



Mental health crisis care: commissioning excellence for Black and minority ethnic groups

A briefing for Clinical Commissioning Groups
March 2013

mind.org.uk/crisiscare



About this briefing

Social contact with compassionate and experienced human beings is the most valuable element of care for me.¹

As a new health care commissioner, you have a critical opportunity to improve and sustain the mental health crisis care available to everyone in the communities that you serve.

Following on from a year long independent inquiry in 2010/11 and Freedom of Information requests made in 2012, we found there are stark inequalities in the way people from Black and minority ethnic (BME) groups are treated when they are in crisis.

This briefing highlights what we think you need to factor in when commissioning crisis care services for people from BME groups.

The briefing focuses on:

- Consultation and engagement in commissioning
- Assuring values and capabilities of organisations and their staff
- Commissioning a range of options
- Information, advocacy, engagement and control.

1. All the quotes in this briefing are from people from BME communities who responded to our enquiry.

Background

I've been in crisis so many times and none of the mental health people know it... Because they just don't listen to me... I wish they could hear me say I'm in crisis without me saying those words... But they won't because they're never around long enough to get to know me and my signs.

Crisis and acute mental health services are a crucial part of mental health care. They provide support and treatment for people when they are most unwell and vulnerable. These services are made up of crisis resolution and home treatment (CRHT) teams, inpatient wards and a variable range of community-based provision.

Over the past three years, we have conducted extensive research into the state of acute and crisis care.

During 2010 and 2011, we conducted a year-long independent inquiry into crisis care. We published the inquiry's findings in November 2011 in our report *Listening to experience*. The inquiry found that people from some BME groups seem to be treated more neglectfully or coercively in the crisis care system than other people.

In August 2012, we sent out Freedom of Information (FOI) requests to all mental health trusts (in England) asking about the crisis care provision in their locality. The FOI responses suggested that different ethnic groups may face different barriers to accessing crisis care.

Specifically:

- There is variable access to CRHT teams, with Indian, Bangladeshi and Chinese people having consistently low referral rates
- Once assessed by a CRHT team, BME groups are generally more likely to be admitted to hospital, especially Black Caribbean people.

More about our Crisis care campaign

You can find out more about our Crisis care campaign by visiting mind.org.uk/crisiscare

There, you'll find our companion briefing *Mental health crisis care: commissioning excellence* and our report *Listening to experience*.

You'll also be able to see why people across the country are supporting our Crisis care campaign.

A summary of findings and recommendations from our previous CCG briefing, *Mental health crisis care: commissioning excellence* can be found on page 14.

What people from BME communities told us

Encourage more social and interactive activities run by ex-inpatients. Because it brings hope and solidarity when you see people who have been in the same situation facilitating creative activities in the hospital.

There has been slow progress on changing the stark inequalities in the acute sector of mental health care for people from some BME groups. They continue to be over-represented in hospital and as detained patients.

We found the themes raised by BME respondents were similar to those made by all respondents but there were some additional emphases.

Though some BME respondents reported good experiences, they also told us about long waits, especially for talking therapies, lack of diversity among staff, and cultural and religious needs not being met.

There were some serious problems with the quality of life on wards and the lack of therapeutic interventions for inpatients. Concerns were expressed around medical dominance and the use of medication, particularly very high doses. There was criticism of how black men are

disproportionately diagnosed with schizophrenia and of the prevalence of community treatment orders (CTOs) among some BME groups.

Communication is critical in mental health treatment and support, and when there is a language difference it is particularly important to address this. We heard about a lack of interpreters, or interpreters being available only once a week, as well as a lack of psychological therapy in the person's own language.

From our research, we did not get a strong sense from mental health services of a strategic drive to overcome ethnic inequalities. This reflects wider concerns that race equality has come down the agenda in recent years. There were some good initiatives. One trust had carried out a cultural audit, while another organisation planned to offer services from a partner organisation's premises which was more accessible for BME groups. However, these examples of inspiring practice were very few.

Our inquiry panel was mindful of BME individuals' and communities' experiences in setting its priority areas for action:

- Humanity
- Commissioning for people's needs
- Choice and control
- A shared approach to healing and recovery.

What mental health trusts told us about crisis care for BME groups

We know that people can struggle to get help when they're in crisis, so we asked mental health trusts (through our 2012 FOI requests) about the capacity of the CRHT teams in their area, which are the gateway to access.

We wanted to find out about issues like staffing levels and service activity, including ethnicity data.

33 trusts gave us a breakdown of ethnicity for their CRHT teams' activities.

Referrals to crisis services²

Indian, Bangladeshi and Chinese groups had consistently lower referral rates to crisis services than the White British group. This was much lower in the case of Chinese people.

The Pakistani group also had lower referrals except in the case of Derbyshire, North East London and Oxfordshire, where referral rates were higher than for White British.

The Other Asian group tended to have higher referrals though not in all areas.

The picture was more mixed for Black Caribbean and African groups, which had lower referral rates in some areas and higher in others, including the two London-based trusts who gave us this data. The Other Black group had more consistently high referrals (though not everywhere).

Assessments

The proportion of people referred who were then assessed was relatively consistent between ethnic groups (in some cases very consistent).

Home treatment

When we looked at the proportion of people referred to CRHT teams who went on to have home treatment, in most cases it was either fairly similar across ethnic groups, or a lower proportion of the White group had home treatment compared with other ethnic groups.

Hospital admission

In most areas, there was a lower proportion of White people admitted to hospital by CRHT teams and a higher proportion of other ethnic groups particularly Black Caribbean. In the South London and Maudsley Trust, the Black groups' proportion of the home treatment population and the inpatient (triage) population was 21 percentage points higher than in the local population. In some areas, the proportion of people referred to CRHT teams who went on to be admitted to hospital was fairly similar across ethnic groups.

2. We worked out referral rates in relation to the ethnicity breakdown of the local working age population (ONS statistics 2009), and used the White British group as comparator.

Analysis of what mental health trusts told us

While there is no definitive interpretation of these figures, it is possible to see trends which chime with previous research.

Possible reasons for ethnicity variations in the use of services include the level of mental health problems among people from that ethnic group; different cultural and practical barriers to accessing care; mental health stigma in some communities or differences in how people are treated including experiences of racism.

Our data suggest that people from BME groups are receiving treatment once they are seen by CRHT teams but that there may be barriers to initial access especially for those from Indian, Pakistani and Chinese backgrounds.

The higher rates of home treatment and hospital admission among BME groups suggests that those who do reach CRHT teams are more unwell than the White group overall. This is consistent with the literature which shows people from BME groups tending to come into contact with mental health services later. The figures are also consistent with people from Black groups being over-represented in hospital.

As our data is specifically about people accessing services through CRHT teams, we will not have counted people admitted through more coercive routes in which Black groups are again over-represented.

Key facts from other sources about BME groups and acute and crisis care

Mental Health Minimum Data Set

- Once in contact with mental health services, rates of access to hospital services were higher for all minority groups (except Any Other ethnic group) than for the White British group.
- Caribbean, African and Other Black groups' rates were roughly double those of the White British group after age and gender had been taken into account (before taking these factors into account, the differences were even wider).
- Less than 40 per cent of White British and Irish inpatients were subject to detention under the Mental Health Act but over 50 per cent of inpatients from the Mixed White and Black African, Caribbean, African and Any Other Black backgrounds were subject to compulsion.
- Census data from 2011 on the ethnicity of the population suggests that rates of access to secondary mental health services generally for BME groups are lower than previously thought.

Source: Mental Health Bulletin for 2011–12 (Health and Social Care Information Centre, 2013)

Other research

- Black people are more likely to present in crisis, with A&E often the first point of contact. Police are more likely to be involved in admissions or readmissions.
- Studies consistently show higher use of inpatient services by Black people and higher rate of compulsory admissions.
- South Asians of all ethnic groups are least likely to be referred to specialist services. In a study in Birmingham they were the most frequent consulters of primary care but less likely than White people to have mental health problems recognised.

Source: Bhui et al, 2003

- Indian, Pakistani, Mixed White and Asian, and Chinese groups use CRHT teams less than White British people do.
- Black African, Black Caribbean and other Black groups use CRHT teams more than White British people do.
- Indian and Pakistani women use CRHT teams to the same extent as they do hospital.
- Indian men and Black Caribbean women use CRHT teams less than hospital.
- Chinese people use CRHT teams and hospital much less than White British people do.

Source: Glover and Evison, 2009

Barriers to seeking crisis care

Staff do not know about how racism can affect one's mental health and generate a crisis.

There are numerous barriers that may reduce different BME communities' use of crisis care.

- Lack of information and awareness of the mental health system, what it offers and how to access it, may prevent people from asking for help.
- Different cultural frames of reference and understandings of mental health may mean that mental health services are not seen as relevant or helpful.
- Health professionals from different cultures may not recognise the mental health element of a person's illness and so not help them access specialist support.
- Individuals and families may hold off from seeking help for as long as possible for different reasons, such as taboos in the community, use of traditional medicines or faith-based healing, or fear.
- Language differences make it harder to access help both practically and emotionally, when psychological distress needs mother tongue communication.
- Experiences of racism both in the wider community and in mental health services are likely to make people mistrustful and reluctant to seek help.
- A lack of understanding within mental health services about the impact racism has, makes it harder for people to receive appropriate support.

When I am ill my health deteriorates fast. Within two days. There is no longer any emergency response. Just routine referral. This means you get worse than necessary before getting help.

Fear and dissatisfaction with services have been shown to play a significant part in Black people's interaction with mental health services.

Over a decade ago, researchers identified 'circles of fear' that stop Black people from engaging with services.

"Mainstream services are experienced as inhumane, unhelpful and inappropriate. Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well integrated with the community... Black people come to services too late, when they are already in crisis, reinforcing the circles of fear."

Sainsbury Centre for Mental Health, 2002

This means that compulsion is more likely to be used, causing more fear and distress and making people more reluctant to come back in future.

A report on the outcomes of 79 national community engagement projects (Fountain and Hicks, 2010) funded through the Delivering Race Equality programme showed that, while not all participants expressed fear of mental health services, fear as a barrier to accessing services was a recurring theme.

People with little or no personal experience of mental illness reported that their biggest fear of seeking help was the stigma, shame and social repercussions.

People who had direct experience of services, particularly as inpatients, reported that their biggest fear was re-engaging with these services. Study participants and the community organisations strongly criticised what they perceived to be an unbalanced reliance on medication, with its unwanted side effects.

A recent study of people's experiences of the care programme approach found that African and African Caribbean respondents had generally poorer experiences than respondents overall (Gould, 2012).

Recommendations: commissioning good quality crisis care services for BME groups in your area

Seeing the patient as a human being and giving them respect and acknowledging their trouble.

One of the reasons for developing gatekeeping by CRHT teams was to ensure an equitable service in which everyone had access to home treatment.

The Department of Health also considered that home-based support could be more acceptable to some BME groups (NAO, 2007). It is therefore all the more important that CRHT teams reach all sections of the community who may need their support.

However it is clear both from people's testimony and researchers' analyses of pathways to care, that addressing ethnic variations in access means looking at the nature and quality of the whole of crisis and acute care.

We understand that referral and service activities will vary between different areas. Some areas will have larger or more diverse BME populations than others, some communities will be well established and may be represented in the workforce, others not. But the need to commission effectively for these groups is just as necessary no matter the size of the diverse population.

All our recommendations involve making links with BME communities and accessing the expertise of BME organisations. Our case study on Norfolk PCT on page 13 shows how this can work in practice.

1. Consultation and engagement in commissioning

Consultation and engagement with BME service users and their families, as well as wider BME communities, is central to effective commissioning.

Are services in your area meeting the acute and crisis care needs of BME communities – are they

fit for purpose, are people satisfied with them, and do they provide value for money?

We recommend you prioritise a review of commissioning for the needs of people from BME communities and develop models of commissioning in which communities can genuinely participate and define their needs and priorities.

The reverse commissioning model (see below), developed by Dr Vivienne Lyfar-Cissé and championed by the NHS BME Network, is a way to do this. It starts with an analysis of the data held by provider organisations to determine how far BME communities are using existing services and this is used to ask communities about their needs, before bringing these groups together in partnership.

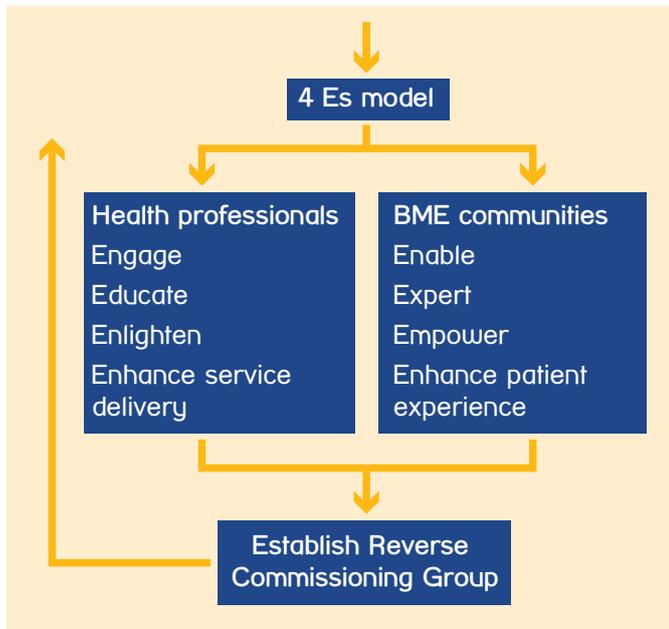
Reverse Commissioning

The Reverse Commissioning process emphasises the need for health professionals to work in partnership with BME service users to overcome ethnic inequalities in health.

The 4Es model is integral to this process and is based on true partnerships that require:

- Health professionals to be
 - better informed regarding how best to engage BME service users
 - better educated about BME service users and their needs
 - able to utilise their enlightenment to enhance and/or improve the service delivered to BME people.
- BME service users to be
 - better informed to become enabled
 - better informed to be empowered
 - encouraged to use their knowledge as expert patients to enhance their experience of the NHS.

The 4 Es Model is outlined below:



Once health professionals and service users have been informed in this way, they can come together more effectively in partnership and use the evidence gathered at the point of provision to influence the commissioning of health services.

2. Assuring values and capabilities of organisations and their staff

All mental health crisis care should be person-centred and support the person who is in crisis in the context of their whole life. This requires cultural awareness among staff as well as personal qualities and values that mean they work with respect and kindness.

The Delivering Race Equality programme (2005–2010) set out twelve characteristics which represented its goals for mental health organisations (see page 14). These are still highly pertinent and should inform your commissioning.

We recommend you:

- include an organisation’s value base as a criterion in awarding contracts or funds and in the assessment of performance and
- set standards for contracted organisations to work to reduce and eliminate ethnic inequalities in service experience and outcomes, improving satisfaction and outcomes for BME groups and providing culturally competent services, as set out in the DRE’s characteristics (see page 15).

Peer support from other people with mental health problems is a highly valued element of care. It provides understanding and empathy from lived experience and can help people find their own strengths and recover. Peer support initiatives should be developed in ways that mean people from BME communities can participate and benefit.

We recommend you commission peer support initiatives and ensure that these cater to and recruit from BME communities.

All mental health providers should involve service users in their organisations, from leadership roles in governance and service design to day-to-day feedback. Measuring service user satisfaction should be routine. People from BME communities should be fully involved in these activities.

We recommend you hold contracted organisations to account on service user involvement and satisfaction, and the engagement of BME service users in this.

3. Commissioning a range of options

Having a range of care options creates choices for service users, meets a diversity of needs, and helps CRHT teams to work more effectively (NAO, 2007). Options could include:

- crisis houses, sanctuaries and recovery houses
- retreats/respice care

- peer/survivor-led services
- BME provided services
- host families
- crisis-focused therapeutic programmes.

Consultation with BME communities and individual care planning may generate ideas for other options.

Where options are designed with the needs of particular communities in mind they may help create the ‘safe spaces’ that have been identified as beneficial. These options could include peer support and mentoring that enables young African and Caribbean men to talk about their emotions (Keating, 2007), or recovery groups in which women can address the impact of negative social experiences and rebuild a positive sense of self and communal identity (Kalathil, 2011).

We recommend you involve communities in reviewing what mix of options would best serve local needs and make sure you engage BME communities in this process, and consider commissioning from BME organisations.

4. Information, advocacy, engagement and control

Information and advocacy are central to access and empowerment, helping people to navigate the mental health system, understand their options and express their needs. It is especially important where people are very unwell, are unfamiliar with the system, or face language barriers.

We recommend you work with other agencies to:

- ensure that individual BME service users can access information and advocacy services tailored to their needs and commissioned from BME organisations
- ensure that there is readily accessible, well publicised local information about what services are offered and that this is promoted to BME communities with the help of local groups.

Choice and shared decision-making are major themes in current health policy and reflect what people want but are often not a reality in mental health care. People’s wishes can be overridden and approaches such as joint crisis care planning are not in common use. Listening to people will lead to more effective care and promote recovery.

We recommend you set standards with contracted organisations so that they demonstrate shared decision-making in treatment and care and use of specialist BME organisations for mediation, advocacy and brokerage to assist as needed.

Personal health budgets

As commissioners you will lead the roll-out of personal health budgets for people with long-term health conditions.

They are particularly effective for people with mental health problems and are a real option for people with long-term conditions who may periodically need to use acute mental health services.

Coupled with joint crisis care planning, personal health budgets could be very powerful tools for securing support that is effective and acceptable; especially for those who are dissatisfied with standard services. They need to be made equally accessible to people from BME communities who may find them a particularly attractive option.

Case study: Norfolk PCT

Commissioned by the Norfolk PCT, the Community Development Programme works in line with the Delivering Race Equality agenda towards improving the health care experience of BME communities in Central Norfolk.

The Community Development Workers (CDWs) act as a bridge between commissioners, service providers and BME communities to increase and improve access to NHS services.

CDWs deliver Cultural Competence training to support local commissioners, the GP surgery and mental health care staff to deliver more culturally sensitive and appropriate services to the communities.

The CDWs arrange consultations with BME communities and provide Mental Health Awareness and Mental Health First Aid training to reduce stigma within the communities. The training is tailored according to the needs of the community members – they have so far delivered the training in Portuguese and Swahili.

They also run Diversity Network meetings which provide a platform for the service providers and commissioners to engage with BME and other diverse communities in Central Norfolk.

The CDWs offer advice to mental health practitioners, individual support to service users and also work in partnership with non-mental health organisations to offer the best support for service users.

The 12 Delivering Race Equality (DRE) characteristics

In 2005, the Department of Health's DRE action plan identified 12 characteristics which it was hoped would describe mental health services in 2010. They are still important goals for mental health commissioners and providers.

- 1) Less fear of mental health care and services among BME communities and BME service users.
- 2) Increased satisfaction with services.
- 3) A reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units.
- 4) A reduction in the disproportionate rates of compulsory detention of BME users in inpatient units.
- 5) Fewer violent incidents that are secondary to inadequate treatment of mental illness.
- 6) A reduction in the use of seclusion in BME groups.
- 7) The prevention of deaths in mental health services following physical intervention.
- 8) An increase in the proportion of BME service users who feel they have recovered from their illness.
- 9) A reduction in the proportion of prisoners from BME communities.
- 10) A more balanced range of effective therapies such as peer support services, psycho-therapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.
- 11) A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services.
- 12) A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

Summary of findings from our November 2012 briefing to CCGs

In November 2012, we published our first crisis care briefing to CCGs called *Mental health crisis care: commissioning excellence*. Here is a summary of our overall findings and recommendations.

Mental health trusts' data³ for 2011–12 showed:

- Huge variations between trusts in rates of access to crisis care services
- Under-staffing in four out of ten trusts
- Limited options beyond hospital and home treatment
- Variations in access by different minority ethnic groups
- Variations in intensity of support.

We recommend that commissioners understand the local context and engage with local communities sufficiently to:

- Commission the right level and mix of services
- Promote safe staffing levels that allow for a timely and effective response
- Ensure easy access to crisis care
- Ensure there are no gaps in provision for people in or on the brink of mental health crisis.

To read our full briefing *Mental health crisis care: commissioning excellence*, visit our website mind.org.uk/crisiscare

3. Based on 47 substantive responses.

End notes

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With thanks to Professor Sashi Sashidharan for his continuing support and advice.

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