

Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change

Report of Findings to LankellyChase Foundation,
Mind, The Afiya Trust and Centre for Mental Health



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February 2014

‘In order for us as poor and oppressed people to become part of a society that is meaningful, the system under which we now exist has to be radically changed. It means facing a system that does not lend itself to your needs and devising a means by which you can change that system. That is easier said than done.’

[Ella Baker – US Civil Rights Organiser]

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Acknowledgements

The authors (Rob Fitzpatrick, Dr. Sarabajaya Kumar, Dr. Ohemaa Nkansa-Dwamena and Laura Thorne) wish to acknowledge all those who generously gave their time as interviewees or who submitted written responses. They would also like to thank LankellyChase Foundation, Mind, The Afiya Trust and Centre for Mental Health for their input and support throughout.

Glossary of terms

Numerous terms relating to **mental health**, **race** and **ethnicity** are contested. The following represent definitions for key terms used in this report.

● Terms for mental health and illness

Mental Health: ‘a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.¹

Mental illness: ‘refers to a diagnosable condition that significantly interferes with an individual’s cognitive, emotional or social abilities e.g. depression, anxiety, schizophrenia’.²

Use of the terms **mental health problems** and **mental illness** is intended to cover a range of conditions and experiences – of varying levels, from mild or moderate to severe.

● Service users and people with lived experience

The words ‘service user’ can in certain contexts be used to restrict a person’s identity – framing an individual as a passive recipient of interventions. Here, the terms ‘service user’ and ‘person with lived experience’ are used to mean something more active and positive. Importantly ‘service user’ defines people who can identify with and recognise shared experiences with a wide range of other people who also use services.

● Terms for race, ethnicity and culture

Stakeholders interviewed, variously used the terms ‘race’, ‘ethnicity’, and ‘culture’ in a range of interchangeable ways. Following Fernando and Keating (2009), here race is referred to as a social construct that exists within a racist society.

‘*Although race is a scientific myth, it persists as a social entity for historical, social and psychological reasons – in fact for all the reasons that result in racism.*’³

The term **Culture** refers to shared characteristics relating to experience, history, language, and belief.

‘*In general, culture refers to conceptual structures – a flexible system of values and worldviews that people live by, define their identities and negotiate their lives by.*’⁴

● Terms identifying minority ethnic groups

In the literature, and engaging with stakeholders, a variety of terms are used to refer to particular groups of people from minority ethnic communities or cultures.

The term **BME** denotes Black and Minority Ethnic groups. This term was generally used under the Labour administration 1997 – 2010, and is now used within the Coalition. It is also widely used within organisations and policy literature. **BAME** denotes Black, Asian and Minority Ethnic groups and is used by some as a term to adequately incorporate ‘Asian’ ethnicities. It became clear from engaging with stakeholders that **BME** is the term that is most widely used and is therefore this has been adopted throughout this document.

● Racism and institutional racism

Racism refers to prejudice, discrimination or antagonism directed against someone of a different race based on the belief that one’s own race is superior.

Institutional racism is defined by Macpherson as:

‘*... the collective failure of an organisation to provide an appropriate or professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping, which disadvantage minority ethnic people.*’⁵

Note

Direct quotations from stakeholders and from the literature are *italicised*.

¹ World Health Organisation (2010) Mental Health: Strengthening our response [Online] <http://www.who.int/mediacentre/factsheets/fs220/en/> [Accessed 30 January 2014]

² NHS Inform (2014) Mental health and wellbeing [online] <http://www.nhsinform.co.uk/mentalhealth> [Accessed 30 January 2014]

³ Fernando, S (2009) “Meanings and realities” in Fernando, S and Keating, F (Eds.) *Mental Health in a Multi-Ethnic Society*, London: Routledge p.19

⁴ Ibid. p.16

⁵ Home Office (1999) *The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William Macpherson of Cluny*; London: Stationery Office

1. Introduction and background

LankellyChase Foundation in partnership with Mind, The Afiya Trust and Centre for Mental Health (the 'partnership group') have come together to develop a programme of work with the aim of promoting lasting positive change in the field of ethnic inequality and mental health. Each of these organisations has a track record of engaging with issues around mental health and ethnic inequalities that makes them well placed to work collectively to develop a change programme.

LankellyChase Foundation works to bring about change that will transform the quality of life of people who face severe and multiple disadvantage. It focuses activity on the persistent clustering of social harms such as homelessness, substance misuse, mental and physical illness, extreme poverty, and violence and abuse, and has a history of supporting grassroots organisations working in the area of mental health.

Mind is a national federated mental health service delivery and campaigning charity with an interest in addressing diversity and equalities in mental health. It currently operates a programme addressing mental health with young African Caribbean men.

The Afiya Trust is a national charity that focuses on reducing inequalities in health and social care provision for people from racialised groups. It supports and maintains national and local networks concerned with the promotion of BME health and social care issues and holds strong links to BME grassroots organisations, the involvement of service users and carers.

Centre for Mental Health is a national policy and developmental charity. In 2002 (as the Sainsbury Centre) it published *Breaking the Circles of Fear*, an influential review of the relationship between mental health services and African Caribbean communities.

The research undertaken

Confluence is an independent consultancy specialising in research and service development in the connected fields of mental health, social care and criminal justice. It was commissioned to provide consultation, research and analysis to enable the partnership group to arrive at a 'Theory of Change', including recommendations for action and investment which can be developed into funded pieces of work. Original research was conducted between October 2013 and January 2014 by a team comprising Rob Fitzpatrick, Sarabajaya Kumar, Ohemaa Nkansa-Dwamena and Laura Thorne. The partnership group provided a steering function throughout this period and also contributed to a

final review of findings and recommendations which took place during February 2014.

The research method adopted an iterative and collaborative approach informed by principles of grounded theory. This utilised:

- A review of relevant policy and research literature (including discussion documents produced by the partnership group).
- In-depth interviews with a purposively selected sample of 24 key stakeholders with personal and/or professional interest in ethnicity and mental health. This included senior clinicians, chief executives of organisations working to address BME health inequalities, academics, frontline staff and experts by experience. Individuals were consulted either face to face, via SKYPE, by telephone call/conference.
- Discussion and debate with partnership group members.

Identified initial research questions included:

- What might be the possible/potential scope for charitable foundations' involvement in the area of ethnic inequalities in mental health? What might be the 'ask' towards government, the corporate sector and the wider voluntary sector?
- Bearing in mind existing societal and health inequalities, what do concepts such as 'recovery' and 'choice' mean in practice for people from BAME backgrounds? Do BAME-informed perspectives on these concepts differ from 'established' understandings?
- How and in what context might 'global' perspectives on mental health help inform an exploration of health inequalities in the UK?
- How can therapeutic, psychoanalytic and systemic approaches to racism and institutional racism help to inform and progress debate, practice and policy?

2. Findings from the evidence and literature review

i) Key headlines and statistics

Headline findings

From engagement with stakeholders, policy literature and research data, it is clear that there exist numerous current and historic examples of vital and promising practice addressing ethnic inequalities in mental health. Considerable energy and commitment is also demonstrated by practitioners, policy makers and activists to develop provision and improve outcomes in this area.

However, this supportive environment for practice development is also grounded by a number of persistent systemic challenges that underpin black and minority ethnic communities' experience of engagement with mental health services or impede the development of effective policy responses. These include:

- **The continuing disproportionate representation of black African and Caribbean men with mental health problems at the 'hard end' of services.**

The most egregious inequalities in mental health care continues to be the overrepresentation of black men at the 'hard end' of services at point of arrest, in prison and within secure treatment. In its most extreme form this is represented by repetition of deaths in custody under restraint.

'This is about mental health and black people right? Actually you are just talking about black people [...] the experience of Black African and African Caribbean men and it is getting worse.'

'There is that whole theme around racism and the perceptions of black men as dangerous which we have observed in terms of excessive [police] response in terms of distressed behaviour [...] the linking narrative is institutional racism – but also institutional misunderstanding of people in mental health crisis by people who are not mental health professionals.'

- **The continuing experience of Black African and Caribbean service users of impoverished or harsh treatment from primary and secondary mental health services.**

'Circles of fear' continue to be experienced by black service users and communities in relation to mainstream mental health services. Treatment is more likely to be harsher or coercive than that received by white service users and characterised by a lower uptake of primary care, therapeutic and psychological interventions.

'It is a fact that there has been little progress and in fact the pattern of service use experienced by

black individuals has worsened such that they experience mental health services in an actively disadvantageous way.'

'When I became a consultant [...] I saw black people being sectioned, given schizophrenic diagnoses, not being given the more respectable diagnoses but the more derogatory ones, those that carry punishment instead of therapy.'

- **Continuing poor access to adequate mental health services across different BME communities.**

Stakeholders consistently described the difficulties experienced by BME service users and communities in effectively accessing services in ways that were meaningful to them. The 'Eurocentricity' of mainstream models of mental health service delivery was identified as a major obstacle to effective practice.

'The bio-medical model is about the "expert relationship" and the psychosocial model is based on a quality relationship between the helper and the person being helped. The New Horizons report concluded that the bio-medical model does not work and that the psychosocial model is more effective. This is true for everyone but particularly for BME communities. But because the vast majority of services are commissioned by the NHS, inevitably they are largely based on the medical model.'

'To get help here you are quickly pushed into the system and in order to get help you have to compromise with the system. You have to talk mental health, you can't talk spirituality, not very much anyway or you get sectioned.'

Statistics

Here follow some key statistics (that are available) in relation to ethnicity and mental health in the UK. They highlight broad and enduring inequalities.

Rates of diagnosis

- People of African Caribbean origin living in the UK have lower reported rates of common mental illness than other ethnic groups. However they are more likely to be diagnosed with severe mental illness and are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.⁶
- African Caribbean people are also prescribed higher doses of medication, even though African Caribbean, West African and Bangladeshi patients

⁶ Mental Health Foundation (2014) Black and Minority Ethnic Communities [Online] Available at: <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/B/BME-communities/> [Accessed 29 January 2014]

cite biological causes for their schizophrenia far less often than white patients.⁷

- In over 50% of studies exploring the reasons for disparity between ethnic groups in relation to mental health outcomes, 'race-based' explanations (including negative stereotyping) are cited.⁸

Primary care

- BME groups as a whole are more likely to report ill health, and experience ill health earlier than White British people.⁹
- Black patients are significantly less likely than non-black patients to have GP involvement in their pathway leading up to a first psychotic episode.¹⁰
- Rates of referral from GPs and community mental health teams to secondary mental health services are lower than average among some Black and White/Black groups.¹¹

Inpatient care

- Detention rates under the Mental Health Act during 2012/13 were 2.2 times higher for black African, 4.2 times higher for black Caribbean and 6.6 times higher for black other ethnic groups than average.¹²
- Black or Black British groups (including Caribbean, African and Any Other Black ethnic categories) showed higher rates of access to hospital services than any other groups.¹³
- Count Me In Census figures¹⁴ recorded that differences between ethnic groups in relation to rates of admission, detention under the MH Act and seclusion remained similar between 2005 and 2010:
 - 23% of inpatients on mental health wards or outpatients on Community Treatment Orders on census day were from black and minority ethnic groups.
 - Rates of admission were lower than average for White British, Indian and Chinese groups, in line with the average for Pakistani and Bangladeshi groups
 - Rates of admission were higher than average for the other minority ethnic groups (particularly for the Black Caribbean, Black African, Other Black, White/Black Caribbean Mixed and White/Black African Mixed groups, who had rates two to six times higher than average)

- Length of hospitalisation was longest for patients from the Black Caribbean and White/Black Caribbean Mixed groups and shortest for patients from the Chinese and Bangladeshi groups

Suicide

- Black Caribbean young men are three times more likely to have been in contact with mental health services in the year before they committed suicide than their White counterparts, and their suicides were more likely to be considered preventable.
- Male Black African psychiatric inpatients are twice as likely to commit suicide as White psychiatric inpatients.¹⁵

The criminal justice system and mental health

- Black Caribbean and Other Black groups have higher than average rates of detention under s37/41 of the Mental Health Act.¹⁶
- Despite constituting only 2.8% of the service user population and only 3.1% of the population of England, 16.2% of people on Community Treatment Orders on 31st March 2013 were from the Black or Black British group.¹⁷
- Black patients (broadly defined) are roughly twice as likely as non-black patients to experience criminal justice agency involvement in their pathways to care during First Episode Psychosis.¹⁸
- Black and other BME prisoners are under-represented in prison mental health team caseloads and within services that may prove beneficial, such as drug court initiatives and Improving Access to Psychological Therapies (IAPT) programmes.¹⁹
- There are a large number of well documented cases of deaths in black men with mental health problems who were under the custody of or the restraint of police officers. These include Roger Sylvester (1999), Sean Rigg (2008), Olaseni Lewis (2010) and Leon Briggs (2013) in police custody having been detained under s136 of the Mental Health Act. Casework conducted by Inquest has shown that a disproportionate number of people with mental health problems who die in or following police custody following the use of force are from black and minority ethnic communities.²⁰
- Over 90% of prisoners have at least one kind of mental health disorder and more than seven out of ten have two or more disorders.²¹ Given that

⁷ McCabe, R and Priebe, S (2004) *Explanatory models of illness in schizophrenia: comparison of four ethnic groups*. British Journal of Psychiatry; 185:25 – 30

⁸ Singh et al 2013 Ibid.

⁹ Institute of Race Relations (2014) Poverty Statistics [Online] Available at: <http://www.irr.org.uk/research/statistics/poverty/> [Accessed 29 January 2014]

¹⁰ Singh et al 2013 ibid.

¹¹ Care Quality Commission/ National Mental Health Development Unit (2011) *Count me in 2010*. London: CQC/ NMHDU

¹² Care Quality Commission (2014) *Monitoring the Mental Health Act in 2012/13*. London: Care Quality Commission

¹³ Health and Social Care Information Centre (2013) *Mental Health Bulletin: Annual report from MHMDS returns – England 2012/13*. Leeds: HSCIC

¹⁴ Care quality commission/ NMHDU (2011) Ibid.

¹⁵ Bhui, K and McKenzie, K (2007) *Final Report: Suicide Prevention for BME Groups in England – Report from the BME Suicide Prevention Project*. Centre for Health Improvement and Minority Ethnic Services

¹⁶ Centre for Mental Health 2013: *Black and minority ethnic communities, mental health and criminal justice*

¹⁷ Centre for Mental Health 2013 Ibid.

¹⁸ Singh et al, 2013 Ibid.

¹⁹ Centre for Mental Health 2013 Ibid.

²⁰ Inquest (2013) *Briefing on deaths in custody for debate on police procedures and mental health*

²¹ Singleton, N, Meltzer, H and Gatward, R (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: Office for National Statistics.

BME communities make up about 25% of the UK prison population (Ministry of Justice, 2012) compared to 11% of the general population,²² it is clear that mental ill health is a significant issue for these groups.

CAMHS and family services

- In any given year 20% of children and young people are said to have a mental health problem but there is no data available about how many are from BME backgrounds. Young people from some BME groups are disproportionately over-represented in the youth justice system, social services and looked-after provision, exclusion from school and educational underachievement.²³

Older people

- Research indicates that older people from different Black and minority ethnic groups in the UK may experience dementia and depression at a higher rate than among indigenous older people.²⁴
- African Caribbean older people have an increased rate of new contacts with services compared with the indigenous older people.²⁵
- Depression among Black and minority ethnic older people from several different groups is known to be associated with a range of disadvantageous conditions including chronic health problems, stroke, poor housing, low family support and poor socio economic status.²⁶

Refugees and migrants

- Refugees and asylum seekers are excluded and marginalised across a number of sectors (healthcare, education, accommodation welfare support and employment) resulting in mental distress and the exacerbation of existing mental health problems. In terms of specific mental health support, there is limited provision of culturally appropriate services in mental healthcare, a lack of therapeutic and psychosocial services available for refugees and asylum-seekers, and pathways into secondary mental healthcare services are often too rigid. Access to CAMHS for refugees and asylum seekers is particularly problematic.²⁷
- Over 50% of refused asylum seekers surveyed reported that their health had worsened since they had arrived in the UK.²⁸

Linkage to wider social factors

- In order to understand different BME communities' experience of mental health problems and of services provided it is also necessary to consider the 'intersectionality' of other aspects of identity and shared social circumstance such as gender, age, religion, disability, health and location.²⁹
- BME communities occupy particular positions of disadvantage in the UK. Inequalities are reflected across all indices of economic and social wellbeing, with African and Caribbean young men being disproportionately affected by these inequalities. For example, African-Caribbean boys are three times more likely to be excluded from school than their white counterparts.³⁰
- Unemployment statistics show that African and Caribbean men and those from 'mixed' backgrounds are between 10 and 20 percent more likely to be unemployed than their white counterparts.³¹
- Poverty is higher among all black and minority ethnic groups than among the majority white population. Men and women from some ethnic groups are paid less on average than those from other groups who have similar qualification and experience.³²
- Nearly 75% of 7-year-old Pakistani and Bangladeshi children and just over 50% of black children of the same age were living in poverty in 2010. About 25% of white 7-year-olds were classed as living in poverty at that time.³³
- BME groups are more likely than others to experience homelessness. For example, in 2011, 26% of the population of Wolverhampton were from BME communities, but these same communities made up about 40% of the homeless cases seen by the local authority.³⁴
- On average, homeless day centres in London approximate that 27% of their clients are members of BME groups, compared to only 11% nationally. Figures for direct access homeless hostels indicate that approximately 38% of clients are from BME groups.³⁵
- Information on ethnicity is not routinely collected by many community organisations including faith groups. Accurate accounts of representation within these services are therefore unavailable.

²² Ministry of Justice (2011) Statistics on Race and the Criminal Justice System 2010. London: Ministry of Justice.

²³ Afya Trust (2011) *Enjoy, Achieve and Be Healthy – The mental health of Black and minority ethnic children and young people*

²⁴ Bhatnagar, KS and Frank, J (1997) Psychiatric disorders in the elderly from the Indian subcontinent living in Bradford. *International Journal of Geriatric Psychiatry*, 12, 907-912.

²⁵ Reeves, SJ, Sauer, J, Stewart, R, et al (2001) Increased first-contact rates for very-late-onset schizophrenia-like psychosis in African and Caribbean-born elders. *British Journal of Psychiatry*, 179, 172-174.

²⁶ Silveira, ERT and Ebrahiim, S (1998b) Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in east London. *International Journal of Geriatric Psychiatry*, 13, 801-812.

²⁷ Mind (2009) *A civilised society: Mental health provision for refugees and asylum seekers in England and Wales*

²⁸ Institute of Race Relations (2014) *Ibid.*

²⁹ Joseph Rowntree Foundation (2011) *Poverty and ethnicity: A review of evidence*

³⁰ Joseph Rowntree Foundation *Ibid* (2011) *Ibid.*

³¹ Berthoud, R (1999) *Young Caribbean Men and the Labour Market: A comparison with other ethnic groups*. York: York Publishing Services and Joseph Rowntree Foundation.

³² Joseph Rowntree Foundation *Ibid.*

³³ The Poverty Site (2014) *Work and ethnicity* [Online] Available at: <http://www.poverty.org.uk/47/index.shtml#def> [Accessed 29 January 2014]

³⁴ Office for National Statistics (2014) 2011 Census: Key Statistics for England and Wales, March 2011 [Online] Available at: <http://www.poverty.org.uk/47/index.shtml#def> [Accessed 29 January 2014]

³⁵ Homeless Link (2011) *Survey of Needs and Provision*. London: Homeless Link

Limitations of data and statistics

‘Why is data not published when we know it is collected systematically?’

‘We are very poor at collating the impact of interventions from the wealth of data and evidence we collect. We only look at outputs not outcomes or impact.’

- There is a paucity of data in relation to ethnicity and mental health. Information about ethnicity is not routinely or uniformly collected by many community organisations and public agencies. Even where there is available data, accurate and up to date accounts of representation within different services are unavailable. Therefore the current overall picture is incomplete.
- It is not always clear which BME populations the statistics refer to, due to the plethora of

terms used to define the various ethnic minority populations under scrutiny. Since much of the data that exists is frequently impossible to disaggregate by ethnicity, it is difficult to either undertake comparative analysis or to draw clear conclusions about particular ethnic groups.

Multiple definitions are used in relation to BME individuals and communities. The ones that are discussed in the report include people of: African origin (including Caribbean) Asian origin (including Indian, Bangladeshi, Pakistani and Chinese), White British and Irish origin. Terms include but are not limited to: (in alphabetical order) ‘African and Caribbean’, ‘Black’, ‘Black African’, ‘Black and Caribbean’, ‘Black and other BME’, ‘Black British’, ‘Black (broadly defined)’, ‘Black Caribbean’, ‘BME groups’, ‘non-black’, ‘Other Black’, ‘Other Mixed Groups’, ‘White/Black’, ‘White/Black African Mixed’, and ‘White/Black Caribbean Mixed’.

³⁶ Department of Health (1999) A National Service Framework for Mental Health: Modern Standards and Service Models

³⁷ Home Office (1999) *The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William Macpherson of Cluny*; London: Stationery Office

³⁸ Sainsbury Centre for Mental Health (2003) *Breaking the Circles of Fear: A review of the relationship between mental health services and African and Caribbean communities*, London: SCMH

ii) Policy history

This section summarises the recent policy history in relation to ethnic inequalities in mental health, and outlines key elements within practice and service development, particularly from a voluntary sector perspective. It begins with a summary of key elements of policy from 1997 to the present Coalition administration. Then, it summarises the current organisation of mental interventions for BME communities (both via ‘mainstream’ services and from specialist BME organisations) and evaluates the contribution of voluntary sector organisations to the knowledge/evidence base. It also provides a critical evaluation of the movements of ‘personalisation’, ‘recovery’ and Improving Access to Psychological Therapies (IAPT) to BME communities and service users. The section finishes with a description of examples of international learning in relation to addressing ethnic inequalities in mental health, arguing that principles for effective community engagement advocated within the ‘global mental health’ movement can be seen to be reflected in many examples of current practice taking place in the UK.

Policy between 1997 and 2010

The impact of Stephen Lawrence and David Bennett

Policy relating to ethnic inequalities in mental health during the early New Labour years, was contained within the 1999 National Service Framework for Mental Health (NSF).³⁶ This discussed a vision of mental health services accountable to government via established

standards and service models. While the NSF identified that BME service users and carers faced specific difficulties in engaging with or accessing statutory mental health services, the methods by which barriers could be addressed were vague.

However, popular and political movements that arose after the racist murder of Stephen Lawrence in 1993 and the death of David ‘Rocky’ Bennett in 1998, placed pressure upon the government to provide a more structured response in relation to mental health. The Macpherson report on the police investigation into the death of Stephen Lawrence opened the door to challenging mainstream understanding about the nature of racial discrimination within society, and the complicity of organisations and systems and introduced the concept of ‘institutional racism.’³⁷

The death of David Bennett in 1998 and the subsequent independent inquiry provided the specific impetus for a different response from government in relation to ethnic minority communities’ experience of mental health services.

*Breaking the Circles of Fear*³⁸ was written at the time that the Bennett inquiry was in progress and identified the failure of the mental health system to adequately engage with African and Caribbean communities. The term ‘circles of fear’ referred to two self-reinforcing processes: the responses of black people to their ‘degrading and alienating’ experiences of mental health services, including their fear of admission to hospital leading to experience of abusive or insensitive use of professional power and/or even death, as was the

case of David Bennett in hospital; and, the endemic fear of black people and communities within 'mainstream' mental health services.

The report identified a number of impediments to improving outcomes in this area. These were **structural** (e.g. the action of bureaucracy and institutional culture), **material** (e.g. the configuration and availability of service provision), **psychological** (e.g. fear of services and stereotypical or racist attitudes) and **educational** (e.g. a lack of information and knowledge).

'*Breaking the Circles of Fear*' proposed a range of actions, notably the establishment of 'gateway' organisations to support the 'reintegration' of black services users into the mental health system. It also recommended the establishment of workforce development programmes for specialist and non-specialist staff devised and delivered in partnership with BME service users and communities.

The report of the independent inquiry into the death of David Bennett³⁹ emphatically stated that institutional racism exists throughout the National Health Service, which adversely impacts on the experiences of black and minority ethnic communities, service users and their families. This was identified as taking place across a range of areas, and included inadequate diagnosis, harsher and more coercive treatment, and poorer engagement with carers and family members. The report concluded with recommendations for government, the NHS and mental health professionals.

The first three recommendations focussed upon the need for mandatory training in cultural awareness and sensitivity including 'training to tackle overt and covert racism and institutional racism'.⁴⁰ The report also demanded acknowledgement at ministerial level of the 'presence of institutional racism in mental health services and a commitment to eliminate it'.⁴¹

The response from government (2003-2004)

Inside Outside,⁴² published by the National Institute for Mental Health in England in 2003, represented the first concerted effort from government to identify how mental health services for black and minority ethnic communities might be improved. Written by an independent mental health academic and psychiatrist, it provided an evidenced case for action, which re-populated the National Service Framework with evidence of inequalities of access or outcome for BME communities.

Crucially, *Inside Outside* recognised that institutional racism exists in the NHS and recommended policy in the areas of combining

workforce development, governance and research governance. It also recommended the recruitment of a national network of Community Development Workers to form better links between specific BME communities and mainstream services.

'... reform inside the mental health system must take place in tandem with investment and development outside in order to be successful.'⁴³

Following a consultation process initiated in late 2003, the Department of Health published its response to the Bennett Inquiry and its policy for delivering race equality in mental health services.⁴⁴ This was notably marked by a refusal from government to recognise institutional racism as existing within the NHS. However, the formal response to the recommendation of the Bennett Inquiry that there should be a ministerial acknowledgement of institutional racism and a commitment to eliminate it was contested.

Nevertheless, the strategy outlined for 'Delivering Race Equality' did present a detailed action plan for 'systemic' reform of mental health services between 2005 and 2010. It discussed areas of national and local action for developing organisations, improved: clinical governance; service delivery; and workforce development to be implemented under a recently developed '10 point plan' for leadership and race equality in the NHS.⁴⁵

Key elements of this strategy launched at the end of 2005⁴⁶ were the establishment of 80 'community engagement projects' and the recruitment of an England-wide network of 500 'community development workers' by 2006. Community engagement projects were capacity developing initiatives supporting closer working between statutory mental health agencies and identified non-statutory organisations. The community development workers (CDWs) were to be tasked with engaging with specific BME communities and forming a bridge to mental health services. The overall objectives and targets for DRE were diverse and ambitious. Targets were set for delivery by the end of 2010/11.

Two further initiatives were presented as part of the action plan. The 'Count Me In Census', an annual survey of mental health service users, was designed to monitor DRE programme outcomes over the course of its 5-year duration. Also, the 'Race for Health' programme (already established in 2002) was set to raise the capacity of 19 Primary Care Trusts to engage with BME communities and develop new ways of partnering to improve services.⁴⁷

A further key strand of 'top down' policy relevant to the implementation of DRE was the establishment

³⁹ Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) *Independent Inquiry into the death of David Bennett*

⁴⁰ *Ibid.*, p.67

⁴¹ *Ibid.*, p.67

⁴² National Institute for Mental Health Excellence (2003) *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*; London: NIMHE

⁴³ *Ibid.*, p.33

⁴⁴ Department of Health (2005) *Delivering race equality in mental health care: An action plan for reform inside and outside services, and The government's response to the independent inquiry into the death of David Bennett*; London: Department of Health

⁴⁵ Department of Health (2004) *Race Equality Action Plan* [Online] http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/DH_4072494 [accessed on 13/01/14]

⁴⁶ Department of Health (2005) *Delivering race equality in mental health care: A summary*; London: Department of Health

⁴⁷ Race for Health (2008) *Driving forward race equality in the NHS*; Manchester: Race for Health

of a 'Single Equalities Scheme' for the Department of Health.⁴⁸ This was part of a wider programme within government to unify departments' activity in relation to different pieces of equalities legislation, including the Race Relations (Amendment) Act 2000, within one programme. Central to the Single Equalities Scheme was the implementation of Equality Impact Assessments across public services.

The Delivering Race Equality programme in practice (2005-2011)

‘... layer upon layer of organisational complexity combined with the politics that went with that... it was negotiating a minefield [...] because there were so many constituents, there was very little room for incorporating ideas which could lead to long-term change.’

The Delivering Race Equality programme was highly complex in its governance and organisation. It involved the Department of Health, the Care Quality Commission and the National Institute for Mental Health Excellence (later the National Mental Health Development Unit) and was responsible for oversight of the delivery of 78 'actions'. This programme was managed through eight regional development centres which were responsible for the network of Community Development Workers, 17 Focussed Implementation Sites established to demonstrate a 'whole system' approach to care, and 20 Clinical Trailblazers focussing on practice. A network of 32 service users and relatives acting as 'DRE Ambassadors' was also recruited to support the programme.

In practice, the development of a national network of Community Development Workers, the on-the-ground foundation for DRE, was problematic in operation. The target of 500 CDWs being recruited was never achieved and there was reported resistance from managers to the 'roll out' of this aspect of the programme in some localities.

Concerns were also expressed about the function of CDWs in practice. Rather than representing a means of enabling BME communities to better organise mental health services from the 'grassroots-up', one stakeholder involved in the programme described their role in the programme as being in fact the to 'organise the community from government'.

They also frequently experienced very challenging experiences in their day to day practice once recruited. One review of DRE, commissioned by a consortium of mental health and specialist BME voluntary sector organisations, including The Afiya Trust and Mind, observed that the CDWs in their

multiple responsibilities as 'change agent', 'service developer', 'access facilitator and 'capacity builder' represented an 'impossible role.'⁴⁹ Additionally, the high expectations were contrasted with their relatively low status within the organisations employing them or in which they operated:

‘One of the biggest issues was the name – we found that as soon as we said we were community development workers we were not treated in the same way.’

In reality, the original ambition of this programme, and the hopes invested in it by mental health professionals, activists and policy makers was never fully realised. Despite the important work of the programmes delivered under the auspices of DRE, findings from the 'Count Me In Census' showed continuing poor outcomes and experiences for black and minority ethnic service users. There was little improvement in key measures of race equality, and even in some cases worsening outcomes.⁵⁰ Limitations were further identified by Mckenzie in relation to the adoption of the 'count me in census' as a means of improving performance driven by 'top-down' policy.

‘The expectation that the census would be the vehicle to help services develop towards DRE is probably a bridge too far.’⁵¹

The overall project was widely considered to have been far too complex and inconsistent in the way that it was organised within localities and existing systems. While DRE was not subjected to a robust independent evaluation, disappointment was clearly expressed within the five year 'internal' review of DRE published in 2011, which was written in the knowledge that the programme was not going to be sustained by the Coalition administration.

‘For those who have been closely involved with the work of the programme, it is difficult to escape the palpable and almost overwhelming sense of frustration [...] which is felt to be due to the inadequacy of a coordinated, systemic response.’

Further, the review stressed the 'difficulty inherent in expecting societal change through a service delivery mechanism.'⁵² Tellingly, the programme review concludes by challenging aspects of the very rationale for DRE's inception.

Raising cultural competence within mainstream services

Following on from the initial recommendations of the David Bennett inquiry, a great deal of work took place over the lifetime of DRE in identifying an effective means of raising the level of 'mainstream' mental health services to better engage with

⁴⁸ Department of Health (2007) *Department of Health Single Equalities Scheme 2007-2010*, London: Department of Health

⁴⁹ RAWOrg (2011) *The End of Delivering Race Equality: Perspectives of frontline workers and service users from racialised groups*. RAWOrg

⁵⁰ Care Quality Commission and the National Mental Health Development Unit (2011) *Count me in 2011*, London: Care Quality Commission

⁵¹ Mckenzie K (2008) *The count me in census: What it tells us and what it does not*; Ethnicity and Inequalities in Health and Social Care 1 (1) pp.62-66

⁵² National Mental Health Development Unit (2010) *Race Equality Action Plan: A five year review*, London: NMH DU p.46

BAME service users and communities. Early policy focussed upon developing the 'cultural competence' of staff through dedicated 'race equality training'. However the success of this training was questioned by Bennett and Kalathill, on account of, in part, negative reports from people receiving training.⁵³

‘I have always argued that training on its own will not address the issue. Training should be part of a much wider strategy to address racial inequalities. And I think where training didn't work is, where it was seen as the only strategy to address racial inequalities. And of course, what training can do is, training can make people uncomfortable [but] training that only makes people uncomfortable is unhelpful.’

Further research has stressed the importance of improved practice in mainstream services' 'cultural competency' in engaging with BAME service users and communities. This needs to be supported across a range of fields and include clear established policies and procedures, sustained workforce development, and the embedding of race equality within professional training programmes.⁵⁴

Policy since 2010

The prioritisation of race equality

Since the formation of the Conservative and Liberal Democrat coalition in 2010, there has been only limited reference within government policy on the topic of BME inequalities in mental health. Many stakeholders to whom we have spoken have expressed concern and frustration about the low level of commitment. They observe:

‘DoH currently has no interest in this area [BME mental health] – it used to ... but things change. We must acknowledge that we are in a system not minded to help BME groups.’

‘This administration is explicitly taking race off the agenda.’

Constraints upon policy

Opportunities for policy development appear to be constrained by wider economic, political and social agendas, including austerity in public expenditure, the reorganisation of the National Health Service and 'localism'.

Austerity: the current programme of economic austerity mitigates against the establishment (at least in the short to medium term) of large-scale national implementation programmes, such as Delivering Race Equality.

Reorganisation of the NHS: restructuring the National Health Service through the creation of NHS England and Public Health England has led to the formation of a completely new infrastructure for local health delivery. This includes Clinical Commissioning Groups, which organise the local delivery of NHS services in England, and Health and Wellbeing Boards that are established to coordinate health and social care provision with local government. In this environment, 'Strategic' level leadership has been weakened by continuing turbulence within the staffing and structure of the 'new' NHS. At the time of writing we also understand that continuing organisational instability means that a key equalities post at NHS England remains unfilled.

One senior manager in NHS England stated that, whilst they are interested in addressing BME mental health inequalities in their organisation's programmes, they currently lack the resources or levers to do anything. They suggested that they would welcome an invitation to partner with charitable funders to work in this area, citing a current partnership between one Foundation and government in relation to 'stigma'. However, in the position that NHS England is in currently, they would welcome BME mental health experts to 'come up with what good looks like on a side of A4' so that this information can be more widely disseminated within government and the NHS.

Localism: the policy of 'Localism' increases the authority and autonomy of local government and public service agencies in relation to the centre.⁵⁵ This is now enacted across government, and presents an obstacle to universal implementation of policy, even where this is contained in official 'guidance'.

A community development specialist employed by a mental health trust spoke about the difficulties they encountered in framing their role as a result of the policy of localism. Whereas previously they had been mandated with a 'Trust wide and strategic role with oversight for BME mental health', they now find that they are required to focus their activity within a single 'locality' area.

‘With the hierarchy here at the moment, race equality is not at the top of their list [...] I think that accountability is missing and there needs to be something in place which is able to get accountability [for race equality] from organisations’.

An example of the limited attention now being paid to race in government policy can be seen in the single recommendation from the Coalition's 2011 'cross-government and all-age strategy' for mental health services, 'No health without mental

⁵³ Bennett, J, Kalathill, J and Keating, F (2007) *Race equality training in mental health services in England: Does one size fit all?* London: Sainsbury Centre for Mental Health

⁵⁴ Sewell, H (2009) *Working with Ethnicity, Race and Culture*. London: Jessica Kingsley

⁵⁵ Communities and Local Government (2011) *A plain English guide to the Localism Act*. London: CLG

health'. The only substantive point that relates specifically to BME groups is the development of market mechanisms for Increasing Access to Psychological Therapies (IAPT) services, so that there can be a 'choice of providers to ensure equal accessibility for all groups, including black and minority ethnic communities.'⁵⁶ Elsewhere, in an echo of the language of race equalities in the 1999 National Service Framework for Mental Health, the document states the latest formulation of BME groups as having 'protected characteristics' within the Equality Act 2010.

The recently published NHS England Equalities 'toolkit'⁵⁷ also appears to have limited usefulness in relation to promoting strategic leadership for addressing ethnic inequalities in mental health. While under the terms of the guidance it presents ethnicity as a 'protected characteristic' and advocates for 'culturally competent' services, the guidance fails to articulate how specifically inequalities can be addressed in practice for BME groups, or how services might be made 'free of discrimination'.

The current outlook for BME mental health equalities within the Coalition remains limited, a mood that is clearly expressed in Sewell and Waterhouse's 2012 summary of current trends for race equality in mental health in a report for The Afiya Trust/NHS Confederation.

*'Whilst numerous national and local initiatives have aimed to improve access, experience and outcomes for BME service users, concrete evidence of improvement remains lacking.'*⁵⁸

Potential opportunities for engagement within new structures

While stakeholders were largely very clear and forthcoming about the challenges and difficulties of addressing ethnic inequalities in mental health in the current policy environment, there was a lesser sense of how new structures could be constructively engaged with or utilised. However, some positive opportunities were identified.

For example, a senior stakeholder from NHS England cited the national mental health leadership commissioning programme that is currently being organised for Clinical Commissioning Group managers (from April 2014) as presenting an opportunity to help promote race equality and increased cultural competence within services. This programme is based upon an earlier pilot that took place in London, which incorporated a strong emphasis upon addressing health inequalities in its programme.⁵⁹

Additionally, the psychiatrist and BME mental health specialist Kwame McKenzie recently proposed the utilisation of 'participatory budgeting' as a means to improve mental wellbeing and addressing health inequalities within excluded communities.⁶⁰ Participatory budgeting is a method whereby communities can become directly involved in the commissioning of local initiatives – making decisions about how public money is spent. Identifying 150 projects taking place in the UK which have adopted this method since 2006, McKenzie argues that participatory budgeting represents a major opportunity for Health and Wellbeing Boards to help develop 'mental capital' within excluded communities, both through what is commissioned and a consequence of the process itself.

'... given the challenges for public health now and in the future, I am not suggesting a specific mental health promotion or mental illness prevention intervention. Instead, I suggest that the health and wellbeing boards use the process through which they work as a way of improving the mental health and wellbeing of their populations.'

*'A robust commitment to shared decision making could be truly transformative for the public's health. Increasing community engagement and social efficacy is key to improving mental health and decreasing inequalities in mental health.'*⁶¹

The 'locked hexagon' is a developmental model proposed by Sewell (2009) which brings together six components required to achieve improved mental health outcomes for BME groups. The individual components are: service users as experts in shaping services; use of narrative approaches; promotion of employment, training, volunteering, education; staff and managers' knowledge and skill development; carer and community engagement; and, targets for percentage improvement in key areas (e.g., admissions).⁶² While this model has yet to be implemented within the new mental health commissioning structures or in a geographical location, each of the individual components have been individually evidenced as effective, and the overall model has been endorsed by the Centre for Social Justice in 2011 in its review of mental health policy.⁶³

Potential of progress in policy

Despite the practical and political challenges, there are a number of areas of progress and promising practice which are currently supported by government. For example, the recently published government action plan for mental health *Closing the Gap*⁶⁴ articulates three areas of current development:

⁵⁶ HM Government (2011) *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. London: Department of Health

⁵⁷ Department of Health (2013) *A refreshed Equality Delivery System for the NHS*. London: Department of Health

⁵⁸ Sewell, H and Waterhouse, S (2012) *Making Progress on Race Equality in Mental Health*. London: Afiya Trust and Mental Health Network, NHS Confederation

⁵⁹ Joint Commissioning Panel for Mental Health (2014) *Every CCG will have a named influential mental health lead that is resourced, knowledgeable, equipped and engaged* [online] <http://www.icpmh.info/commissioning-tools/leadership-and-network-development/> (accessed 31 January 2014)

⁶⁰ McKenzie, K (2014) "Using participatory budgeting to improve mental capital at the local level" in *If you could do one thing: Nine local actions to reduce health inequalities*. London: British Academy for the Humanities and the Social Sciences

⁶¹ McKenzie, K (2014) *Ibid* p.73

⁶² Sewell, H (2009) *Leading Race Equality in Mental Health*, *The International Journal of Leadership in Public Services* 5 (2) p.p. 19-27

⁶³ Centre for Social Justice (2011) *Completing the Revolution: Transforming Mental Health and Tackling Poverty*. London: Centre for Social Justice

⁶⁴ Department of Health (2014) *Closing the Gap: Priorities for essential change in mental health*. London: Department of Health

- An exploration about why BME communities have been less likely to access NHS psychological therapies in a study is being conducted in partnership with the Race Equality Foundation;
- The establishment of a 'stigma reduction' pilot focusing on African and Caribbean young men as part of the *Time to Change* programme, focusing on African and Caribbean young men; and,
- The development of a 'National Operating Model' for Liaison and Diversion services, engaging with people with mental health needs at the point of arrest or appearing at court (including BME people and gang members).

Liaison and Diversion is to be developed as an 'all-age model' at ten pilot sites across England where it is being commissioned to implement an 'all age approach' from April 2014. However, concern has been expressed from stakeholders about the systemic focus of the new pilots, which follow on from a longer standing government programme for Liaison and Diversion. For example, it has been noted that funding for pilots is to be from the 'point of arrest', which may require existing liaison and diversion schemes to move away from prevention and any 'pre-arrest' engagement with people 'at risk of offending'. One stakeholder observed that 'in order to receive a service you will have to commit a crime'. The focus of 'at point of arrest' runs the risk of creating an 'escalator' for young people into the criminal justice system.

'We need to unpack what is going on, unpack their childhood, a lot more work needs to be done closely with individuals. When people are found on the street, they need to be assessed correctly. People who find themselves in the criminal justice system, they need to be assessed correctly, break that cycle.'

Concerns have also been expressed by stakeholders that the overall network of pilots is at risk of reinforcing already existing thresholds for access to statutory mental health services, thereby continuing to effectively excluding many people with multiple

and complex needs. With a few exceptions sites are also reportedly ill-prepared (in most cases) to provide culturally responsive services to BME young people and adults who have been referred.

Policing and BME Mental Health

'Police had attended incidents where there had been deaths [of black men in police custody] before – but no learning came out of it – nothing got implemented. The problem was the values didn't match the desire to implement policy.'

*'Minorities are policed more – they have more chance of coming into contact with the coercive arm of the state'*⁶⁵

'I have been involved in one of those systems and the sheer violence that you feel, and I don't mean that in a physical sense, that you feel when you are powerless. The violence of the system gets you and it is horrific.'

In further developments outside coalition policy, over the last 12 months there has been increasing interest from the Association of Chief Police Officers and the Metropolitan Police in relation to engagement with black men with mental health problems in police custody. Following the deaths under police restraint of Olaseni Lewis and Sean Rigg among others, the Metropolitan Police commissioned the independent review of mental health and policing in London.⁶⁶ This recommended a much clearer and more effective relationship between community mental health services and the police, to ensure that the mental health needs of people detained by the police are identified and addressed.

Furthermore, there has been increased pressure, from Members of Parliament across all political parties, for action to be taken to improve police processes and strengthen trust between black communities and the police. This is demonstrated by a recent debate on black deaths in custody supported by the organisations 'Inquest' and 'Black Mental Health UK'.⁶⁷

⁶⁵ Service user quoted in Care Quality Commission (2014) *Monitoring the Mental Health Act 2012/13*. London: Care Quality Commission, p.20

⁶⁶ Independent Commission on Mental Health and Policing Report (2013)

⁶⁷ Inquest (2014) 2011 Census: Parliamentary Debate on Black Deaths in Custody [Online] Available at: <http://www.inquest.org.uk/media/news/parliamentary-debate-on-black-deaths-in-custody-to-take-place-monday-2-dec> [Accessed 29 January 2014]

iii) UK practice and learning

The organisation of BME mental health interventions

Mental health services and specialist resources available to people from BME communities are provided in a range of ways. This can include 'generic' primary and secondary provision available to the general population and specially commissioned services delivered by statutory

agencies. Services provided by specialist voluntary sector organisations can be directly commissioned by statutory agencies; or be supported by formal or informal skill sharing partnerships between statutory agencies and voluntary organisations. Additionally, other 'grassroots' interventions operate independently, for example via faith communities, or committed activists and

campaigners, supported to a varying degrees via charitable funding.

Since the closure of Delivering Race Equality in 2011, and the ending of programmes of 'clinical trailblazers' and 'focussed implementation sites' and similar initiatives, there has been a reported contraction in the numbers and scope of community development specialists working within mental health trusts and in the overall activity of specialist BME mental health organisations. Further, with the absence of central or binding guidance for statutory agencies around addressing BME mental health inequalities, statutory agencies lack incentives to form and sustain partnerships with voluntary sector and grassroots organisations.

Further, the very concept of 'separate' BME services is in itself contested by sector specialists. This is clearly expressed by Bhui and Sashidharan (2003). While separate mental health services are argued to be able to afford better provision for ill-served and discriminated-against communities, and help to develop an evidence base for emergent service models, they can also let mainstream services 'off the hook' and delay the creation of more culturally competent workforce.⁶⁸

*'If you look to provide services specifically for black people you create ghettos and silos. Single culture organisations can work for a time in terms of positive discrimination but in the end they just reinforce the sub standards in the wider system.'*⁶⁹

Voluntary sector-led evaluation

In the context of continuing ethnic inequalities in mental health unaddressed by 'mainstream' provision, a wide variety of voluntary sector activity continues to take place within communities.

Indicative examples of the range of voluntary sector or community-led programmes which have been or are currently being evaluated include:

- **East London Community Healers Project** is a partnership between East London NHS Trust and community traditional healers, to promote dialogue between practitioners working within very different sets of traditions and to improve the accessibility of mental health services within BME communities. This was evaluated in 2013 by the Tavistock Foundation on behalf of the Kings Fund.⁶⁹
- **Hopscotch Asian Women's Centre** is an organisation based in Camden London which engages with Asian Women and their families. In 2009 it produced an evaluation of a community led research project focussing on the mental health needs of young people from the Bangladeshi community. This project was supported by the University of Central Lancashire and the National Institute for Mental Health in England as part of the DRE programme.⁷⁰
- **Right Here Newham** engages with BME young people and seeks to address the effects of violence, mental wellbeing, social isolation and access to services through operating a boxing programme. The programme is being evaluated by the Mental Health Foundation.⁷¹
- **St Mary's Community Centre, Sheffield** has developed a programme engaging with newly arrived Pakistani women using 'appreciative enquiry' which allows women to tell their own stories and develop critical reflection on their experiences with a view to developing coping strategies. A (currently unpublished) evaluation of 'critical appreciative process' linked to the St Mary's Community Centre describes a 'web of narratives' that critical appreciative processes generate which can provide source material from which to develop a consciousness about 'who one is' and 'who one can be'.⁷²
- **Strengthening Families, Strengthening Communities.** The SFSC programme has been established by the Race Equality Foundation to develop an evidence base for targeted interventions with parents and children from BME communities to promote mental health and wellbeing. Based on an intervention originally developed in the United States, the programme seeks to improve interactions between parents and children, and an evaluation was published in 2013.⁷³
- **Trailblazers** was a project developed as part of Delivering Race Equality in East London to increase access to talking therapies for Black men with mental health problems. It was designed to give a deeper understanding of the responses required by services endeavouring to engage effectively with this group. It employed a narrative therapy approach derived from a 'tree of life' model⁷⁴ designed to resonate with the cultural and historical world views of service users, allowing a safe space in which Black men could express and explore their experiences in a validating and supportive context. A full evaluation of the project was published 2009.⁷⁵
- **Wandsworth community empowerment network (WCEN)** which supports a network of community and faith based organisations and people which works to improve the way public services are designed, delivered and received. According to a recent evaluation:

⁶⁸ Bhui, K and Sashidharan, S (2003) *Should there be separate psychiatric services for ethnic minority groups?* British Journal of Psychiatry 182 pp10-12

⁶⁹ Hills, D, Aram, E, Hinds, D, Warrington, C, Brissett, L and Stock, L (2013) *Traditional Healers Action Research Project*. Final report by The Tavistock Institute of Human Relations for the King's Fund.

⁷⁰ Akter, S, Begum, M and Sarwar, Z (2009) *Report of the community-led research project focusing on the mental health needs of young people from a Bangladeshi background from the London borough of Camden*. London: Hopscotch

⁷¹ Paul Hamlyn Foundation and Mental Health Foundation, *Boxing Clever?* (online) <http://www.right-here.org.uk/home/assets/pdf/newham-case-study> (Accessed 25 January 2014)

⁷² Ridley-Duff, R and Duncan, G (2013) *Critical appreciative processes as a methodology for studying the production of consciousness*. Appreciative Inquiry: a method of working with disadvantaged people, 17th March 2013, St Mary's Community Centre. (Unpublished)

⁷³ Kartsen, S (2013) *Evaluation of the Strengthening Families, Strengthening Communities Programme 2009-2010*. London: Race Equality Foundation.

⁷⁴ Ncube, N (2006). The tree of life project using narrative ideas in work with vulnerable children in Southern Africa. *The International Journal of Narrative Therapy and Community Work*. 1, 3-16.

⁷⁵ Cartin, M (2009) *Trailblazers – An Introduction to talking therapies for African and Caribbean Men with mental health problems*. London: Mellow/East London NHS Foundation Trust

‘The ultimate goal should be that service users become partners in managing their own health. However this is a major shift that requires a lot of experience and commitment in the co-production of services and, perhaps, it can only be possible when systemic barriers at community, public agency and state levels are brought down.’⁷⁶

The above examples demonstrate some of the wide range of research activity which is or has been led from the voluntary sector and grassroots organisations. Additionally, a repository of data exists from the DRE programme. However, in the absence of central policy, adequate resourcing or a central body to collate and disseminate learning, such information remains disparate and uncoordinated.

Personalisation and Recovery

Over recent years, the movements of ‘personalisation’ and ‘recovery’ have made a powerful impact within mainstream mental health. Personalisation has been described as the means by which ‘people with mental health problems can take as much control as possible over their support arrangements, to pursue their recovery and social inclusion on their own terms’.⁷⁷ It emphasises the needs and requirements of individuals over that of service providers, and is linked to the development of market mechanisms within health and social care through ‘personal budgeting’ of services.

The concept of ‘recovery’ in the UK mental health sector has been routinely defined from a paper published in the United States by Anthony (1993). In this, recovery is described as:

‘a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of a new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illnesses.’⁷⁸

As ‘consumer-based’ movements, both personalisation and recovery challenge the way that mental health services have traditionally been provided. They validate personal objectives over the aims and policy makers and providers. In theory they also incentivise more responsive and effective services by disrupting complacency and rewarding innovation in the wider market place for services. Both personalisation and recovery have informed a great deal of thought and a wide range of initiatives within mainstream mental health.

However, our engagement with stakeholders and review of the literature demonstrates clear concerns about both the application and relevance of both movements for many BME service users. One stakeholder strongly expressed frustration with the way in which the personalisation and recovery movements have gained credence within ‘mainstream’ mental health policy and practice. In their view, these movements do not reflect the social conditions of, and choices available to, many BME service users and communities. ‘For recovery to work, people have to have something positive to ‘recover’ to.’ Another commented: ‘how can you recover without gainful daytime activity?’

While in theory, ‘recovery’ is seen as something which ought to be welcomed on account of its validation of service user experience and choice, stakeholders describe a very different reality, which frequently prioritises the requirements of service providers.

‘I find this approach is good but it is being abused by the health system [...] Hospitals are under pressure to “recover” people and end a patient episode [...] I hear from patients who are afraid of going on a “recovery” programme because they won’t get anything else after that.’

Furthermore, recovery can in practice be delivered as a management ‘tool’ in a way that can be actively discriminatory to BME service users. For example, one stakeholder described how in one locality, the implementation of a ‘recovery star’ programme (based upon a model originally developed for the Mental Health Providers Forum⁷⁹) fails to consider the actual options open to some BME women who lack choice or voice, within their families or communities.

‘We have to “do” the recovery star because we get funding for it – but it’s not meaningful for some people from BME communities.’

For recovery to be meaningful for BME service users it needs to speak to their ‘lived’ and political experience. However, some recovery literature can effectively ‘depoliticise’ experience, when it reflects the requirements of organisations and systems over people. For example, a detailed report commissioned by a statutory agency about a recovery programme engaging with BME women in Scotland failed in its findings to make any reference to race, racism or any other form of social disadvantage.⁸⁰

However, this sharply contrasts with independently produced initiatives, which clearly place the ‘experience’ of recovery within a wider social and political structure. For example, Kalathil (2011),⁸¹ in a study of BME women’s experience of recovering

⁷⁶ Hatzidimitriadou, E, Mantovani, N and Keating, F (2012) *Evaluation of co-production processes in a community-based mental health project in Wandsworth*. London: Kingston University/St George’s University of London.

⁷⁷ Social Care Institute for Excellence (2009) *Personalisation briefing*. London: SCIE

⁷⁸ Anthony, WA (1993) *Recovering from mental illness: The guiding vision of the mental health service system in the 1990s*. *Psychosocial Rehabilitation Journal* 11(4) pp.11-23

⁷⁹ Triangle/Mental Health Providers Forum (2009) *Mental Health Recovery Star*

⁸⁰ National Resource Centre for Ethnic Minority Health/ NHS Scotland (2008) *Black and minority ethnic recovery group: report from the project*. Glasgow: NRCEMH

⁸¹ Kalathil, J (2011) *Recovery and Resilience: African, African-Caribbean and South Asian Women’s experience of recovering from mental illness*. London: Mental Health Foundation and Survivor Research

from mental illness, observes that for many women existing recovery frameworks did not take account of racism, or other forms of discrimination, that they experienced.

Improving Access to Psychological Therapies

‘We’ve had the biggest intervention ever in last 10 years but it’s hardly ever talked about. Labour introduced IAPT – there hasn’t been an intervention that has had such an impact in the last 100 years. It hasn’t necessarily serviced all groups but it still is the biggest intervention.’

The national programme for Improving Access to Psychological Therapies (IAPT) came out of the Marmot Review which proposes ‘the most effective evidenced-based strategies for reducing health inequalities in England from 2010.’⁸²

Although IAPT has been expanding to include more holistic approaches, Cognitive Behavioural Therapy (CBT) still dominates the therapeutic interventions on offer and features heavily on the training of low intensity and high intensity workers, within services. However, some services have tried to engage with clients from BME groups, by asking them which types of intervention might be deemed more appropriate. For example, South London and Maudsley’s (SLAM) community psychology programme employs a BME clinical psychologist who combines their own psychological expertise with their cultural knowledge of the local community and faith groups. This collaborative approach has helped foster and embed culturally relevant psychologically informed approaches that are accessible and meaningful for clients from BME communities.

‘IAPT has been shown in some areas to be very successful with black communities and that’s

because you can present it as a label free intervention. We don’t say “come to your local MH service”. It is available at the GP and that makes it open access and less stigmatising.’

One stakeholder interviewed described how their organisation has found a way round delivering IAPT via CBT:

‘We developed a good relationship with the Mental Health Trust and were delivering counselling to the BME community in GP surgeries until recently when they were forced to adopt a CBT approach. But we continue to work with some GP surgeries who happen to be mental health lead commissioners and who don’t want CBT, they want psychological counselling.’

Nevertheless, in a written submission, one stakeholder expressed strong reservations about what they see to be ‘Eurocentricity’ of ‘mainstream’ IAPT programmes and their relevance for many BME service users and communities.

‘Although developed to improve access to psychological therapy for all individuals, it is my experience that whilst the IAPT programme purports to address the needs of BME communities, this is not always the case. The training of high/low intensity therapists and the delivery of therapy is still very much couched in a Eurocentric framework, and there is less of an initiative to develop interventions and engage with communities based on their unique narratives, discourses and cultural/ historical experiences. So it is still very much one size fits all in practice despite what may be put down on paper.’

‘Is there no data in the public domain at all regarding ethnicity yet? There are requirements to collect this data.’

iv) International practice and learning

‘We have to change our approach to mental health, and in relation to our communities, and how we think about our communities, and learn from other communities who do things differently ... So if we are going to make a difference, it does mean being really creative and thinking in a different way. If we really want to be responsive to communities and they are saying, these are our resources, this is what we think wellbeing is, then it will mean speaking with pastors, shamans, you know, entertaining ideas around spirits, critical ideas, all kinds of things that we are not very comfortable with in the western psychological frames.’

This section outlines the potential contribution of learning from the Global Mental Health agenda to the addressing of ethnic inequalities in mental health in a UK context. Global Mental Health (GMH) is described by Patel (2013) as ‘the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide’.⁸³ It exists informally as an international network of mental health professionals and researchers, and more formally through the Centre for Global Mental Health, based at the London School of Hygiene and Tropical Medicine, which conducts research and disseminates findings into GMH.⁸⁴

⁸² The Marmot Review (2010)

⁸³ Patel, V and Prince, M (2010) *Global mental health: A new global health field comes of age*. Journal of the American Medical Association 303(19): pp.1976-7.

⁸⁴ Centre for Global Mental Health (online) <http://www.centreforglobalmentalhealth.org/> (accessed 17 February 2014)

‘Mental health is not like coronary surgery, most psychological treatments are low-tech. We need to look at “task shifting”. We should be looking to shift to people with no professional backgrounds to bridge the mental health gap. We don’t require such a top heavy structure and this has been shown time and time again.’⁸⁵

The application of GMH in practice involves the pragmatic management of scarce financial resources, careful thought about the role and function of professionals, and the deployment of capabilities of communities to more fully engage in the delivery of mental health services. At a recent presentation at the RSA, Vikram Patel coined the acronym SUNDAR to describe the aspects of change within mental health service provision with GMH seeks to effect.⁸⁵ These are:

- **Simplify the message and unpack the treatment:** Where possible, mental health interventions are ‘simplified’ of technical jargon and ‘unpacked’ so that specific tasks can be delivered by people who are not clinically trained.
- **Deliver services where people are:** Mental health services are available in places which are readily accessible to communities, including ‘non-health’ settings.
- **Affordable and available human resources:** The human resources for mental health services are determined by what is affordable. Greater involvement of communities in the delivery of services.
- **Reallocation of specialists to train and supervise:** Clinicians maintain a vital role of supervising and training people from local communities to deliver interventions. ‘Task sharing’ between mental health professionals and communities represents an essential element of this activity.

With its history of developing mental health provision in resource-poor areas where mental health services are remote or even in practice non-existent to communities, the GMH approach lends itself conceptually to application in relatively resource-rich areas, where BME also communities also experience difficulties in accessing effective ‘mainstream’ mental health provision. Because of its emphasis upon community and grassroots-led service delivery, it also appears to be readily applicable to help inform the development of mental health services that are more culturally competent and relevant. Interventions developed and delivered within communities and using trusted settings such as places of worship or local commercial hubs can help serve to minimise stigma surrounding mental health, reframe the power

dynamics between service users and professionals and potentially improve clinical outcomes within BME communities.

Additionally, there is an emerging international evidence base around the efficacy of pharmacological or psychological interventions delivered to the community within in the community. This includes studies conducted by Cohen et al (2011)⁸⁶ across Africa and Asia, and Shin et al (2012)⁸⁷ in Russia.

While not necessarily being formally aligned to the term or the movement, principles integral to the global mental health approach can already been identified within a number of current and former programmes in the UK which seek to develop accessible talking therapies or to improve the involvement of BME communities in the development and delivery of mental health services. These include the Wandsworth Community Empowerment Network, East London Community Healers Project, St Mary’s Sheffield, Trailblazers and Right Here Newham (these are described more fully in the previous section). Further, the ‘locked hexagon’ service development model for improving outcomes for BME mental health service users as developed by Sewell⁸⁸ incorporates elements which are congruent with principles developed within GMH, such the use of narrative approaches and closer carer and community engagement.

Applied to a UK context, the Global Mental Health agenda holds a potential for helping to transform the relationship between BME communities and mental health services, increasing levels of trust and accountability and challenging the privileging of westernised and Eurocentric discourse within mental health. Further, the learning from developing more responsive mental health services for BME communities may also help create foundations for better service responses for the wider population. To illustrate this, Patel et al (2011) argues that research pertaining to minority ethnic individuals and mental health in high income countries, echoes the ‘*experiences we have described in low income countries and point towards some universal truths about adapting psychological therapies across cultures and health systems*’.⁸⁹

⁸⁵ Patel, V (2013) *The Global Mental Health Crisis: What the Rich World Can Learn From the Poor* (online) <http://vimeo.com/66692761> (accessed 25 January 2014)

⁸⁶ Cohen, A, Eaton, J, Birgit, R, George, C, Manuel, B, De-Silva, M and Patel, V (2011). *Three models of community mental health services in low income countries*. International Journal of Mental Health Systems. 5(3) pp. 1-10

⁸⁷ Shin, SS, Livchits, V, Nelson, AK et al (2012). *Implementing evidence-based alcohol interventions in a resource-limited setting: Novel delivery strategies in Tomsk, Russia*. Harvard Review of Psychiatry, 20 (1), pp. 58-67.

⁸⁸ Sewell, H (2009) *Ibid*.

⁸⁹ Patel et al 2011 (*Ibid*)

v) Systemic challenges: Understanding and responding to institutional racism

‘I get a sense of equality fatigue, where people don’t want to hear about it anymore and that it has had its day.’

‘DoH currently has no interest in this area – it used to but things change. We must acknowledge that we are in a system not minded to help BME groups. Something is needed from the outside.’

An overwhelming response from stakeholders we have engaged with is that of profound disappointment and weariness at the seeming lack of long-term progress, in relation to addressing ethnic inequalities in mental health – extending to policy, practice and tangible outcomes for BME services users and communities. It appears that despite ‘top down’ national initiatives, including Delivering Race Equality and the implementation of equalities legislation, anxiety about racism and institutional racism maintain a toxic and paralysing effect within the mental health system.

This section presents an exploration of some of the personal, organisational and systemic challenges which racism and institutional racism present for both mainstream services and the BME mental health sector. It concludes by describing a range of strategies and techniques, which over a sustained period of time can help to address racism and institutional racism in mental health services, by helping to improve dialogue and discourse at interpersonal, organisational and institutional levels.

The past in the present

A fundamental and recurring theme that underpins an exploration of race and ethnicity in mental health services is the continuing legacy of colonial history and intergenerational trauma.

‘When people bring up this issue, people tend to have an adverse reaction and the conversation does not always go anywhere very quickly. When you look at this from various levels, perceived discrimination is toxic to mental health and the reaction to that response leads to further mental health difficulties. The inherent power dynamic is difficult to alter and from power stems perceived discrimination which is rooted in historic realities.’

Frantz Fanon⁹⁰ (1925-1961) provides a powerful account of how the collective and personal experience of people of African and Caribbean origin is inextricably bound by histories of colonialism, racism and social injustice, which

contribute to psychological harm. This thesis presents a clear ‘starting point’ for an exploration of the relationship of history to BME mental health. More recently, the concept of ‘Post-traumatic slave-syndrome’ developed by Joy DeGruy⁹¹ describes how the historical trauma of slavery continues within Caribbean and African-American communities today which impact upon collective identity, mental wellbeing and self-esteem. McKenzie-Mavinga (2009) expands on this theme by arguing that people of all races carry the ‘ancestral baggage’ of history, whether consciously or not.⁹²

Perhaps the most egregious example of the continuing legacy of colonial history in mental health remains the overrepresentation of Black men at the ‘coercive’ end of mental health services.

‘I was discussing (giving) a talk on Trailblazers with a senior colleague (from another Trust) ... he said to me: “We don’t want to hear about heavy things like slavery ... we want more practical solutions like having more black staff” ... but what the men had said clearly and on numerous occasions was that they had drawn that parallel between slavery and their experience of being sectioned, being “snatched” from their families, being held against their will, being physically restrained, those sorts of things.’⁹³

‘The evidence is in criminal justice, mental health, education, employment everywhere. I would also say poor white people suffer, but we are talking about race in relation to mental health, and if you are poor and black you will suffer more. The stats tell you where to look.’

A delivery of established models of ‘mainstream’ mental health practice to BME service users and communities without consideration of culture or identity can represent a repetition of historical injustice. An example is the delivery of cognitive behavioural therapy (CBT) to people from BME communities in a manner that emphasises ‘individual’ concerns, while denying norms of ‘collective’ experience. McKenzie-Mavinga further argues that ‘therapy’ in itself is derived from a Eurocentric frame, which shapes the training of mental health professionals and to an extent also frames research in the mental health field.

‘I think that it seems that the black community are not feared, but, we are not understood. So, if we are angry, if we are upset, if we are agitated, it is not understood [...] I just think a lot of the time on the mental health side of things – we are just not understood.’

⁹⁰ Fanon, F (1986) *Black Skin, White Masks*, London: Pluto

⁹¹ DeGruy Leary, J (2005) *Post Traumatic Slave Syndrome*. Milwaukie, Oregon: Uptone Press, 2005

⁹² McKenzie-Mavinga, I (2009) *Black issues in the therapeutic process*. Basingstoke: Palgrave Macmillan

⁹³ Cartin, M (2009) *Trailblazers: An evaluation report*. London: Mellow/East London NHS Foundation Trust p.38

⁹⁴ Davids, MF (2011) *Internal Racism*, London: Palgrave Macmillan

‘...We cannot blame every case of mental illness in the black and minority ethnic community [...] we cannot look for racism as a causal factor in every case. But I think we need to consider the possibility in every person we work with. That is again the tricky issue that practitioners aren’t equipped to have these sorts of conversations with people.’

Institutional racism and institutional defence

The psychoanalytic concept of ‘internal racism’ (M Fakhry Davids⁹⁴) shows how historical patterns of racial oppression can become ‘internalised’ by people of all ethnicities and then re-enacted in interpersonal relationships, organisations and systems. Central to this is the idea of an ‘internalised’ relationship between self and a racialised ‘other’ that serves to hold those experiences which a person does not wish to own. This includes anxieties around race and difference. The dynamic of ‘internal racism’ – the projection and interplay of these ‘disowned’ parts of self – finds expression in anxiety or conflict linked to race. This dynamic can be seen to be closely linked to the systemic challenges presented by the theme of institutional racism’.

However policy in relation to race equality since the 1990s has largely failed to take into account the action of defences operating at interpersonal, organisational and institutional levels which can affect the responses of public services. This can be clearly seen in the ‘backlash’ to the theme of institutional racism within the police since the publication of the Macpherson report, as has been described by Shiner (2010),⁹⁵ and in other fields, including mental health.

An absence of a sense of momentum from government, the voluntary sector or within wider society may be indicative of institutional defences linked to race. At a governmental or strategic level it is frequently possible to observe sterile or ‘bureaucratised’ discourse in relation to ethnic inequalities in mental health. This may represent an institutional or systemic defence to remove anxiety from systems through the use of terms such as ‘co-production’, ‘recovery’, or conversely tough talk to ‘eradicate’ racism which fails to produce concrete outcomes.

Anxiety in relation to race appears to be specifically felt within mainstream voluntary sector and public organisations – with currently little clear sense of how to engage ‘meaningfully’ within this area.

‘At the launch of the last Government mental health plan there was not one black person on the stage and no mention of that absence. I mentioned it and there was a real frisson around the room, a ringing of hands. The system is singularly ineffective at “inclusion”. It is a separate issue and mainstream mental health organisations are not doing their jobs.’

Fernando (1998) suggests that ‘racist action can be camouflaged by overt liberal sentiments, often without the person responsible realising it’.⁹⁶ This can be particularly important in relation to individuals who are in a position to affect and shape policy. Alternatively, the ‘regressive unarticulated set of beliefs’ identified in a discussion paper produced by LankellyChase Foundation, Mind, The Afiya Trust and Centre for Mind⁹⁷ which are observed to be held by some statutory leaders may link directly to the exercise of personal, organisational and systemic defence and the actual lack of change within organisations.

Systemic challenges within the BME Mental health sector

People currently working in or involved with the BME mental health ‘sector’ either as advocates practitioners or activists frequently have to find ways of containing or coping with trauma and fragmentation taking place at personal, organisational and systemic levels. This takes place on account of a combination of historical, political and economic/resource factors.

The existence of a BME mental health ‘sector’ implicitly challenges a split between ‘service user’ and ‘professional’ as political, social and clinical commitment is based upon a shared understanding of culture and history. Aymer (2002), commenting on the experiences of black social work professionals writes:

‘Black practitioners carry their histories of hurt, loss and reunion, migration and racism with them and this lends a particular meaning to the idea of “therapeutic” in them.’⁹⁸

Alleyne (2004) argues that through the interrelation of their practice and experiences of racism, black professionals can experience a wounded sense of self, and risk developing stigmatic stress and protective postures within their working and personal lives. To manage this dynamic, Alleyne writes that black professionals need to develop an ability to reflect and understand their own fears and relationship with racism and its complex manifestation.⁹⁹

⁹⁵ Shiner, M (2010) *Post-Lawrence Policing in England and Wales: Guilt, Innocence and the Defence of Organisational Ego*. British Journal of Criminology 50 pp 935-953

⁹⁶ Fernando, S, Ndegwa, D and Wilson, M (1998) *Forensic Psychiatry, Race and Culture*. London: Routledge p.149

⁹⁷ LankellyChase Foundation (2013) *Review of a short consultation exercise on ethnic inequalities in mental health by LankellyChase Foundation, Mind, The Afiya Trust and the Centre for Mental Health*. London: LankellyChase Foundation

⁹⁸ Aymer, C (2002) *The dilemmas for black social work professionals: Therapeutic implications*.

Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community Volume 16 (1) pp.15-21

⁹⁹ Alleyne, A (2004). Black identity and workplace oppression. *Counselling and Psychotherapy*. 4(1),

¹⁰⁰Stevenson, S (2012). *Race and gender dynamics as an organisational defence against anxiety within a specialist multi-disciplinary child and family assessment service*. *Organisational and Social Dynamics*. 12(2). 131-144.

At an organisational level, trauma and fragmentation experienced within BME communities also appears to be sometimes mirrored within BME-led organisations which frequently operate without requisite resources or infrastructure. In working in such an environment, stresses within communities can be repeated through highly challenging organisational and team dynamics.

An example of this is illustrated by Stevenson (2012) who describes the complex dynamics of difference which was enacted in a specialist child protection agency engaging with BME children and families. As internal and external relationships for the organisation became symbolically associated with conquest and colonisation, a highly defended social associated with psychic retreat emerged within the group.¹⁰⁰

Further, one stakeholder interviewed also observed conflict and division within BME communities in relation to engagement with the political process to address ethnic inequalities in mental health:

‘The black community is divided about the issue. There are those who use the arena to their own ends, try to use the system against itself, but they end up getting sucked in to it. There are others who are part of the system and understand it deeply, but are afraid to make a noise about it... because racist stereotypes come into play. The black community ends up arguing within itself.’

Trauma and fragmentation within BME communities can also be seen to also be manifest in inter-organisational relationships, presenting a major challenge for organisations seeking to establish a shared vision or consensus for action. In this context, sectoral stakeholder events can frequently appear in part to act as ‘lightning conductors’ for highly charged thoughts and emotions, entrenching existing positions while exhausting those attending and paralysing further discourse.

Historic lack of progress to address ethnic inequality has had a profoundly demoralising effect upon the BME mental health sector. The withdrawal of interest and support from government has severely weakened the capacity of organisations, which in turn, experience instability and fragmentation. Additionally, most stakeholders interviewed expressed an overwhelming sense of ‘consultation fatigue’ both from government and the charitable sector. Many also expressed scepticism regarding the intentions of charitable foundations seeking to engage in this area. The following written communication clearly expresses a strong feeling within the sector:

‘Just repeating the patterns of the past, we are seeing that the prospect of funding in this area that has been neglected by many agencies has now been put back on their agenda, and will last as long as it is an income generator. BMH UK have already seen this begin to happen with agencies even using our organisations name for this purpose, (such practices are being dealt with swiftly).

The flurry to set up commissions, round tables and the like give the appearance of activity but add insult to injury for those communities who are facing generational injustices who have already made it clear what needs to change. They don’t want any more talk, just action, I think the phrase used for black Britain is “consultation fatigue”.

The way to address the issues raised in many of your questions would be long-term sustained investment in the African Caribbean led and run services that have been serving African Caribbean communities over represented in the most secure parts of the mental health system consistently for the past 10, 20 and in some cases 25 years. Any other activity will result in what was seen after the DRE debacle post David Bennett.’

(Matilda MacAttram, Black Mental Health UK).

Silenced and suppressed voices

A number of potential silenced or suppressed ‘voices’ in relation to discourse around ethnic inequalities and mental health within ‘mainstream’ organisations, communities and at a policy/strategic level have been identified:

BME workers in ‘mainstream’ organisations

A particularly pernicious effect of institutional racism within organisations and systems, remains the shocking level of personal and cultural isolation which black mental health professionals experience in their organisations. The experience of being the sole black worker in a mainstream ‘white’ organisation is deeply problematic as they can represent a receptacle for anxieties and fears about race within the organisation.

The experience of isolation or silencing within their organisations can lead BME workers and specialists to develop conscious ‘tactics’ as a way of navigating what can be an emotionally complex system.

‘When you hit people at the right level in the right way [...] you can get inside their thoughts and it is that game that you have to play and it is an interesting game and unless you know the rules of the game you will lose, so you just have to learn the rules. But that is no excuse for not having a better system where you shouldn’t have to learn these silly rules.’

‘Thinking about black people in white institutions [...]. The system is other people. If you agree, you are colluding with the system. You could call it collusion but it might actually be strategic and a wise strategy to “collude” or go along with mainstream views up to a point, in order to get some change rather than none.’

Women, young people and older people

From our engagement with stakeholders and the literature, women, young people and older people are frequently absent or constrained from leading discourse.

‘There is a hierarchy of oppression [...] it can be used to avoid the argument altogether and it’s right that poor white people, women, young people for that matter also get it in the neck but, if you are poor and black you will suffer more.’

White people in conversation with their colleagues and BME sector specialists

Conversely, the isolation of black workers within organisations is mirrored by white workers who can feel constrained from articulating their views and experiences in relation to race and difference, or in seeking creative solutions with their colleagues. For example, one white stakeholder expressed strong frustration about their capacity to constructively engage with discourse: ‘I don’t have permission to talk about race’. They stated that if they propose a ‘generic’ response in stakeholder meetings, they are accused of not considering the specific circumstances of BME communities. On the other hand, if they propose a targeted approach, they are accused of wishing to marginalise communities. They said they can leave meetings feeling embarrassed, ashamed and helpless, as if it’s their job to ‘shut up and take it’.

The self-exclusion or disengagement of committed white professionals from discourse around ethnicity presents a further systemic barrier.

‘The Trans-Cultural Psychiatric Society became a big movement within psychiatry. We had white psychiatrists who came and went – they came to meetings and said we feel abused. We are not racist but we carry the burden of what the rest of society is doing. Several people left.’

Strategies for addressing institutional racism in mental health

‘Individuals, professions, institutions feel threatened by any discussion around race, it’s something that has [...] I’m thinking back to a situation in Tottenham, talking to the police about use of s136 and it was like pulling teeth. Their arms were up, their legs were out. My technique was to talk for an hour or so and slowly try and deconstruct their fears and get them to the stage where you find enough common ground to get them to open up. It’s not a discussion that can be had in fear.’

‘In terms of engaging with people, what are the sets of circumstances required to allow conversations that are less toxic to take place?’

This section identifies possible tactics, identified by stakeholders and from the literature as possible means to address racism and institutional racism in mental health service provision. In order for ‘mainstream’ public and voluntary sector organisations to engage effectively with community-led groups, new ways of sharing discourse may need to be identified. This was described by one stakeholder as needing a process of ‘de-MBA-isation’ requiring challenging perceptions of commissioners and civil servants about the role that communities can play in the organisation and delivery of mental health and other services, and engaging with them in a process of continuing discourse.

‘Credibility in terms of genuine community engagement is about peer to peer symbolic engagement, i.e., you get the local CCG Chairperson to meet directly with the local Imam, Pastor etc (who is a senior, respected and important figure in his community) in a community space. You acknowledge and facilitate the ritual symbolism (around hospitality for example) by enabling the community to engage with the commissioner face to face on their terms. If you get intelligent, black leaders telling their story in their own way, those narratives elicit an emotional response.’

Finding ways of addressing the emotive content of discourse to develop new ways of formulating local relationships was identified as being important by stakeholders. Framing institutional racism

as a 'technical' term rather than an operative or pejorative term used in 'top-down' decisions has also been recommended.

'The problem with institutional racism as a phenomenon is that there has been a refusal to accept it as such. If we look at the definition of what constitutes institutional racism from Macpherson, it exists undeniably. People adopt defensive positions due to a failure to accept or understand institutional racism. It is worth trying to unpick this problem by putting aside what we call it and responding to the elements within the phenomenon.'

'It feels important to deal with these contested issues in a non-threatening, "under the radar" kind of way. I no longer use the term black, I use the term inequalities because it is less threatening and does not turn people off – they can engage.'

A need for public agencies and BME communities to engage in an ongoing and restorative process to understand historical harm and tackle continuing institutional racism in health services has been highlighted within New Zealand. Here representatives of Maori communities organised by the group Tamaki Treaty Workers have established a forum with health agencies to develop a restorative dialogue and improve equity in the policy process and the funding of health services.¹⁰¹ Applied to a UK context, a similar approach has been proposed by Shiner as being needed to improve relationships between the police and some BME communities.¹⁰²

A number of stakeholders described a process 'unlearning' as being necessary to start to re-frame discourse around race and ethnicity in mental health:

'I had to unlearn what I trained for. Once you got into real life what is actually happening on the ground ... training is limited.'

A crucial factor in addressing institutional racism within mental health appears to be the creation of spaces where discourse involving communities, service users, practitioners and managers can be developed over time. Such an approach can help to counter default positions of avoidance or disengagement within mainstream services. Examples of initiatives include:

- **Thinking Space** was originally established to develop the capacity of staff and trainees at the Tavistock and Portman NHS Foundation Trust to 'think about racism, and other forms of hatred toward difference in ourselves and others and seeks to promote curiosity, exploration and learning about difference, by paying as much

attention as to how we learn (process) as to what we learn (content)'.¹⁰³ It organises regular public meetings and events.

- **BRAP** is a 'think fair tank', which aims to inspire and lead change to make public, private and voluntary sector organisations fit to the needs of a more diverse society. It has written extensively on the challenges within 'mainstream' services around engaging with racism and institutional racism.¹⁰⁴
- **Black and Asian Therapists Network** communicates stories of psychological health and well being to communities and to the general public. Discourse and reflection are encouraged through the development of seminars and space to explore issues experienced by BME practitioners and service users in the therapeutic process.¹⁰⁵
- **Black men on the couch** is a programme of events organised by the UK Council for Psychotherapy to encourage awareness among black men around talking therapies and promote discourse around emotional wellbeing.¹⁰⁶

¹⁰¹Tamaki Treaty Workers – November 2013 (Online) <https://docs.google.com/file/d/0BzrCC7Gc6oevZUx4RHdYek1Sbmc/edit?pli=1> [accessed 17 February 2014]

¹⁰²Shiner (2010) Ibid.

¹⁰³Rowe, F (Ed.) (2013) *Thinking Space: Promoting Thinking about Race, Culture and Diversity in Psychotherapy and Beyond*, London: Karnac

¹⁰⁴<http://www.brap.org.uk/> [Accessed 17 February 2014]

¹⁰⁵*The Black and Asian Therapists Network* (Online) <http://www.baatn.org.uk/> [accessed 17 February 2014]

¹⁰⁶UK Council for Psychotherapy *Project 20:20 – Black Men on the Couch* (Online) http://psychotherapy.org.uk/14-3-a01.co.uk/project_2020.html [accessed 17 February 2014]

3. Analysis

‘There is hope. The fact that mental health is in the mandate for NHS England – that we have parity of esteem – is progress and would never have happened previously. I would argue against the idea that we have stasis. I would argue that it is glacially slow in relation to race [...] and it is very frustrating and lives have been lost, damaged destroyed as a result.’

‘We have spent 40 years going round in circles. We need a serious plan which can make a serious impact.’

The starting point for this investigation was the shared recognition amongst LankellyChase, Mind, The Afiya Trust and Centre for Mental Health, that there is a need for concerted action around the ethnic inequality that exists within mental health. The following analysis is based upon findings from the original research undertaken and subsequent discussion with the partnership group.

i) Underpinning principles

The consultation’s starting point was a shared recognition amongst LankellyChase, Mind, The Afiya Trust and Centre for Mental Health that there was a need for concerted action around the ethnic inequality that exists within mental health. The following is the result of learning from the extensive review and consultation activities as well as discussion within the partnership group.

The findings overall highlight the extent to which the inequalities that exist are grounded in evidence and present major systemic and practice challenges for mainstream delivery, activists and for BME communities. Further, the process of undertaking this work has highlighted conceptual and practical challenges that arise in even attempting to explore this highly charged issue.

While almost all stakeholders involved in this project have been enthusiastic, forthcoming and open to engage, the dynamics of discussions have recurrently been characterised by the expression of profound disappointment, anger and weariness at the perceived stasis or glacial change within the system. These are demonstrated in the ‘headline’ findings of this research: the continuing disproportionate experience of black African and Caribbean men with mental health problems at the ‘hard end’ of services; the continuing experience of Black African and Caribbean service users of impoverished or harsh treatment from primary and secondary mental health services; and, continuing poor access to adequate mental health services across different BME communities. A sense of disengagement (and ‘toxic interaction’) between many BME communities and ‘mainstream’ mental health, including parts of the voluntary sector, has always been implicit or close to the surface in these discussions.

‘It is a fact that there has been little progress, and in fact the pattern of service use experienced by BME individuals has worsened such that they experience mental health services in an actively disadvantageous way. We fail them.’

There remains a wider issue about mental wellbeing across BME communities. Some stakeholders argue that this agenda should therefore be framed as a public health issue and not just a secondary care one.

‘If I could re-draw the work of the DRE programme I would start far sooner on the road to mental health... the issue is that [BAME mental health] is a public health agenda.’

‘Ensuring that there continues to be a sense of integrity about getting this right – that it is not going to be put away in the race equality sidings.’

This highlights that the starting point for finding ways forward must therefore be characterised by identifying the positive and promising practice that currently exists within communities and organisations, and also the need to learn from the recent policy history, while not repeating its mistakes.

‘We’ve done the rigid structure stuff [...] we need to create new ways of thinking and Lankelly is well placed to do that. [However] it would lose credibility if it went down the path of something we have already done. Its role is to create a new script.’

There is evidence of promising avenues for development, based upon examples of local practice, the development of discourse and themes presented by the ‘global mental health’ agenda. Based upon learning from the extensive review and consultation activities as well as discussion within the partnership group, key principles that must underpin the recommended ways forward include:

Accountability

The clear message from the consultation is that the primary accountability of any initiative must be to those who are impacted, which includes service users or people with lived experience, their families, and to their communities.

‘I think that accountability is missing and there needs to be something in place which is able to get accountability [around race equality] from organisations.’

We observe that while the Delivering Race Equality programme was inspired by service users, families, communities and mental health campaigners, it became co-opted as part of a ‘top down’ delivery programme within government. A new approach needs to avoid default deference to government, the mental health ‘establishment’ and policy makers.

‘I despair of another piece of legislation going through, it has nothing to do with that, it is about human beings involved in the system, how we change their mindsets and get them to behave in a way that is acceptable.’

An alternative approach which ensured accountability to communities would ascribe importance to a wider range of voices within the mental health and wellbeing discourse, promoting co-working and collaboration between mainstream services the populations they ‘serve’, including those with lived experience, traditional healers, faith leaders and community elders.

‘I am always going back to a more community based thing, communication. I still stand by that. It still works. I still stand by that.’

‘Having faith in doing something different. And that means giving up power, a lot of powerful groups that have been powerful for a long time, release power and give it to the community.’

One practical way which accountability to communities could be implemented is through a technique of ‘participatory budgeting’. By working with an identified community to jointly develop and commission a programme or intervention targeting health inequalities, local commissioners can address their objectives while explicitly demonstrating direct accountability to BME service users and communities.

Any approach taken needs to be bottom-up in terms of its sources of intelligence, learning and decision making – and therefore requires structures to be facilitative and open. A focus on the ‘grassroots’, rather than being ‘top-down’ should encourage some of the open thinking described by the global mental health movement for example: the use of members of the community as ‘mental health workers’; the deployment of professionals in an advisory or supportive role; and the location of services within spaces and contexts which are accessible to communities, such as faith organisations, educational settings and meeting places for young people or older people’s

organisations. With reference to BME communities there should be a specific focus upon potentially silenced or suppressed members – for example, children and young people, older people and women.

‘Mental health is not like coronary surgery, most psychological treatments are low-tech. We need to look at “task shifting”. We should be looking to shift to people with no professional backgrounds to bridge the mental health gap. We don’t require such a top heavy structure and this has been shown time and time again.’

Leadership

Given the multiplicity of the issues surrounding ethnic inequalities in mental health, and the complexity associated with systems and processes, sustaining existing and developing new leadership at local, national and at a wider intellectual level is crucial:

‘Leadership is critical and the development of frontline leaders is important – it is about promoting long term support to enable critical thinking.’

‘I think we can change things by first of all creating leaders.’

Local leadership which takes into account the voices and needs of all sections of BME communities (including young people, older people and women) is a prerequisite for accountable development. Strategic or ‘umbrella’ leadership is also essential to ensure that there is an effective connection between what goes on locally and national policy agendas.

‘we need a RSA-type approach and throw a lot of balls in the air.’

There is also a need for wider ‘thought leadership’ to promote new learning and the development of discourse involving communities, sectoral specialists and policy makers. The bringing together of local leadership, national leadership and wider ‘thought leadership’ will serve to create and sustain a sense of challenge, help establish alternative visions, and develop the foundations for future systemic change in this area.

The positive appreciation of assets

While there exists a profound and legitimate level of weariness, disappointment and anger within the BME mental health sector relating to the lack of mainstream success around achieving progress, stakeholders also universally expressed a profound and continuing commitment and enthusiasm for positive change to happen.

To draw upon the very powerful well of support within the mental health sector and within communities, it is essential to adopt an 'asset-based' approach. This will emphasise and validate the strengths that lie in individuals and communities (not just organisations), rather than in a 'traditional' approach based on a definition of a problem.

‘There are several good examples of where people are trying to improve the quality so it's not as if we don't know what the key issues are but these services don't have penetration into the NHS.’

‘So you know there are lots of experiences, lots of examples of positive black role models in communities. Community leaders and youth leaders, people who do incredible stuff, incredible work, who don't get recognised, don't get recognition...’

Creative discourse

The research has identified and surfaced a range of profound challenges around framing and responding to issues of ethnicity, racism and institutional racism, which affect the action of both the mental health 'mainstream' and the BME specialist sector. Due to being embedded in the intergenerational experience of racism, defences operating at personal, organisational and institutional levels, these challenges can appear overwhelming to those who encounter them.

‘Why is it that people find it so difficult to have a conversation? The underlying problem is we can't talk about it but it's a demographic time-bomb.’

However the evidence indicates that the formation and facilitation of spaces where discourse involving communities, service users, practitioners and service commissioners can be developed over time, can help to improve dialogue in relation to race, ethnicity and innovative practice, and also curtail avoidance or disengagement from mainstream services.

‘Individuals, professions, institutions feel threatened by any discussion around race. People adopt defensive positions. It is worth trying to unpick these problems by putting aside what we call them and responding to the elements within the phenomena.’

The partnership is clear that the changes they want to see will take time to happen and so it is important to show commitment to creatively develop discourse over a time-period that extends way beyond the standard lifetime of conventional government-led, charitably funded or otherwise bureaucratic delivery programmes. For example,

one stakeholder described 'at least a generation's work' as being required for the task of developing dialogue, discourse and the foundations for positive change in this area.

Applying a 'phased approach' over an extended time period

‘The system is too well defended to change easily or quickly. We need to build change by stealth.’

It should be emphasised that any process promoting lasting positive change in this area will both require time and the phasing of activity, analysis and reflection. Individuals or organisations that are adopting interesting and innovative approaches and appear to be achieving positive outcomes will need to be supported to establish empirical evidence relating to their work over an extended time period.

The partnership is clear that the changes they want to see will take time to happen and so it is important to show commitment to creatively develop practice and discourse over a time-period that extends way beyond the standard lifetime of conventional government-led or charitably funded delivery programmes. (One stakeholder described that 'at least a generation's work' as being required for this purpose.)

‘It is not the headline stuff that creates change, it is the day to day slogging.’

‘In this sort of society you can't change things radically, you change things little by little and to do that you have to collaborate, compromise and negotiate.’

‘We have not been swayed by the latest policy directives and have not chased the money in that respect. We need to be looking at funding things for a minimum of five years to have a hope of seeing real, sustainable difference. This approach takes time and so we need to fund long term in order to develop a methodological framework.’

Drawing upon progressive models, movements and practice

Stakeholders and partner organisations identified a range of movements, practice and historical learning that should be integrated into any response to addressing ethnic inequalities in mental health. These include:

Creatively applying principles from 'global mental health'

More effective use of available resources, the opening up of the delivery of mental health interventions to members of the community and a changing of the role of professionals to facilitators

and enablers, as advocated by the global mental health movement, represents a major opportunity to improve the accessibility of mental health services within BME communities (and also more generally within society).

‘So how about connecting with barbers, thinking about what kinds of skills they are using, maybe supporting or offering support and learning also, because it is a two way kind of learning approach. That is a community psychology approach to mental health which is so radically different to what we are doing at the moment.’

Learning from social movements

The example of a number of historical social justice movements may provide techniques to learn from and adapt. These include the women’s rights, environmental, hospice and AIDS/HIV movements. However it is the Civil Rights and the Anti-Apartheid movements, which present the strongest resonance in relation to addressing ethnic inequalities in mental health. Civil Rights’ integral identity as a black-led endeavour conducted by black and white in partnership provides a model for a movement, which will avoid the isolation experienced by both BME and white stakeholders. Both can start to collectively address the significant interpersonal, organisational, systemic and political challenges of institutional racism and defence.

‘We need to learn what we can from what went before: Civil Rights movement in the United States, and equalities campaigning in the UK in the 1970s and 80s.’

‘I see social movements as the way of achieving real, long term change. We can learn from Civil Rights, gay rights movements etc.’

ii) Ways forward and concluding comments

Based upon the previously collectively identified principles that must underpin possible ways forward, this section identifies a number of areas in which the partnership group could take forward a programme of work involving user-led organisations, communities, sector specialist organisations, local statutory agencies, the voluntary and private sectors and government.

Many stakeholders have stressed the need for a long lasting and effective programme addressing ethnic inequalities in mental health which is neither static nor glacial, but which places the individual

Personalisation and a diversity of available interventions

The principle of personalisation needs to extend to BME communities. The range of provision available where required should include: clinical services delivered from a bio-medical model; psycho-social interventions (including culturally sensitive IAPT provision); and community-led models in a variety of relevant settings and contexts (for example those engaging with faith communities, traditional healers, women, young people and older people).

‘I have always argued that [...] because people come late to services, they present with something that may look like schizophrenia, so if people get support much earlier on, and I don’t mean mental health services, young men get support with identity stuff, you know, how to deal with aggression, anger, all those sorts of things, then we may be able to stop things from escalating. It is about resilience, identity, it is something that is more like a social model rather than a medical model.’

Acknowledging individual priorities and context

Mental health provision for BME communities (and indeed for all communities) should acknowledge and inter-relate to the wider social determinants of health and wellbeing and take into account opportunities for prevention and early intervention. A consideration of the necessary ‘intersectionality’ includes employment, education, housing, financial security, criminal justice, engagement with the political process and the accountability of public services to the communities they serve.

‘It is an economic problem, it is an educational problem, it is a housing problem. It is a selection of issues and mental health services aren’t here to deal with social issues of this nature. So the typical psychiatric response is medication and I don’t think you can medicate social issues.’

and community at the heart of the process. They would like to see thought leadership, new ways of thinking and the creation of a ‘new script’.

‘They (LankellyChase and partners) need to call it like it is. If this is another hand wringing exercise it is not good enough.’

Facilitating thought leadership

Given the LankellyChase, Mind, Afiya Trust and Centre for Mental Health’s long standing work in relation to ethnic inequalities in mental health,

the convened partnership group is well placed to take responsibility for 'thought leadership' in this area. This should involve a facilitative role; creating opportunities and platforms for a range of stakeholders including BME grassroots organisations, mainstream mental health services, policy makers and others.

'Is this exercise part of the game or is it going to be really far reaching? My take on this is we've looked at what's gone on in the last 20 years and we're saying it hasn't really pushed forward hard enough [...] I would want to see Lankelly encouraged to be the thought leaders in this field because they can be.'

A multiplicity of platforms may be required to support and sustain different kinds of conversations, including:

- A resourced alliance bringing different stakeholder groups, organisations and interested individuals together over time;
- Sharing information about practice taking place in different fields relating to ethnicity and mental health;
- Creating bridges to potentially under-represented or unheard groups in the framing of discourse around ethnic inequalities in mental health, including younger people, older people and women.
- Facilitating discourse and dialogue between professionals working within 'mainstream' services and BME specialist organisations, the users of services and communities. This should also include space for white professionals to develop their perspectives and voices.
- Exploration of digital mechanisms such as twitter, blogs and forums offer such an opportunity to engage a much wider and more diverse group of stakeholders.

'We need to look at how leadership within organisations is able to focus internally. Leadership is critical [...] it is about promoting long term support to enable critical thinking.'

Developing an independent learning observatory for BME Mental Health

The argument for an independent 'observatory', with the function or capacity to collate, synthesise and analyse data, and draw out policy implications, seems persuasive. Such a body could conduct a range of functions, which would be essential in starting to establish a wider framework of

accountability of mental health services to BME communities.

'There needs to be a national body with accountability regarding data. People need to be held to account. Why is nothing published on institutional racism? We ignore the evidence but who challenges that? Whether it works or not depends on what is meant by an observatory. It would be useful to pull together the wealth of existing evidence but it would be insufficient alone. People are not persuaded by information alone, it is about how you use it to hold people to account in terms of mental health.'

As an authoritative and independent voice, a BME mental health 'observatory' could assist 'mainstream' and other organisations to monitor and address existing ethnic inequalities in mental health. In widening the mental health definition to include mental wellbeing, and recognising that community organisations make a vital contribution, it could initiate and facilitate important public discussion. This could include conversations about how to ensure that relevant data is captured to assist in ensuring the community can hold both public and voluntary sector organisations to account.

'... gathering examples of what good looks like, so my way of trying to move the system forward is to give people the data which says, look you have got an issue, you need to get all the partners in your patch round the table and have a look at why this is an issue.'

'... everybody knows we've got a problem. Everybody knows we've had this problem for 30 years. Now we need to know in which communities have we got the biggest problem and what can we do to help them? Which comparable communities with the same people, people with the same background and the same spectrum, don't have the problem? So what can we learn from the ones who don't have the problem or the ones who have sorted it?'

Learning generated and the phasing of activities or priorities for an 'observatory' should be 'grassroots-led' rather than centrally driven. Guided by both clinical and socially scientific discourse and accountable to BME communities, an 'observatory' could do the following.

- Clarify how to better define and measure inequalities. For example, conducting a 'reverse audit' of the current data flow from front line services to determine what is currently being collected.

- Utilise NHS and local data sets to analyse current trends.
- Find examples of effective service models and community leadership (both national and international) and disseminate. It could, for example, usefully evaluate the 5-year dataset from DRE with a particular focus upon the outcomes generated by 'grassroots-led' initiatives which were developed and supported as part of the programme.
- Actively hold agencies to account for their practice and engagement in this area.

Strengthening and sustaining leadership in the sector

There is a need to support and develop BME individuals who have already been identified as leaders, as well as identifying an emerging field of future BME leaders, including women, older adults and young people. The partnership group could seek to develop and oversee an appropriate means for identifying current and future leaders and support them financially as well as through leadership development, coaching and access to a broader network of a like-minded 'Fellowship'.

‘Providing young people with the opportunity to develop and exercise leadership can have benefits for the individual young person, their peer group and society more broadly. The emotional and social skills that enable effective leadership have broader significance beyond their potential to prepare young people to take on formal leadership roles; these skills are crucial to young people’s successful transition to adulthood. Additionally, youth leadership can serve as a vehicle for tackling pressing social challenges and catalysing positive social change.’ (pp6)¹⁰⁷

‘You see lots of black males who are doing fantastic work, so much to say and so much which would be important to say who don’t get that recognition.’

Continuing to support BME-led grassroots organisations

As well as supporting individuals, there remains a continuing need to support 'grassroots' organisations which seek to address ethnic inequalities in mental health, either as part of their stated mission, or through their wider engagement within the community. Organisations operating in other areas of multiple disadvantage would provide helpful knowledge, insights and discourse in relation to BME mental health.

‘We must consider how we drive funding down to small, specialist organisations.’

‘...we have all these fabulous programmes and they all sound great but where is it happening? Who is making them happen locally and how did that come about and what’s the constellation of individuals and circumstances that you need to get things together.’

Evaluating the applicability of the principles of Global Mental Health

While Global Mental Health presents a prospective opportunity to address ethnic inequalities in mental health (and provide a model for wider application) its potential application in a UK context is currently unevaluated. The partnership group therefore has a potential role to support an exploration of this model, its presence within existing schemes and the potential for further development.

‘The Global Mental Health movement will transform it (the system) but mental health is not global it is local and it is something that comes out of the cultures and the contexts in different places and it changes. The concept of mental health is manufactured, has come out of certain ways of thinking about our behaviour and our beliefs being located in the brain. This has come out of the study of madness from a particular cultural framework and ways of thinking about people as different bits. This approach is worth challenging.’

Concluding comments

While this investigation of ethnic inequalities in mental health has been a relatively small-scale project, it has surfaced a number of conceptually challenging issues linked to the nature and possibilities for change in this field. Through engagement with stakeholders and the literature there appear to be few easy or quick 'wins'. Instead, a range of different responses are required to take place over a time frame which lies outside of the reach of conventional policy or funding processes. Further, unlike earlier delivery programmes which have been characterised by 'top-down' approaches, these need to place BME communities at the centre of all accountability.

To develop a theory of change relating to ethnic inequalities in mental health, the analysis of institutional racism as being an 'independent variable that intersects with other variables'¹⁰⁸ in this field represents a strong and compelling starting point. Further, the action of defence mechanisms operating at personal, organisational and institutional levels appears to represent a defining dynamic of institutional racism within 'mainstream' service provision which will need to

¹⁰⁷Ali, R, Hewes, S & Kahn, L (2009). *Taking the lead: Youth leadership in theory and practice*. London: The Youth Foundation.

¹⁰⁸ LankellyChase Foundation (2013) Ibid.

be addressed in any systemic response. Here, the need for the development of discourse involving BME service users, their communities and people working in or organising mental health services will be crucial. Learning from earlier mistakes of top-down delivery programmes, it will also be important to avoid institutional triumphalism (or defence), and bypass the reliance on 'easy answers' in order to think about what 'good-enough' might in fact look like over the long term.

