

# treading water

strengthening action : furthering impact

**focussed  
implementation  
site  
development  
programme**

Final Report - Feb 07



## ACKNOWLEDGEMENTS

Throughout this commission, brap worked closely with Loretta Fuller, Focussed Implementation Site Project Co-ordinator, who was the nominated contact from the wider project steering group. To this group - Jackie Lynton, Simon Thompson, and Ranjit Senghera - and especially to Loretta Fuller, we would like to record our thanks.

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# 1. Introduction and context

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*Delivering Race Equality in Mental Health Care* (DRE) is an action plan for achieving equality and tackling discrimination in mental health service provision in England for all people of black and minority ethnic (BME) background, including those of Mediterranean origin and East European migrants.

DRE arises from responses to three key recent reports:

- Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England<sup>1</sup>
- Delivering Race Equality: A Framework for Action; and
- The independent inquiry into the death of David Bennett<sup>2</sup>

The independent inquiry into the death of David Bennett - a 38-year-old African-Caribbean man who died whilst an inpatient in Norfolk Mental Care NHS Trust in October 1998 following a period of physical restraint - has been of especial importance, of course. In much the same way that the murder of Stephen Lawrence shone a spotlight on failings in the police service, David Bennett's death while in care is seen as highlighting clear and longstanding inequalities in access, experience and outcomes for BME mental health service users. So, *Delivering Race Equality in Mental Health Care* is intended to offer a coherent programme of work for achieving equality and service transformation in our mental health services, especially in what have become termed the 'building block' areas of:

- **ensuring more appropriate and responsive services** - developing organisations and the workforce; improving clinical services; and improving services for specific groups, such as older people, asylum seekers and refugees, and children.
- **improving community engagement** - engaging communities more effectively in the planning of services.
- **utilising better information** - improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services.

## 1.1 Purpose of this work

It is against this backdrop, then, that the Strategic Health Authority for Birmingham and the Black Country, as part of its work to ensure the robustness of individual Trust's action plans for service transformation, commissioned us to offer specialised race equality assistance. In particular, the SHA wanted us to help analyse individual Trust's action plans with a view to assessing whether the objectives these set out - and the race equality thinking and practice underpinning them - were sufficiently robust to help meet *Delivering Race Equality's* (DRE) key priorities of:

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<sup>1</sup> National Institute for Mental Health in England (NIMHE) [2003]: [www.nimhe.org.uk](http://www.nimhe.org.uk)

<sup>2</sup> Department of Health [January 2005].

- Less fear of mental health services among BME communities and service users and increased satisfaction with these services;
- A reduction in the rate of admission of people from BME communities to psychiatric inpatient units;
- A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;
- Fewer violent incidents that are secondary to inadequate treatment of mental illness;
- A reduction in the use of seclusion in BME groups;
- The prevention of deaths in mental health services following physical intervention;
- More BME service users reaching self-reported states of recovery;
- A reduction in the ethnic disparities found in prison populations;
- A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
- A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and the planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

As part of DRE's call for 'focused implementation sites', which are a means of concentrating effort and sharing good practice, the SHA chose to use brap's support as part of a regional pilot programme.

Our key purpose, then, was not to add to the already demanding targets, plans and strategies facing mental health planners, but rather to offer practical assistance and support to Local Implementation Teams (LITs) that would help them:

- Gain a better understanding of race equality issues and practice;
- Revisit and critically reflect on their action plans;
- And interrogate their decision-making in light of the fresh thinking currently reshaping the race equality agenda.

Our work has had three main dimensions to it:

- A review of Trusts' existing action plans and equality strategies and a review of key policy documents;
- A review of the BME ethnicity data, information-gathering and monitoring used by Trusts in the region to inform service delivery priorities;
- And the development of practical resources, including a facilitation aid or framework, which will help LITs assess their progress on race equality issues

and, in particular, whether their local delivery plans will help meet national service transformation objectives.

In carrying out this work we have had three key objectives:

- To provide 'light touch' advice to mental health Trusts in Birmingham and the Black Country on how they could both strengthen and further develop their existing action plans - with a key longer-term aim that any changes to service provision should be amenable to mainstreaming, thus delivering improvements for everyone.
- The production of a short and succinct report indicating 2 or 3 key area focused action that can progress equality.
- And the creation of an easy to use framework that will help Local Implementation Teams audit and augment their plans for improving race equality practice.

The commission also included the review of individual action plans and an examination of the Autumn Themed Reviews. It also attended Local Implementation Team and BME sub-group team meetings across the region, both as participating and non-participating observers, and held one-to-one meetings with key commissioners.

As part of strengthening action plans we devised a 'Thinking Outside the Box' workshop to provide a 'learning space' in which participants could reflect on and think more critically about the priorities that they had identified as part of the initial action planning process and, in particular, how these could be converted from 'short term project based responses' into part of the mainstream agenda for change. The resources used for this session are in Appendix 1.

## **1.2 Participation in the programme**

This programme of work - perhaps best described as a portfolio of analysis, reflection and support - was commissioned by the Strategic Health Authority for Birmingham and the Black Country in October 2005 and commenced in January 2006.

Nine mental health trusts participated in the programme: Heart of Birmingham, Dudley, Wolverhampton, Walsall, South Birmingham, North & East Birmingham, Sandwell and Solihull.

Given that the purpose of this programme of work has been to provide specialist local support to leaders and local implementation teams charged with planning and delivering improvements in mental health services for BME service users, it is important to mention at the outset the problems many Trusts experienced in making sure that staff had sufficient time and capacity available to participate in, and make best use of, this programme of support. This is clearly a fundamental problem and further highlights the need that exists within the health service to invest appropriately in creating an enabling environment for those at the sharp end of responding to Government service improvement initiatives.

## 1.3 Scope of this report

The emphasis of this work programme has been on 'support in action' - providing practical assistance and support - rather than lengthy reporting, and for this reason this report will be kept as short and as practical as possible.

This report will, therefore, provide an overview of the key findings arising from our work and, in particular, those issues and challenges that are most widely shared by the regions' Trusts. A brief series of recommendations accompany this summary, which we believe offer practical guidance and can help further focus Trusts' efforts towards service equality. It is also important to say that this report should be read in conjunction with the 'facilitation aid' we have developed for use by local implementation teams.

## 2. Findings

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### 2.1 The drivers for change

From our literature review it is clear that Trusts are responding to a range of recommendations endorsed by the National Health Service. It would be disingenuous to comment upon the strategies suggested by Trusts without acknowledgement of these drivers for change.

In 2004, following the publication of the independent inquiry into the death of David Bennett and the launch of Delivering Race Equality in Mental Health Care, all Trusts were required to develop and detail the care pathways for all users of secondary care services. For BME service users in particular there is an element of risk at various points on the mental health care pathway and 'Count Me In', the recent National Census of inpatients in mental health hospitals and facilities in England and Wales, provides concrete statistical evidence regarding over-use of the Mental Health Act to detain BME users, their longer lengths of stay, their limited access to alternative treatments and higher dosages of medication.<sup>3</sup>

Discriminatory services, 'culturally inappropriate' assessments and significant differentials in the experience and outcomes of BME as opposed to white ethnic mental health service users has focused Delivering Race Equality on what might be described as a three-pronged approach to addressing discriminatory practices in mental health. These can be characterised as:

- More effective and more standardised approaches to the gathering of intelligence and data on BME mental health needs and experience of the service, and more effective utilisation of this data in service design, modification and delivery;
- 'Cultural competency' training at all levels of the service to address covert and direct personal and institutional racism and discrimination;
- And significantly increased community outreach and consultation as a means of ensuring greater engagement with BME communities and a better understanding of BME mental health needs.

It is also an underpinning requirement of DRE that actions to achieve these ends should also be amenable to embedding in the mainstream of mental health service provision.

And yet DRE itself raises some concerns that have been voiced regarding the clarity of its objectives. It has highlighted, for example:<sup>4</sup>

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<sup>3</sup> NHS West Midlands 'Beyond Basic Chatter' Focused Implementation Site project update [November 2006].

<sup>4</sup> *Delivering Race Equality in Mental Health: An Action Plan for Reform Inside & Outside Services: Annexe – Summary of critical responses to the DRE framework*, p.76, Department of Health.

- a) Confusion between the processes of community development and community engagement, with the roles of Community Development Worker and race equality leads insufficiently delineated;
- b) A significant but ill-defined role for the voluntary and community sector;
- c) An over-emphasis - and an unqualified emphasis - on 'race', which might perpetuate the concept of biologically or genetically distinct and 'humanly' different 'races'.
- d) An over-reliance on bolt-on solutions to address issues of mainstream deficiency.

An examination of existing Trust action plans tends to reflect the points above. There is not only continuing confusion regarding some key DRE objectives, but also a widespread tendency to fall back on established procedures in, for example, commissioning services from third sector organisations - rather than critical reflection on, and interrogation of, these practices to determine their true effectiveness.

In the following summary we attempt to draw together these key issues, as they emerged to us in our examination of the region's action plans and in the subsequent discussions and workshop activity.

## **2.2 Overview and observations**

### **a) Introduction**

Most Trusts have followed the Delivering Race Equality policy directives regarding consulting with the community to plan services. Hence black and minority ethnic service users, carers and BME third sector organisations have a presence on many if not all planning teams. Public services have been encouraged to move in this direction by government and other bodies, a move which is seen as fulfilling demands for more effective consultation, involving the voluntary and community sector more effectively and giving black and minority ethnic communities a greater say in service delivery.

While there is no doubt that some benefits will flow from this involvement - not least a breaking down of the 'them and us' divide - we were struck by how little the process is being interrogated or examined in an effort to better understand its potential shortcomings.

### **b) Commissioning**

It must also be said that current community representation and engagement techniques in the health service are also tending to reinforce what we have come to term an 'ethnicised response' to equality. For example, black and minority ethnic 'representatives' are still sought on the grounds that they effectively represent a community - such as, for example, Sikhs, African Caribbeans or Pakistani Muslims - rather than for any expertise or competence they may have.

As well as reinforcing well-documented patterns of community exclusion<sup>5</sup> - where the voices of young people and women in particular may go unrepresented by 'community leaders' - such approaches also perpetuate the notion that BME communities are undifferentiated and homogenous, thereby ignoring the diversity that exists *within* diversity. Singling out individuals to represent specific communities or groups may also encourage community representatives to pursue a narrowly focused agenda which is not necessarily in the interests of the wider community. Indeed, it may also be the case that community or 'group representation' models perpetuate rather than dispel stereotypes, and it is perhaps this aspect which is of most concern in the context of DRE and its central focus on identifying 'cultural needs'.

Most importantly, however, we cannot ignore how these stereotypical assumptions not only serve to de-skill professional staff - who are being told, subliminally, that they do not 'have what it takes' to deliver services to these 'special' groups, but also inform commissioning and service delivery strategies.

In our work with the Trusts we saw a widespread effort to commission *culturally sensitive* services, but it was clear that many practitioners did not recognise the difference between culturally *sensitive* and culturally *specific* services. This misunderstanding is perhaps best illustrated in the way Trusts have commissioned, for example, services for people of Bangladeshi descent to be delivered by a Bangladeshi organisation - or services for African Caribbean people to be delivered by an African Caribbean organisation. Such service delivery is, in essence, culturally *specific*. Worryingly, we also found that these 'culturally specific' providers were unlikely to be questioned about their equality policies or approach; it was assumed that equality would be a given. This not only ignores the diversity within diversity issue highlighted previously (and thus the potential for service users to encounter other forms of discrimination), but also fails to address the potential for racism within such provision. Additionally, little thought was given to assessing the quality standards of such organisations; this omission potentially risks the creation a two-tier health system and further perpetuation of inequality.

Perhaps Trusts should be analysing more critically the equality gap they are trying to plug with this type of activity? If mainstream service provision is currently unable to ensure equitable access, treatments and experiences to *all* service users - then it is **the culture of mainstream provision** that has to be addressed and '*sensitised*'. It is the racism and discrimination that manifest themselves in the day-to-day culture, practices, interactions and treatment encountered by service users that surely lie at the core of the problem?

The commissioning of culturally specific services does not address this problem head-on, it side-steps it. Consequently, this approach will neither have the anticipated impact on the change agenda, nor enhance a better understanding of the causes of inequality. Moreover, as a consequence, mainstream provision is allowed to continue delivering poor services to black and minority ethnic people.

We hesitate to make such an obvious observation, but throughout the plans devised by Trusts, there was an emphasis on initiating action that is *external to the service*. By this we mean that the role of the community development worker (access and engagement) and the role played by the voluntary and community sector (commission alternative provision), were the main focus of local implementation

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<sup>5</sup> brap has written extensively on community engagement issues and race equality. See especially: *Community Consultation: A Guide* (brap briefing paper 1); *Do They Mean Us?* (brap briefing paper 3) and *From Anti-Racism to Diversity* (brap briefing paper 6) – all available at [www.brap.org.uk](http://www.brap.org.uk)

delivery. The matching of potential service users to those of the same ethnicity was, in the main, seen as a 'fix' for all of the failings of the mental health sector. Indeed, those involved identified this as a progressive strategy and as evidence of good practice.

Our view, however, is that while the strategy may succeed in diversifying the provision currently on offer, there is little evidence that this external commissioning demonstrates a greater understanding of how to commission for 'quality of experience'. In fact there is an overwhelming assumption that provision which is managed and developed by those of the same ethnic group as their potential clients will, by default, meet the requirements of the DRE.

As part of this consultancy we visited two culturally led service providers. In both cases we were shown that the provision had proactively dealt with many of the recommendations within the DRE - in particular those to do with alternative modes of therapy and issues of restraint. There is, however, no clear evidence that commissioning frameworks are able to assess beyond a 'cultural' fix; the current assessment is not sufficient to guarantee either an improvement in the quality of the provision or in the choice of services, across the board, offered to clients. There is a massive contradiction here, in which BME clients could be signposted to BME service provision, thus further stereotyping these service users and *decreasing* the choice of provision that is on offer to them.

### **c) 'Chicken or Egg'**

While we understand that the pressure to adopt 'culturally specific' services may emerge from community consultation, it can also be argued that there is something of a chicken-and-egg situation here. Community consultation and engagement approaches built on 'group representation' models are more likely to result in demands for culturally specific services. Hence commissioners are pushed towards funding what might be called 'black on black' services regardless of whether this is what all black and minority ethnic individuals want or whether such provision offers genuinely greater quality or value. The effect on mainstream services, however, is potentially more damaging and longer-term in that it encourages the thinking that the key to service transformation lies in enabling minority communities to 'look after their own'. Ironically, it can also be argued that this type of approach further reduces the interaction between mainstream service professionals and BME service users.

If the commissioning of culturally sensitive services is to be an option designed to provide greater choice, high quality services to clients, and a means of addressing inequality - then an evidence-base, which demonstrates these benefits is required. Commissioning should be conducted on the basis of offering a sound, quality alternative, rather than a pigeon-holed match based on stereotypical assumptions. The sustainability of this strategy should also be examined.

### **d) Sustainability**

Perhaps the most significant issue is that in the long term this kind of 'outsourcing' may be neither sustainable nor amenable to mainstreaming. To begin with, as diversity increases - *as diversity becomes more diverse* - it will become increasingly difficult to 'slot' people into particular ethnic groups. Therefore, to encourage the expectation that all individuals will have their service needs met on the basis of their specific cultural needs - whether these derive from ethnicity, faith or belief, or cultural customs - is impractical; when coupled with Patient Choice it begins to suggest that a service modelled primarily on 'cultural identity' will produce service expectations that

massively outstrip the capacity not just of the statutory health services, but also of their non-statutory partners. This tends to be borne out by population trends identified in the 2001 Census. For example, one of the fastest growing 'groups' in Birmingham and the Black Country is that of people of mixed or dual heritage. If current ethnicised service provision remains the norm then the future is fraught with difficulty.

These are complex issues and in some cases they are even counter-intuitive: how could culturally sensitive services fail to be an unalloyed good? Nonetheless, we do need to find a 'space' in which even the most challenging issues can be discussed and examined openly and freely and without fear of inadvertent or unintended racism. Indeed, the overwhelmingly positive response to the opportunities our work has offered for discussion with mental health service staff, at various levels, convinces us that one of the most beneficial outcomes of this work (and the broader thrust of DRE) could be a climate that is far more conducive to these difficult debates.

There is also a broader point to be made about third sector commissioning in general. Although DRE and indeed many other aspects of Government policy revolve around a dramatically increased role for the third sector in public service delivery, we were surprised to find that few if any commissioning guidelines exist which clarify commissioners' expectations of services delivered by the voluntary and community sector - in particular how these should contribute positively to the patient experience and help meet the key objectives of Delivering Race Equality.

#### **e) The community development worker**

One of the strategies employed to transform mental health services for black and minority ethnic people is to employ a number of community development workers for each locality, this is a requirement from central policy makers. These post holders are meant to be the interface between the community and the service, helping communities understand the services available to them, and helping the service to consider how it might change in order to improve the access, outcome and experience of mental health services.

These are extremely high expectations and it will be a challenge for Trusts to select the appropriate individuals for these positions given that some communities have definite assumptions about who can best serve them. Their focus is not always on skills, but rather on group or community membership. Indeed, whilst community development workers are keen individuals, who want to make connections in the community, their somewhat 'blinkered' perception of the role is illustrated in the casual use of terms such as 'the Asian community' or 'our people'. These clearly imply that they have assumptions about group identity, as well as having very definite ideas about whom they serve, how they work with them and how expectations are to be met. We may be describing two differing skill sets here, one relating to access and connectivity, and the other related to correct signposting and offering choices. Community development workers may then, with the very best of intentions, serve to reinforce the stereotypes of existing provision, rather than illuminate the choices and opportunities open to both the Trusts and potential client groups.

#### **f) Cultural competence training for staff**

The need for staff to receive cultural competence training was featured in all of the actions plans we saw, in line with one of the DRE recommendations. The issue of appropriate training for mental health service staff is important because what has been available in the past is clearly either inadequate or has had little impact on practice.

At the time of conducting this work, national initiatives were being developed to address staff training. These seemed to represent a response to the legislative obligation, stated in the Race Relations Amendment Act 2002, to deliver staff training. We have observed, however, that this strategy may have let Trusts 'off the hook' with very few of them exploring and taking ownership of the training and development best suited to their staff cohort and their specific needs.

There are two central issues here. Firstly, although we are aware of the pilot staff training programme, there is little other evidence of the roll-out of cultural competence training to the mainstream workforce. Secondly, the content or curriculum of such training has rarely been considered critically in terms of progressive approaches to equality or the equality outcomes staff will be expected to contribute to more effectively.

It is difficult to understand how conventional 'cultural competence' training would have preserved the life of David Bennett. Does understanding the foods that certain ethnic groups may eat, or the music people listen to, or the religious practices they follow, reduce or remove racially discriminatory practice? Does cultural competence help staff to understand the causes of inequality in the service? A 'cost-benefit' analysis of this view of development has not taken place and its 'real' potential is therefore relatively unexamined.

It would in many respects seem more sensible to ensure that all practitioners adopt aspects of the role of Community Development Worker. By this we mean that new benchmarks regarding interpersonal skills and time spent engaging with individuals should be an expectation of all staff. The personal touch, involving treating people with dignity and respect, can reap dividends and create the capable workforce and organisation recommended in Delivering Race Equality.

### **g) Workforce representation**

When it comes to workforce diversity, there are a number of features of the National Health Service, particularly of the mental health sector, that make it unique. In terms of the proportion of staff from black and minority ethnic communities employed, the sector appears to be 'healthy' in terms of representation. Although what Trevor Phillips has termed 'snowy peaks' are definitely a feature of the service's upper management structures, nurses and doctors are fairly representative of the population as a whole. Indeed, in some parts of Birmingham and the Black Country clinicians from BME backgrounds - particularly in mental health services - constitute the majority.

On these grounds, if workforce diversity alone can be said to be a sufficient guarantee of equality, there should be no evidence of black and minority ethnic service users experiencing discriminatory treatment. It should simply not exist. In reality, of course, this is not the case. Black and minority ethnic clinicians must by definition treat Black and minority ethnic people in some cases, yet the access, experience and outcome of this engagement remains disproportionately negative. Consequently, a key challenge for the Focussed Implementation Site project is recognising that an increasingly diverse workforce does not naturally bring equality in its wake. Trusts must think more critically about how to ensure that *all* staff work in non-discriminatory ways; employing staff that 'look like' their client group, be they 'White' or 'Black', is clearly no guarantee of this.

Evidently, the kind of power relationships that result (albeit unwittingly) in discriminatory treatment cannot be ignored, nor can the historical tendency to stigmatise and marginalise people who experience mental ill health. Similarly, and perhaps more importantly, the evidence that suggests that these very factors are still a part of our health service culture must be acknowledged. It must also be remembered that practitioners may also be subject to prejudice and discrimination. This is clear from the report into the 'suicide' of clinician Daksha Emson; she kept her own struggle with mental ill health a secret, for fear of the stigma she would endure from her peers. Workforce diversity is a good thing, but if it is the *only* thing that Trusts pursue in the name of organisational change, then it is not enough.

#### **h) Monitoring and analysis of data**

Mental health services in Birmingham and the Black Country have recognised the need to be more intelligent, critical and probing with regard to scrutinising existing data. For example, while data regarding black and minority ethnic population distribution is available, these figures alone do not enable an in-depth analysis of changing service take-up patterns. This is especially relevant in relation to those who may be forced to seek services outside of their own residential area because of inadequate local provision. Indeed, population statistics alone may lead some providers to assume that the numbers of BME users in their localities are too low to justify further action in the form of service transformation. There is an irony in this latter response, given the desire to create greater patient choice, because the ethnicity of the people who may choose to access services outside of their residential locality cannot be predicted. Such a response by mental health service providers, then, can no longer be justified on this basis. This monitoring data, then, represents a starting point for an interrogation of user needs and service deficits, but in most of the Action Plans we examined the collection of this data was presented as an end in itself and many Trusts fail to look beyond its collation.

Partly as a consequence of the work being undertaken in the focused implementation site project, a 'Better Information Group' has been established to take a more systematic approach to monitoring, data collection and analysis. This is crucial to the transformation of mental health services for black and minority ethnic people. But if we examine initiatives underway in Birmingham and the Black Country it is clear that even though Trusts' monitoring generates widely different information there is little practical variation in what Trusts do. With data collection covering each locality now being overseen by the Better Information Group, this offers the potential for more systematic analysis and interpretation. However, realising this potential will also depend, crucially, on the existence/development of more robust skills, expertise and equalities understanding amongst those with responsibility for data analysis and interpretation. This activity could represent a real move toward forcing Trusts to take an 'inside out' approach, rather than the 'outside in' strategy that seems to characterise most other types of action.

Despite the differences in the demographic patterning across the area, it was noted by the review team that all Trusts are operating in much the same way. There is little variation in their activity, and no evidence that local data is used to inform action and improve services. For example, in areas where there is a high percentage of ethnic minority groups, cultural provision is being actively commissioned. It could be argued that in these areas the sheer numbers of potential BME clients should have signalled the need for a more comprehensive strategy for service transformation rather than the creation of specialist provision that may only be available to a few. There is little evidence that existing analysis cross-references or triangulates the data available on current service provision against client satisfaction and existing and future

demographic trends. In actuality, many elements of this equation are discussed and debated separately. For example, access remains the domain of the community development worker, BME issues are the concern of BME subgroups, and issues of restraint and apprehension the domain of the police.

Given that we have noted that data rarely informs action, lack of data, especially at a local level, prevents any action at all. Trusts with little or no data were at a loss as to where to begin and did not have the skills to link equality-related issues to data which was in their domain. Even incomplete data, when extrapolated, can indicate causes for concern and areas where action needs to be taken.

### 3. Conclusions

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There are real challenges to keeping Delivering Race Equality and the other initiatives aimed at service improvement for black and minority ethnic people on the agenda. Indeed, the United Kingdom has over 30 years of race relations legislation on the statute books and yet as a society our commitment and understanding often shows little progression. To engender real change, strong and confident leadership is crucial and without this we are unlikely to see real, sustainable service transformation - especially as in the NHS's case there are many competing and even conflicting targets and in such a climate the most difficult issues are often pushed to the back of the priorities' queue.

The following six conclusions represent areas in which key efforts need to be focused:

- a) Trusts need to think more critically about the proposals they are adopting. The creation of black and minority ethnic reference groups, increased consultation, and the enhancement of governance structures, for example, are not in themselves strategies that can transform service provision. Thus far there is very little evidence of these measures having a transformational impact on existing core services.
- b) We are concerned in particular by the community engagement initiatives currently being funded. Black and minority ethnic 'representatives' are still being sought on the assumption that they represent a *community* rather than for any specific expertise or competence they bring to the table. Thus it can be argued that some of these initiatives have the potential to perpetuate rather than challenge and dismantle stereotypes.
- c) Virtually all of the action plans we examined emphasise the commissioning of 'culturally sensitive' services - but in too many instances what this means in practice is *culturally-specific* services. This encourages users to see themselves as different from others, with needs that cannot be accommodated within mainstream provision.
- d) There are inadequate guidelines regarding what third sector commissioning is intended to achieve in the context of DRE. The added value of third sector service delivery is not routinely assessed for impact, effectiveness and demonstrable change that would benefit the whole service. The 'politics' of working with culturally specific providers often makes it difficult to apply the objectivity and scrutiny required of existing services. Furthermore the lack of progress in relation to 'race' equality and service provision often means that culturally specific services offer a 'quick win'. Nevertheless we recognise the important role the third sector plays in contributing to diversity and choice in provision. Mental health Trusts have encouraged these sorts of 'advocates'. Now there is a need to help the third sector develop if they want to 'remain in the game'.
- e) Cultural competence training, as traditionally conceived, would have been ineffective in saving the life of David Bennett and we remain unconvinced that such measures can meet the transformational objectives of DRE. Unfortunately, we have observed colleagues still thinking they need to 'know' about 'difference' before they can deliver a professional public service.

- f) There are, however, encouraging signs. In the process of implementing DRE recommendations some Trusts are transforming their understanding of race equality issues. Even if their present proposals prove insufficient to achieve the desired service transformation, they still represent a foundation for further growth and development.

## 4. Recommendations

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Given the plethora of recommendations, strategies and priorities, we were specifically requested to focus on the two or three things that Trusts could do to really enhance the quality of service provision. We anticipate that Trusts will select those that are applicable. These are detailed below:

- a) The development of systematic commissioning and evaluation frameworks for third sector provision. This should mean that commissioners are able to assess the overall quality of provision, potentially enabling it to move from the realm of 'project' to mainstream. It should also allow for the identification of good practice, which can be applied to all provision, as well as highlighting where regressive practice remains unchallenged.
- b) Careful consideration should be given to the role data collection plays within the overall improvement strategy. The critical questions here are how much and what type of data do we really need in order to take action on discrimination? Trusts must avoid data collection strategies that become an end in themselves. Once collected, data should be used by those with the analytical skills to illuminate its meaning so it can be used to support more effective decision making.
- c) The term 'mainstreaming' needs to be better understood. Trusts should be clear about which actions contribute to a better quality of service provision overall.
- d) The transformational structures and processes used in both developing and delivering on recommendations in mental health need to be reviewed. A great deal of energy and resource has gone into processes such as the creation of sub-groups, conducting consultation, reviews and conferences. Now the mental health sector needs to be honest about whether any of this activity has had an impact on mainstream services and led to progress.
- e) Improving the equality understanding, skills and competence of staff overall is a key recommendation. Staff confidence needs to be raised, so that they can better lead, interrogate and apply interventions that will bring about demonstrable change.
- f) There is a need to consolidate what has already been accomplished. There appears to be little collective memory of either previous equality initiatives or benchmarks on progress made/distance travelled. Without a more coherent strategy, service improvement initiatives become just that - stand alone initiatives. Thus if this initiative is to have any lasting impact or legacy then focussed leadership and coordination of the development programme is important.

# Appendix 1: Question framework for service commissioners

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1. How do you measure the value added of commissioning against ethnicity? By this we mean, what is it that the service provider will be doing differently?
  - Can you pin down what patients will get that will enhance or transform their 'access, experience and outcome'?
  - Have you established mechanisms to evaluate the above?
  - What will you do if this new provision does not work and fails to deliver the changes that you seek?
2. What exactly will the culturally matched service offer to people?
  - Improved confidence in the service - if yes, how will you capture this?
  - Better quality of service - if yes, how will you capture this?
  - How will this strategy benefit the whole workforce?
  - Is the intention to use clinicians and staff that share the same ethnicity as the service user, or is this not part of what you are promising? There are areas that have near 100% black and minority ethnic clinicians and yet the same issues arise when it comes to black and minority ethnic users.
3. Who will qualify as being suitable or eligible for the particular service? Are all Africans, Muslims, Irish people the same?
  - Given that growing numbers of the total UK population self describe as being of mixed or dual heritage and most are UK born, how will they stand? Who will decide?
4. Coupled with question 3, how will you deliver Patient Choice?
  - If patients are offered a culturally specific service - is this an improved choice, or a choice made for them.
  - Will they be offered a choice of either a culturally specific service or a generalist service?
  - If a patient has chosen not to go with the ethnicised service that would appear to be 'right' for them, can they be served in mainstream?
  - What is mainstream provision leaving out or missing that the other service is providing?
5. How are you using commissioning as part of your strategy? Is a culturally matched service intended to be a short-term measure, designed to address a particular issue or shortcoming of the mainstream service. Or is it long-term, thus seeming to release mainstream provision from developing the skills and competence needed to deal equitably and professionally with anyone who presents with mental health issues?

It is really important to be clear about what you are commissioning. A culturally matched service may work for some. There are patients who will feel that they are more comfortable and understood in this setting, but there are some real consequences - in terms of expectations, legacy, quality & resources that need discussion if your service goes down this road. It is important to have thought about them prior to committing resources to this kind of service delivery.

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