Gloucestershire COUNTY COUNCIL

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Transforming Care, Transforming Communities

NHS
Gloucestershire
Clinical Commissioning Group

# #BlackLivesMatters

## Gloucestershire's Mental Health Services

# 1.0 FORWARD

Addressing mental health inequalities in our ethnic minority communities has long been a priority, recently highlighted in the NHS Long-Term plan and the 'Advancing mental health equalities strategy'.

For many years, there has been a disproportionate number of individuals from ethnic minorities in inpatient services in Gloucestershire with mental health conditions. COVID-19 has again put this inequality into the spotlight, as it's affected all areas of our society, with the biggest impact on people from ethnic minority backgrounds. A recent survey by MIND has shown that existing inequalities has had a greater impact on the mental health of people from different backgrounds than white people during the pandemic.

The Black Lives Matter movement has similarly highlighted racial inequality and it's this momentum that gives us a chance to assess our position locally, understand and listen to why there is this disproportionality, challenge how things have been done previously, and drive forward mental health equality for all.

This report brings together all we know about individuals from ethnic minority[1] backgrounds and access to mental health services in Gloucestershire in the context of Black Lives Matters, the 2019 report on *'The use of the Mental Health Act in Gloucestershire'*[2] and the Director of Public Health's 2020 report *'Beyond Covid: Race, Health and Inequality in Gloucestershire'.*

This report concludes with some recommendations and change for action in Gloucestershire, which will be used as a basis for consultation with Gloucestershire's multi-agency Covid-19 BAME Task and Finish Group, Gloucestershire Health & Care (GHC) NHS Foundation Trust's Social Inclusion & Partnership Team, Gloucester's Race Equality Commission as well as other local community groups and organisations. Final recommendations will be based on these conversations and taken to all relevant decision-making bodies in the local health and social care community/ Integrated Care System (ICS). This will include Gloucestershire's Mental Health and Wellbeing Partnership Board and Mental Health Clinical Programme Group.

We remain committed to working in partnership with colleagues across the system to improve mental health lived experience of ethnic minority communities in Gloucestershire.

**Karl Gluck – Head of Integrated Commissioning for Adult Mental Health, Advocacy and Autism**

Gloucestershire County Council (GCC) and Clinical Commissioning Group (CCG)

[1] In line with recent government guidance, we use 'ethnic minorities' to refer to all ethnic groups except the White British group. This includes White minorities, such as Gypsy, Roma and Irish Traveller groups. In some of our local data tables, we draw a distinction between people from a Black Caribbean background/Black ethnic group excluding White minorities and ethnic minorities, which includes both groups. We have used Census classifications to collate our data. The term 'BAME' (Black, Asian, Minority Ethnic) is only used in this report when referencing quotes or external resources. Also, wherever possible we use the word 'individual' for people with lived experience/ 'service users'

[2] 'Use of the Mental Health Act in Gloucestershire', D Pugh, P Southam, September 2019

## 2.0 Background/National Context:

**2.1** In England and Wales, nearly a fifth of people come from an ethnic minority background[3]. The mental health of ethnic minority communities is important because people from these communities often face individual and societal challenges that can affect access to healthcare and overall mental and physical health.[4]

**2.2** CQC's 2018 report[5] on the rise in detentions under the Mental Health Act (MHA) highlighted that people from ethnic minority groups are much more likely to be detained than those in White British groups. As Figure 1 shows, people from Black Ethnic groups are nationally having much higher rates of detention than those who are White and are over-represented in local detained populations.

**2.3** NHS Digital annual figures for 2017-18 do not reverse this trend. Amongst the 5 broad ethnic groups known, detention rates for the 'Black or Black British group (288.7 per 100,000 population) were over 4 times the rate for the White group (71.8 per 100,000 population). As well as being sectioned, people from a Black Caribbean background are also more likely to; come into contact with mental health services through the police (under section 136 MHA), be re-admitted to hospital under the MHA, be given a Community Treatment Order, be admitted to a secure hospital, and therefore have poorer outcomes over time. A 2018 meta-analysis of ethnic differences in admissions for psychiatric disorders[6] concluded that ethnic minorities were more likely to be compulsorily admitted than White patients, but that there was no significant difference in compulsory admittance rate between Asian and White patients.

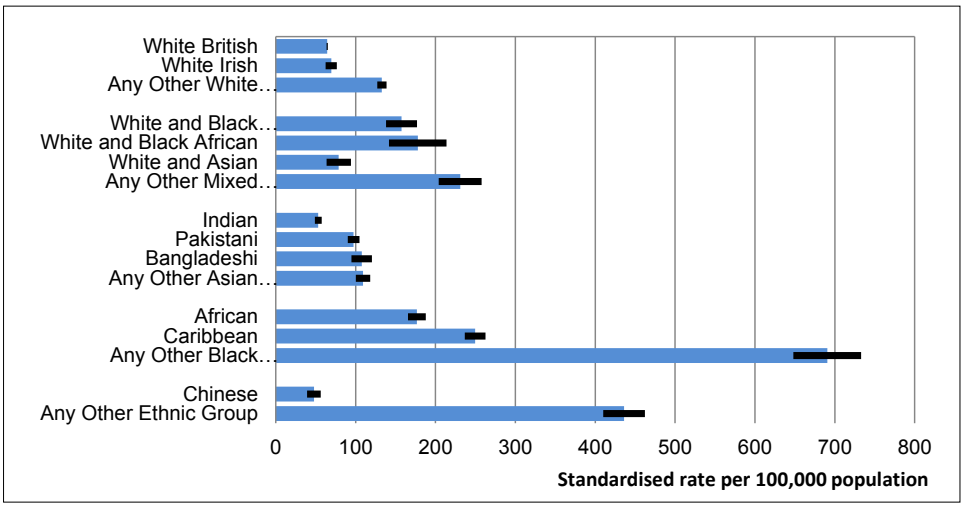



**Figure 1. NHS Digital: Detention rates per 100,000 by ethnicity**

**2.4** Steve Richards, MHA Reviewer and Edge Training Director, demonstrates just how longstanding this issue is and how it spans across at least five successive Prime Ministers. Before the CQC was created, the MHA Commission was the statutory monitoring body. Between them, they have reported on the overrepresentation of ethnic minority MHA detentions for over 30 years. The following are key extracts.

[3] Office for National Statistics (11 December 2012) Ethnicity and National Identity in England and Wales: 2011. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

[4] National Institute for Mental Health in England. (2003). Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England, London, Department of Health

[5] http://www.cqc.org.uk/sites/default/files/20180123_mhadetentions_report.pdf

[6] A Cheng et al 'Ethnic differences in compulsory admissions for psychiatric disorders in the UK: systematic review and meta-analysis', The British Student Doctor, 2018; 2(2):3-16

2.4.1 **1985 - Mental Health Act Commission (MHAC) – biennial report**
Reporting on the views of ethnic minority groups, before statistics were even available, the MHA Commission stated: *'There are suspicions about the way in which the mental health laws are operated, at times they **feel against their best interests,** and there is a feeling that cultural features are not always sufficiently considered when diagnoses of mental illness are made. Research studies appear to support such anxieties in some districts.'*

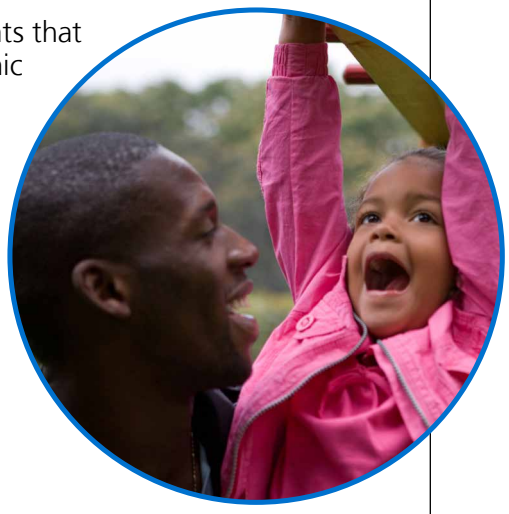
2.4.2 **2009 - Twenty-four years later just prior to being replaced by the CQC, the MHA Commission stated:** *'It is now well-known that, even when standardised for age, such data on admission levels show **disproportionately high levels of detention** amongst Black patients (in particular Black-Caribbean and Black-African patients).'*

2.4.3 **2015: Mental Health Act 1983: Code of Practice** – (1.14) *'People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, **race, religion** or belief, sex and sexual orientation, and culture. **There must be no unlawful discrimination.'***

2.4.4 **2018/19: Care Quality Commission – annual MHA report:** *'Known rates of use of **community treatment orders (CTOs)** have continued to be higher in 2018/19 for Black or Black British people, with **53.8 uses** per 100,000 population, compared with **6.4 uses** per 100,000 population for White British people'. This is 8 times greater rate of use.*

2.4.5 **Tackling the impact of racism is the number one priority to reduce ethnic inequalities in mental illness, according to findings of a national consultation conducted by Synergi Collaborative Centre.** *'Ethnic minority people have a higher risk for experiencing symptoms of psychoses, a diagnosis of psychoses and more adverse pathways to and through care'* reads the report. Kamaldeep Bhul CBE, Synergi's Director and Professor of Cultural Psychiatry and Epidemiology, Queen Mary University said *'After 50 years of these persistent inequalities we need a different approach as we are not getting it right as a society. People don't understand the importance of tackling ethnic inequalities in a healthy society nor the causes as we have not listened to people with lived experience'.*[7]

2.4.6 The **CQC's** most current **2019/20 MHA report** comments that the well-known overrepresentation of patients from ethnic minority backgrounds continues with detention rates for the broad 'Black or Black British' group (321.7 detentions per 100,000 population) over four times those of the White group (73.4 per 100,000). The report also states that the most deprived areas have the highest rates of detention (147.9) detentions per 100,000 population), approximately three and a half times higher than the rate of detention in the least deprived area (42.8 detentions per 100,000 population).



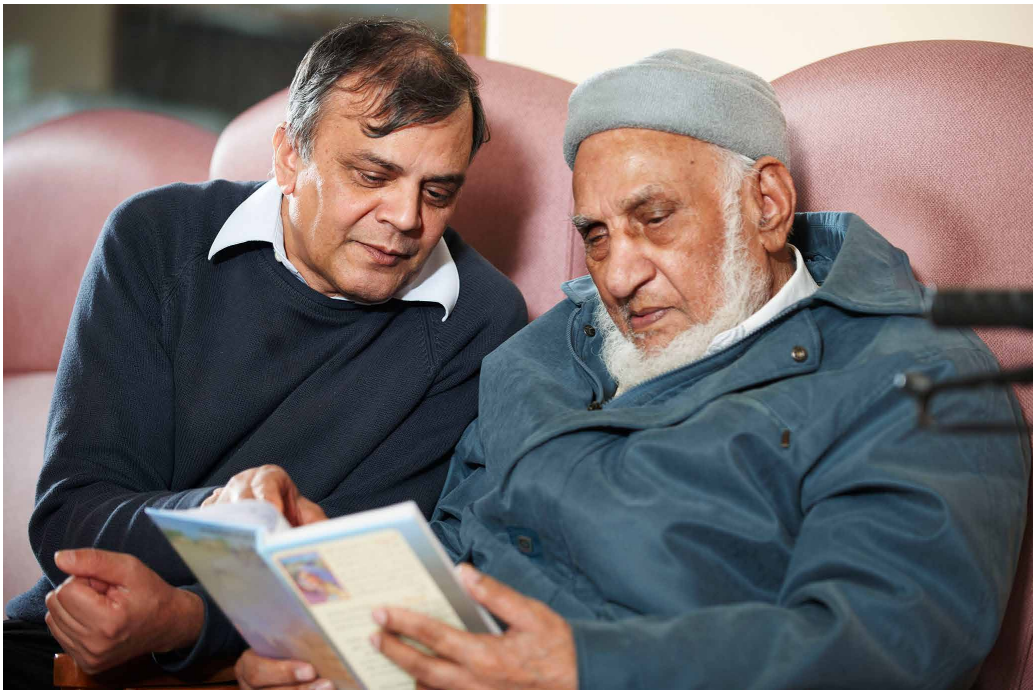
[7] Kamaldeep Bhui reported in Mental Health Today, 09.10. 2019

2.4.7 The **2020 Lawrence Review Report** commented that '*Not only are BAME people dying at a disproportionate rate, they are also overexposed to the virus and more likely to suffer the economic consequences'.*[8] This was supported by MIND's 2020 survey of over 14,000 adults over 25 years old who found that existing inequalities in housing, employment, finance and other issues have had a greater impact on the mental health of people from different ethnic minority groups than White people during the pandemic'[9].

2.4.8 The ONS report 'Coronavirus and the social impacts on different ethnic groups in the UK: 2020'[10] concluded that most ethnic groups in the UK experienced a worsening of their self-reported mental health between 2019 and 2020. The mental wellbeing of those in the Indian ethnic group may have been particularly affected as they reported greater difficulty with sleep over worry between 2019 and the initial lockdown (April 2020) and had higher scores than other groups on a measure of self-reported mental health difficulties.

2.4.9 **A 2021 Exeter University Business School and University of Glasgow report**[11] concluded that ethnic minority men experienced a far greater deterioration in their mental health during COVID-19 lockdown.

**2.5** One of the primary drivers of the **Wessely Independent Review of the MHA** was to investigate the disproportionate number of people from ethnic minority communities detained. As well as reviewing data and evidence, the review strove to learn lessons from people with lived experience of the system. Professor Simon Wessely makes some salutary comments in his foreword to the report[12]:



[8] Executive Summary Lawrence Review, www.lawrencereview.co.uk/chapters/executive-summary

[9] MIND (2020) 'The mental health emergency: how has the coronavirus pandemic impacted our mental health?', London: MIND – www.mind.org.uk

[10] Coronavirus and the social impacts on different ethnic groups in the UK:2020 www.ons.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/cornavirus

[11] Plos One journal from the University of Exeter Business Scholl and the University of Glasgow, 2021 – www.theguardian.com/world/2021/jan/06/british-bame-mens-mental-health-survey

[12] Modernising the Mental Health Act, increasing choice, reducing compulsion, Final report of the Independent Review of the Mental Health Act 1983, December 2018

2.5.1 *'When I started my career in psychiatry research, one of my earliest papers back in 1989 was on the subject of the over representation of those of Black African and Caribbean heritage amongst those diagnosed with schizophrenia. Now,* ***30 years later, it is sad to record that little has changed.*** *There does appear to be more consensus that this increase is real, and not an artefact, and also that it is related to* ***experiences of discrimination, exclusion and racism.*** *There is also consensus that even taking this into account, the* ***use of coercion is far greater in this population,*** *finding its most painful expression in the statistic that those of Black African or Caribbean heritage are over eight times more likely to be subjected to Community Treatment Orders than those of White heritage.'*

2.5.2 '*So we have to accept the painful reality of the impact of that combination of* **unconscious bias, structural and institutional racism, which is visible across society, also applies in mental health care.** *We need to acknowledge and take responsibility for past failings, and the* **manifest inequalities in our mental health system.** *Having taken responsibility, we need clear steps to reduce the disparity in outcomes, supporting behaviour change at every level'.*

2.5.3 The Report's chapter on ethnic minority communities starts with the statement that '*profound inequalities exist for people from ethnic minority communities in accessing mental health treatment, their experience of care and their mental health outcomes'*. Many of the headline recommendations are designed to improve the experiences of people from ethnic minority groups. For its primary recommendation, the review backed the formation of an Organisational Competence Framework (OCF) to help mental health providers understand what steps they need to take to improve provision for ethnic minority groups and meet their obligations under the Equality Act 2010. The OCF is intended to encourage organisations to engage with people from the local area by requiring them to seek feedback about care and treatment. A similar recommendation was made locally in *'The use of the MHA in Gloucestershire' 2019 report.*[13]

2.5.4 Culturally appropriate advocacy was another recommendation proposed by the review which it suggested could help increase engagement with services among ethnic minority groups. It found generic advocacy was *'poor at proactively engaging ethnic minority' individuals.*

2.5.5 Finally, an 'underrepresentation' of specific ethnic minority backgrounds within the mental health workforce was identified as another issue contributing to poor experiences of ethnic minority individuals in services. Wessely backed the NHS Workforce Race Equality Standard programme, designed to ensure employees from ethnic minority backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

**2.6** It is noted the Royal College of Psychiatrists have committed to put together '*…an ambitious new race equality strategy, which will look closely at the training curricula, practice guidelines and much else.' (July 2020)*[14].

[13] Implications of the Wessely Report on the use of the MHA in Gloucestershire, D Pugh, P Southam, September 2019
[14] Reply to open letter by 166 members of the Royal College of Psychiatrists published in the Guardian on 14 July 2020


**2.7** In October 2020 the Department of Health's Mental Health and Inequalities Strategy[15] was launched. It summarises the core actions that NHSE and NHS Improvement will take to bridge the gaps for communities fairing worse than others in mental health services in terms of inequalities of access (underrepresentation in some services and overrepresentation in others), experience and outcomes. Ethnic minority groups generally have poorer recovery rates in talking therapy services (IAPT) than White-British groups. The strategy will include roll out of the Patient and Carer Race Equality Framework (PCREF) to improve access, experience and outcomes for ethnic minority communities. The latter has been developed to support mental health services improve ethnic minority experiences of care as recommended by Wessely's Independent Review. In the short term, examples of positive practice will be shared and in the longer term the framework and its effectiveness will be tested in different sites and settings. This may be an opportunity for Gloucestershire to participate and lead in making improvements for its ethnic minority community.

**2.8** 'Think Local Act Personal'[16] sought examples of what good, personalised community-based care and support looks like for people from the ethnic minority community. This is hoped to include examples of good inclusive practice including, people organising their own support through direct payments, grassroot community organisations working specifically with ethnic minority communities; and Council approaches to reduce care inequalities and improve equality of outcomes. This will produce positive practice that we can learn from and emulate in the future.

**2.9** On 13 January 2021 the Government published a White Paper[17] setting out a plan to implement the Wessely report recommendations with pledges to empower individuals control their care and treatment as well as to tackle racial disparities. Taking 'decisive action' to tackle racial disparities in the use of the Act will include piloting culturally appropriate advocacy services and the further development of the PCREF. It also includes action to develop a representative workforce for purpose to advance mental health equalities and core organisational and staff competencies. The latter aligns closely to Chapter 8 of Gloucestershire's Director of Public Health's Annual Report.

**2.10** In March 2021, the Government's Commission on Race and Ethnic Disparities (CRED), published its report.[18] There is a brief section on mental health under 'health' on pages 222-225. Whilst the report goes someway to highlight the disparities in mental health care and impact racism has on mental health in ethnic minority communities, many see it as a failure to make firm recommendations to bring about change. However, it puts forward the view that the '…*Mental Health White Paper should help towards reducing high detention rates and building trust amongst all patients, and particularly those from Black ethnic minority groups'.* The foreword, authored by Dr Tony Sewell also states; *"We no longer see a Britain where the system is deliberately rigged against ethnic minorities"* shifting responsibility away from institutionalised and structural racism and historic precedents and denying that racism continues to impact individuals. It ultimately failed to achieve the Commission's desire to 'approach the issues of racial and ethnic disparities in a balanced way' as it suggests that the lived experience of many ethnic minority people is not underpinned by institutional racism. It is proven that 'racial trauma' can lead to various mental health issues including but not limited to, *"depression, hypervigilance, chronic stress, fatigue, bodily inflammation, and symptoms like PTSD"*[19] .

[15] 'Advancing mental health equalities strategy', NHSE, September 2020 reference 001559

[16] 'Good, personalised care and support for people from BAME communities – call for examples', 02.12.20 www.thinklocalactpersonal.org.uk/News/Good-personalied-care-and-support

[17] Reforming the Mental Health Act – GOV.UK, 13.01.2021, Read the Mental Health White Paper

[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974507/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf

[19] https://www.bbc.com/future/article/20200804-black-lives-matter-protests-race-mental-health-therapy

## 3.0 Local Position:

**3.1** **Figure 2** demonstrates the percentage of detained patients from an ethnic minority background in Gloucestershire, subject to Section 136, Section 2 and Section 3. The definition includes White minorities ('any other White') as used in RiO (GHC's electronic care record system) and is based on self-classification. It should be noted the ethnic minority total is made up of a wide ethnic mix, with no one ethnic group dominating. On the basis of a Gloucestershire ethnic minority population of 8.4% at the last Census (2011) the chart demonstrates the following:

- Section 136 detentions are largely below 8.4%, with exception of spikes in 2012 and 2017
- Section 3 detentions are largely in line with the ethnic minority population
- Section 2 detentions are above the local ethnic minority population percentage, at around 10%-12%.

**3.2** It should be noted that numbers are relatively small so any increase or decrease of section 2 or 3 detentions will be reflected in a significant percentage change. For example, data for January to March 2018 show that: of the 107 Section 136 detentions, 8% (8.5) were ethnic minority, of the 103 Section 2s, 16% (16) were from ethnic minority backgrounds and of the 47 Section 3s, 11% (5) were from ethnic minority backgrounds.

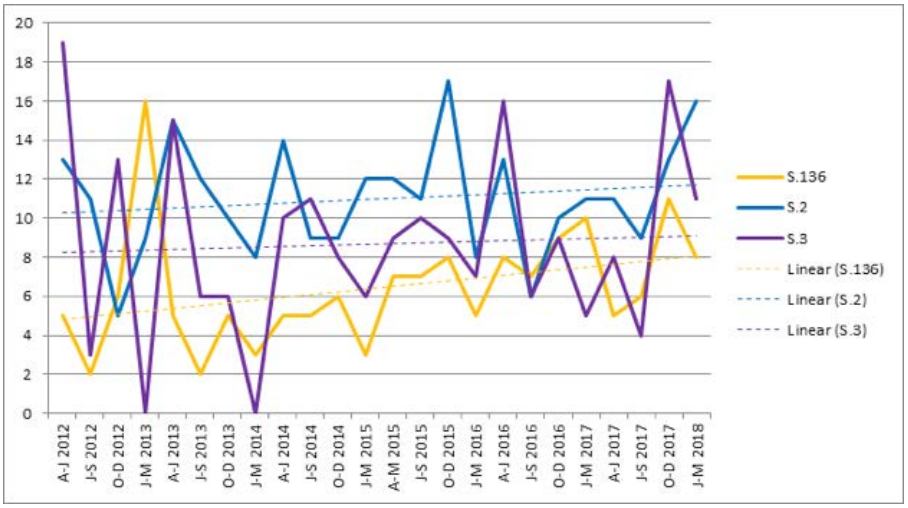



**Figure 2: Ethnic minority detention rates by ethnicity in Gloucestershire as a percentage of overall detentions.**

**3.3** **Table 1** RiO data from April 2015 to September 2018 demonstrates the average percentage of ethnic minority admissions excluding 'White other' for Section 131 (informal), Section 2 and Section 3 and the same averages for the ethnic minority community including 'White other'. Key points from the table are as follows:

- 6% ethnic minority admissions excluding 'White other' is above Gloucestershire's ethnic minority population at 4.6%
- 12% ethnic minority admissions including 'White other' is significantly above the ethnic minority population, including 'White other', of 8.4%
- Informal admissions in both ethnic minority groups are significantly below White admission rates of 51%
- Section 2 rates are higher in ethnic minority groups (42%) compared to White (30%).

| Ethnic Group | Admissions and Sections of MHA | Percentage |
|---|---|---|
| 1. Ethnic minority – excluding 'White other' minorities. 4.6% of Gloucestershire's population (2011 Census | Average % of admissions | 6%* |
| | S131 (informal) | 36% (2% of 6%) |
| | Section 2 | 42% (3% of 6%) |
| | Section 3 | 17% (1% of 6%) |
| 2. White 95.4% of Gloucestershire's population (2011 Census) | Average % of admissions | 94%** |
| | S131 (informal) | 51% (48% of 94%) |
| | S2 | 31% (29% of 94%) |
| | S3 | 16% (15% of 94%) |
| 3. Ethnic minorities – including 'White other' minorities. 8.4% of Gloucestershire's population (2011 Census) | Average % of admissions | 12%*** |
| | S131 (informal) | 38% (4% of 12%) |
| | S2 | 42% (5% of 12%) |
| | S3 | 16% (2% of 12%) |
| 4. White British 91.6% of Gloucestershire's population (2011 Census) | Average % of admissions | 88%**** |
| | S131 (informal) | 51% (46% of 88%) |
| | S2 | 30% (27% of 88%) |
| | S3 | 16% (14% of 88%) |

**Table 1: Ethnic minority and White MHA Admissions (Section 131, Section 2 and Section 3) to Gloucestershire Inpatient Units from April 2015 to September 2018.**

3.3.1 Community Treatment Orders (CTO) data not included in the above shows that for 2019/20 there were 12 per 100,000 population double that of the White community amounting to 16% of CTOs'. The trend for people from an ethnic minority background is static but downward for White British people. It is noted that POhWER, our local IMHA provider, are planning to work more proactively with people subject to CTOs which may lead to a better understanding of why people from the ethnic minority community are so disproportionately represented in this section of the MHA.

**3.4** CCG data on ethnicity for mental health services from April 2019 to July 2020 is based on GP registered population so is not identical to the MHA data. However, in general it supports the findings shown above. It includes all admissions and referrals and demonstrates the following:

- The largest difference between GHC individuals and the CCG population can be seen in admissions. 8.6% of GHC admissions are from ethnic minority backgrounds compared to 5.9% of the ethnic minority population. This is driven by Black or British Black individuals who account for 4.5% of admissions compared to 1.1% of the population.
- The same disparity can be observed in MHA admissions. 12.1% of GHC admissions are ethnic minority individuals compared to 5.9% ethnic minority population. Black or British Black individuals/patients account for 7.3% of MHA admissions compared to 1.1% of the population.

**3.5** In terms of **gender** the GHC data also demonstrates that across all ethnic backgrounds there were more female admissions for 70% (28 months) of this period of time. However, for ethnic minority, including White other, there were more male admissions for 64% (25 months) of this period of time. There were no significant differences across average length of Section.

**3.6** An average per year of AMHP assessment data for 2017/18 – 2020/21 shows 79% (848) of assessments were on White British, 5.2% (53) Black, 4% (43) White non-British and 1.3% (17) Asian. Other ethnic groups were less than one percent. The figure of 5.2% for Black people is significantly disproportionate to the population size of **1.1%**. However, with 9.5% (103) unknown it is difficult to draw definitive conclusion. **Figure 3** displays data for April 2020 – March 2021 which shows **77%** of those assessed but not detained were White British and 11% were from an ethnic minority. A bigger concern is that 148 individuals (11% of all assessments) were recorded as "unknown ethnicity". Staff recording issue versus individual perception and assimilation to an ethnic group/ classification is subjective and difficult to quantify in some cases.

**Assessments Split by Ethnicity**

| | |
|---|---|
| Mixed | 6 |
| Other Ethnic Group | 18 |
| Asian | 15 |
| White-non British | 55 |
| Black | 63 |
| Unknown | 148 |
| White-British | 1,026 |
| Grand Total | 1,331 |

**Ethnicity Split**

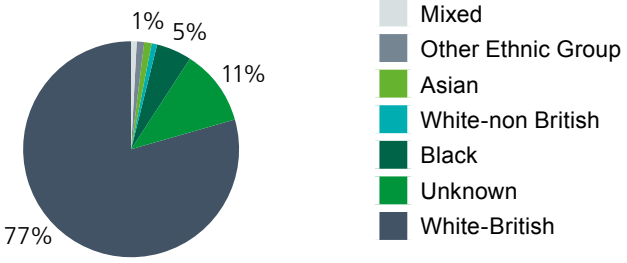



**Figure 3: Assessments split by ethnicity**

**3.7** Research by Laidlaw and Pugh[20] into 5 years of operating the Maxwell Suite (Section 136 health-based Place of Safety) demonstrated that as with the earlier study (2010) when compared with census data from 2011 there was a marginal over representation of Black/African/Caribbean/Black British Groups (1.7% vs 0.9%) and mixed/multiple ethnic groups (1.7% vs 1.5%). In contrast, there was some underrepresentation in White groups (91.1% vs 95.4%) and Asian/Asian British (1% vs 2.1%). More recent data from RiO from 5 December 2020 to 25 February 2021 shows 77% were White British and 7.21% from the ethnic minority community including 'White Other' so roughly in line with the ethnic minority population size. The figure for 'Black' people was 1.75%, only slightly above the population size. However, again the figure for not known/not disclosed was high at 16% making definitive conclusions difficult to draw.

**3.8** In the development of Gloucestershire's response to the national Mental Health Crisis Care Concordat in 2014, a 'Due Regard' assessment was carried out under Section 149 of the Equality Act 2010. Mixed data quality makes drawing definitive conclusions difficult with no common cross agency approach to data collection. Cheltenham's Crisis Resolution and Home Treatment Team didn't meet criteria 4.2 of the Home Treatment Accreditation Scheme (HTAS) review namely that they *'monitor quality and experience received by people from equality target groups'*

**3.9** Some ethnic groups are overrepresented among clinical populations of people with dual diagnosis[21], now known as co-existing conditions. This is defined as a serious mental illness combined with misuse of substances. UK studies have reported dual diagnosis rates of 20–37% across all mental health settings and 6–15% in addiction settings.

[20] D Pugh and J Laidlaw, Medicine, Science and the Law (April 2016 Vol 56(2) 99-106)

[21] Carrà, G., Johnson, S. Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK. Soc Psychistiatrist Epidemiology 44, 429–447 (2009).

**3.10** Nationally, there is a growing concern over unmet mental health needs among ethnic minority individuals within the criminal justice system, particularly in the youth justice system.[22] A 2016 report on the youth justice system found over 40% of children in England and Wales are from ethnic minority backgrounds, and more than one third have a diagnosed mental health problem.[23] It is suggested that the level of need may be even greater as it has also been found that ethnic minority individuals are less likely to have mental health problems or learning disabilities identified upon entry to the justice system.[24]

**3.11** Gloucestershire's Appropriate Adult service reported that for children and young people between 1 April 2019 to 31 March 2020, the number of males was 197 compared to 58 for females (a total of 255). Ethnicity was 175 White British, 1 White Irish, 8 other ethnic group, 3 any other Asian, 9 any other white, 6 any other black, 3 any other mixed, 13 Mixed white & Black Caribbean, 7 Black Caribbean, 4 Black African and 23 were not recorded. Data recorded for vulnerable adults, showed the number of males as 221, and 49 females (a total of 270). Ethnicity recorded 224 White British, 1 White Irish, 3 any other ethnic group, 4 any Asian, 10 any White, 3 any Black, 4 any other Black, 4 mixed White & Black Caribbean, 3 Black Caribbean, 2 Black African, 2 other mixed, and 10 not recorded. The overall percentage of detained people from Black and Minority Ethnic communities was 16.1%, disproportionate to Gloucestershire's ethnic minority community numbers, so a potential disproportionate use of this service.

**3.12** The Wessely report has a section on *'Culturally-appropriate advocacy'* pointing out that a lack of cultural understanding can make poorer outcomes worse for patients from ethnic minority communities, and potentially reinforce barriers to earlier engagement with services. They further point out that advocates are well placed to help patients voice their individual needs and can be crucial to establishing a better foundation for appropriate care and treatment – '*The provisions of culturally-appropriate advocacy is key to reducing additional stresses and anxieties that could exacerbate a patient's mental condition'.*

**3.13** Independent Mental Health Advocate IMHA data from 1 April 2019 – 30 June 2020 demonstrates the following:

- 686 cases including the 119 preferred not to identify their ethnicity plus unknowns (111)
- 491 were White British (71%) compared with overall population figure (91.6%).
- 27 were "Other White "(3.9%) [25]
- 49 were ethnic minorities[26] excluding Other White and Irish, making 7.1% against a Gloucestershire ethnic minority population of 4.6%. However, when looked at admission rate of 6%, this figure is not significantly disproportionate.
- 76 were ethnic minorities including Other White making 11% against a Gloucestershire ethnic minority population of 8.4% (including Other White). However, when looked at

**3.14** It would appear that the IMHA Service is reaching ethnic minority populations and whilst the numbers are small, they are proportionate to the inpatient population of April 2015 to September 2018.

[22] The Lammy Review. An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System.(2017) Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf White, C. Incarcerating youth with mental health problems: A focus on the intersection of race, ethnicity, and mental illness (2016). *Youth Violence and Juvenile Justice,* 14(4), 426-447. https://doi.org/10.1177/1541204015609965

[23] Taylor, C. (2016). Review of the youth justice system in England and Wales. Ministry of Justice. Retrieved from: https://www.yjlc.uk/wp-content/uploads/2016/12/Review-of-the-Youth-Justice-System.pdf

[24] TheLammy Review as above

[25] Other White + Irish + Gypsy/Irish traveller

[26] Mixed ethnicity, Asian/Asian British, Black/Black British, White Asian, White/Black Caribbean, African, Caribbean, Indian, Pakistani, Other ethnic group

**3.15** CCG data on ethnicity for mental health services for April 2019 to November 2020 is based on GP registered population so is not identical to the MHA data which is based on the Census with slightly different population figures. The ethnic minority representation in GHC varies significantly between services but due to low numbers it is difficult to draw robust conclusions. Overall, ethnic minority referrals to GHC services reflect the CCG population with 5.1% compared to 5.9%. However, this varies by category as Black and Mixed individuals are overrepresented and Asian and Other individuals are underrepresented.

**3.16** Whilst we have largely excluded dementia services from this report, we have data on the Memory Assessment Service (MAS) and Community Dementia Service (Symptom Management) (CDN) caseload from 2016/17 to 2020/21. This data adds to the overall picture and reinforces some of our conclusions. A yearly percentage average shows 82% (32,681) were White British, 2% 'Any other White background', 1% Irish (White) and 1% Caribbean (Black or Black British). There were only 142 cases from the Indian (Asian or Asian British) community and less than 100 from other ethnic groups. The Indian (Asian or Asian British) figure appears particularly low.

**3.17** **Data recording** remains a problem. A quote from Gloucestershire's Director of Public Health's Report, *'It makes me sad that 20+years later in my career we are still talking about data being collected, which is the basics of science'.* 40 years later in my career I (D Pugh) echo this. The former report states that *'ethnicity information is not always completed which limits what we can draw from the data'. Clearly as is later stated 'robust equalities data is necessary to identify the root causes of inequality, determine whether interventions are working, attribute any outcomes and prevent inequalities.'* Perhaps unsurprisingly it is no different in the world of mental health. Much CCG mental health data from GHC has insufficient recording of ethnicity to draw many robust conclusions. Snapshots of data collection from the 2020 GHC CRHTT service review found 16% unknown (February 2019) and 12% unknown (October 2019). Recommendation 16 of the latter report is to '*Improve recording of 'Protected Characteristic'* data in order that meaningful conclusions can be drawn from the data, in particular to reduce the number of 'unknown'. Section 136 data from 5 December 2017 to 15th February 2021 shows 16% as not known or not discussed and AMHP data from 2017/18 to 2020/21 shows an average of 9.5% (103) were unknown each year during that period. Data from the Memory Assessment Service (MAS) and Community Dementia Service (CDN) for the five years from April 2016 onwards showed an average of 13% as 'not stated'. Data from POhWER for April 2019 – July 20 shows 'not known' as 111 out a total of 491 so this is also an issue in the non-statutory sector. Data from the Independence Trust for April 2019 – March 2020 shows 458 out of 1217 active referrals as '*Declined to answer or information otherwise not gathered'.* Data on the ethnicity of people exiting the service was not collected so on this indicator it is not possible to assess whether the service meets the needs of people from the ethnic minority community.

## 3.18 Case Study 1.

3.18.1 Haris, a 40-year-old British male of Pakistani origin, has lived in Cheltenham with mental illness for more than 20 years. Haris's main carer started to notice a change in his attitude and behaviour in his late teens; when he failed to attend school, became increasingly withdrawn, and eventually stopped talking. Incidents at home escalated; and Haris frequently became aggressive and subsequently physically violent towards members of his family. The police were only called by the family when the situation became so volatile that lives were at risk. This delay in police involvement was due to the stigma in his local community associated with mental health, lack of awareness of it being an illness as well as the fear of entering the mental health system. Haris was detained under the Mental Health Act and taken to a secure unit for treatment, where he remained for two weeks.

3.18.2 After the two weeks, Haris returned home, but the incidents resumed and the cycle repeated. It was clear that Haris posed a serious risk to his family, so he was given supported accommodation and allocated a specialist support worker. Haris stated that he heard voices in his head, and this would cause him to become fearful even within his own home. He would return to his family home where he felt most secure and would refuse to leave, even to go out for a walk as he felt people on the street were pointing and talking about him.

3.18.3 Haris was eventually diagnosed with schizophrenia and now has a strict medication program. He has had several relapses which has resulted in him returning to the secure unit for reassessment/review of his medication. His main carer has struggled with understanding his condition and the mental health system. English is not her first language, and she is unable to comprehend the consultations which she attends with him. As Haris speaks English, an interpreter is not provided so the carer has to rely on what he tells her. Detail is usually sparse and often inaccurate.

3.18.4 The Carer feels unsupported and ignored as services are directed at Haris, even though she provided for all of his needs. He does not take up any of the external services or activities offered and insists on staying at his carer's home. He remains inactive spending his day watching TV, eating and smoking, which has also impacted on his physical health. His carer feels that due to his lack of engagement, the mental health services have given up on him. It is the carer who has to fully manage the day-to-day care of Haris, and this can be extremely challenging and frightening. Due to the stigma associated with mental illness and the complex processes of the mental health system the carer is unable to easily access help or assistance from community or health services. The only support/advice she has received has been from Community Workers who are known to her, speak her own language and understand her culture.

3.18.5 The carer would like to see a more person-centred approach which would enable Haris to progress towards a more structured life. Currently, she feels that he is in a hopeless situation and she worries about his future when she may not be around. She would like for him to resume a 'normal' life, become part of the community again and eventually integrate into the wider society.

## 3.19 Case Study 2.

3.19.1 An interpreter known to the family and individual with mental illness was brought into the inpatient unit to provide support. It transpired that the interpreter was actually advising the individual not to take medication they had had been prescribed as well as advising them not to engage with their treatment plan. The interpreter was also filtering out information from the clinician to the individual and visa versa, meaning that each party was not receiving full information.

3.19.2 The ethnic minority health member of staff who provided this case study also had other experiences of interpreting services that are of concern:

i) Young children who attend local schools and speak limited English are being used as an interpreter/translator for their parents, often from war torn countries and thus exposed to constantly reliving trauma and sometimes torture stories in graphic detail.

i) Often interpreters do not have any medical/mental health training or background which results in English medical terminology being misinterpreted or misunderstood.

**3.20** Local ethnic minority staff describe the following issues around the use/misuse of interpreters:

- Carers rely on mental health patient or family member to interpret during consultations with healthcare staff. General lack of focus on communication needs of the carer
- Different providers have different criteria for hiring staff, some with no qualification requirement
- Interpreters using a 'pure Gujarati' to a Muslim family who spoke a different version of Gujarati. The Interpreters dialect was one more commonly used by Hindus. No checking by the Interpreter whether the family understood him
- No pre-meeting/discussion about how the interview is to be conducted e.g. one sentence at a time and breaks
- Incorrect interpretation of the information presented by the worker resulting from failure to check his/her understanding with the worker

**3.21** Issues around poor use of interpreters are also identified in the Kingfisher Treasure Seekers and Inclusion Gloucestershire survey in 3.22 below suggesting this is an issue of staff understanding and training. There are existing policies and guidance on the use of translation and interpretation services in both GCC and GHC[27]. The former is strong on best practice on expected qualifications of interpreters and means of feedback for any practice issues. Whilst the GHC policy doesn't state how to provide feedback or explicitly state the level of qualifications expected of interpreters, GHC does use a recognised European framework which requires all their interpreters to meet and adhere to a set of specific qualifications and standards. We would recommend review of all policies across the Integrated Care Sector (ICS), with the focus on staff awareness and training in the use of interpreters and translation services.

[27] Gloucestershire County Council Guidance for Staff in using Translation and Interpretation Services (01.12.2016 updated Dec 2020) and Translation and Interpretation Policy, GHC, August 2020.

**3.22** Gloucestershire's Public Health team worked with Kingfisher Treasure Seekers to undertake the 'Glos Talks' project as a locally rooted awareness campaign against mental health stigma in Gloucestershire. There is a countywide tackling stigma multi-agency group that oversees the project with a wider emphasis across Gloucestershire. As an action within the local Mental Health Crisis Care Concordat, the project was asked to take a specific look at the experience of the local ethnic minority community. Kingfisher Treasure Seekers worked with Inclusion Gloucestershire to carry out an independent survey[28] of people's experiences of accessing mental health services, with a specific focus on the ethnic minority community. The research (and subsequent report) was carried out independently. The co-produced survey (Appendix 3) was conducted in late summer 2020 and attracted 62 responses. Of these 68% (42) were 'White-British' and 32% (20) ethnic minorities including 6.5% who preferred not to state their ethnicity. The majority of the respondents were female, and this was the case in all ethnic groups except those from Asian Indian and Arab backgrounds. So the numbers are small, but some of the issues resonate and support a number of the issues identified within this report e.g. poor practice in use of interpreters. **Executive summary** headlines were as follows:

- 72% of individuals felt that they had experienced discrimination in some form.
- Only 38% of individuals were keen to talk to their close family about mental ill health.
- Only 8.6% of individuals were keen to talk to their colleagues about mental ill health.

Note: these percentages relate to the sample as a whole; and not just responses from ethnic minority participants.

**3.23** The following is a summary of key findings around the ethnic minority community and mental health:

- **Interpreters:** 5 people (8%) of the total respondents (62) indicated that they had not been offered the option of an interpreter when they might have needed one. For those who had used one (19 people), their experience was largely not effective (74%) with only 5 people stating that the interpreter service had been wholly or partially effective. The poor experience of those from non-White British backgrounds was particularly evident. The survey recommends improved translation and communication surrounding medications and side effects and further research around the effectiveness of translators at medical appointments.

- **Training of Healthcare Staff:** 11 people (19%) felt that healthcare staff were never or not often trained to meet an individual's cultural needs and 12 people (21%) stated this was sometimes the case. The survey recommends further strengthening of cultural awareness and effective communication for healthcare professionals including reception staff.

- **Discrimination:** Respondents were asked if they felt they had been discriminated against on a range of grounds, including age, gender, religion, sexuality and ethnicity. 39 people (72%) across the whole sample (including white British and ethnic minority respondents) stated they had been discriminated against and 2 people (3.5%) were unsure if they had experienced discrimination. 50% whom identified as Asian Indian experienced discrimination on the grounds of ethnicity and religion, compared to 0 people who identified as White British. *'Feel I'm not clever enough to know what's ailing me'* – Black or Black British-Caribbean respondent. *''You have to be from our community to understand how bad it is'* – White Gypsy Traveller respondent. Recommendations included 'Improved Attitudes', 'Reasonable Adjustments' and 'Improved Training and Information'

[28] Health Inequalities: accessing health services in Gloucestershire with particular focus on BAME communities, Inclusion Gloucestershire and Kingfisher Treasure Seekers, October 2020.

- **Mental Health Services:** 61 people responded to a question asking whether they had ever used mental health services and 37 (60%) were currently or had in the past. The samples were too small to draw any comparative data based on ethnicity. Questions were asked about the emotions people felt using mental health services. Nearly 70% sometimes, frequently or always felt shame and over 70% experienced disappointment. *'Disgust' – 'The shame was in relation to my experiences. Disappointment was in relation to a bad therapist, once changed the therapist was great! Mental health services need a complete overhaul in general for everyone, not just minorities'* – Asian or British Asian – Pakistani respondent.

- **Strategy Development:** 50 people responded about whether they felt the needs of their cultural group were considered by health and social care when developing strategies. 20 people (36%) felt their cultural needs were considered and 14 (26%) did not. There was a higher percentage representation in this response from Asian Indian, Black Caribbean, Arabs, White – travelling community and 'Prefer not to say'.

**3.24** In April 2019 – March 2020, the **Community Advice Links Mental Health Service (CALMHS)** delivered by the Independence Trust, had 1,217 active referrals into the service. Of these 1217, the table below represents how many identified as being from an ethnic minority background. However, the very high unknown figure of 458 makes any meaningful analysis impossible.

| Ethnicity | Total Clients |
|---|---|
| African | 1 |
| Any other Asian background | 5 |
| Any other Black background | 1 |
| Any other ethnic group | 5 |
| Any other mixed background | 4 |
| Any other White background | 17 |
| Black / Black British | 6 |
| British | 700 |
| Caribbean | 2 |
| Chinese | 3 |
| Indian | 3 |
| Irish | 5 |
| White and Asian | 3 |
| White and Black Caribbean | 4 |
| Declined to answer or information otherwise not gathered | 458 |

**Table 2. Community Advice Links Mental Health Service (CALMHS) Active Referrals April 2019 – March 2020.**

**3.25** A retrospective analysis of cases could identify options for alternative and earlier interventions to detention. There was an undertaking in November 2020 to do this in GHC but at the time of writing nothing has been received and this has been included as a recommendation.

**3.26** In summary, local data reflects the national position with both an **overrepresentation** of the ethnic minority community under compulsory powers of the MHA and **underrepresentation** in other services. Regrettably there is insufficient recording of ethnicity data in many community services to draw and robust or reliable conclusions. This is just not good enough in 2021.

**3.27** As part of our preliminary consultation on the data in this report a number of additional sources of data have been suggested for inclusion. They are as follows:

- Early intervention services such as IAPT and more recent preventative services commissioned by Public Health (subsequently established IAPT ethnic minority data on numbers accessing the service is not available via the CCG yet).
- Suicide prevention data.
- Mental wellbeing of Children and Young People from an ethnic minority community via the Online Pupil Surveys.
- Contact with the 'Reduce Offending Group'.

**3.28** Relevant data will be included if it is readily available, or it will be checked out later if the consultation process confirms it would be helpful to have any of the above to inform current or make new recommendations.

**3.29** Finally, ethnic minority **workforce issues**. The Wessely review of the MHA found there were not enough staff from certain ethnic minority backgrounds, in particular Black African and Caribbean communities, working in mental health services. They reported that they felt misunderstood by those delivering therapy and that this was then used as a reason to exclude them. The report recommended that in line with the NHS Workforce Race Equality Standard programme, greater representation of people from Black African and Caribbean heritage should be sought in all professions, in particular psychological and occupational therapy. They also recommended that people from Black African and Caribbean heritage should be supported to rise to senior levels of all mental health professions, especially psychiatry and management. Both of these recommendations were accepted by the Government and are reflected in January 2021 MHA White Paper. There is reference to the *'2020/21 People Plan'* which 'sets out the urgency required to intensify efforts across teams and organisations' and require all local areas to take action. At the time of the local Wessely report[29] the then Joint Director of HR/Organisational Development at 2gether NHS Foundation Trust was very supportive of these recommendations stating that they fitted well with the '*Workforce Race Equality Scheme*' (WRES) and a paper on *'Diverse Leadership for a Transformational Organisation'* which had been endorsed by the Shadow Boards in April 2019. We also note that local Councillors are predominately White British, as are the overwhelming majority of senior staff in GCC and across the ICS. It is encouraging however that GCC has recently become a signatory of the *'Business in the Community Race at Work Charter' and its 'Five Calls to Action'.*

[29] Implications of the Wessely Report on the use of the MHA in Gloucestershire, D Pugh, P Southam, September 2019

# 4.0 Inequalities and Disproportionate use of the MHA

**4.1** The Director of Public Health's 2020 Report makes it clear that knowing the differences between ethnic minority groups, compared to the general population in Gloucestershire, helps us understand the driving force for health inequalities. Underpinning this is the experience of discrimination. *'Structural, institutional and interpersonal forms of racism together shape the experience of minority ethnic groups and contribute to the persistent differences in health and wellbeing that BAME people face'.* These are also present in mental health services particularly around MHA detentions. Wessely comments that *'the explanations given for these detentions are often based on stereotyped assumptions and not backed up by evidence and may be driven by structures which are inherently biased against Black African and Caribbean people'.* The focus groups of ethnic minority communities consulted as part of the review stated they *"overwhelmingly… felt there was a lack of cultural awareness in staff and a need for culturally appropriate care"*. Concerns around racism, stigma, stereotyping and **overmedication** were also raised. Gypsy, Roma and Traveller communities can have similar difficulties to those who are homeless in that their living status makes it more difficult to access healthcare.

**4.2** *However* Wessely concludes that there is *'no single or simple remedy to resolve this situation'*. The following is an attempt to account for the disparities outlined above:

a) **Experiences of deprivation and discrimination.** Research suggests that experiencing racism can be stressful and have a negative effect on physical and mental health.

b) **Social and economic inequalities.** Ethnic minority communities are often faced with disadvantages in society. They are more likely to experience poverty, have poorer educational outcomes, higher unemployment, more contact with the criminal justice system, and may face challenges accessing or receiving professional services.

c) **Historical legacies of slavery and migration.**

d) **Differences in social and family support and mental health stigma.** Different communities understand and talk about mental health in different ways. In some communities, mental health problems are rarely spoken about and can be seen in a negative light. This can discourage people within the community from talking about their mental health and may be a barrier to engagement with services.

e) **Public and professionals' perceptions of risk.** The criteria for detention under Sections 2 and 3 of the MHA and the criteria for arrest under Section 136 involve, among other things, subjective assessment of whether someone poses a risk to themselves or others. These criteria in themselves might open the door to biases. It is possible subconscious bias stereotypes of Black people; men especially operate at a subconscious level on decision-makers at the point of assessment under the MHA. Sneha Khilay of Edge Training and Consultancy talks about 'unconscious bias' and whilst a normal, healthy aspect of our cognitive ability can lead us to make assumptions about a person because of an aspect of their identity such as race, ethnicity, gender etc. Without realising it, we can have unconscious biases that either favour those who match our own identity, or the identity that is most culturally privileged.

f) **The reasons for and impact of recreational substances use.**

g) **The role of structural racism within health, social care, education, criminal justice, and other institutions;** A 2016 report on the youth justice system in England and Wales found over 40% of children are from ethnic minority backgrounds, and more than one third have a diagnosed mental health problem.

h) **Distrust of mental health services,** possibly due to past experiences. This means people don't contact services until it's too late by which time they are in crisis or the impact of their distress results in contact with the criminal justice system (CJS) (the latter are 40% more likely to come into contact with mental health services through the CJS.

i) **Lack of cultural and language appropriate communication,** meaning people are not taken seriously when presenting with symptoms.

j) **Lack of access to psychological treatment at an early stage, particularly for Black-African and Caribbean men.**

k) **Lack of clinical training** on presentation of different illnesses.

## 5.0 What can be done

**5.1** In terms of solutions it is suggested that work needs to be done to tackle the possible fear of mental health services which has developed amongst ethnic minority communities, due to their past experiences. Culturally acceptable alternatives to detention need to be considered, such as primary care and community-based solutions. In the past, the Gloucester and Forest of Dean crisis teams have taken initiatives under the Crisis Care Concordat umbrella to reduce the 'engagement gap' and make their service more accessible to ethnic minority communities. A local Community Development Worker describes two positive examples of this intervention.

i) **Example 1**: A Muslim lady who was at Wotton Lawn Hospital during Ramadan refused to take her medication as she wanted to carry on fasting. Staff got in touch to see if there was anything I (the Community Development Worker) could do to help. I went in and spoke to the lady in question and advised her that she was in fact going against the teaching of Islam by refusing her medication. She needed to engage with her treatment plan, recover fully and then make up the missed fasts once she was discharged. She agreed to a compromise and started taking her medication but did not eat or drink during the day

ii) **Example 2:** On another occasion a Muslim male had been admitted to Wotton Lawn Hospital. When well, this individual would have a full beard and say his 5 daily prayers. Due to his episode of ill health however, he informed staff that he was taking a break from practicing his faith, which staff recognised as being due to his illness. I went and spoke to him, reassuring him that the Trust was committed to meeting his religious & cultural needs and would support him in fulfilling his religious duties. Shortly after my visit, the individual asked staff for a prayer mat and a room in which to say his prayers

**5.2** We also have the very positive example of the 'Gloucestershire BME Network for Dementia' which is now 5 years old. The group was set up to continue work that initially started with a BME CQUIN, set up by the CCG to increase access to Dementia services for people from ethnic minority communities in Gloucestershire. Membership includes representation from GHC, Age UK, the Alzheimer's Society, Gloucestershire's Older Person's Assembly (GOPA), POhWER Advocacy, Gloucestershire's Carers Hub, Green Square, GCC and Fairshares. Aims of the group include bringing people together who work in ethnic minority communities and share good practice; improving access for ethnic minority individuals and their carers, providing post-diagnostic information, support and raising awareness of memory problems and dementia in ethnic minority communities, as well as providing a mechanism for the voices of people from ethnic minority communities to be heard and supported to influence local services.

**5.3** Key achievements have included communication, networking and sharing of knowledge, an information resource for ethnic minority communities, Carer Education Groups, awareness of the signs and symptoms of Dementia, Dementia Videos in different languages and having a better understanding of the experience of people from ethnic minority communities when undergoing memory assessment. The latter has resulted in

- Changes to assessment tools that are used
- Training provided to staff to understand needs and cultural differences
- Feedback to interpreting and translation services.

**5.4** All of the above are positive examples of what could be adapted by all mental health services. The Mental Health Foundation[30] summarise the need for greatly increased cultural competency in mental health services as:

- practical improvements in language (interpreting, translating and literacy support),
- meeting faith-related and religious needs,
- providing culturally appropriate food,
- accessing gender-specific services and staff,
- increasing the ethnic diversity of staff,
- addressing and reducing experiences of racism and discrimination.

**5.5** On the basis we don't have clear unequivocal data/evidence to support or reject each explanation for existing inequalities without undertaking ongoing and lengthy research, it is clear that a combination of the ten recommendations at the end of this report would go a long way to creating a more accessible, equitable mental health service with better outcomes for our local ethnic minority community. We have built on some of the more overarching recommendations from the Director of Public Heaths 2020 Annual Report where they are relevant to the mental health issues within this report. We have also consulted ethnic minority staff, community organisations and individuals in honing these recommendations. But we have to go further. As Mini Mangat, head of patient engagement at Connect Health, stated in a webinar promoted by MIND *'It's not as easy as taking our workshops to communities, we need to establish lasting relationships though adapting and co-creating culturally-sensitive initiatives. We should be getting our practitioners in front of these people to build relationship – not the other way around'.*[31]

**5.6** One immediate and current opportunity which could address many of the issues raised, particularly earlier access to services, is the Community Mental Health Transformation project. Earlier preventative action through building a new, inclusive community-based offer (based on redesigning community mental health services) will contribute to a national 370k increase in access by 2023/24. This should include members of the ethnic minority community who have previously stayed outside of mental health services. Addressing inequalities in mental health care is a strand that runs through the design and policy framework.

[30] Mental Health Foundation, 'Black, Asian and Minority Ethnic (BAME) communities, 2021 https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities

[31] Mimi Mangat, Connect Health as reported by MIND from Connect Health Change webinar series, December 2020

## 6.0 Recommendations

**6.1** Consult with GCC Black Workers Network, Gloucestershire's multi-agency BAME COVID-19 Task and Finish Group, GHC Social Inclusion and Partnership Team and local ethnic minority community groups about these draft recommendations.

6.1.1 Use the opportunity presented by the MHA White Paper consultation to engage ethnic minority staff and local community through webinars and distribution of relevant and accessible information.

**6.2** Endorsement of recommendation 1 from the Director of Public Health's report to a) *'require comprehensive and good quality ethnicity data collection in all public services (directly provided and commissioned) including death registration; and b) put in place cultural intelligence training and messaging to improve response rates.'*

**6.3** Offer to pilot the Patient and Carers Race Equality Framework (PCREF) and to include development of cultural competence training for staff which will in turn include 'subconscious bias' training.

**6.4** Ensure mental health commissioners use standard Equality Impact Assessments, as well as ethnic minority data and experience feedback to inform commissioning decisions. Training for commissioners should explicitly cover the differences in access, experience and outcomes for ethnic minority individuals, (including refugees and asylum seekers) and their responsibilities in addressing these.

**6.5** Address traditional ethnic minority experiences of poorer access to mental health services and poorer outcomes, primarily through the Community Mental Health Transformation Programme. This to include a personalised care approach, strong partnership working and consistent support of local ethnic minority community and voluntary-based organisations to develop a robust infrastructure.

**6.6** Review the use of interpreter policies and guidance by health and social care staff in mental health services across the ICS. Establish if further guidance/awareness/training is required to ensure compliance plus application within commissioned services.

**6.7** Review quality of culturally appropriate advocacy, with a view to engage in a national pilot.

**6.8** Investigate the need for regular specific mental health focussed community events.

**6.9** Analyse a sample of ethnic minority admissions under the MHA to identify possible options for alternative and earlier interventions.

**6.10** Take action that supports greater representation of people from ethnic minority heritage across all mental health professions. Develop ethnic minority career progression pathways including mentoring, reverse mentoring, leadership training and sponsorship.

**Noor Al-Koky**
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**18.02.21**