Research paper

Improving the quality of access to mental health information and care: the views of health practitioners and social work professionals in Wales

Roiyah Saltus BA(Hons) MA PhD

Research Fellow, Centre for Research and Innovation in Care Sciences, University of Glamorgan, Wales, UK

ABSTRACT

Factors such as 'race' and ethnicity, socio-economic status and geographic location impact on the level of access to information and treatment, as well as on the utilisation, experience and knowledge of mental health and social care provision. This paper reports on one aspect of a study to improve access to mental health information and care to targeted black and minority ethnic (BME) groups living in a large city in Wales. Although there is anecdotal evidence to suggest that England-based studies have relevance in Wales, there remain major gaps in our knowledge of the mental health needs of BME people in Wales. The BE4 study was the first study in Wales since devolution that sought to examine and provide a baseline of evidence of the mental health information and care needs of BME groups. This paper provides an analysis of the perceptions of mental health nurses, social workers and other health and social care professionals in relation to the quality of access to mental health information and care given to BME people in Wales, and seeks to contribute to the cross-national evidence base of research being conducted to underpin the development of culturally competent practice frameworks.

Keywords: black and minority ethnic (BME) groups, cultural competence, devolution, mental health, Wales

Introduction

Over the past two decades, research has shown that factors such as 'race' and ethnicity, socio-economic status and geographic location impact on the level of access to mental health information and treatment, as well as on the utilisation, experience and knowledge of mental health and social care provision (Sashidharan, 1993; Smaje, 1996; Bhugra *et al*, 1997; Fernando *et al*, 1998; O'Connor and Nazroo, 2000; Arai and Harding, 2002). It is also increasingly evident that how services are used and experienced by individuals from different ethnic groups is just as much a product of their own beliefs, needs and expectations as it is a product of the attitudes and perceptions of service providers (Owens *et al*, 1991; Nazroo, 1997). Stereotypical views of black and minority ethnic (BME) people, racism, and cultural ignorance have been shown to undermine the way in which health and social care service providers assess and respond to minority ethnic patients and clients (Currer, 1994; Cochrane and Sashidharan, 1996). Some, therefore, must struggle with a health and social care system that is not yet adequately equipped to respond to their needs, despite statutory obligations and legal requirements (Lloyd and Fuller, 2002). These disparities suggest that 'mainstream' mental health services may be failing to meet the needs of BME people, resulting in a spiral of disaffection, reluctance to seek help and re-admission to hospital in times of crisis (Secker and Harding, 2002). In a recent publication on the perceptions of African and African-Caribbean service users by Keating *et al* (2003), this was explained as 'circles of fear', with staff members perceiving service users as potentially dangerous, and service users perceiving services as harmful.

Socially ascribed differences such as 'race', ethnicity, and religion have become increasingly significant considerations for mental health practitioners, as well as health policy makers. Recent drivers include the Race Relations (Amendment) Act 2000 that insists that public authorities provide a quality of service to BME groups that does not exclude and discriminate. Also important are recent publications such as *Inside Outside: improving mental health services for black and minority ethnic communities in England* (Department of Health, 2002), *Delivering Race Equality: a framework for action* (Department of Health, 2004) and *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* (Department of Health, 2005). Although these documents differ in their focus and emphasis, taken together they aim to provide the framework for achieving equality of access, experience and outcomes to BME mental health service users in England (Bhui *et al*, 2004).

Like all public services in the UK, in Wales, attempts are being made to critically appraise the NHS, and work to ensure that a robust and responsive service is provided to all members of the population. According to the 2001 Census, the number of people from BME backgrounds in the UK was 4.6 million (7.9% of the total population). Out of a population of approximately 2.9 million people in Wales, in 2001, 2.1% (60 900) were from BME backgrounds. Since 1991, there have been increases in the proportion of African, Indian, Pakistani, Bangladeshi, and Chinese people living in Wales, as well as an increase in the number of people who classified themselves according to 'Mixed' categories listed in the census classification system. Although there are pockets of BME people living throughout Wales, the minority ethnic population is largely concentrated in urban areas of the south east, with by far the largest concentrations in Cardiff and Newport (25 700 and 6600, respectively), accounting for over half the total and representing 8.4% and 4.8%, respectively, of census-enumerated population in these two local authority areas.

The challenge to modernise mental health services in Wales is great. In a report on mental health trusts in the UK, the Commission for Health Improvement (since taken over by the Healthcare Commission) stated that both policy and services are less developed in Wales, and that an older, more institutional model of care is prevalent (Commission for Health Improvement, 2004, p. 6). Added to this is the dearth of knowledge about the health and healthcare needs of BME groups (Aspinall, 2003; Walters, 2004). Although there is anecdotal evidence to suggest that England-based studies have relevance in Wales, there remain major gaps in our knowledge of the mental health needs of BME people in Wales. Equally important, there remain major gaps in our knowledge of the perceptions of health and social care practitioners seeking to provide appropriate mental health information and care.

It is also important to note that Wales has a long history of minority ethnic settlement. Thus, the histories, settlement patterns, residential status and occupational profiles of BME groups in Wales are different from those elsewhere in the UK, and it is important to consider the particularities of the Welsh context when examining the health and social care of BME groups. Of importance is the 'hyper (in)visibility' of BME groups: the awareness and acceptance in Wales of the long-established presence of diverse ethnic groups, which exists alongside a lack of attention to the impact of such diversity on Welsh society and which works to render BME groups invisible. In their recent analysis of contemporary Welsh society, Williams *et al* (2003) note that although there is an increasing focus on diversity and equality in public policy, this paradox remains. On the one hand, there is a renewed interest at policy level, research and in the media while a plethora of policy statements carry the statement *and ethnic minorities*. On the other hand, there is growing awareness of disenfranchisement, compounded by marginalisation, widening inequalities and widespread racism.

However, devolution has opened up new opportunities for assessing and addressing equality issues. Policy shifts in Wales have led to the amalgamation of health and social care policy making. With constitutional reform, the equality of opportunity directive has been thrust to centre stage and, as Chaney and Fevre (2002) suggest, the merits of the 'Welsh model' equality duty are based on the fact that it is all-embracing in scope, requires government to be proactive in all equality matters, and conveys legally enforceable rights. Coupled with the requirements of the Race Relations (Amendment) Act 2000, this statutory framework suggests a strong equalities context within which to develop effective and appropriate health and social care strategies for all population groups in Wales.

Aims of the BE4 study

This paper reports on one aspect of a two-year study: the perceptions of mental health nurses, social workers and other health and social care professionals in relation to the quality of access to mental health information and care given to BME people in a large Welsh city. The BE4 study was the first study in Wales since devolution that sought to examine and provide a baseline of evidence of the mental health information and care needs of specific BME groups. Drawing

on the census classification system, further links were made to the following subgroups: black African, Bangladeshi, African/black Caribbean, Chinese, Indian and Pakistani. The South Asian subgroups were expanded into the following ethno-religious categories: Pakistani Muslims, Bangladeshi Muslims, Punjabi Sikhs and Gujarati Hindus. Other subgroups that reflected the city's demography that were added include Somali, Sudanese and Yemeni.

The funding for the study was secured by a national BME mental health voluntary organisation who commissioned a university in south east Wales to conduct the study. The wider aims of the BE4 study were as follows:

- to carry out a needs assessment in order to provide a baseline of evidence of the mental health and social care information and treatment needs of the target groups
- to identify gaps in access to service provision and care, making recommendations in how to develop a multi-agency, multi-sector, multi-professional practice framework.

Methodology and ethical considerations

In keeping with the aims of this project, a mixed research methodology was used, one that drew on aspects of action research and qualitative data collection to explore, describe and develop an understanding of the experiences of a sample of health and social care/welfare professionals. The sample was purposive, with snowballing technique/reference sampling also employed (see Table 1). Recruitment was targeted at the following organisations and services: local statutory community mental health teams (CMHT), as well as

health, mental health, social care and welfare professionals including midwives, general practitioners (GPs), alternative health therapists, community workers and researchers. Health and social care professionals working in the equalities sector were also invited to participate. The inclusion and exclusion criteria reflected the aim to develop a sample of practitioners, professionals, advocates and researchers based in the health, social care/work and equalities statutory and non-statutory sectors in Wales, who worked with a significant number of people from the targeted BME backgrounds. A significant majority of people interviewed worked in the front-end of services, and were seeking to address the immediate and often complex needs of individuals they were in direct contact with in a pressurised, often understaffed and under-resourced working environment.

Approval to conduct this study was obtained from the local research ethics committee, the NHS trust covering the area where the study was conducted, and the university research ethics committee. A letter of invitation and an information leaflet were provided for each potential participant, detailing the aims of the study, what was to be required in terms of time commitment, and what was to happen to the data collected. The leaflet also stated that participation was entirely voluntary, and that all data would be anonymised. All participants were required to sign a consent form prior to the interview, and were given two to three weeks to decide whether they wished to be part of the study.

An interview protocol was developed and was divided into a number of topics. The topics covered in the interviews with this group of participants included: working with a diverse client base; solutions to specific issues; the role of non-statutory services; and commissioning and management issues. BE4 staff conducted the interviews. Flash cards with key phrases taken from the interview protocol were also used to

Table 1 Mental health nurses, social workers and other health and social care professionals who took part in the study ($n = 44$)

Sector	Professionals
Statutory health	GPs ($n = 2$); midwives ($n = 2$); community nurse ($n = 1$)
Voluntary health	Community nurse ($n = 1$)
Statutory mental health	Mental health nurses ($n = 14$)
Voluntary mental health	Mental health workers ($n = 11$)
Statutory social care	Social workers ($n = 5$)
Voluntary social welfare	Community health workers ($n = 5$); community development workers ($n = 3$)

help generate discussion. Unlike a list of questions, cards can be shifted around and exchanged between the interviewee and the interviewer, and this makes them a great interactive tool. Designed to look like a deck of cards, the block text on the cards was in a range of colours (maroon, aqua, purple, blue, green, and yellow), and each colour represented a key research theme and topic to be discussed. The cards were useful in that they allowed people to 'handle' key concepts and use the cards to guide the discussion.

Analysis of data

The interviews were tape recorded and transcribed verbatim. Data analysis was conducted using an inductive approach: the constant comparative method (Maykut and Morehouse, 1994). Relevant themes within the text were gradually identified, compared and coded. Two members of the research team took part in the analysis of the data. The NVivo computer software package was used to help in the coding process. The research literature and list of topics underpinning the interview schedule were used to help refine the themes. Several themes emerged from the data that are of importance to this paper: 'addressing common barriers', 'working with a diverse client group', 'ethnic monitoring and patient profiling', and 'strong managerial leadership'. Each theme is discussed below, with excerpts taken from the data gathered from the participants. It was considered important to make use of direct quotations that allow the voices of the participants to be heard.

Addressing common barriers

Several key issues were raised under this theme. The first was the use of terminology in a multi-ethnic setting, and the fact that terms, especially mental health terms, do not easily translate across cultures and languages. With this came confusion as to the range of mental illnesses understood in western psychiatry and psychology, which had led to the rejection of the term mental health used by some health professionals. As one mental health nurse commented:

'Well one of the clients we have, when she was first referred, she asked why she had to come to us and I said because this is a mental health project and she became almost hysterical and said "what do you mean, mental health? Mental health!", and I said, "oh you suffer with depression don't you", and she said "oh depression". Depression was acceptable but the label mental health wasn't and I have seen that in other people ... the word mental health is not used.'

Secondly, the awareness of stigma was understood by some of the participants to be an important element that shaped how people from BME backgrounds approached and engaged with services. It was clear that there was an awareness of the fact that social rejection of people with mental illness labels included rejection from community activities, leisure pursuits, employment, and relationships. A mental health nurse put into context the stigma often associated with mental health. As the respondent stated:

'It is a very uncomfortable term and it is a label, a stigma ... I know it is in wider society, but I think the people we work with it is even harder ... I think it is because of this word [pointing to the next card] "community" and their status and position in the community and I think that plays a major role ... the link with community and being part of the community ...'

For another respondent, a mental health nurse, it was important to see the link between stigma and wider societal discrimination, racism and social exclusion that work to layer, in particular ways, the care given to, and expected by, people from BME backgrounds. As the respondent stated:

'BME patients go through discrimination and when the stigma of mental illness is attached to them, it is what I call double discrimination ...'

A third issue identified as a common barrier was that of language and communication barriers. This was an overwhelming concern for all those interviewed. Although a common and often noted problem, this issue was considered of particular importance for older people from BME communities, including those from the Caribbean who might speak Patois or English with a strong accent. From the perspective of one respondent who worked in BME community health and social welfare, and who provided information to people who could speak and read English, there is more to consider than the provision of information in relevant languages. It is also important to provide appropriate messages. As she stated:

'I kept saying to them [my clients] ... these leaflets are in your GP practices within your surgeries or if you go to the hospitals you could ask for this information ... and what people have talked about is, yes there are leaflets around ... but the leaflets are not something that we could relate to straight away.'

Working with a diverse client group

More proactive mental health nurses, midwives, social workers and social welfare professionals appeared to take pride and have added confidence in personal engagement strategies. It is a skill that has to not only

be built on, but used in everyday practice, as explained by one participant:

'I certainly think it is something that can be built upon ... it is one thing knowing the theory, it is another thing knowing it in practice. The fact that I am working in [areas] with the highest ethnicity mixes [in Wales] throws you into the middle of something and you suddenly have to embrace and understand quickly ... you have to find a way to change your thinking and processes to accommo- date them.'

Moreover, the development of more responsive, ap- propriate care and treatment models that are linked, but not necessarily rooted in the dominant western medical model remains an important theme to emerge in relation to this group's work with their diverse client groups, as the following excerpts highlight:

'Other concerns are what examples [there are] that might be culturally transferable ... It is finding examples to get that point over is the hardest. It is just a bit of, you try something, it works, you try something else, it doesn't ... It is a bit of trial and error ...'

Another respondent stated:

'I would like a lot more on culturally appropriate ways of dealing with issues that affect the communities we work with, you know, issues that are their priority rather than our priority.'

Linked to this is the need for ongoing, practical training to supplement and build up into a profes- sional competence the skills needed to work with a diverse client base:

'There is information that gives you understanding of people's beliefs, but how [do] those beliefs impact on your professional interactions? [I am] very aware of issues to do with public holidays and religious festivals and things like Ramadan and times that we could visit people, but very often those have been picked up by trial and error rather than [via] a particular training package.'

Ethnic monitoring and patient profiling

Although many participants were aware of the im- portance of ethnic monitoring, there is clear indi- cation that the structures and training for effective and useful data collection are presently lacking. As one health and social care service manager, explained:

'Yes a real bugbear with me. Our social workers just refuse to do it sometimes, and as far as I am concerned, the argument's been won, there is very good reason for monitoring ethnicity. It is one of the mandatory fields and yet they say they are too embarrassed to ask, which is ridiculous. We ask them whether they are incontinent, but not what their ethnic origins are.'

For others, the issue was not only ethnic monitoring, but the importance of patient profiling, being aware of the ethnic, cultural, social and environment factors which impact on one's mental health, as highlighted by the comments made by two service managers:

'It might be someone who is white who is Welsh ... we actually need to consider what their background is as to whether they need a female or a male or a nurse or social worker, or whoever, in that they might have been traumatised through domestic violence ... You don't know about people's experiences, so if you have got that information along with the ethnicity then that again helps meet that patient's needs.'

The second manager stated:

'We are beginning to keep data on ethnicity in respect of access. We are at quite an early stage ... [but] we don't record it adequately and one of my jobs is to try and look at developing the system so we do actually do that 100% of the time ... [You] can't actually deduce a great deal from what we have at present, apart from anecdotally. If we don't know what the need is we can't meet it and that is not just about Race Relations Act, that is also about care planning ... That is the kind of thing we need to do, we need to make sure that it is happening in an organised way.'

A related concern is the need to put all these issues into a broader, albeit specific context, as one participant stated:

'[I] think we could probably do more in terms of broader training about services to black and ethnic minority people because I don't think services have got a full view of their responsibilities ...'

With this was the long-standing and well-established evidence base underpinning the need for changes in how services are designed.

Strong managerial leadership

One flash card that sparked comment was *ethnicity agenda*. Most comments centred on the need for clarity, the need in Wales for leadership and the need for support from above. The following excerpt highlights some of the tensions involved in seeking to make change and the need for clear leadership:

'My perception is that they are keen to turn things around, but I just wonder how able they are to have mechanisms to change things around. It raises a question mark because it hasn't happened to date. I know it is a really big issue ... but we have to plan how to change some services in mental health ... but there are no drivers ... there are no project managers to see it through.'

Discussion and conclusions

In presenting the findings, it is important to note one important limitation of this study: the small number of people interviewed means that generalisations cannot be made. What the findings offer, however, is a snapshot of evidence that can be used to contribute to and inform the 'normative base of policy and practice' (Cortis, 2004), with regard to enhancing the quality of access to mental health information and care available to BME people in Wales.

The findings highlighted a number of key points. First, despite the diverse professional backgrounds and numerous sites in which the participants worked, there was a general awareness of the barriers faced by people from BME backgrounds and strategies to, when appropriate, adapt care to be congruent with the client's needs. Second, it became evident that there are a number of gaps that need to be addressed. From the findings, it is evident that the more proactive health and social care professionals we interviewed had an understanding of the cultural mores of their clients, making effective use of interpreters, gaining the support of BME health workers, and building up links with relevant BME voluntary mental health organisations and community groups – all key aspects of providing care in a multicultural context. However, there were, at the same time, limited indications of reflection about these strategies or ongoing training to augment skills in order to ensure that professionals were open to encounters with a range of people, and could competently assess and development appropriate care packages.

It is also important to note that although a significant number of those interviewed were proactively working to find positive strategies to delivering care in a multi-ethnic, multicultural setting, there were people who were less aware and engaged. Strategies for improving the quality of information and care are being developed, but remain highly individualised, patchy and isolated.

Many of the participants acknowledged the need to promote good practice and use it to underpin the development of practice frameworks that not only address, but provide action plans for, improving existing services and developing new services. This did not, however, translate into having such good practice readily available and accessible, highlighting the need for the strategic implementation of an equalities and diversity agenda which cascades throughout the mental health services. From the data it is clear that the work to embed issues of equality and diversity on a strategic level and to ensure that organisational frameworks are put in place in order to foster and support both clients and staff has yet to be completed.

Finally, the hyper in/visibility of BME people in Wales (south east Wales in particular), devolution and the new opportunities for assessing and addressing equality issues, coupled with the formalised amalgamation of Wales health and social care policy making are all key to understanding (i) the general consensus of the participants of the need to incorporate cultural sensitivity in their practice; and (ii) the lack of operational frameworks to change practice and foster competent care. Although operating within a rigorous overarching equality framework, there are in Wales no regional or national strategies or policies specifically intended to improve the mental health of minority ethnic groups or the care and treatment they receive from mental health services (Saltus and Kaur-Mann, 2005). Thus, unlike other parts of the UK, health advocates, mental health practitioners, as well as managers and commissioners in Wales do not yet have to hand the sharp teeth of a specific policy that most often underpins national operational directives and the development of new practice frameworks. Research to increase the evidence base in this area and the development of policies and practice frameworks rooted in an equalities agenda are necessary if the integrated health and social care system in Wales is to truly become robust enough to appropriately address the mental health needs of its increasingly diverse population.

REFERENCES

Arai L and Harding S (2002) *Health and Social Care Services for Minority Ethnic Communities in the United Kingdom: a review of the literature on access and use.* Occasional Paper No 9. Glasgow: Research Medical Council.

Aspinall P (2006) *A Review of the Literature on the Health Beliefs, Health Status, and Use of Services in the Minority Ethnic Group Population and of Appropriate Health and Social Care Interventions.* Cardiff: Welsh Assembly Government.

Bhugra D, Leff J, Mallett R *et al* (1997) Incidence and outcome of schizophrenia in whites, African-Caribbeans and Asians in London. *Psychological Medicine* 27:791–8.

Bhui K, McKenzie K and Gill P (2004) Delivering mental health services for a diverse society. *BMJ* 329:363–4.

Chaney P and Fevre R (2002) *An Absolute Duty. Equal opportunities and the National Assembly for Wales.* Cardiff: Institute of Welsh Affairs.

Cochrane R and Sashidharan S (1996) *Mental Health and Ethnic Minorities: a review of literature and implications for services in ethnicity and health.* York: NHS Centre for Reviews and Dissemination.

Commission for Heath Improvement (2004) *What CHI has Found in Mental Health Trusts. A sector report.* www. healthcare-commission.org.uk/_db/_documents/04000051. pdf (accessed 10 August 2006).

Cortis J (2004) Cultural Diversity. Managing society's difference and diversity. *Multicultural Nursing.* Sample issue:13–18.

Currer C (1994) Pathan women in Bradford – factors affecting mental health with reference to racism. *International Journal of Social Psychiatry* 30:72–6.

Department of Health (2002) *Inside Outside: improving mental health services for Black and Minority Ethnic communities in England.* London: Department of Health.

Department of Health (2004) *Delivering Race Equality: a framework for action.* London: Department of Health.

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.

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

Keating F, Robertson D, McCulloch A and Frances E (2003) *Breaking the Circles of Fear. A review of the relationship between the mental health services and African and Caribbean communities.* London: The Sainsbury Centre for Mental Health.

Lloyd K and Fuller E (2002) Use of services. In: Sproston K and Nazroo J (eds) *Ethnic Minority Psychiatric Illness Rates in the Community.* Department of Health. London: The Stationery Office.

Maykut P and Morehouse R (1994) *Beginning Qualitative Research: a philosophic and practical guide.* London: The Falmer Press.

Nazroo J (1997) *Ethnicity and Mental Health: findings from a national community survey.* London: Policy Studies Institute.

O'Connor W and Nazroo J (2000) *Ethnic Differences in the Context and Experience of Psychiatric Illness: a qualitative study.* London: The Stationery Office.

Owens D, Harrison G and Boot D (1991) Ethnic factors in voluntary and compulsory admissions. *Psychological Medicine* 21(1):185–96.

Saltus R and Kaur-Mann K (2005) Black and minority ethnic mental health service users in Wales: a snapshot of their views. *Mental Health Nursing* 25(5):4–7.

Sashidharan S (1993) Afro-Caribbeans and schizophrenia: the ethnic vulnerability hypothesis re-examined. *International Review of Psychiatry* 5:129–44.

Secker J and Harding C (2002) Users' perceptions of an African and Caribbean mental health resource centre. *Health and Social Care in the Community* 10(4):270–6.

Smaje C (1995) Ethnic residential concentration and health: evidence for a positive effect? *Policy and Politics* 23(3): 251–69.

Smaje C (1996) The ethnic patterning of health: new directions for theory and research. *Sociology of Health and Illness* 18(2):139–71.

Walters V (2004) *Health, well-being and access to health and social care of selected minority groups.* Unpublished paper presented to the Selected Minority Groups Task and Finish Group, Welsh Assembly Government.

Williams C, Evans N and O'Leary P (2003) *A Tolerant Nation? Exploring ethnic diversity in Wales.* Cardiff: University of Wales Press.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Dr Roiyah Saltus, Research Fellow, Centre for Research and Innovation in Care Sciences, University of Glamorgan, Pontypridd, Wales CF37 1DL, UK. Tel: +44 (0)1443 483194; fax: +44 (0)1443 483095; email: rsaltus@glam.ac.uk