CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but **we want to consult on:**

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

The mental health of black and minority ethnic (BME) communities needs to be given greater prominence in both policy and in practice. Research indicates that BME communities experience significant racism and greater isolation compared to the wider majority population. Studies also illustrate examples of an increased prevalence of mental health problems, an underrepresentation in the use of mental health services and evidence of particular forms of stigma and discrimination towards people with mental health problems from BME communities. We welcome the development of a new mental health strategy and anticipate that it will give priority to those in Scotland who encounter the most mental health inequalities including those from BME communities. We acknowledge mental health and ethnicity is a contested area and different views exist on how to understand and address the needs of BME communities. There is much that we just do not know about the mental health of people from BME communities such as patterns of service user. The lack of consistent ethnic monitoring makes it difficult to know conclusively where the most important gaps lie. However, within this response we have included the views from the Ethnicity in Mind membership which includes a wide range of over 30 organisations with an interest and expertise in ethnicity and mental health. One area of interest that requires further investigation is around use of community services. We know from studies that people from BME communities use mental health services at a later point and often present in crisis. What we don't know is how effectively they are being supported in the community by other organisations. We assume that we need to address barriers to community based mental health services but what we can't say clearly is whether this is the best approach or whether our focus should be on building capacity within BME organisations based in the community. Within this response we have assumed and from our collective experience we believe that we need to do both to provide choice and a similar range of supports available to the majority population. However, this area needs to be researched alongside communities themselves to identify what actually works in practice to support people from BME communities. Throughout this response we have called for community development approaches to be adopted as we believe that communities themselves have these answers and the solutions to improving their mental health. When considering services collectively we believe there is a need for services to adopt a human rights approach. This means changing the way services are designed and delivered and making

tackling racism and discrimination a strategic objective. If structural discrimination is to be addressed within services then the mental health workforce need to understand and act to address the multiple layers of discrimination that can impact on the lives of members of the BME community who also experience the stigma of having a mental health problem and may also be female or in later life. Services can believe that they are operating in a culturally competent manner, however stereotyping can occur even when practitioners have cultural awareness. A human rights approach requires that all people who use services are treated in a person-centred and equitable manner. This approach should be central to all cultural competency training and support that is provided to the mental health workforce.

Scotland has led the way in mental health improvement work by prioritising work on mental health promotion, preventing of mental ill health and recovery and we would anticipate that this strategy will seek to continue this important work. However, we would make the case that universal approaches that work at a population level although potentially producing health gain may actually service to increase inequalities. Therefore we would expect that this strategy would aim to build on our experience in mental health improvement to create a more proportionately and equitable framework that will guide mental health services and the wider public sector towards activities and interventions that will improve outcomes for those most marginalised in our society. Within this response we call for commitments that will help to level the playing field for people from BME communities.

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

The workforce supporting BME communities need to be competent to practice and understand the impact of racism and discrimination on mental health and have an understanding of how to effectively embed a human rights approach in practice. This requires effective leadership and the provision of learning opportunities for staff working across all services. Ethnicity in Mind provides a network where staff from a range of organisations can come together to explore these complex issues. The main focus of this network is to promote research focused on ethnicity and mental health, however a similar approach or an extension of this network would provide a safe space for staff to come together from both the

equalities sector and mental health to share perspectives and practice. Leadership is a key challenge, however a reinvigorated leadership programme that supports collective action on equality issues could potentially create equality champions and produce innovative approaches to BME mental health improvement. Service user leadership is an emerging theme within mental health but further work is required to widen this to include BME service users: In doing so we would expect to see a rise in expectations and awareness of rights amongst BME service users. The learning from the diversity strand of VOX could be further disseminated to support similar work within local service user organisations.

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

There is a key leadership role for the Ethnicity in Mind Network to develop its research and knowledge exchange work in this area to both build the evidence base and ensure this is effectively disseminated. The role of the Network is important in continuing to provide opportunities for developing meaningful equality focused partnerships to improve policy and practice. There remains much that is unknown in relation to mental health improvement for people from BME communities. In terms of support for those that experience mental health problems but also in relation to improving mental health and wellbeing across the whole community. If we are to learn how to build on what works and to be clear what gaps exist it will be vital to work alongside these communities to explore what services and ultimately outcomes are meaningful to them. We know for example that family life can be an important culture feature and that family based approaches may be required rather than the often individualistic service approach often adopted by the majority community. This strategy should therefore make provision for a programme of community development work that will enable us to engage fully with BME communities to explore mental health. The prevalence of mental health problems and poor outcomes for BME communities make a compelling case for investing in this area now to prevent 'failure demand' at a later date and to ensure that we are working to address the inequalities that result from poor mental health.

The Sanctuary Network has begun work with women who have experienced pre-migration trauma and further information is available within the joint Sanctuary response.

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Data is available within the recent data linkage study that can be used to help develop more adequate responses to the needs of BME community members experiencing mental distress. This data needs to be analysed and used to inform our work on suicide prevention and self-harm reduction through Choose Life. Post 2013 there needs to be a continued focus on suicide prevention and self- harm, however these activities will need to take account of the self-harm incidence and patterns within BME communities. For example studies have emerged that identify self-harm amongst south Asian women as being an issue that needs addressed. Choose Life needs to work closely with BME communities and focus more specifically on the risk factors associated with suicide and self-harm within these. Poor data collation makes it difficult to gain a clear picture of the numbers of BME community members in distress and this needs to be improved if we are to learn how to respond effectively. It is essential that equality impact assessment on suicide prevention training is undertaken and that we ensure that BME community members are playing a full role as trainers and participants. Overall, this is an area where we need to build capacity amongst BME community organisations to enable them to identify community members who are at risk and to offer support and signpost where appropriate. This will require investment in both time and financial terms but these preventative actions should be a cost effective approach in the longer term. There is a fundamental need to work with communities to address stigma and discrimination that can often hinder help-seeking and Choose Life and see me need to align closely on this agenda.

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?

A greater focus on stigma and discrimination within BME communities is essential. The Mosaics and Sanctuary Programmes have produced some evidence of what interventions are effective and our research from the ASPEN project concurs that direct work with communities is likely to have the greatest impact on not only knowledge and attitudes but also behaviour such as discrimination. These programmes of work have produced clear evidence that arts-based approaches can be very effective as catalysts for discussion around mental health (building on work of Equally Connected in the Lothian's and the Scottish Mental Health Arts and Film Festival's Moving Minds programme). Therefore we need to begin to move away from a reliance on social media campaigns to a multi-level approach where campaigns raise awareness and direct targeted work within communities aims to produce actions that support sustained behavioural change. It is also not financially sustainable to work to achieve change across all of society rather a targeted approach that focuses on areas where the most harm is done is needed. We would argue that the BME populations should be a priority in recognition of the multiple layers of discrimination that they encounter. Within MHF's and Sanctuary's current work on the Amaan project, we are exploring with women refugees and asylum seekers where to focus mental health awareness training. We recognise that we can't

provide training to all services and are therefore targeting services where we can have the most impact. If our stigma reduction work in Scotland is to be effective it will need to focus down on where the damage is greatest and where we can affect change. Discrimination on grounds of disability is illegal but yet it remains common place in relation to mental health. We would hope that moving forward this strategy and future work on stigma and discrimination takes the opportunity to highlight the legal position in terms of both equality and mental health legislation. Future programmes of work on stigma should have strategic aims that include raising awareness of the legal position and promoting use of legislation.

Discrimination in relation to ethnicity needs to be tackled within services to promote equity and staff should be equipped with the skills to address racism within their teams. Staff should have an understanding of equality legislation and the principles of the Mental Health (Care and Treatment)(Scotland) Act 2003 and feel able to enact these principles on a daily basis. Brief training programmes may not be adequate to affect this cultural change and can be tokenistic. Facilitation and support may be necessary to work with teams to impact assess all of their policies and procedures to ensure that they are enacting knowledge acquired through training. Reflective learning environments are required to create safe spaces for practitioners to talk through their experiences and concerns.

Question 5: How do we build on the progress that *see me* has made in addressing stigma to address the challenges in engaging services to address discrimination?

See me need to prioritise tackling stigma and discrimination experienced by BME communities and use images and messages that BME communities can relate to, building on the work of the Mosaics programme. Although some actions have been taken around working with BME communities see me need to embed more of a focus on equalities in their strategic plan including developing a better understanding of the impact of 'double and multiple stigma'. There are examples of 'good practice' at community level such as the Equally Connected Programme where different approaches have been applied to raise awareness around mental health within BME communities and to challenging discrimination/stigma (e.g. using the arts) which could be transferable. The Moving Minds event at the Scottish Mental Health Arts and Film Festival is a good example of a supportive and creative learning environment and over the past two years cohorts of nursing and social work students have participated in these events. Year round activities that create this supportive learning environment need to be developed in general as these opportunities have the ability to challenge perceptions by providing contact with people from BME communities and exposure to their stories. In general arts based approaches have the ability to both provide this exposure but also the distance required to allow audiences to explore highly emotive subjects. This is a particularly promising model for enhancing cross cultural understanding and people from BME communities have told us repeatedly that arts interventions are a preferred approach.

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

This is a key area and if we are to have an impact on the prevalence of mental health problems we need to focus on improving mental wellbeing within BME communities. To achieve this, the strategy needs to support engagement with a wide range of community and faith organisations that can play an important role in promoting and protecting mental wellbeing. There are promising examples of this such as the work of VOX and the Mosaics programme with faith leaders that could be developed further. Working in partnership with BME community organisations to ensure mental health is on their agenda is crucial. Public bodies need to recognise this involves building capacity within BME community organisations and that they need to invest time and money in doing so. Community development approaches are important in working with BME communities as work on Mosaics and Sanctuary has shown. We also know that for many cultures family life is central to wellbeing and therefore work to promote wellbeing needs messages that are built around knowledge of what will help the target audience to hear. In general the evidence on mental health promotion gathered by LSE gives some direction on the actions that can have an impact such as school and employment based programmes. In relation to BME when undertaking these mental health promotion activities we need to also explore risk factors such as racism and multiple discrimination. This is an agenda that goes beyond the reach of this mental health strategy but there are opportunities to influence work in this area through initiatives such as the curriculum for Excellence, SMHAFF and the work of see me. It is important that racism is viewed as a determinant of poor mental health and a risk factor for mental health problems. Those programmes that interact with the general public need to be clear in these messages. Where there is promising practice and small scale short term initiatives in this area, there is currently no framework for supporting this equality focused work and ensuring learning is disseminated. The loss of the leadership provided through the race equality programme within NHS Health Scotland has left a significant gap. Leadership in this area is required to ensure it remains a priority.

The evidence that does existence in relation to promoting wellbeing has usually centred on what works for the majority population, for example we don't know whether volunteering has the same wellbeing benefits to the BME population. Research is needed but also pilot testing approaches within BME communities can be very effective.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

The CAMHS workforce needs to be trained and supported to ensure cultural competence and be clear on the role of family within different cultures. Where existing CAMHS are not the best form of support or have failed to engage alternative services need to be available especially where language is an issue. The role of BME community organisations should be given greater prominence and mental health literacy increased within these. It is important to build on existing promising practice in relation to mental health

promotion in schools through Cirriculum for Excellence by ensuring that key messages around the impact of racism as a risk factor are built into the programme. In addition, youth counselling services need to be culturally competent in meeting the needs of BME communities to ensure that BME young people have access to less stigmatising support at the earliest point. Existing early years and parenting programmes such as Triple P have been developed within countries where the majority population is white, these will need to be adapted to meet the needs of BME parents and children. GAMH have undertaken some limited activities adapting Triple P and learning from this should be disseminated. A demonstration project would be welcomed where a culturally modified version of Triple P could be piloted, which may contain key elements of peer support, community leadership and facilitated discussions rather than formal training approaches.

Question 8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

Ethnic monitoring is of major concern as this prevents a clear picture of prevalence and patterns of service use from emerging. We need to improve ethnicity coding and work with ISD Scotland to ensure better quality data and mapping of accessibility of CAMHS services for BME communities. For CAMHS to be accessible to young people from BME communities a range of supporting activities to engage communities will be required including work to address stigma and promote help-seeking. NHS workforce will require national leadership and support from see me to undertake this work in stigma reduction within BME communities confidently. Workforce development opportunities will be required such as leadership initiatives and safe learning spaces as previously described. Again cultural awareness around the role of the family is key. Links with schools, including the role of school psychologists need to be considered in relation to training provided to ensure cultural competence. Young people from BME communities who experience mental health problems will encounter multiple layers of discrimination and be amongst the most disempowered in our society. Services supporting young people from schools and universities through to the criminal justice system need to be aware of the impact of this multiple discrimination. We acknowledge that this is a challenging agenda but feel that the mental health strategy should commit to providing leadership through training and support to wider public sector organisation in relation to mental health. Equality should be an underpinning principle in any such training. A trainer for trainers approach to cascading knowledge and building capacity within wider public services will help to make this a more efficient and sustainable over the longer term. In general equality sensitive indicators for HEAT targets are required.

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

General campaigns to improve help-seeking, such as Breathing Space should prioritise work with BME communities in recognition of the additional

risk factors that they encounter and use key messages that will more effectively engage with them. Protective factors within BME communities are little understood and research is required to explore these further and build on what works. There needs to be a greater use of initiatives to improve mental health that are meaningful to BME communities such as peer support for people whose mental health is at risk. We also need to create a safe space for people from BME communities who may be in distress. We need to work with existing social networks to encourage people to take action to improve their mental health e.g. work with faith leaders. There is a strong case to ensure that counselling services and psychological therapies are culturally competent and to consider whether current dominant approaches such as CBT are appropriate for BME communities. It is crucial that a person-centred approach is adopted when working with people from BME communities to avoid being either too eurocentric or ethnocentric. Asset based community development approaches should be applied to support and empower BME communities to develop activities aimed at improving their mental health. Initiatives such as Living Life to the Full need to be equality impact assessed and pilot tested within BME communities to ensure cultural competence. MHF's Moving Minds project explored the concept of self-management with refugees and asylum seekers and the learning from this project could be further exploited to develop self-management resources and tools for use within BME communities.

Question 10: What approaches do we need to encourage people to seek help when they need to?

We need to review whether current national training initiatives such as Scottish Mental Health First Aid and suicide prevention training are culturally appropriate and employ sufficient numbers of trainers from BME communities. We need better signposting information for BME communities to ensure greater awareness of what services can be accessed and their entitlements. Stigma within communities and self-stigma needs to be addressed to promote help-seeking and see me should apply asset based community development approaches to engage BME communities. Breathing Space, liaison psychiatry, crisis services and other first contact services need to respond well on initial contact and help signpost people onto day time services that will meet their needs. These first contact services need to be aware of the additional barriers that people from BME communities encounter in making transitions through services and should have protocols in place to address these e.g. interpreting services set up in advance/point of referral to ensure that first contact with day time services is a positive experience.

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

We need to build on the excellent work of the Ethnicity in Mind Network in bringing together a range of partners to develop our knowledge of mental health and ethnicity and use this knowledge to improve practice. The mental health strategy should provide a framework that extends beyond NHS and mental health services and considers transitions between services but also between community and specialist mental health services. We need to work in partnership with community and faith organisations to ensure early intervention and good access to treatment. We need training for interpreters in how to recognise and respond to mental distress and training for GPs in recognising specific mental distress experienced by BME communities. Equality impact assessments should be undertaken within crisis services to ensure that they meet the needs of BME communities. Integrated Care Pathways should focus specifically on the care pathway relevant to the needs of BME communities. Workforce development is a key issue and a range of staff should be trained and supported on the mental health needs of people from BME communities (e.g. A&E staff, police, ambulance staff).

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

The Ethnicity in Mind Network should be supported to undertake specific research on how 'evidence based' care and treatment meets the needs of BME communities. This would involve a greater role for qualitative research. At times there may be a need to critique the notion of what evidence based practice means for BME communities and consider if treatments that are understood as 'evidence based' within SIGN and NICE guidelines actually meet the needs of BME communities. Within the NHS there is a need to build this knowledge into the KSF process. Brief one day equality training for staff is often inadequate in giving them the confidence to translate this knowledge into practice. Facilitation and support is required to enable them to embed culturally competent practice within all of their policies and procedures. Pilot testing approaches within BME communities can inform modifications on interventions and whether these are culturally relevant.

Question 13: What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?

Integrated Care Pathways require more of a focus on the needs of BME communities. BME community members who use services may need particular support in making transitions between different services. The role of GPs is particularly important in ensuring these transitions are appropriate and GPs may need training to ensure this happens. We also need to ensure other service providers, particularly homelessness and social work services, are effective in supporting transitions for people from BME communities. A programme of work on ICP's for BME communities could be undertaken by NES a process which would itself bring key organisations together to explore these issues collectively.

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

People from BME communities have the right to be included in the development of services that may improve their mental health. They should be able to see the impact of their involvement and receive feedback on improvements made as a result. VOX have worked to achieve this nationally but more is required to have an impact at a local level. Local service user involvement structures are traditionally developed around western concepts of involvement and support is required to make these structures more accessible to BME communities or to provide alternative approaches in parallel. Public bodies need to recognise that even within a climate of reduced resources, investment in involvement activities are vital to ensure that service achieve outcomes for the people that use them. This involves building capacity within service user organisations and they need to invest time and money in doing so.

Question 15: What tools are needed to support service users, families, carers and staff to achieve mutually beneficial partnerships?

There needs to be a greater use of community development approaches in order to support mutually beneficial partnerships between families and services. The role of the family within different cultures needs to be understood and balanced with the needs of the service user. This can be complex in practice for example with regard to equality for women. The current approach to workforce training is often not adequate to support staff to deal with these issues. Opportunities for reflection in safe supportive learning environments are required to allow staff to explore these issues without fear of judgement. The Ethnicity in Mind Network already provides this opportunity but its current area of focus is research. A similar support mechanism focused on practice is needed. Such a network whether real or virtual (or both) needs to bring together a range of practitioners from NHS, voluntary sector and wider public services. Equality groups, service users and organisations such as the Mental Welfare Commission would add important perspectives. The previous regional networks of the NHS Health Scotland race equality programme fulfilled some of these functions and its loss has left a gap in relation to supporting practice. Mentoring for practitioners could also help to share learning between organisations and disciplines in some of these complex areas as well as helping to achieve strong and effective partnerships.

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

A starting point is to ensure that all resources and initiatives aimed at promoting these approaches amongst the workforce also consider the central theme of equality and have a human rights focus. In terms of BME communities this will mean avoiding being too euro or ethnocentric. We

need to also recognise the intersectional issues, for example the needs of LGBT people from BME communities. There are some complex issues that arise when balancing a person centred approach with cultural competency such as equality and the role of women in different cultures. These issues need to be acknowledged and explored. Staff will need safe spaces to reflect on practice without fear of judgement both at an individual level within supervision sessions but also collectively. The loss of the race equality programme's regional networks means there is currently no mechanism to bring practitioners together in this way with community members and colleagues from wider public services. Ethnicity in Mind does create this kind of space but currently the key focus is on research. However this network has been effective and the model could also be applied to support practice. NES have a significant part to play in ensuring that workforce development resources centre on equality as a key principle and the Mental Welfare Commission have an important role in promoting the equality principle of the mental health legislation and both these organisations should be further supported in undertaking these roles.

Question 17: How do we encourage implementation of the new Scottish Recovery Indicator (SRI)?

The SRI needs to focus more of the specific recovery needs of BME communities. We need to ensure that an equality impact assessment is undertaken on the SRI.

Question 18: How can the Scottish Recovery Network develop its effectiveness to support embedding recovery approaches across different professional groups?

By its nature the Scottish Recovery Network has a central focus on the human rights of people with mental health problems. It would therefore be expected that the network would advocate for those who encounter additional barriers to recovery and experience multiple discrimination. The network should therefore aim to influence workforce development through NES (and appropriate professional bodies) and in doing so should ensure that the perspectives of people from BME communities are represented at all stages. The Recovery Network has undertaken work initially with NRCEMH and latterly with health improvement leads in Glasgow and organisations such as GAMH in relation to recovery and some progress has been made. The recent employment of a network officer with a remit for equalities has been particularly welcomed. However there needs to be further work prioritised to ascertain whether all aspects of WRAP, peer support and the SRI work have relevance to BME communities. We need to ensure all recovery tools are not only relevant but also culturally competent. Where this is not the case alternative approaches need to be explored. All tools and support mechanisms should be routinely equality impact assessed and pilot tested with BME people who have experienced mental health problems as they are being developed. Although some of this work has been done a systematic approach is required. SRN's effectiveness should be measured against outcomes which include the experience of people with mental health problems from BME communities. A general but important point is that the concept of recovery is one that has developed within majority communities internationally and although some progress has been

made in relation to minority communities in Australia and Canada for example, there is need to explore the concept more fully within BME communities in Scotland to gain a greater understanding of how SRN can help.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

In general, mental health services need to be both ethnically sensitive and be able to address family stigma. They need to support all families in their caring role and reach out to those who encounter the greatest barriers. Within mental health services there is often a lack of awareness in relation to the role of family within different cultures and as a result practitioners often find it difficult to engage BME families in ways that are acceptable and respectful. The Minority Ethnic Carers of People Project (MECOPP) provides specialist services for families and carers from BME communities. MECOPP have found that it is clear that many BME carers are either unaware of, or have difficulty in accessing, mainstream health and social care support services. This can mean that the 'burden' of caring for someone impacts disproportionately on their physical and emotional wellbeing. The impact of caring on one's mental health has been well-documented elsewhere. The development of link workers that can support people from BME communities to make the transition between services would be an important development as often carers have to undertake these roles. Specialist services that provide a safe space for BME carers such as MECOPP or GAMH carers service need to be further developed and the expertise from within these services shared. NHS boards should see this proactive approach as a funding priority to reduce the 'failure demand' that results from a lack of appropriate support for carers.

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Staff need to be supported to develop culturally competent approaches and to be aware of the particular dynamics within families in BME communities and that these are varied. The expertise from within specialist carers services such as MECOPP and GAMH should be shared across organisations. For example MECOPP has worked extensively with Gypsy/Traveller carers to build their confidence and skills as community trainers, enabling them to deliver awareness-raising training to service-providers. The pilot has been very positively evaluated so far and this model could easily be developed with other communities and rolled out across health boards.

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

Question 21: How can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

We are starting from a different point with regard to people from BME communities. Currently lack of ethnic monitoring makes it difficult to establish patterns of use but all indications are that service use is often at crisis point. Uptake of community based services at an earlier stage appearing poor for members of BME communities. Ethnic monitoring should be mandatory across all NHS and NHS commissioned services to allow us to gain a clearer picture of patterns of service use. However, in general there is significant redesign required to ensure that current community NHS and social care services are accessible to people from BME communities. The mental health workforce, require appropriate cultural competency training and reflective learning environments to explore practice and service redesign needs to involve people from BME communities in a meaningful way. Within communities there are a range of BME organisations and more emphasis should be put on supporting them to identify people who may be experiencing problems with their mental health and to enable them to signpost to more specialist mental health services. This requires investment in training and support for community based BME organisations. First contact services such as liaison psychiatry within general hospital settings, A&E staff, crisis services and GP's need to be supported to work competently with people from BME communities and appropriate training and support that explores cultural and equality issues alongside mental health needs to be a priority for these services.

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

We should have equality indicators on all HEAT targets so that NHS Boards have to demonstrate progress in relation to BME communities. Data recording and monitoring needs to be mandatory e.g. in relation to the HEAT target linked to SIMDR. If we are to improve accessibility to services we will need to fill the gaps in data collection for BME communities that currently exist. Much further work needs to be undertaken to fully understand the significance of 'double stigma' and for some groups, such as Gypsy/Travellers, the impact of racism and/or 'feeling you have to hide your identity/ethnicity' on your mental health. We are aware from our work with these groups that this stigma can have a significant impact on people's lives, but more information is required to enable us to understand how we can best provide accessible and appropriate support.

Question 23: How do we disseminate learning about what is important to make services accessible?

There needs to be a forum to share knowledge and expertise in relation to working with people from BME communities, where the voluntary and statutory sectors come together to support, promote and share knowledge in this area. The loss of the regional networks that were developed by NRCEMH and the NHS Health Scotland race equality programme means there is currently no shared learning environment beyond Ethnicity in Mind (where the main focus is on research). However the Ethnicity in Mind network provides a transferrable model. There needs to be more cross-departmental working and knowledge transfer to make services more accessible to people from BME communities. NES has a key role to play in disseminating learning to inform clinical and workforce training. NES should connect with the work of Ethnicity in Mind to benefit from evidence from research in this field and to engage with a wide range of perspectives. Mandatory staff training on ethnicity recording linked to the KSF process is required. It is important to provide mental health awareness training to interpreters to ensure that they are provide sensitive and appropriate services. It is also important that we raise awareness mental health and expectations within BME communities themselves and work through current service usEr involvement structures to support them to reach out to service users, such as PFPI and local user forums. However it is important to be mindful that these structures may not be the most appropriate way of engaging with people from BME organisations and we need to learn from the work of VOX in establishing innovative ways to engage.

Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Gaps exist in relation to children and young people from BME communities, refugees and asylum seekers, Gypsy/Travellers, women, people subject to human trafficking, and BME community members who are LGB or T. We need to recognise and equip the mental health workforce to address intersectional issues, for example the needs of female asylum seekers. There are a number of service gaps that exist for BME people including access to advocacy services and to psychological therapies as well as counselling services. Overall, to promote help-seeking and reduce stigma it is important to develop work that engages the wider BME communities to build their capacity to identify people who may be at risk and to provide local support and where appropriate signposting to more specialist services.

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

Safeguards should be improved within criminal justice system to look at how

we appropriately meet the mental health needs of people from BME communities using that system. Competency of staff working across different settings needs to be enhanced to allow them to identify and respond effectively to the mental health needs of BME communities. For example improved quality of equality based mental health training and facilitation is required for homelessness and social work services. We also need to encourage the NHS to develop joint projects with the voluntary sector. Voluntary sector are often now seen as commissioned services rather than valued partners. This is an ethos that needs to shift in general, however it is particularly important when working with BME communities where the voluntary sector provide a strong support role. The commissioning arrangements should be reviewed to support the development of strong interagency partnerships rather than the current approach to commissioning which can be divisive.

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

In general an effective mental health strategy should not only consider NHS health services, but also the vital intermediary role that the voluntary sector play in supporting people to move from NHS services to community life. Other public services that support vulnerable people also need to be considered and the strategy should provide leadership for these services in relation to the central element of mental health. For example the strategy should create opportunities for joint work with homelessness services. This is a very wide agenda and it is accepted in this response that the scope of the strategy is limited. However, a number of manageable commitments could be achieved and would begin to shift culture. For example when considering stigma and discrimination in relation to people from BME communities, see me should work to develop capacity within a wide range of equality and community organisations including faith communities to take this work forward. Equally training programmes such as ASIST should be pilot tested within BME communities and community members trained as trainers (including faith leaders and youth workers).

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Employment practice and accessibility of professional training needs to be considered to allow us to recruit sufficient numbers of workers from BME communities. This will require the support of professional bodies, universities and employability services to ensure this happens. Cultural competence needs to be given greater prominence within the KSF process. Workforce development resources including individual support and supervision processes need to focus on values, culture and behaviour as

well as skills and knowledge and line managers need training creating reflective learning environments for staff working within their teams. For example debriefing sessions following critical incidents have long been considered to be best practice in supporting reflection, practice improvement and wellbeing of staff but in practice these are not consistently provided. Developing a more reflective environment is vital if practitioners are to be supported to explore complex issues such as identity, culture and human rights.

Question 28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

This survey also needs to identify the training needs of staff in relation to providing psychological therapies for people from BME communities. Improvements in ethnic monitoring will help us to establish current uptake but research is also required to establish the effectiveness of different therapies in engaging BME communities and how these therapies can be made more culturally competent. We need to be very wary of assuming that therapies that were evaluated for effectiveness within white communities are transferrable to other ethnic groups. This is often the case for many therapies that are considered to have the strongest evidence base and are recommended in NICE and SIGN. These may also be effective for other ethnic groups with modifications but there is insufficient knowledge about what these modifications should be or indeed whether they are transferrable at all.

A survey focused on cultural competence within the workforce and that identified training and support needs would be particularly welcome.

Question 29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

There needs to be more of an emphasis on person centred and community development approaches. Clinical training should contain person-centred approaches and community development skills for new clinicians and workforce development opportunities should be available for existing practitioners. It cannot be assumed that NHS practitioners have these skills already. For example CPN training was withdrawn a number of years ago and this training was additional to the RMN qualification with a particular focus on community working. At this time community work was viewed as a speciality rather than normal practice as it is today, however some key issues where explored related to community life during this training and this gap has not been filled. Overall, we need to make better use of the training programme that we have and develop new programmes where there are gaps. There is a clear role for NES in ensuring ethnicity is given more prominence within these. For example the 10 Essential Shared Capabilities training needs to be rolled out to all staff as this covers important capabilities such as challenging inequality, respecting diversity and user-centred practice.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

We need to find out if psychological therapies are appropriate in meeting the needs of BME communities.

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge?

Current benchmarking of services does not take into account the needs of BME communities. This makes service improvement work in this area difficult. It will be important to work alongside BME communities to establish what outcomes are meaningful to them. Developing benchmarks for best practice in relation to BME communities should be a priority. This will enable us to develop training and development opportunities for staff to enable them to achieve this standard of practice and to undertake well informed service improvement activities. Ethnic monitoring data needs to be generated to give us more information about patterns of service use again to inform the development of best practice and to ensure that least restrictive and equality principles of the mental health law are being adhered to. Most research on BME communities has focused on the challenges and barriers to service uptake and as a result much is known. We need to move this research agenda on now to consider what works in overcoming these and BME communities themselves need to be central to this process.

Question 32: What would support services locally in their work to embed clinical outcomes reporting as a routine aspect of care delivery?

Ethnic monitoring needs to be carried out alongside clinical outcome reporting to support analysis of the effectiveness of different aspects of care and treatment. Clinicians and wider practitioners are not currently routinely recording ethnic data which would indicate that there may be a significant training need. This ethnic monitoring should be mandatory and failure to record should be viewed as a performance issue.

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

NHS Boards need to ensure their staff develop expertise and knowledge in the mental health needs of BME communities. NES has a pivotal role in supporting staff development in relation to working effectively with BME communities through existing competency frameworks. Mental health services need leaders who will advocate for change in relation to equality and we need to embed this into NHS leadership programmes. The mental

health workforce need safe spaces to explore often complex issues relating to human rights and culture and learning environments such as the Ethnicity in Mind Network should be supported with local as well as national opportunities available. In moving forward it will be important to embed a learning culture within services where staff feel able to reflect on their practice. Staff support and supervision/development practices within services are often either inadequate or not evenly applied. These processes need to be reviewed to ensure that culture, values and behaviour as well as skills and knowledge can be explored. Line managers require training that enables them to support staff to reflect on their practice (including more complex issues in relation to human rights and culture).

Question 34: What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?

We need strong leadership to challenge tokenism in relation to equality and diversity and to develop a meaningful approach to equalities work with BME communities. The Mental Health Strategy needs to link with the Community Engagement and Renewal Bill. All aspects of staff development should be equality impact assessed. This should begin with professional training course materials and all professional development thereafter. In an area of work where people from BME communities may be at their most vulnerable, encountering stigma, discrimination and racism, it is fundamental that the mental health workforce is able to engage with them in an equal and respectful way to ensure that they do not compound these social injuries.

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

Mandatory training is required for staff in all aspects of legislation and what this means for working effectively with BME communities. This should include equality legislation in addition to mental health law with support for staff in relation to how these interact. Impact of this training on practice should be monitored through the Mental Welfare Commission with particular regard to the principle of equality within the Mental Health (Care and Treatment)(Scotland) Act 2003. Staff often focus on sections of mental health law related to compulsion, however more work needs to be undertaken to raise the profile of sections 25 -31 and the role of staff in supporting services users back into community life. Specific programme of training is required to update staff from the work on Inclusion in Mind. This training should also remind staff that all the sections of the act are underpinned by guiding principles including the principle of equality. Training should be participatory and provide real examples and narratives from BME service users to ensure that staff are able to fully understand the importance of these sections in supporting recovery.