rutland:  
A documentary analysis**

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## Summary

It is well documented that people from Black and minority ethnic communities experience severe inequalities in our mental health services. Leicester is one of England's most culturally diverse cities with approximately 50% of its population from Black and Minority Ethnic groups, particularly those of South Asian origins. Our aim was to map the experiences of people from Black and Minority Ethnic Communities using the Mental Health Services in Leicester and Leicestershire. Focusing on five key documents on mental health and ethnicity and associated literature this documentary analysis addressed the following questions:

1. To what extent do we understand the MH needs of BME communities in Leicester and what do we need to know to improve this understanding?
2. To what extent do services meet the needs of BME individuals and how could this be improved?

### ***Recommendations***

The mental health and wellbeing strategies indicate that community involvement is deemed central to mental health care in Leicester. Based on the documentary analysis and supporting information, our recommendations to the health and social care commissioners, Local authorities and service providers are as follows:

1. Along with ethnic monitoring of service usage, the health and social care commissioners and services in Leicester, Leicestershire and Rutland should address four key areas for shaping its strategy and services: (a) Do we understand the diverse needs of Black and Minority Ethnic communities in Leicester? (b) Do our services meet their diverse needs and aspirations? (c) Do we provide an appropriate and professional service to Black and Minority Ethnic communities? (d) Do we achieve equally high outcomes for all ethnic groups in all our various activities?

2. The lack of research evidence about access to mental health services in Leicester and Leicestershire by people from BME communities, user and carer experiences indicates that it is vital that work is undertaken with utmost urgency to identify the lived experiences of people from BME communities and to develop more inclusive strategies and services.
3. The over/under representation of BME individuals in certain types of MH treatment should be addressed and programmes to correct these imbalances should be implemented. Statistics pertaining to this should be ascertained regularly and complemented by data concerning the experiences of BME individuals using such services.
4. There is an urgent need for research to identify why referral rates to appropriate mental health services are so low for some BME communities in Leicester and Leicestershire. This will help services to respond to the needs of users & carers and to provide early intervention services.
5. A more detailed and transparent presentation of the methods and findings concerning patient experience data from BME individuals using MH services would be valuable. Furthermore, an examination of how such data can transpire to the MH strategy and service planning is the key for the mental health promotion of all in Leicester and Leicestershire and Rutland.
6. Leicester's Health and Wellbeing Strategy highlights that early detection; prevention and resilience is the key for improving the mental health of the people of Leicester. In shaping this strategy a detailed examination of the approaches, its outcomes and its impacts for BME communities in Leicester is required. It is vital that we actively engage with the BME communities in Leicester and Leicestershire to explore: (a) their experience of current MH services offered, and (b) what they would like to see implemented into MH strategy and care.
7. The process of active engagement with BME users and carers in Leicester should be evaluated by commissioners and service providers. This will help commissioners to identify *what works* for the local population and for evidence based commissioning.
8. There should be increased involvement from Black and Minority Ethnic voluntary and community organisations in shaping the mental health strategy, the commissioning of mental health services, and in the evaluation of the outcomes achieved from the Health and Social care services.

# **Mental health Services for Black and Minority Ethnic groups in Leicester, Leicestershire and Rutland: A Documentary Analysis**

## ***Introduction***

Mental ill-health represents the largest single illness experience within the UK, accounting for approximately 23% of the total illness burden (Palmer, 2013). The UK Coalition Government has acknowledged that positive mental health (MH) is central to economic success, quality of life and key to improving education and employment outcomes, whilst reducing problems associated with homelessness, drug-use and crime (DOH, 2011). Furthermore, tackling MH problems is considered of equal importance to addressing those associated with physical health (DOH, 2014). MH services amount to significant financial expenditure, providing for nearly 1.6 million individuals in England between 2012 and 2013 (NHS Confederation, 2014). Whilst incidences of common mental disorders have increased, investment in adult MH services dropped in 2011/12 for the first time since 2001/02 and they are expected to experience further reduction of support in 2013/14 (NHS Confederation). Consequently, there are increasing pressures to provide more efficient and cost-effective MH services whilst improving outcomes. The Future Vision Coalition (FVC, 2008) provided a new vision for MH services acknowledging the significance of recognising MH as an issue for the whole population. However, they also expressed the importance of cultural contexts and catering for the varied needs of ethnically diverse populations. Despite aims for equality in such services, progress has been uneven between different areas and groups of individuals (DOH, 2011). Services are reportedly less effective at meeting the needs of individuals from certain Black and Minority Ethnic (BME) communities (DOH), although such groups can experience higher incidences of MH problems (Palmer, 2013).

## ***Aims and Method***

Our aim was to map the experiences of people from Black and Minority Ethnic Communities using the Mental Health Services in Leicester and Leicestershire. Focusing on five key documents on mental health and ethnicity this documentary analysis addressed the following questions:

1. To what extent do we understand the MH needs of BME communities in Leicester and what do we need to know to improve this understanding?
2. To what extent do services meet the needs of BME individuals and how could this be improved?

The following five items of local policy literature available for examination were:

- Directorate of Public Health and Health Improvement: Count-Me-In Census DRAFT (CMIC: 2006)
- LCPCT Directorate of Public Health and Health Improvement Count-Me-In Census (CMIC: 2007)
- Directorate of Public Health and Health Improvement Count-Me-In Census DRAFT (CMIC: 2008)
- Mental health needs of Black and Minority Ethnic communities in Leicester, Leicestershire and Rutland (FIS, 2008)
- Improving Health in Leicester: Annual Report of the Director of Public Health and Health Improvement 2008/09 (IHIL, 2008)

We included the NHS Leicester City joint commissioning strategy for Mental Health 2011-2013 in this documentary analysis. These were then considered in the context of the wider MH strategies and research about MH and the BME community.

## ***MH census data for Leicester, Leicestershire and Rutland.***

The information presented in the CMIC (2006; 2007; 2008) documents was typically quantitative, pertaining to demographic information regarding Leicester patients in MH treatment. Details included: age, ethnicity, language and religion of inpatients; information regarding referrals and detentions under the MH Act. In some instances,

interpretations and recommendations were provided for these data. Despite the development of the Choice agenda, the Leicestershire Partnership Trust (LPT) was the only provider of primary and secondary MH care for local individuals in 2006, 2007 and 2008. It was acknowledged that this may imply limited choice for patients (CMIC, 2006). Throughout these three documents, comparisons were made with national statistics. Whilst the numbers of inpatients appeared to reduce nationally, there was minimal change in the local population in 2006. However, there were higher than average local reductions in inpatients during 2007 and 2008. In similarity to national statistics (e.g. NHS, 2014) there appeared to be higher proportions of Black African/White British inpatients than other ethnic groups.

According to the CMIC (2006), the local data revealed a similar proportion of BME inpatients to those identified nationally, but there were some notable contrasts. Mainly, a disproportionately higher number of inpatients from Indian backgrounds were reported in all three CMIC documents. Leicester is one of England's most culturally diverse cities with 50% of its population consisting of individuals from BME groups, particularly those of South Asian origin (ONS 2014, Palmer, 2013). Furthermore, Leicester experiences on average, higher incidences of mental illness. Whilst it is unclear from the CMIC documents whether this explains the inflated numbers of inpatients from Indian backgrounds, effective care strategies should be appropriate to the diverse Leicester population. Furthermore, a lower than national average number of inpatients from Leicester declared they were not religious (CMIC, 2006) or did not state a religious belief (CMIC, 2006; 2008). The role of religion has been considered a key component in MH services in Leicester and different religions have different views on MH (MHJCS, 2010). Religion and spirituality play an important role for BME communities in Leicester (MSRC Report 2001) and should be explored in conjunction with MH care and its potential integration into therapeutic practices. There is research evidence to show that religion and spirituality play a significant role in the healing and recovery process. The Mental Health Foundation recommends that *clinicians and service providers should recognise that spirituality needs to be considered as part of the whole-person approach to the care and treatment of an individual* (MHF 2008).

When broken down in terms of age, there were certain patterns regarding inpatients from the various BME groups. The local data (CMIC, 2006) demonstrated that 22.2% of inpatients aged 18-24 were from an Asian or Asian British and Indian backgrounds, compared to 7.7% nationally. Whilst data presented in CMIC (2007) and CMIC (2008) were not directly comparable, the latter indicated that a smaller percentage of inpatients from such backgrounds represented this age group in 2008. However, approximately 30% of this age group consisted of non-White inpatients, indicating that BME individuals continued to be over-represented in this category. Other comparisons made between local and national data indicated higher proportions of White inpatients and those of Black or Black British Caribbean background in the over 50 age group (CMIC, 2006). A more in-depth analysis of age and ethnicity was presented in the CMIC (2008) document. The proportions of inpatients from the 25 – 49 age groups from Asian/Asian British and Black/Black British backgrounds were significantly higher than those recorded as being White. In general, 62% of White British inpatients were >50 years, whereas those from other ethnic groups were more likely to be under 50, as might be predicted from ONS Census data on the age profile of the national population.

In resemblance to the national figure, 13.6% of referrals to LPT came from GPs in 2008, which was a reduction from the 19.1% figure in 2006. White British and White Irish groups were most likely to experience referrals in this way (CMIC, 2007). The largest percentage of referrals (61% in 2006, 66.7% in 2007, 70.6% in 2008) came from 'other clinical speciality' (CMIC, 2008), but it was unclear as to the precise definition of this category in all three documents. The majority were White British, but referral rates within each ethnic group were high in 'Other White', 'Asian Indian' and 'Black Caribbean' categories (CMIC). Local referrals from Social Services were slightly smaller than the national average, whereas Community MH teams referred far fewer inpatients than the national average (CMIC). In all three documents, there was an absence of referrals from employers or carers and it was proposed that this may indicate a local deficit in the agenda surrounding Mindful Employment (CMIC, 2007).

It was evident from these documents that the data from Leicester, Leicestershire and Rutland differed in some respects, from national data regarding MH care for BME

individuals. This may reflect the complex demography of Leicester and possibly implies that MH services may need to be adapted to suit a more culturally diverse population or that in some respects it has been successful in so doing.

### ***MH Services for BME communities in Leicester***

The FIS (2008) document brought together statistics and other information pertaining to the MH needs of working age adults from the various BME communities in Leicester, Leicestershire and Rutland and their experiences of MH Services. This document sought to assess the progress and inform the Delivering Race Equality in Mental Health Care (DRE) programme which was implemented in 2005. It was urged that the analyses reported within the FIS document should be treated with some caution due to incomplete data in some areas, data from different years being combined, a high percentage of individuals not stating their ethnicity and relatively small numbers of individuals from certain ethnic groups.

Generally, Asian communities were under-represented in certain MH services (e.g. social care assessments, voluntary sector counselling, employment and housing support) but over represented in others (e.g. day services). Black/Black British communities were also under-represented in certain MH services (e.g. residential care placements, counselling and secondary services such as dynamic psychotherapy) and over-represented in others (e.g. social care assessments, employment support and general psychiatry inpatient admissions). Typically, Black/Black British were over-represented in the more acute areas of MH, but under-represented in the preventative and recovery-focused service models. A series of interviews revealed that BME individuals perceived a lack of information regarding MH conditions, medications and their side-effects, a lack of knowledge regarding talking therapies and their availability, the need of better understanding of different cultures. This data also highlight the need to explore the roles of family and community, the impact of stigma regarding MH services, experiences of being misinterpreted, and most importantly the experience of racism. However, the FIS (2008) reported a number of projects operating locally which aimed at Asian/Black British communities including: the Akwaaba Ayeh project which provides MH

support to adults from Black and Asian communities in the city; the Savera Resource Centre, Adhar Project and Basera Mental Health Project which provide MH day services to adults from Asian communities.

Whilst reports of interview surveys represent encouraging progress, a more detailed presentation of the methods and findings would have been useful. These were presented as validation studies of baseline assessments, but it was unclear at what point in MH care the interviews occurred. It may be advantageous to interview individuals from BME communities at various points throughout their MH care and focus on their experiences of particular avenues of care. Furthermore, this research was conducted in 2008 and may not reflect current practices in MH care. New strategies regarding prevention and resilience are being implemented throughout England and the diversity of the population requires strategies which can also be flexible to suit cultural variety (Dowrick et al., 2013). It would be fruitful to examine whether such approaches could be implemented in Leicester and the experiences of BME individuals in such intervention/ treatment approaches.

### ***Aims for improvement in MH care for BME communities in Leicester***

The IHIL (2008) document was an annual report for 2008-2009 concerning general health in Leicester. Its section on MH highlighted the importance of delivering race equality in such services. It summarised the data presented in the documents reviewed (as on page 2) alongside national and local policy regarding MH care among individuals from BME communities. It was acknowledged that numerous actions should be implemented by 2010 which would help address the disproportionate rates of admission and compulsory detention among individuals from BME communities, the fear of MH care and dissatisfaction with certain services. Furthermore, aims of encouraging a more active role of communities and service users in MH care were presented.

Whilst there are multiple new strategies designed to cater for BME communities, there are reports of disparity between policy and practice regarding MH among BME individuals (Shah et al.2009). For example, in a survey of Psychiatry Consultants, Shah et al. identified that the vast majority of Consultants reported taking into

consideration the role of culture and ethnicity whilst assessing patients for decision making capacity (DMC). However, in practice, 40-50% of the Consultants reported that more than half of their patients, whose first language was not English, were not supplied with an interpreter when being assessed for DMC. Cambridge et al. (2012) report that mental health service users with limited English proficiency are rendered doubly vulnerable by the combination of their illness and their language difficulties. These observations breached policy and practice regulations, particularly when considering the important outcomes of DMC assessments. Whilst Shah et al. acknowledged that the small response rate of Consultants may have impacted the findings; there have been other reports of policy regulations not being implemented in MH care settings for BME individuals (Bradby et al., 2007). Furthermore, the Department of Health (DOH, 2003) recognised that institutional racism and lack of cultural competency was a big concern in the NHS, particularly regarding MH services. Perceptions and experiences of racism by BME individuals living in England and Wales have been found to be inversely related to mental and physical health (Karlseon & Nazroo, 2002). For example, respondents who experienced verbal racial abuse were 50% more likely to report their health to be poor or fair. Dowrick et al. (2013) identified two general reasons why individuals with mental ill-health are disadvantaged. Firstly, suitable treatment may not be available to them at the appropriate time and location; Secondly, when care is accessed, their interaction with caregivers may discourage help-seeking or divert it into ineffective forms for their needs.

The Joint Commissioning Strategy for Mental Health (MHJCS, 2010) reported a need to develop more appropriate MH care for BME groups. There is a reported over representation of individuals from Black/Black British receiving care, whilst an under-representation of individuals from South Asian origins receiving care. Additionally, there is a further challenge to meet the need of individuals from new migrant communities, some of whom may have experienced trauma prior to their arrival in the city. The MHJCS acknowledged the potential advantages of community engagement and proposed this as an important strategy for improving MH care. They also highlighted how organisations such as the voluntary sector could offer valuable contributions. However, MH plans specified within this report seemed unclear, undeveloped and somewhat vague, especially in light of the earlier finding

regarding low levels of community-based referral. There appeared to be a lack of specific direction for MH care development for BME communities implemented in Leicester. BBC News from Radio Leicester (BBC 2012) stated that inequalities are still experienced by the South Asian community in Leicester and reported that “*People of South Asian origin with mental health problems are missing out on treatment*”. Therefore, it is vital that we engage with the BME communities in Leicester and Leicestershire to explore their views on: (a) current MH services offered, and (b) to identify what they would like to see implemented into MH strategy and care.

### ***Dissatisfaction among BME Communities***

The MHJCS (2010) reported that BME communities tended to reflect a general dissatisfaction regarding the quality of MH care they received. Bradby et al. (2007) explored the experiences of Child and Adolescent Mental Health Services (CAMHS) among families of South Asian origins in areas of a Scottish City with high populations of such individuals. CAMHS were typically reported in an unfavourable light and themes of discrimination, fear of stigma regarding children’s ‘madness’ and tolerating culturally inappropriate services were identified. Negative cultural connotations associated with mental illness were also identified and the authors specified that these areas needed to be addressed, to improve representation from such communities. In the literature examined throughout this analysis, there appeared to be a lack of reported research identifying the voice of BME communities in Leicester, at least in relation to Mental health issues, since the work of Shah et al (1998). Kim and Lorion (2006) highlight the importance of understanding of MH disparity amidst cultural diversity and a need for researchers, practitioners and policy-makers to re-adjust and re-align their focus to account for an increasingly diverse population. They highlighted the importance of research focusing on cultural experiences of MH services and stressed the significance of culturally competent interventions.

The DOH (2011; 2014) highlights multiple reasons why MH services may fail some BME groups. These include discrimination, stigma associated with MH, the diversity

between various BME groups and inequalities, and also religion and beliefs systems. Furthermore, aspects of identity and experiences of inequality have been found to interact. For example, BME individuals have been reported as more likely to live in deprived areas, thus, experiencing a combination of negative experiences associated with their ethnic identity, socio-economic status and living environment (DOH, 2011). Tackling these inequalities has been outlined as a major goal for the UK Coalition Government (DOH), but amidst expenditure cuts, such approaches are likely to be more challenging. The NHS Confederation (NHS, 2014) reported that investment in MH care dropped in 2011-12 for the first time since 2001-02, including investment in three priority areas (crisis resolution, early intervention and assertive outreach).

### ***What works?***

Current initiatives for improving access into to psychological therapies (e.g. GP Quality Outcomes Framework and Improving Access to Psychological Therapies) have been criticised for focusing insufficiently on demand issues and factors significant to the patient journey (Dowrick et al., 2013). The importance of experiences was highlighted frequently by the DOH (2011; 2014), particularly regarding those of BME individuals. Whilst this has been examined in other areas across the UK (e.g. Bradby et al., 2007; Dowrick et al. 2013), there appears to be limited research investigating the experiences of individuals from BME groups in Leicester and furthermore, research into what works among such individuals. Leicester appears to be less in tune with its BME community when considering its approach to MH. For example, the MHJCS (2010) conducted an online survey regarding the sort of services people wanted. They reported statistical survey data from a predominately White sample (80%), acknowledging that further engagement needed to be facilitated among BME groups. Whilst quantitative surveys may provide valuable information regarding 'what works', qualitative data may also highlight important components of this construct.

BME patients using well-being interventions based CBT approaches generated using the Improving Access to Mental Health in Primary Care (AMP) programme (Dowrick

et al., 2013), showed considerable improvements when compared to those encountering existing care procedures. It was implemented across disadvantaged localities across the North of England (Liverpool and Manchester) and the community engagement intervention was instrumental in encouraging individuals to partake in the AMP programme. The authors concluded that MH expertise exists in BME communities but needs to be nurtured (Dowrick et al. 2013). Community interventions can allow organisations to develop knowledge, relationships and trust, and psychosocial interventions should be adaptable to meet the needs of underserved groups. Additionally, primary care should not be the only point of access to high quality MH care. As *multileveled intervention* can be greater than the sum of its parts (Dowrick et al. 2013), it is vital that its implementation is explored with BME communities and its effectiveness evaluated.

## **Conclusion**

*Closing the Gap, Leicester's Health and Wellbeing strategy 2013 to 2016* highlights that improving mental health and emotional resilience of the people of Leicester can only be achieved by: (1) promoting the emotional wellbeing of children and young people; (2) addressing common mental health problems in adults and mitigating the risks of mental health problems in groups who are particularly vulnerable; and (3) supporting people with severe and enduring mental health needs. As to how this relates to the Black and Minority Ethnic population of Leicester will need to be examined and appropriate strategies and action plans will need to be implemented and its impacts evaluated.

## **Recommendations**

The mental health and wellbeing strategies indicate that community involvement is deemed central to mental health care in Leicester. Based on the documentary analysis and supporting information, our recommendations to the health and social care commissioners, Local authorities and service providers are as follows:

1. Along with ethnic monitoring of service usage, the health and social care commissioners and services in Leicester and Leicestershire should address

the four key areas for shaping its strategy and services: (a) Do we understand the diverse needs of Black and Minority Ethnic communities in Leicester? (b) Do our services meet their diverse needs and aspirations? (c) Do we provide an appropriate and professional service to Black and Minority Ethnic communities? (d) Do we achieve equally high outcomes for ALL ethnic groups in all our various activities?

2. The lack of research evidence about access to mental health services in Leicester and Leicestershire by people from BME communities, user and carer experiences indicate that it is vital that this work is undertaken with utmost urgency to identify the lived experiences of people from BME communities and to develop more inclusive strategies and services.
3. The over/under representation of BME individuals in certain types of MH treatment should be addressed and programmes to correct this imbalance should be implemented. Statistics pertaining to this should be ascertained regularly and complimented by data concerning the experiences of BME individuals using such services.
4. There is an urgent need for research to identify why referral rates to mental health services are so low for BME community in Leicester and Leicestershire. This will help services to respond to the needs of users & carers and to provide early intervention services.
5. A more detailed and transparent presentation of the methods and findings concerning patient experience data from BME individuals using MH services would be insightful. Furthermore, an examination of how such data can transpire to the MH strategy and service planning is the key for the mental health promotion of ALL in Leicester and Leicestershire.
6. Leicester's Health and Wellbeing Strategy highlight that early detection; prevention and resilience is the key for improving the mental health of the people of Leicester. In shaping this strategy a detailed examination of the approaches, its outcomes and its impacts for BME communities in Leicester is required. It is vital that we actively engage with the BME communities in Leicester and Leicestershire to explore: (a) their experience of current MH services offered, and (b) what they would like to see implemented into MH strategy and care.

7. The process of active engagement with BME users and carers in Leicester should be evaluated by commissioners and service providers. This will help commissioners to identify what works for the local population and for evidence based commissioning.
8. There should be increased involvement from Black and Minority Ethnic voluntary and community organisations in shaping the mental health strategy, the commissioning of mental health services, and in the evaluation of the outcomes achieved from the Health and Social care services.

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