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Research paper

Responding to ethnic diversity: black service users' views of mental health services in the UK

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ABSTRACT

UK literature on mental health services for black service users relies heavily on perceptions of professionals, carers and community representatives. This paper focuses solely on the views of service users on existing services and how they might be improved. It is based on thematic analysis of material derived from focus groups and individual interviews conducted with South Asian and African-Caribbean mental health service users within one local area. It considers the implications for the likelihood of the current UK government's initiative *Delivering Race Equality* achieving significant improvement in services for black service users.

The analysis highlights the role of socio-economic exclusion in shaping black service users' experiences of mental health problems and that this is a barrier to achieving a reduction in black and ethnic minority hospital admissions. Cultural and institutional exclusion compound this, leading to continuing insensitivity towards the needs of black service users within both hospital and community-based services. The participants supported many of the initiatives outlined in *Delivering Race Equality* and wanted to see more culturally appropriate services for recovery; further development of the cultural competence of staff within mainstream services; and educational programmes about mental health directed at minority communities. It was a source of particular disquiet to participants that they perceived so little response by mental health services to their consistently expressed views about what was needed. The paper concludes that more systematic consultation with black service users and a commitment to change within mainstream services is essential, or insensitivity to ethnic diversity will remain a defining characteristic of UK mental health services.

Keywords: cultural sensitivity, ethnic minorities, mental health, service user perspectives, UK

Introduction

Despite recognition of the inadequate response of UK mental health services to ethnic diversity and more than 10 years of calls for action, little has been achieved (Fernando, 2005). The current UK government, however, sees *Delivering Race Equality* as marking 'a new determination' (Department of Health, 2005, p.7) to produce change, and by 2010 expects mental health services to be characterised by fewer black and ethnic minority hospital admissions, less discriminatory inpatient care and increased satisfaction amongst black service users. This article reports on the investigation of African-Caribbean and South Asian mental health service users' views of existing services within one local area and how these services might be improved. Details of the South Asian participants' views have been published elsewhere (Bowl, 2007). Hence the particular focus here is on the views of African-Caribbean people who use mental health services; differences and similarities between these two groups; and the implications of the findings for the likelihood of *Delivering Race Equality* achieving significant change.

Different ethnicity, different experiences

In comparison to the white population in the UK, members of African-Caribbean communities who have mental health difficulties make less use of first-line support services (Bhui *et al*, 1995; Commander *et al*, 1999); experience greater use of compulsory powers and secure accommodation (Jones and Berry, 1986; Davies *et al*, 1996; Singh *et al*, 1998; Audini and Lelliott, 2002); receive medication more often and in higher doses; and are far less likely to receive non-physical interventions, such as counselling or cognitive behavioural therapy, collectively known as 'talking therapies' (Callan and Littlewood, 1998). In comparison, members of South Asian communities also make less use of first-line supportive services than the white population and are more likely to experience inpatient care (Bhui *et al*, 2003). Although previously identified as less often subject to compulsory powers (Bowl and Barnes, 1993; Thomas *et al*, 1993), recent evidence shows that South Asian people are more often compulsorily admitted under the 1983 Mental Health Act than members of the white population (Koffman *et al*, 1997; Lelliot and Audini, 2003; Bowl, 2004). Both African-Caribbean and South Asian service users also express less satisfaction with services than their white counterparts (Parkman *et al*, 1997; Sandamas and Hogman, 2000).

Explanations for ethnic difference and solutions proposed

One focus of concern has been to explain differences between ethnic groups in identified rates of mental illness. The lack of consistent evidence to support earlier ideas about biological 'ethnic vulnerability' (Fernando, 1991) has seen the focus pass to social explanations (Sharpley *et al*, 2001; Morgan *et al*, 2004). McLean *et al* (2003) identify socio-economic exclusion as a key factor in trying to understand the particular experiences of African-Caribbean mental health service users. They draw attention to the link between lower socio-economic status and poor mental health and argue that members of black communities are more exposed to lower earnings and unemployment. They also experience racism, which can be both a chronic and an acute stressor (Chakraborty and McKenzie, 2002).

Others see this as a variant of the notion of *ethnic vulnerability*, reinforcing the idea that black people objectively experience poorer mental health (Sashidharan, 1993; Barnes and Bowl, 2001). They acknowledge the effects of socio-economic disadvantage on rates of mental ill health but are more concerned about how this is reinforced by disparities in mental health services (Sainsbury Centre for Mental Health, 2002) and place emphasis on the role of cultural and institutional exclusion within that specific context.

McLean *et al* (2003) identify cultural exclusion as mental health services' inability to offer appropriate understanding to ethnic minority service users – shown by difficulties in understanding what people say, because workers do not speak the same language; by misunderstanding what they mean or want because of the cultural incompetence of staff; and by misinterpreting particular behaviours as signs of mental illness. Ultimately this can lead to inaccurate diagnosis or to black service users disengaging from services. Institutional exclusion, arising from the application of standard procedures that do not acknowledge difference and disadvantage those who have specific needs, including those arising from ethnicity, can exacerbate this.

Keating and Robertson (2004), focusing specifically on African and African-Caribbean communities, characterise this in different terms, referring to the *circles of fear* that underpin poor relationships between black communities and mental heath services, the fears of black service users about mental illness itself; their fears about the way services will respond to them that often delay help seeking; and the fears of professionals about engaging with black service users.

Proposals to counter the discriminatory treatment of black service users have been detailed extensively (Jennings, 1996; Bhugra and Bahl, 1999; Sainsbury Centre for Mental Health, 2002). Developing the cultural competence of staff, whether by employing greater numbers of black staff and/or training white staff to enhance cultural sensitivity and understanding, is a key feature (National Institute for Mental Health in England (NIMHE), 2003). *Delivering Race Equality* (Department of Health 2005), which sets out a five-year action plan to reduce inequalities between ethnic groups, includes a requirement that all mental health practitioners receive race equality and cultural capability training and that their cultural capability be monitored. *Delivering Race Equality* also encourages local mental health service commissioners to strengthen engagement with minority communities, partly through the appointment of 600 community development workers, and to make greater use of non-statutory provision from within ethnic minority communities. This reflects an acknowledgement of the limited achievements of mainstream services and the success in engaging with black service users that underfunded ethnic minority projects have often been able to achieve.

There is, however, debate about whether separate ethnic minority provision is the best route to less discriminatory treatment (Bhui and Sashidharan, 2003; Burman *et al*, 2003). An over-emphasis on cultural differences can be seen to imply that culture is a 'problem' for members of ethnic minority groups, perhaps even implicated in their mental health difficulties. There are also significant cultural differences within the groups we refer to as African-Caribbean or South Asian. Just how specialist would services have to be to meet the full range of needs they present? Hence, for some observers, there is a need to focus on changing mainstream services to ensure that they adopt a more person-centred approach that addresses the cultural context of all service users (Secker and Harding, 2002a; Bhui and Sashidharan, 2003).

Despite the current policy concerns for consulting stakeholders, the voice of black service users has been relatively absent from published work, even that recognising the importance of understanding 'the interactional dynamics within communities shaping the relation between the community and the health service' (McLean *et al*, 2003, p.660). Often, despite a commitment to their involvement, 'the views of Black users were voiced by mainly white user organisations, professionals or black carers' (Jennings, 1996, p.338). Where black service users have been included in research, it is often difficult to isolate their particular views, because they are not distinguished from larger participant groups of which they are a part (Roach, 1992; Sainsbury Centre for Mental Health, 2002). Nonetheless, consistent themes have emerged from relatively small-scale studies exploring the views of service users from a variety of ethnic minority backgrounds (Secker and Harding, 2002a; 2002b; Bhui *et al*, 2002; Warfa *et al*, 2006). These include concerns about limited attention to the specific cultural and religious needs identified by service users; the relative neglect of their social needs; and the impact of racism. Within inpatient treatment, service users experienced a sense of powerlessness, engendered by insufficient explanation of what was happening to them and no role in determining the nature of intervention. More positively, hospital was identified as, at times, an important refuge and there was appreciation of the emotional support, time and attention given by some workers. Ethnic matching was not seen as a panacea but support was given to resources where particular cultural needs were recognised.

The goal of the research reported here was also to focus solely on the experiences of South Asian and African-Caribbean service users. It explored their views of the origins of their mental health difficulties, their experiences of local services and their ideas about how those services might change. The local health authority commissioned the work and the results were reported to the local implementation team responsible for developing responses to the National Framework for Mental Health. While the health authority did not require separate formal ethical review, its Mental Health Act subgroup took responsibility for approval of the methodology.

Research context and methods

Previous research has provided useful insight into different pathways into services and outcomes for black service users. However, it has largely adopted epidemiological or survey approaches and been criticised for revealing little of the processes underpinning these pathways and outcomes (Morgan *et al*, 2004). The research has also been seen as identifying few policy responses (Sainsbury Centre for Mental Health, 2002). The research reported here, which took place in 2002 in a Midlands metropolitan borough, built on recognition of the role the perceptions of those who make up a particular social world have in shaping it (Fay, 2000). Its aim was to gain further insight into the processes shaping black service users' engagement with services and the likelihood of them benefiting from those services by focusing on their perceptions of the roots of their mental health problems; of interactions with services; and of how changes to provision might benefit them.

Focus groups are an established method for gathering information about people's experiences and understandings (Krueger and Casey, 2000). Pilgrim and Waldron (1998), furthermore, had demonstrated the benefits of service users working together on sharing ideas about services and formulating possible developments. Hence the aim became to bring together focus groups of service users drawn from the two largest black ethnic minority groups in the borough to familiarise them with the project's intentions; to facilitate and record their discussion; and give feedback and authenticate conclusions drawn by the researchers from across the groups. Focus groups were to include some service users brought together specifically for the research and others who already met regularly as part of service provision.

The author and two service user colleagues from outside the borough first spent time in six settings – an African-Caribbean mental health resource centre; the local psychiatric hospital; a residential resource for African-Caribbean men; and three support groups catering for South Asian service users – establishing relationships with workers and service users and familiarising them with the project, thus providing the groundwork for a meeting within each setting at which the primary information collection took place. These six meetings, which lasted between an hour and a half and two hours, were intended to be conversational.

They started with reiteration of the purpose of the research and reassurances about confidentiality. It was also made clear that there was no obligation to participate and that participants would have access to the research findings. Participants were asked first to simply talk about their own mental health experiences and then to describe any particularly good or bad experiences. Subsequent prompts led to discussion of the particular services they were now using, including what they had expected, what benefits they derived and what they saw as particular strengths and weaknesses of those services. If they were not until that point discussed, further prompts asked about participants' views on mainstream services – hospitals, general practitioners (GPs) and other community services. Prompts then focused in turn on ideas that participants had for changes in services and whether or not they felt they or other members of their community had needs that were not being met at the moment.

The author and one of the service user researchers are white, and the other is from a South Asian background. Whether this inhibited participants' responses can only be speculated upon. What can be reported is that participants responded positively to the time the researchers spent with them before the data collection meetings and the responses they gave within them indicated that they felt able to share both intimate and critical reflection within them. Group facilitators and/or researchers, one of whom spoke several South Asian languages, provided interpretation where required. The intention to tape record meetings was not carried out, reflecting the sensibilities of some group participants. Instead the two researchers at the meetings took notes and, immediately after the meetings, supplemented those notes with immediate recollections and wrote full accounts of the meetings.

Preserving the authenticity of the service users' voices was challenging. The questions asked, the meetings' structure and the recording process, which lost some of the direct verbatim feel of participants' comments, all shaped what is reported. Within these constraints the researchers have striven to facilitate the authentic voice of the service users; everything that could be heard or remembered was recorded. Although the resources were not available to undertake a complete multilayered thematic analysis characteristic of phenomenological approaches (Moustakas, 1994), the analysis was initially structured around themes that emerged from that data and were then reviewed in further meetings with the service user groups. Particularly illustrative verbatim comments identified during this process appear in quotation marks.

The service user participants

It was important to include in the research as wide a range of African-Caribbean and South Asian mental health service users as possible. Approaches were, therefore, made to all local resources specifically catering for black service users, for permission to ask for volunteers to participate. One of the researchers then met with the service users and sought their consent to take part. The local psychiatric hospital and community mental health teams were also asked to identify individuals who might be prepared to take part. All service users attending the community-based group settings specifically catering for black service users agreed to take part, with the exception of those unable to attend through ill health or appointments elsewhere. The psychiatric hospital identified several inpatients and three discharged patients willing to participate. These individuals represented the majority of black patients in contact with the hospital during the fieldwork period that staff identified as able to communicate sufficiently to participate. Given the sensitivities of several of these service users and the logistics of their management within the hospital, rather than involve them within focus groups, individual interviews following the same broad agenda and conversational structure were undertaken.

Efforts at bringing together other individual service users were less successful, and community mental health teams only identified two participants not already engaged in the research. The impact of this on the representativeness of views elicited is uncertain. It is possible to be confident that black service users in contact with hospital services and making regular use of community-based recovery services were well represented. Their views alone provided a valuable insight into how services and black service users in sustained contact with them interacted. Those being supported within the community, without regular contact with group settings, were less well represented. It is only possible to speculate upon how different their views might be. They might include both those able to rely on resources within their own families and communities without the need for extended formal support and those who might be more critical and feel less well served by local services (see Table 1).

All the participants were regular long-term mental health service users whose ages ranged from 21 to 60 plus years. Most of the African-Caribbean participants had a diagnosis of schizophrenia and two of bipolar disorder. All but two described inpatient experiences, six referred specifically to having been 'sectioned' (compulsorily detained), and one was subject to a compulsory order when interviewed.

Table 1 Sample

	Men	Women	Individual interviews	Group interviews
African-Caribbean	9	4	8	5
South Asian	11	15	3	23

It has become common practice within UK mental health policy to use the term 'black and minority ethnic' (BME) to indicate a range of groups experiencing discrimination and disadvantage arising from both skin colour and cultural difference, including those of Irish and Eastern European origin. This article focuses specifically on only two of those groups – those of African-Caribbean and South Asian origin – and refers to them collectively as 'black'. 'South Asian' is used collectively for those of Bangladeshi, Indian and Pakistani origin.

Four South Asian service users identified their diagnosis as schizophrenia, but most described themselves as experiencing depression. The majority described inpatient experiences, and three had been compulsorily detained, including two subject to compulsory orders when interviewed.

Socio-economic exclusion

Participants from African-Caribbean and South Asian groups made similar links between their mental health problems and employment, money, accommodation and social networks. Several talked about being out of a job or being unable to earn enough to meet their outgoings as factors contributing to the pressure that precipitated illness. Others saw no longer being able to work as compounding their problems; they were used to providing for others and found dependency hard. Most of those still of working age wanted to work, not just for the financial rewards, but to reinforce their sense of achievement and worth. While they recognised that they might not be able to take on the responsibilities they previously had or work full-time, the feeling was that more could be done to provide support in finding work. None was in paid regular employment at the time of the research. Money problems affected everyone. Benefits were restricted and debt, threats from utility companies and even meeting the costs of transport to clinical appointments were seen as creating anxiety that further affected their mental health.

Those in residential settings wanted at some point to move into their own accommodation. Like other participants, they wanted some form of normal social life. At the African-Caribbean male residential facility where some lived, the men missed the chance to meet women. Participants who lived alone talked about not being able to go out in the evening, which is when they could be lonely and feel most distressed. Some had had negative experiences in social clubs and pubs because people did not understand about mental health. They wanted to be able to use normal social settings in the community and not be rejected.

These are problems that characterise the sense of social exclusion experienced by many service users (Social Exclusion Unit, 2004). However, participants saw them as compounded by their ethnicity. Many South Asian participants felt their limited English language skills intensified the vulnerability arising from their ill health and felt a particular need for support and advocacy when in difficulty with utility bills, with benefits or in contact with doctors and community psychiatric nurses.

African-Caribbean participants focused more explicitly on the impact of racism. They argued that white people hold the power and:

> 'black men always get the blame'.

They talked about pressures on black people, for example at school, from the people around them and at work.

> 'White people don't treat you properly – you get the hard jobs.'

One worked for years as a bricklayer's labourer but was not allowed to lay bricks. He could do it, yet:

> 'the white man get to lay bricks and roof tiles. It do something to you inside'.

Cultural exclusion

South Asian participants identified several aspects of cultural exclusion in their experience of psychiatric services. These included unacceptable problems with the availability of interpretation and the use of standard psychiatric assessment tools that did not recognise the influence of their educational backgrounds and experiences on their findings. There was also little recognition of their specific cultural and religious

needs within hospitals or of the influence of cultural backgrounds upon community-based assessments (Bowl, 2007).

Some of the African-Caribbean participants saw being brought into the mental health system as a form of control. Two had come to mental health services following criminal convictions, and another after a long series of unsuccessful spells in a variety of care settings where he was perceived as disruptive. Despite this, few of the African-Caribbean participants expressed the view that they had experienced racial insensitivity within the mental health system or even voiced criticisms of psychiatrists, recognising their own extreme distress at times and need for skilled help:

> 'they are the experts' and
>
> 'someone has to do the job'

were typical responses. One participant felt very differently and had experiences similar to those identified by African-Caribbean service users elsewhere (Sainsbury Centre for Mental Health, 2002). She felt psychiatrists were prone to stereotype black service users as schizophrenic and dangerous.

> '[Doctor's name] is famous for it. He's a bastard. He puts you on a section just like that.'

While she recognised that she and other black service users had been ill and needed support, that did not justify being treated without respect.

Institutional exclusion

The impact of organisations simply failing to acknowledge difference, what McLean *et al* (2003) identify as institutional exclusion, was seen in many participants feeling more comfortable in settings intended for service users from similar backgrounds. For several African-Caribbean participants, relatively simple things like appropriate food, prepared well, were seen as very important. People also described feeling more comfortable within African-Caribbean settings because people would understand the 'specifics' of what they were going through.

Others were less certain. One argued:

> 'it's a white society, you need to mix with whites, they can put you right – show you how to succeed'.

He wanted to work, wanted a job and felt segregation could be negative. However, he still thought places were needed where black men could go and talk and not be perceived as a problem. He felt positively about being able to talk about problems, such as unjust treatment by the police, at the African-Caribbean resource centre he attended and being really understood. He did not think there would need to be segregation if white people were less racist.

There were mixed views about black workers in the mental health system. Some did not see a critical difference between white and black workers. Yet others thought that black workers brought 'a certain energy and understanding' and that you 'simply got on better with people of the same colour'. One participant was particularly critical of white workers' reluctance to work with him:

> 'they always want to pass you on – it doesn't make you feel right'.

Some expressed the view that seeing black people working in valued caring and supportive roles gave black service users confidence in their own worth. How workers carried out their role was important, however. Participants said they had experienced good black workers and bad and that trust and reliability were important as well as colour.

There were some differences in the examples of institutional unresponsiveness to their particular needs that South Asian service users identified. They also expressed a strong preference for familiar cultural settings. In the resource centres catering specifically for South Asian service users, despite linguistic, religious and national diversity, they felt there were also significant cultural similarities. Consequently, it felt safer to share their particular concerns there than within many other service settings. They also perceived little effort by services to help South Asian families or communities better understand mental ill health or treatment. Alongside this were what they saw as a particular lack of understanding within their families and communities of the nature and impact of mental illness and the negative effect that has on support and care available to them.

Wider views of services

Inevitably, participants expressed some views that they did not see as particular to their experience as black service users and which echoed those of other service users (Baker, 2000; Rose, 2001). Three stand out as nonetheless relevant to understanding what is reported here. First, a common perception was that inpatient treatment was not oriented towards recovery. There was no emphasis on facilitating return to a manageable life in the community. Secondly, there was a perceived lack of both rehabilitative activity and attention to individual needs in the local psychiatric hospital; nor did participants feel that they were told enough about either their medication or what was wrong with them. Participants saw knowing how long they would have to take medication, whether there

was any prospect of one day not having to and how this could be achieved, as an important aspect of being prepared for recovery.

A final concern for many participants was that the views that they expressed were not new and yet, despite extensive lobbying from within their communities, services had changed very little. As far as they could see, developing procedures to enable the distinctive voices of African-Caribbean and South Asian service users to be heard, not just through one-off research but on a continuing basis within the planning of mental health services was critical if real change was to be achieved.

Delivering race equality: the prospects

The methodological limitations of this research have been discussed above. It is also relatively small scale and focused on the experiences of service users within one particular borough and so cannot be assumed to be representative of the experiences of black service users across the UK. Nonetheless, there are similarities with the findings of other service user research (Bhui *et al*, 2002; Sainsbury Centre for Mental Health, 2002; Secker and Harding, 2002a, 2002b; Warfa *et al*, 2006), suggesting that they may have more than local significance.

The research highlights the complex impact of social exclusion on black service users' lives. In common with other mental health service users, they experienced the forms of socio-economic disadvantage prominent within the UK government's policy discourse on exclusion (Social Exclusion Unit, 2004). This appeared to encompass more than simply a denial of access to employment and material resources. They lacked jobs and some would have liked to work, while others, recognising that they were unlikely to work again, wished to have other opportunities for occupation and support. However, both African-Caribbean and South Asian services users felt that their mental health status and people's reaction to it created a further form of exclusion in denying them opportunities for a normal life. It impacted upon their housing, their family life and whether or not they could use ordinary social settings. Their perception was also that a further layer of exclusion to that experienced by other service users was added by their ethnicity. Their experiences, of course, were not identical and, while both groups experienced socio-economic exclusion, African-Caribbean service users were more likely to stress the contribution of racism shaping that exclusion, while South Asian service users stressed their difficulties in negotiating with various government agencies and private companies impacting upon their lives.

Mental health services figured prominently in the lives of these service users and to a degree they saw those as valuable. Here too there was evidence of a two-layered exclusion effect. First, there was a perception that services failed to adequately address their desire to make progress, for movement, to be helped to settle back into an ordinary life. This came through inattention to individual needs and the particular concerns that service users had that they felt needed to be addressed if recovery was to be achieved. At best, in this respect services were not working to combat service users' feelings of exclusion. That is something that would match with the experience of many service users (Social Exclusion Unit, 2004) and is not particular to black service users.

The research has demonstrated how both cultural and institutional exclusion within hospital and community-based services add a further layer of exclusion to the experience of black service users. In doing so the research makes some contribution to closing the gaps identified by Morgan *et al* (2004) in understanding the processes determining the interaction of ethnic minority service users and mental health services. African-Caribbean service users in this research were less inclined to identify issues as cultural exclusion than their South Asian counterparts were, although they did express concern about the impact of stereotyping. Cultural exclusion did not completely discourage those who were respondents in this research, but they did experience it as alienating them from mainstream provision and they did feel that it deterred others from getting the help that they needed.

Cultural exclusion was reinforced by institutional exclusion, with many black service users expressing a preference for settings that recognised and respected their particular cultural preferences. Several expressed the view that it felt unsafe to share their particular concerns within many other service settings. The insensitivity of practices within inpatient facilities to individual needs, whether based on culture or other sources of difference, was seen as an important contributor to black service users' unease.

To what extent does *Delivering Race Equality* (Department of Health, 2005) address the issues raised in this research? Black service users in this research identified the need for support to enter employment and advocacy concerning debt, benefits, legal entitlements and other matters. They saw opportunities for a normal social life as significant resources for mental health improvement. While the current UK government sees these as legitimate areas for engagement by mental health services within the *National Service Framework* (Department of Health, 1999) and *Mental Health and Social Exclusion* (Social Exclusion Unit, 2004), *Delivering Race Equality* makes no significant

reference to these areas. Nonetheless, the continuing influence of socio-economic exclusion is likely to be a barrier to achieving its target of reducing black and ethnic minority hospital admissions.

Other core targets of *Delivering Race Equality* (Department of Health, 2005) are to reduce the discrimination within inpatient care and increase the satisfaction of black service users. The strategies for mainstream services it outlines include developing practitioners' cultural capability and involving members of ethnic minority communities within inpatient care in supporting and advising patients. These would meet some of the needs identified by participants within this study. Its intentions to also draw on the expertise of independent provision by minority communities would accord with their support for culturally appropriate services for recovery. Currently these services remain limited in quantity and service users in this research were also concerned that they were not always resourced or monitored to ensure that they were of an appropriate standard. Fulfilling their hope that standards of provision and finance for these services would be on a par with other facilities will be a challenge for commissioning strategies stimulated by *Delivering Race Equality* (Department of Health, 2005).

Participants in this research did not see encouragement of independent provision and mainstream services accepting responsibility for culturally appropriate support as mutually exclusive strategies. Nor did they consider that this was just about considering staffing and training needs, but felt that it also meant thinking imaginatively about how other changes to service structures could impact upon black service users. A local proposal given positive support was the establishment of a single access point within primary care services. This circumvented the need for GP referral to specialist mental health services, which had been identified as problematic for black service users, and could facilitate earlier contact by potential service users. Nonetheless, this was unlikely to facilitate greater access for black service users without other attempts to break 'the circles of fear' (Sainsbury Centre for Mental Health, 2002) that inhibit that early contact. An important step would be to enhance the level of individual attention and support within inpatient facilities. Another would involve sharing more information with service users, exploring different understandings of illness, its meaning to service users, what might constitute recovery and why particular decisions are made. Such an approach could both meet service users' identified need to know more and lead to greater understandings by professionals of the cultural context of their experience. By focusing on the need for understanding of any individual's experience it would also represent a move away from problematising difference (Bhui and Sashidharan, 2003; Burman *et al*, 2003).

Whether *Delivering Race Equality* (Department of Health, 2005) will meet its core targets remains an open question. The strategies it outlines do not address the underlying socio-economic exclusion experienced by black service users. There has also been criticism of the reliance on the voluntary sector for achieving the required changes to mental health service provision (Sardar, 2004) and of the failure to meet targets for the appointment of community development workers and establishment of ethnic diversity training (McKenzie and Bhui, 2007). Locally, following this research, commissioners have made progress. Health promotion workers have targeted engagement with local ethnic minority communities, focusing on developing understanding of the nature of mental ill health and the support that service users need. Black service users, including some who participated in the research, have been recruited to scrutinise local commissioning proposals. Commissioners have also required that staff appointed to the functional teams, such as assertive outreach, crisis intervention and home treatment, required by the *National Service Framework for Mental Health* (Department of Health, 1999) are representative of local communities. While not guaranteeing the cultural capability sought within national policy initiatives, this meets one of their expectations. However, progress has been limited in the other areas highlighted by the research. For example, commitment by commissioners to extend support for culturally appropriate recovery-oriented services has not been matched by the availability of new funding. The Mental Health Trust has also cited the absence of increased resources as limiting responses to the reported concerns about inpatient care.

Conclusion

The insensitivity of UK mental health services to ethnic diversity is an enduring problem and *Delivering Race Equality* (Department of Health, 2005) comes during a period of great turbulence, characterised by multiple policies and circulars and major changes to service structures. Critical to ensuring that mental health services continue to pursue the objectives of *Delivering Race Equality* is the regular involvement of service users in monitoring progress, training, planning and service provision. Such participation has been consistently advocated within the UK since the NHS and Community Care Act in 1990, so it is significant that these black service users felt that their distinctive voice was still not being heard. Heeding the lessons of service users' experiences is vital if fundamental change is to be achieved. Listening, however, is not enough. Change will not be achieved easily. Unless the involvement of black service users is matched by a willingness to find the resources over a sustained period to

address the concerns they put forward, insensitivity to ethnic diversity will remain a defining characteristic of UK mental health services.

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CONFLICTS OF INTEREST

None.

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