Department of Health

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

Policy

HR/Workforce

Management

Planning

Clinical

Performance

Partnership Working

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Author	Department of Health
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Description	This document combines (a) a five-year action plan for reducing inequalities in Black and minority ethnic patients' access to, experience of, and outcomes from mental health services; and (b) the Government response to the recommendations made by the inquiry into the death of David Bennett.
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For Recipient's Use	

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

Contents

Executive summary

Delivering Race Equality in Mental Health Care (*DRE*) is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants.

It draws on three key recent publications in particular:

- *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*;
- *Delivering Race Equality: A Framework for Action*; and
- the independent inquiry into the death of David Bennett (although *DRE* itself is not a direct response to the inquiry's report).

David Bennett was a 38-year-old African-Caribbean patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff. As well as *DRE,* this document contains the Government's formal response to all the recommendations made in the report of the inquiry into David Bennett's death. The responses are overwhelmingly positive and, taken together with the action plan in *DRE*, comprise a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users.

The programme is based on three 'building blocks', first proposed in the consultation version of *DRE*:

- **more appropriate and responsive services –** achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children;
- **community engagement –** delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and
- **better information –** from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

DRE itself is just one component of a wider programme of action bringing about equality in health and social care. For example, *National Standards, Local Action* is the Department's current care standards and planning framework. Among the core standards that it sets out are:

- that healthcare organisations must challenge discrimination, promote equality and respect human rights (C7(e)); and
- that organisations must enable all members of the population to access services equally (C18).

DRE will support the implementation of Sir Nigel Crisp's 10-point race equality action plan in the NHS, and will also help NHS trusts to fulfil their obligations under the Race Relations (Amendment) Act 2000.

The vision for *DRE* is that by 2010 there will be a service characterised by:

- less fear of mental health services among BME communities and service users;
- increased satisfaction with services;
- a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;
- a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;
- fewer violent incidents that are secondary to inadequate treatment of mental illness;
- a reduction in the use of seclusion in BME groups;
- the prevention of deaths in mental health services following physical intervention;
- more BME service users reaching self-reported states of recovery;
- a reduction in the ethnic disparities found in prison populations;
- a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
- a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and

- a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

A new BME Mental Health Programme Board, directly accountable to Ministers, has been set up at the Department of Health to oversee this action plan and the wider BME mental health programme. It will be informed by the BME National Steering Group, which is jointly chaired by the Minister of State for Health and Lord Victor Adebowale (Chief Executive of Turning Point).

Implementation of *DRE* should be a matter for everyone involved in planning, managing or delivering mental health care. Focused implementation sites will be established to help identify and spread best practice.

Summary of this Report

In the Bengali, Gujarati, Hindi, Punjabi and Urdu languages

কার্যনির্বাহমূলক সংক্ষিপ্তসার

আইরিশ ও মেডিটেরেনিয়ান দেশজাত এবং পূর্ব ইওরোপের থেকে আগতরা সমেত, ইংল্যান্ড-এর কালো ও সংখ্যালঘু এথ্নিক্ (বিএম্ই - BME)শ্রেণীভুক্ত লোকদের সকলের জন্য দেওয়া মানসিক স্বাস্থ্যের সার্ভিসে (পরিষেবায়) সমতা আনা ও বৈষম্যের বিরুদ্ধে ব্যবস্থা নেওয়ার কাজের পরিকল্পনা হচ্ছে *ডেলিভারিং রেস ইকোয়ালিটি ইন্ মেন্টাল হেল্থ কেয়ার (DRE) (মানসিক স্বাস্থ্যের সেবা দেওয়ায় জাতি/বর্ণগত সমতা)*।

তিনটি প্রধান প্রকাশণাকে বিশেষ করে এর মধ্যে ধরা হয়েছে:

- *ইনসাইড আউটসাইড, ইমপ্রুভিং মেন্টাল হেল্থ সার্ভিসেস্ ফর ব্ল্যাক এ্যান্ড মাইনরিটি এথ্নিক কমিউনিটিজ্ ইন ইংল্যান্ড (Inside Outside, Improving Mental Health Services for Black and Minority Ethnic Communities in England)*;
- *ডেলিভারিং রেস ইকোয়ালিটি: এ ফ্রেমওয়ার্ক ফর এ্যাক্শন (Delivering Race Equality: A Framework for Action)*; এবং
- ডেভিড বেনেট-এর মৃত্যু সম্বন্ধে নিরপেক্ষ অনুসন্ধান (যদিও *ডেলিভারিং রেস ইকোয়ালিটি* এই অনুসন্ধানের রিপোর্টের সরাসরি প্রত্যুত্তর নয়)।

ডেভিড বেনেট ছিলেন একজন এ্যাফ্রিকান-ক্যারিবিয়ান রোগী, যাকে কর্মচারীরা জোর করে ধরে রাখার পরে, 30শে অক্টোবর 1998 তারিখে, একটি মধ্যম রকমের বন্ধ সাইকিয়াট্রিক (মানসিক রোগ সংক্রান্ত) ইউনিটে তার মৃত্যু হয়। *ডেলিভারিং রেস ইকোয়ালিটি* ছাড়াও, ডেভিড বেনেট-এর মৃত্যু সংক্রান্ত অনুসন্ধানের রিপোর্টে করা সবক'টি সুপারিশ সম্বন্ধে কেন্দ্রীয় সরকারের রীতিগত উত্তর এই কাগজটিতে দেওয়া হয়েছে। এই উত্তরগুলি খুবই ইতিবাচক এবং *ডেলিভারিং রেস ইকোয়ালিটির* কাজের পরিকল্পনার সঙ্গে একসাথে ধরা হলে, কালো ও সংখ্যালঘু এথ্নিক মানসিক স্বাস্থ্যের সার্ভিস ব্যবহারকারীদের সার্ভিস পাওয়া, অভিজ্ঞতা ও ফলাফলের সমতা অর্জন করার জন্য একটা সমন্বয়পূর্ণ কার্যক্রম এতে রয়েছে।

ডেলিভারিং রেস ইকোয়ালিটি সম্বন্ধে পরামর্শ করার সংস্করণে প্রস্তাবিত তিনটি 'ভিত্তি প্রস্তরের' ওপর ভিত্তি করে এই কার্যক্রমটি তৈরী করা হয়েছে:

- **আরও উপযুক্ত ও প্রতিবেদনশীল সার্ভিস** - প্রতিষ্ঠান ও কর্মীদের বিকাশের জন্য, চিকিৎসা সংক্রান্ত সার্ভিসের উন্নতি করার জন্য এবং বয়স্ক লোক, এ্যাসাইলাম সীকারস্ (আশ্রয়প্রার্থী) ও উদ্বাস্তু, এবং শিশুদের মত বিশেষ গোষ্ঠীগুলির জন্য সার্ভিসের উন্নতি করার উদ্দেশ্যে কাজ করার মাধ্যমে এটা অর্জন করা।

- **সমাজের জড়িত হওয়া** - আরও স্বাস্থ্যবান সমাজের মাধ্যমে, এবং পরিকল্পনা করার ব্যাপারে সম্প্রদায়গুলিকে জড়িত করার জন্য কাজ করার মাধ্যমে এটা করা। এই কাজে 500 নতুন কমিউনিটি ডেভেলপ্মেন্ট ওয়ার্কাররা সাহায্য করবেন।

- **আরও ভাল তথ্য** - এথ্নিক সম্প্রদায়গুলির সম্বন্ধে আরও উন্নত নজর রাখার ব্যবস্থা, আরও ভালভাবে তথ্য বিলি করা ও ভাল পদ্ধতি, এবং কার্যকরী সার্ভিস সম্বন্ধে জ্ঞান বাড়িয়ে এটা করা হবে। মানসিক স্বাস্থ্যের রোগীদের নিয়মিত আদমসুমারী (সেনসাস্) করা এর মধ্যে থাকবে।

স্বাস্থ্য ও সামাজিক সেবায় সমতা আনার ব্যাপারে আরও ব্যাপক কার্যক্রমের শুধুমাত্র একটা অংশ হচ্ছে *ডেলিভারিং রেস ইকোয়ালিটি*। যেমন, *ন্যাশনাল স্ট্যান্ডার্ডস, লোকাল এ্যাক্শন* (জাতীয় মান, স্থানীয় কাজ) হচ্ছে এই ডিপার্টমেন্টের বর্তমান সেবার মান ও পরিকল্পনার কাঠাম। এতে দেওয়া প্রধান মানগুলির মধ্যে রয়েছে যে:

- স্বাস্থ্যের সেবা সংক্রান্ত প্রতিষ্ঠানগুলিকে অবশ্যই বৈষম্যের বিরুদ্ধে ব্যবস্থা ও সমতার ব্যাপারে উদ্যোগ নিতে হবে এবং মানবাধিকারকে মর্যাদা দিতে হবে (C7(e)); এবং
- জনসাধারণের সকলের সমানভাবে সার্ভিস পাওয়ার ব্যবস্থা করতে হবে (C18)।

ন্যাশনাল হেল্‌থ সার্ভিসে জাতি/বর্ণগত সমতা আনার জন্য সার নাইজেল ক্রিস্পের দশটি পয়েন্টের কাজের পরিকল্পনার সাথে *ডেলিভারিং রেস ইকোয়ালিটি* সহযোগিতা করবে এবং রেস রিলেশনস্ (এ্যামেন্ডমেন্ট) এ্যাক্ট 2000 অনুসারে তাদের দায়িত্ব পালন করতে এন্‌এইচ্‌এস্ ট্রাস্টগুলিকে সাহায্য করবে।

ডেলিভারিং রেস ইকোয়ালিটির কল্পনা হচ্ছে যে 2010 সালের মধ্যে এমন একটা সার্ভিস তৈরী হবে যার বৈশিষ্ট্যগুলি হবে:

- কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়গুলি ও সার্ভিস ব্যবহারকারীদের মধ্যে মানসিক সাস্থ্যের সার্ভিস সম্বন্ধে ভয় কম থাকবে;
- সার্ভিসগুলি সম্বন্ধে সন্তোষ বাড়বে;
- সাইকিয়াট্রিক ইন্‌পেশেন্ট ইউনিটে কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়গুলির লোকদের ভর্তি হওয়ার হার কমে যাবে;
- কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়ের সার্ভিস ব্যবহারকারীদের বাধ্যতামূলকভাবে ভর্তি করার সামঞ্জস্যবিহীন হার কমে যাবে;
- মানসিক রোগের অনুপযুক্ত চিকিৎসার করার ফলে যেসব হিংসাত্মক ঘটনা ঘটে তা অপেক্ষাকৃত কম ঘটবে;
- কালো ও সংখ্যালঘু এথ্‌নিক গোষ্ঠীর লোকদের জন্য একা রাখার ব্যবস্থা ব্যবহার করা কমে যাবে;
- শারিরীক হস্তক্ষেপ করার ফলে মানসিক স্বাস্থ্যের সার্ভিসে মৃত্যু ঘটার সংখ্যা কমে যাবে;
- আরও বেশী সংখ্যক কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়ের সার্ভিস ব্যবহারকারীরা ভাল হয়ে যাওয়াটা নিজেরা জানাতে পারবেন;
- হাজতে থাকা লোকদের সংখ্যায় জাতিগত অসামঞ্জস্য কমে যাবে;
- আরও সুষম ধরনের কার্যকরী থেরাপী থাকবে, যেমন সমান অবস্থার লোকদের দেওয়া সহায়তার সার্ভিস, সাইকোথেরাপিউটিক ও কাউন্সেলিংয়ের চিকিৎসা, এবং তার সাথে সাংস্কৃতিকভাবে উপযুক্ত ও কার্যকরী ওষুধপত্র দেওয়া;
- পেশাদারদের প্রশিক্ষণ (ট্রেইনিং) দেওয়া, মানসিক স্বাস্থ্য সংক্রান্ত নীতি গড়ে তোলা, এবং সার্ভিসের পরিকল্পনা ও ব্যবস্থা করার ব্যাপারে কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়ের লোকদের ও কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়ের সার্ভিস ব্যবহারকারীদের আরও সক্রিয় ভূমিকা থাকবে; এবং
- কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়গুলিকে উপযুক্ত ও প্রতিবেদনশীল মানসিক স্বাস্থ্যের সার্ভিস দেওয়ার ক্ষমতাসম্পন্ন কর্মীবৃন্দ ও প্রতিষ্ঠান থাকবে।

এই পরিকল্পনা ও কালো ও সংখ্যালঘু এথ্‌নিক সম্প্রদায়ের লোকদের জন্য দেওয়া আরও ব্যাপক মানসিক স্বাস্থ্য সংক্রান্ত কার্যক্রমের তত্ত্বাবধান করার উদ্দেশ্যে ডিপার্টমেন্ট অফ্ হেল্‌থ-এ একটি নতুন বিএম্‌ই (কালো ও সংখ্যালঘু এথ্‌নিক) প্রোগ্রাম বোর্ড গঠন করা হয়েছে। এদের সরাসরি মন্ত্রীদের কাছে কৈফিয়ৎ দিতে হবে। মিনিস্টার অফ্ স্টেট ফর হেল্‌থ এবং লর্ড ভিক্টর এ্যাডেবোওয়ালে-এর (টার্নিং পয়েন্ট-এর চীফ এক্সেকিউটিভ্) যৌথ সভাপতিত্বে চালানো বিএম্‌ই ন্যাসনাল স্টীয়ারিং গ্রুপের থেকে এরা তথ্য পাবেন।

মানসিক স্বাস্থ্যের সেবার পরিকল্পনা, পরিচালনা ও সেবা দেওয়ার সাথে যারা জড়িত আছেন তাদের সকলের জন্যই, *ডেলিভারিং রেস ইকোয়ালিটিকে* কাজে পরিণত করাটা হচ্ছে খুবই জরুরী। ভাল পদ্ধতি শনাক্ত করে ছড়িয়ে দেওয়ার জন্য কাজে পরিণত করাকে কেন্দ্র করে কাজ করার জায়গাগুলির প্রতিষ্ঠা করা হবে।

કાર્યકારી સંક્ષેપ

'ડિલિવરિંગ રેઇસ ઈક્વાલિટી ઈન મેન્ટલ હેલ્થ કેર' (ડી.આર.ઈ.) (માનસિક આરોગ્ય સંભાળના ક્ષેત્રમાં વર્ણીય સમાનતા પૂરી પાડવી), એ ઇંગ્લેન્ડમાં આઈરિશ અથવા મેડિટરેનિયન વંશના તેમજ પૂર્વ યુરોપમાંથી આવેલાં સ્થળાંતરકારો સહિતનાં કાળાં અને લઘુમતી વંશનાં તમામ લોકો માટે માનસિક આરોગ્યની સેવાઓમાં સમાનતા પ્રાપ્ત કરવા અને ભેદભાવ દૂર કરવા માટેની એક કાર્ય યોજના છે.

તે ખાસ કરીને તાજેતરનાં ત્રણ મુખ્ય પ્રકાશનો ઉપરથી માહિતી લે છેઃ

- *'ઈનસાઈડ આઉટસાઈડ, ઈમ્પ્રુવિંગ મેન્ટલ હેલ્થ સર્વિસીસ ફોર બ્લૅક એન્ડ માઈનોરિટી એથનિક કમ્યૂનિટિઝ ઈન ઇંગ્લેન્ડ' (અંદર બહાર, ઇંગ્લેન્ડમાં કાળાં અને લઘુમતી કોમનાં લોકો માટે માનસિક આરોગ્યની સેવાઓમાં સુધારા કરવા);*
- *ડિલિવરિંગ રેઇસ ઈક્વાલિટીઃ અ ફ્રેમવર્ક ફોર એક્શન (વર્ણીય સમાનતા પૂરી પાડવીઃ પગલાં લેવા માટેનું માળખું);* અને
- ડેવિડ બેનેટના મૃત્યુ પાછળ કરવામાં આવેલી સ્વતંત્ર તપાસ (જો કે ડી.આર.ઈ. પોતે આ તપાસના રીપોર્ટનો સીધો પ્રતિસાદ નથી).

ડેવિડ બેનેટ 38 વર્ષનો આફ્રિકન કેરેબિયન દર્દી હતો, જેને એક સુરક્ષિત સાઈકિઆટ્રિક યૂનિટ (મનોચિકિત્સા વિભાગ)માં એક કર્મચારી દ્વારા અંકુશમાં રાખવામાં આવવાથી 30 ઓક્ટોબર 1998ના રોજ તેનું મૃત્યુ થયું હતું. ડી.આર.ઈ.ની સાથે સાથે આ દસ્તાવેજમાં ડેવિડ બેનેટના મૃત્યુની તપાસના રીપોર્ટમાં કરવામાં આવેલી ભલામણો સામે સરકારે આપેલા ઔપચારિક પ્રતિસાદનો પણ સમાવેશ કરવામાં આવ્યો છે. આ પ્રતિસાદો અત્યંત હકારાત્મક છે અને ડી.આર.ઈ.ની કાર્ય યોજનાની સાથે તેમને લેવામાં આવે તો માનસિક આરોગ્ય સેવાનો ઉપયોગ કરનારાં કાળાં અને લઘુમતી કોમનાં લોકો માટે સેવાઓ મેળવવાના માર્ગોની સમાનતા, અનુભવ અને પરિણામો પ્રાપ્ત કરવા માટેનાં કામોનો એક સુસંગત કાર્યક્રમ બને છે.

આ કાર્યક્રમ ત્રણ ''પાયાના પથ્થરો'' ઉપર આધારિત છે, જેને *ડી.આર.ઈ.*ની ચર્ચાવિચારણાની આવૃત્તિમાં પહેલા પ્રસ્તાવ કરવામાં આવ્યા હતાઃ

- **વધારે સુયોગ્ય અને પ્રતિસાદાત્મક સેવાઓ** - સંસ્થાઓ અને કાર્યદળનો વિકાસ કરવા માટેના, તબીબી સેવાઓમાં સુધારા કરવા માટે અને વૃદ્ધ લોકો, અસાયલમ સીકરો અને શરણાર્થીઓ તેમજ બાળકો જેવાં અમુક ખાસ જૂથો માટેની સેવાઓમાં સુધારા કરવા માટેનાં પગલાં મારફતે પ્રાપ્ત કરવી

- **સામાજિક સંડોવણી** - વધારે આરોગ્યપ્રદ સમાજો મારફતે અને આયોજન સેવાઓમાં સમાજોને સાંકળવા માટે નવાં 500 કમ્યૂનિટિ ડિવેલોપમેન્ટ વર્કરોના ટેકા સાથેનાં પગલાં લઈને પૂરી પાડવામાં આવે છે.

- **વધારે સારી માહિતી** - લઘુમતી વંશમૂળની વધારે સારા પ્રમાણમાં દેખરેખ રાખીને, માહિતી અને સારા કાર્યવ્યવહારનો વધારે સારી રીતે ફેલાવો કરીને અને અસરકારક સેવાઓ વિશેની જાણકારીમાં સુધારો કરીને. આમાં માનસિક આરોગ્યના દર્દીઓની નવી નિયમિત રીતે કરાતી વસતી વણતરીનો સમાવેશ થશે.

આરોગ્ય અને સામાજિક સંભાળમાં સમાનતા લાવવા માટેનાં પગલાંના વિસ્તૃત કાર્યક્રમનો *ડી.આર.ઈ.* ફક્ત એક ભાગ છે. દાખલા તરીકે, 'નેશનલ સ્ટાન્ડર્ડ્સ, 'લોકલ એક્શન' એ હાલમાં ડિપાર્ટમેન્ટનાં સંભાળનાં ધોરણો અને આયોજનનું માળખું છે. તે જે મુખ્ય ધોરણો નક્કી કરે છે, તેમાં નીચેનાંનો પણ સમાવેશ થાય છેઃ

- આરોગ્ય સંભાળની સંસ્થાઓએ ભેદભાવને પડકારવો જ જોઈએ, સમાનતાને બઢતી આપવી અને માનવ અધિકારોનું સન્માન કરવું જ જોઈએ (C7(e)); અને
- સંસ્થાએ જાહેર જનતાનાં તમામ સભ્યો સમાન રીતે સેવાઓ મેળવી શકે તેમ કરવું જ જોઈએ. (C18).

ડી.આર.ઈ. સર નાઈજલ ક્રિસ્પની વર્ણીય સમાનતાને દસ પગલાંની કાર્ય યોજનાનો એન.એચ.એસ.માં અમલ કરવાને ટેકો આપશે અને તે એન.એચ.એસ. ટ્રસ્ટોને 'રેઈસ રીલેશન્સ (અમેન્ડમેન્ટ) એક્ટ' 2000 હેઠળ તેમની ફરજો પૂરી કરવામાં પણ મદદ કરશે.

*ડી.આર.ઈ.*નું લક્ષ્ય એ છે કે 2010 સુધીમાં સેવા નીચેનાં લક્ષણો પ્રાપ્ત કરશેઃ

- બી.એમ.ઈ. (કાળાં અને લઘુમતી વંશના) સમાજોમાં અને સેવાના ઉપયોગકર્તાઓમાં માનસિક આરોગ્યની સેવાઓ વિશે ભય ઓછો થવો;
- સેવાઓથી થતો સંતોષ વધવો;
- સાઈકિઆટ્રિક ઈનપેશન્ટ યૂનિટોમાં બી.એમ.ઈ. સમાજોમાંથી લોકો દાખલ થવાના દરમાં ઘટાડો થવો;
- ઈનપેશન્ટ યૂનિટોમાં સેવાનાં ઉપયોગ કરનારાં બી.એમ.ઈ. લોકોને ફરજિયાત અટકાયતમાં રાખવાના અપ્રમાણસર દરમાં ઘટાડો થવો;
- માનસિક બીમારીની અપૂરતી સારવારને કારણે થતા હિંસક બનાવો ઓછા થવા;
- બી.એમ.ઈ. જૂથોનાં લોકોને એકાંતમાં રાખવાનું ઓછું થવું;
- શારીરિક દખલગીરી બાદ માનસિક આરોગ્ય સેવામાં થતાં મૃત્યુનું પ્રમાણ ઓછું થવું;
- સેવાનાં વધારે સંખ્યાનાં બી.એમ.ઈ. ઉપયોગકર્તાઓ પોતાની જાતે સાજા થતા હોવાનું જણાવી શકે તે હાલતે પહોંચવાં;
- જેલની વસતીમાં મળી આવતી લઘુમતી વંશનાં લોકોની વિષમતાઓમાં ઘટાડો થવો;
- સાંસ્કૃતિક રીતે યોગ્ય અને અસરકારક હોય તેવી, સાથીદારના ટેકાની સેવાઓ, મનોચિકિત્સા સારવાર અને કાઉન્સેલિંગની સારવારો, તેમજ દવાઓની મદદ વડે કરવામાં આવતી દરમ્યાનગીરીઓ જેવા વધારે સમતોલિત શ્રેણીના અસરકારક ઉપચારો;
- વ્યવસાયિકોની તાલીમ, માનસિક આરોગ્યની નીતિના વિકાસ અને સેવાઓની જોગવાઈઓમાં બી.એમ.ઈ. સમાજો તેમજ સેવાનાં બી.એમ.ઈ. ઉપયોગકર્તાઓની વધારે સક્રિય ભૂમિકા; અને
- બી.એમ.ઈ. સમાજોને યોગ્ય અને પ્રતિસાદાત્મક માનસિક આરોગ્યની સેવાઓ પૂરી પાડવા માટે સમર્થ કાર્યદળ અને સંસ્થા.

આ કાર્ય યોજના અને વિસ્તૃત બી.એમ.ઈ. મેન્ટલ હેલ્થના કાર્યક્રમ ઉપર નજર રાખવા માટે ડિપાર્ટમેન્ટ ઓફ હેલ્થમાં નવું બી.એમ.ઈ. મેન્ટલ હેલ્થ પ્રોગ્રામ બોર્ડ સ્થાપવામાં આવ્યું છે, જે સીધા જ મંત્રીઓને જવાબદાર છે. તેને બી.એમ.ઈ. નેશનલ સ્ટીયરિંગ ગ્રુપ દ્વારા માહિતી પૂરી પાડવામાં આવશે, જેનું અધ્યક્ષપદ મિનિસ્ટર ઓફ સ્ટેટ ફોર હેલ્થ અને લોર્ડ વિક્ટર એડીબોવેલ ('ટર્નિંગ પોઈન્ટ'ના ચીફ એક્ઝેક્યુટિવ) સંયુક્ત રીતે સંભાળશે.

*ડી.આર.ઈ.*નો અમલ એ માનસિક આરોગ્ય સંભાળના આયોજન, વહીવટ કે તે પૂરી પાડવામાં સંકળાયેલી દરેક વ્યક્તિ માટે તાકીદની બાબત હોવી જોઈએ. શ્રેષ્ઠ કાર્યવ્યવહારોને ઓળખવા અને તેમનો ફેલાવો કરવામાં મદદ માટે કેન્દ્રિત કરાયેલી અમલની જગ્યાઓ સ્થાપવામાં આવશે.

कार्यकारिणी सारांश

Delivering Race Equality in Mental Health Care (DRE) (डिलिवरिंग रेस इक्वॉलिटी इन मेंटल हैल्थ कैअर (डी आर ई) एक ऐसी कार्य योजना है जो आयरिश, मेडिटरेनियन (भूमध्यसागरीय) मूल और पूर्वी यूरोपीय प्रवासियों समेत, इंग्लैंड के सभी अश्वेत और अल्पसंख्यकों के लिए समान मानसिक स्वास्थ्य सेवाएँ कायम करने और इस सेवाओं में भेदभाव मिटाने के लिए बनाई गई है।

यह ख़ास तौर पर, हाल ही के तीन प्रमुख प्रकाशनों पर आधारित है :

- *Inside Outside, Improving Mental Health Services for Black and Minority Ethnic Communities in England (इंसाइड आउटसाइड, इम्प्रूविंग मेंटल हैल्थ सर्विसेज़ फ़ॉर ब्लैक ऐंड माइनोरिटी ऐथनिक कम्यूनिटीज़ इन इंग्लैंड)*;
- *Delivering Race Equality: A Framework for Action (डिलिवरिंग रेस इक्वॉलिटी : अ फ़्रेमवर्क फ़ॉर ऐक्शन);* और
- डेविड बैनेट (David Bennett) की मृत्यु की स्वतंत्र जाँच (हालाँकि ख़ुद *डी आर ई*, इस जाँच का सीधा नतीजा नहीं है)।

डेविड बैनेट एक अफ़्रीकी-कैरिबियाई मरीज़ था, जिसकी मौत एक मीडियम सिक्योर सायकिऐट्रिक (मध्यम स्तर की सुरक्षा देने वाले मनश्चिकित्सीय) यूनिट में वहाँ के कर्मचारियों द्वारा नियंत्रण में रखे जाने के बाद, 38 साल की उम्र में अक्तूबर 1998 को हुई। *डी आर ई* के अलावा, इस दस्तावेज़ में डेविड बैनेट की मृत्यु की जाँच में हुई सभी सिफ़ारिशों के प्रति सरकार के औपचारिक जवाब भी शामिल हैं। ये सभी जवाब अत्यंत सकारात्मक हैं और, *डी आर ई* की कार्य योजना के साथ मिलकर, मानसिक स्वास्थ्य सेवाएँ इस्तेमाल करने वाले अश्वेत और अल्पसंख्यकों को समान पहुँच, अनुभव और अच्छे परिणाम हाँसिल करने के लिए एक ठोस कार्यक्रम प्रस्तुत करते हैं।

यह कार्यक्रम तीन `बिल्डिंग ब्लॉक्स` या मूल सिद्धांतों पर आधारित है जो तब प्रस्तावित हुए थे जब *डी आर ई* पर परामर्श हुआ था :

- **अधिक उचित और लोगों की ज़रूरतों पर आधारित सेवाएँ** – जो संगठनों और कार्यदल को विकसित करके उपलब्ध कराई जाती हैं, ताकि क्लिनिकल (रोग विषयक) सेवाओं को बेहतर बनाया जा सके और कुछ खास समूहों के व्यक्ति, जैसे कि अधिक उम्रदार लोग, असायलम सीकर्ज़ (शरण माँगने वालों), रैफ़यूजीज़ (शरणार्थियों) और बच्चों को बेहतर सेवाएँ प्रदान हों।

- **सामुदायिक संपर्क** – जो अधिक स्वस्थ समुदायों द्वारा और समुदायों के साथ मिलकर सेवाएँ आयोजित करने के लिए काम करें और 500 नये कम्यूनिटी डेवलप्मेंट वर्कर्ज़ (Community Development Workers) का सहारा लें।

- **बेहतर जानकारी** – जो जातीय मूल से जुड़े मुद्दों की अधिक बेहतर निगरानी, जानकारी व अच्छी कार्यप्रथाओं की सूचना के बेहतर प्रचार द्वारा और प्रभावशाली सेवाओं की जानकारी को बेहतर बनाकर होगा। इसमें शामिल होगी नई और नियमित आधार पर होने वाली मानसिक स्वास्थ्य के मरीज़ों की एक जनगणना यानी सेंसस।

डी आर ई खुद स्वास्थ्य और सोश्यल कैअर में समानता लाने के लिए एक अधिक व्यापक कार्यक्रम का केवल एक हिस्सा है। उदाहरण के लिए, *National Standards, Local Action (नैशनल स्टैंडर्सद्ध लोकल ऐक्शन)* डिपार्टमेंट की वर्तमान देखभाल के मानकों ओर योजना की रूपरेखा प्रस्तुत करता है। उसके द्वारा स्थापित मूल मानकों में निम्नलिखित शामिल हैं :

- स्वास्थ्य से जुड़ी देखभाल वाले संगठनों को भेदभाव का विरोध करना होगा और समानता को बढ़ावा और मानव अधिकारों को सम्मान देना होगा (C7(e); और

- संगठनों को सभी लोगों को समान रूप से सेवाएँ प्राप्त करने में सहायता देनी होगी (C18)।

डी आर ई एन एच एस (NHS) में सर नाइजेल क्रिस्प (Sir Nigel Crisp) की दस सूत्रीय जातीय समानता कार्य योजना के लागू होने को सहारा देगी, और एन एच एस ट्रस्टों (न्यासों) को रेस रिलेशंज़ (अमेंडमेंट) ऐक्ट (Race Relations (Amendment) Act) 2000 के अंतर्गत, अपनी ज़िम्मेदारियाँ निभाने में भी मदद देगी।

डी आर ई चाहती है कि वर्ष 2010 तक ऐसी सेवा क़ायम हो जाएगी जिसकी विशेषताएँ निम्नलिखित होंगी :

- बी एम ई (BME) यानी अश्वेत और अल्पसंख्यक जाति के लोगों और सेवा लेने वालों में मानसिक स्वास्थ्य सेवाओं के प्रति डर कम हो जाना;
- सेवाओं से संतुष्टि में बढ़ोत्तरी;
- बी एम ई समूह से इनपेशेंट (अस्पतालों के अंदर के) मनश्चिकित्सकीय यूनिटों (psychiatric inpatient units) में भर्ती होने वालों की दर में गिरावट;
- इनपेशेंट यूनिटों से सेवा लेने वाले बी एम ई समूह के लोगों का कम्पल्सरी डिटेंशन यानी अनिवार्य आधार पर रोक लिए जाने की दर घट जाना;
- मानसिक बीमारी के अपर्याप्त इलाज की वजह से होने वाली हिंसात्मक घटनाएँ कम हो जाना;
- बी एम ई समूह के लोगों को अकेले रख दिए जाने (seclusion) की दर में गिरावट;
- शारीरिक रूप से दखल देने के बाद मानसिक स्वास्थ्य सेवाओं में हुई मौतों में गिरावट;
- बी एम ई समूह में से ऐसे लोगों की संख्या का बढ़ना जो खुद यह दर्ज करते हों कि वे ठीक हो गए हैं;
- जेल में बंद लोगों में अल्पसंख्यकों की असाधारण दर में गिरावट;

- तरह–तरह की अधिक समन्वयित सेवाएँ उपलब्ध होना जैसे कि पीअर ग्रूप सपोर्ट (peer support services) यानी अपने जैसों का सहारा दिलाने वाली सेवाएँ, सायकोथैराप्यूटिक (मनश्चिकित्सकीय) और काउंसिलिंग (सलाहकारी) उपचार, और फ़ारमाकोलोजिकल (औषधशास्त्र) द्वारा इलाज जो लोगों की संस्कृति के अनुकूल और प्रभावशाली भी है;
- पेशेवरों की ट्रेनिंग, मानसिक स्वास्थ्य नीति विकास और सेवाओं के नियोजन और प्रदान करने में, बी एम ई समुदाय के लोगों और इस समूह में से सेवा लेने वालों द्वारा एक अधिक सक्रिय भूमिका निभाना; और
- एक ऐसा कार्यदल और संगठन जिसमें बी एम ई समुदाय के लोगों को उचित और उनकी ज़रूरतों के अनुकूल मानसिक स्वास्थ्य सेवाएँ प्रदान करने की क्षमता है।

इस नई कार्य योजना और बी एम ई लोगों के लिए तैयार की गई अधिक विस्त्रित मानसिक स्वास्थ्य कार्यक्रम पर नज़र रखने के लिए, डिपार्टमेंट ऑफ़ हैल्थ (Department of Health) ने एक नवीन बी एम ई मेंटल हैल्थ प्रोग्राम बोर्ड (BME Mental Health Programme Board) का गठन किया है। इसको बी एम ई नैशलन स्टीयरिंग ग्रूप (BME National Steering Group) से जानकारी मिलेगी ओर इस ग्रूप के अध्यक्ष हैं मिनिस्टर ऑफ़ स्टेट फ़ॉर हैल्थ (Minister of State for Health) तथा लॉर्ड विक्टर अडिबोवेल (Lord Victor Adebowale) जो टर्निंग पॉइंट (Turning Point) नामक संस्था के चीफ़ एग्ज़ेकिटिव हैं)।

मानसिक स्वास्थ्य के नियोजन, प्रबंध और प्रदान करने से जुड़े सभी लोगों के लिए *डी आर ई* का लागू होना एक प्राथमिकता होनी चाहिए। अच्छी कार्यप्रथाओं का पता लगाने और प्रचार करने में मदद देने के लिए जारी करने वाले ख़ास केंद्र स्थापित होंगे।

ਕਾਰਜਕਾਰੀ ਖ਼ੁਲਾਸਾ

ਡਿਲਿਵਰਿੰਗ ਰੇਸ ਇਕੁਆਇਲਟੀ ਇਨ ਮੈਂਟਲ ਹੈਲਥ ਕੇਅਰ (ਡੀ ਆਰ ਈ), (ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਨਸਲੀ ਬਰਾਬਰਤਾ ਦੇਣੀ, *Delivering Race Equality in Mental Health Care* (*DRE*)) ਇਕ ਅਜਿਹੀ ਵਿਵਹਾਰਕ ਸਕੀਮ ਹੈ ਜੋ ਇੰਗਲੈਂਡ ਵਿਚ ਕਾਲੇ ਅਤੇ ਨਸਲੀ ਘੱਟ ਗਿਣਤੀ ਲੋਕਾਂ (Black and minority ethnic status (BME)), ਜਿਨ੍ਹਾਂ ਵਿਚ ਆਇਰਿਸ਼ ਜਾਂ ਮੈਡੀਟ੍ਰੇਨੀਅਨ ਦੇ ਲੋਕ ਅਤੇ ਪੂਰਬੀ ਯੂਰਪੀਅਨ ਪ੍ਰਵਾਸੀ ਵੀ ਸ਼ਾਮਿਲ ਹਨ, ਲਈ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਬਰਾਬਰਤਾ ਲਿਆਉਣ ਅਤੇ ਵਿਤਕਰਿਆਂ ਨਾਲ ਨਜਿੱਠਣ ਲਈ ਤਿਆਰ ਕੀਤੀ ਗਈ ਹੈ।

ਇਹ ਖ਼ੁਲਾਸਾ ਹੇਠ ਲਿਖੀਆਂ ਤਿੰਨ ਪਬਲੀਕੇਸ਼ਨਾਂ 'ਤੇ ਆਧਾਰਿਤ ਹੈ:

- *ਇੰਨਸਾਈਡ ਆਊਟ, ਇੰਮਪਰੂਵਿੰਗ ਮੈਂਟਲ ਹੈਲਥ ਸਰਵਿਸਿਜ਼ ਫ਼ੱਾਰ ਬਲੈਕ ਐਂਡ ਮਾਈਨੌਰਿਟੀ ਐਥਨਿਕ ਕਮਿਉਨਿਟੀਜ਼ ਇਨ ਇੰਗਲੈਂਡ* (ਇੰਗਲੈਂਡ ਵਿਚ ਕਾਲੇ ਅਤੇ ਘੱਟ ਗਿਣਤੀ ਲੋਕਾਂ ਨੂੰ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਬਰਾਬਰਤਾ ਦੇਣੀ) *(Inside Outside, Improving Mental Health Services for Black and Minority Ethnic Communities in England)*;
- *ਡਿਲਿਵਰਿੰਗ ਰੇਸ ਇਕੁਆਇਲਿਟੀ: ਅ ਫ਼੍ਰੇਮ ਵਰਕ ਫ਼ੱਾਰ ਐਕਸ਼ਨ;* ਅਤੇ
- ਡੇਵਿਡ ਬੈਨਿਟ ਦੀ ਮੌਤ ਬਾਰੇ ਇਕ ਸੁਤੰਤਰ ਜਾਂਚ ਪੜਤਾਲ (ਭਾਵੇਂ ਡੀ ਆਰ ਈ ਇਨਕੁਆਇਰੀ ਦੀ ਰਿਪੋਰਟ ਦਾ ਸਿੱਧਾ ਜਵਾਬ ਨਹੀਂ)

ਡੇਵਿਡ ਬੈਨਿਟ ਇਕ 38 ਸਾਲਾਂ ਦਾ ਐਫ਼ਰੋ-ਕੈਰੀਬੀਅਨ ਮਰੀਜ਼ ਸੀ, ਜਿਹਦੀ ਮੌਤ ਸਟਾਫ਼ ਦੀ ਹਿਰਾਸਤ ਵਿਚ ਇਕ ਮੱਧਵਰਗੀ ਸੁਰੱਖਿਅਕ ਸਾਈਕੈਟਰਿਕ (ਮਾਨਸਿਕ ਰੋਗ) ਯੂਨਿਟ ਵਿਚ 30 ਅਕਤੂਬਰ 1998 ਨੂੰ ਹੋ ਗਈ। ਡੇਵਿਡ ਬੈਨਿਟ ਦੀ ਰਿਪੋਰਟ ਬਾਰੇ, ਇਨਕੁਆਇਰੀ ਦੀ ਰਿਪੋਰਟ ਵਿਚ ਜੋ ਸੁਝਾਅ ਦਿੱਤੇ ਗਏ ਸਨ, ਉਨ੍ਹਾਂ ਬਾਰੇ ਡੀ ਆਰ ਈ ਅਤੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਵਿਚ ਸਰਕਾਰ ਦੇ ਹੁੰਗਾਰੇ ਬਾਰੇ ਦੱਸਿਆ ਗਿਆ ਹੈ। ਇਹ ਹੁੰਗਾਰਾ ਕਾਫ਼ੀ ਚੰਗਾ ਲਗਦਾ ਹੈ ਅਤੇ ਡੀ ਆਰ ਈ ਦੀ ਵਿਵਹਾਰਕ ਸਕੀਮ ਇਸ ਨੂੰ ਧਿਆਨ ਵਿਚ ਰੱਖਦੇ ਹੋਏ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਵਾਲੇ ਕਾਲੇ ਅਤੇ ਨਸਲੀ ਘੱਟ ਗਿਣਤੀ ਦੇ ਲੋਕਾਂ ਲਈ ਸੇਵਾਵਾਂ ਤਕ ਪਹੁੰਚ ਵਿਚ ਬਰਾਬਰਤਾ, ਤਜਰਬਿਆਂ ਅਤੇ ਸਿੱਟਿਆਂ ਬਾਰੇ ਇਕ ਉਚਿੱਤ ਪ੍ਰੋਗਰਾਮ ਤਿਆਰ ਕਰੇਗੀ।

ਇਹ ਪ੍ਰੋਗਰਾਮ ਹੇਠ ਲਿਖੇ ਤਿੰਨ ''ਮੁੱਖ ਥੰਮਾਂ'' 'ਤੇ ਆਧਾਰਿਤ ਹੋਵੇਗਾ ਜਿਨ੍ਹਾਂ ਬਾਰੇ ਡੀ ਆਰ ਈ ਦੇ ਪਹਿਲੀ ਸਟੇਜ ਦੇ ਸਲਾਹ ਮਸ਼ਵਰੇ ਵਿਚ ਸੁਝਾਅ ਦਿੱਤੇ ਗਏ ਸਨ:

- **ਜ਼ਿਆਦਾ ਚੁੱਕਵੀਆਂ ਅਤੇ ਉੱਤਰਦਾਈ ਸੇਵਾਵਾਂ** - ਅਜਿਹੀਆਂ ਸੇਵਾਵਾਂ ਦੇਣਾ ਜੋ ਸੰਸਥਾਵਾਂ ਅਤੇ ਵਰਕਫ਼ੋਰਸ ਦੇ ਵਿਕਾਸ ਵਿਚ ਵਾਧਾ ਕਰਨ, ਡਾਕਟਰੀ ਸੇਵਾਵਾਂ ਵਿਚ ਸੁਧਾਰ ਕਰਨ ਅਤੇ ਬਜ਼ੁਰਗ ਲੋਕਾਂ, ਅਨਾਥਾਂ ਅਤੇ ਸ਼ਰਣਾਰਥੀਆਂ ਅਤੇ ਬੱਚਿਆਂ ਲਈ ਸੇਵਾਵਾਂ ਵਿਚ ਸੁਧਾਰ ਲਿਆਉਣ।

- **ਕਮਿਊਨਿਟੀਆਂ ਨੂੰ ਸ਼ਾਮਿਲ ਕਰਨਾ** - ਸੇਵਾਵਾਂ ਜੋ ਸਿਹਤਮੰਦ ਕਮਿਊਨਿਟੀਆਂ ਵਲੋਂ ਦਿੱਤੀਆਂ ਜਾਣ ਅਤੇ ਜਿਨ੍ਹਾਂ ਦੀ ਪਲੈਨਿੰਗ ਸਮੇਂ ਉਨ੍ਹਾਂ ਨੂੰ ਸ਼ਾਮਿਲ ਕੀਤਾ ਜਾਏ, ਅਤੇ ਇਨ੍ਹਾਂ ਦੀ ਸਹਾਇਤਾ 500 ਨਵੇਂ ਕਮਿਉਨਿਟੀ ਡਿਵੈਲਪਮੈਂਟ ਵਰਕਰ (ਕਾਮੇ) ਕਰਨਗੇ।

- **ਵਧੇਰੇ ਚੰਗੀ ਜਾਣਕਾਰੀ** - ਨਸਲੀ ਘੱਟ ਗਿਣਤੀਆਂ ਬਾਰੇ ਲੇਖਾ ਜੋਖਾ ਕਰਨਾ, ਚੰਗੇ ਕੰਮਾਂ ਅਤੇ ਜਾਣਕਾਰੀ ਦੇ ਢੰਗਾਂ ਬਾਰੇ ਜਾਣਕਾਰੀ ਮੁਹੱਈਆ ਕਰਨਾ ਅਤੇ ਪ੍ਰਭਾਵਸ਼ਾਲੀ ਸੇਵਾਵਾਂ ਬਾਰੇ ਗਿਆਨ ਵਿਚ ਵਾਧਾ ਕਰਨਾ। ਇਸ ਵਿਚ ਮਾਨਸਿਕ ਸਿਹਤ ਦੇ ਰੋਗੀਆਂ ਬਾਰੇ ਬਾਕਾਇਦਾ ਮਰਦਮ ਸ਼ੁਮਾਰੀ ਕਰਨਾ ਵੀ ਸ਼ਾਮਲ ਹੈ।

ਡੀ ਆਰ ਈ ਆਪਣੇ ਆਪ ਵਿਚ ਸਿਹਤ ਅਤੇ ਸਮਾਜਿਕ ਦੇਖਭਾਲ ਵਿਚ ਬਰਾਬਰੀ ਲਿਆਉਣ ਵਾਲੇ ਵਿਸ਼ਾਲ ਪ੍ਰੋਗਰਾਮ ਦਾ ਇਕ ਛੋਟਾ ਜਿਹਾ ਹਿੱਸਾ ਹੈ। ਉਦਾਹਰਣ ਵਜੋਂ, ਨੈਸ਼ਨਲ ਸਟੈਂਡਰਡਜ਼ (ਕੌਮੀ ਮਿਆਰ), ਅਤੇ ਵਿਭਾਗ ਦੇ ਮੌਜੂਦਾ ਦੇਖਭਾਲ ਕਰਨ ਦੇ ਮਿਆਰਾਂ ਅਤੇ ਪਲੈਨਿੰਗ ਫ਼੍ਰੇਮਵਰਕ ਲਈ ਸਥਾਨਕ ਕਾਰਵਾਈ ਕਰਨਾ। ਇਸ ਦੇ ਮੁੱਖ ਮਿਆਰ ਇਹ ਸੈੱਟ ਕੀਤੇ ਗਏ ਹਨ:

- ਸਿਹਤ ਦੀ ਦੇਖਭਾਲ ਕਰਨ ਵਾਲੀਆਂ ਸੰਸਥਾਵਾਂ ਵਿਤਕਰਿਆਂ ਨੂੰ ਜ਼ਰੂਰ ਘਟਾਉਣ, ਮਨੁੱਖੀ ਅਧਿਕਾਰਾਂ ਪ੍ਰਤੀ ਸਤਿਕਾਰ ਅਤੇ ਬਰਾਬਰੀ ਨੂੰ ਬੜ੍ਹਾਵਾ ਦੇਣ (C7(e)); ਅਤੇ
- ਸਾਰੀਆਂ ਸੰਸਥਾਵਾਂ ਆਪਣੇ ਸਭਨਾਂ ਮੈਂਬਰਾਂ ਨੂੰ ਇਕੋ ਜਿਹੇ ਤਰੀਕੇ ਨਾਲ ਸੇਵਾਵਾਂ ਤਕ ਪਹੁੰਚ ਕਰ ਸਕਣ ਦੇ ਯੋਗ ਬਣਾਉਣ (C18).

ਡੀ ਆਰ ਈ ਐੱਨ ਐੱਚ ਐੱਸ ਲਈ ਨਸਲੀ ਬਰਾਬਰਤਾ ਬਾਰੇ ਸਰ ਨਾਈਜਲ ਕਰਿਸਪ ਦੇ ਦਸ ਪੁਆਇੰਟਾਂ ਨੂੰ ਲਾਗੂ ਕਰਨ ਵਿਚ ਸਮਰਥਨ ਦੇਵੇਗੀ, ਅਤੇ ਐੱਨ ਐੱਚ ਐੱਸ ਟ੍ਰਸਟਾਂ ਨੂੰ ਵੀ ਰੇਸ ਰੀਲੇਸ਼ਨਜ਼ (ਸੋਧਿਆ) ਐਕਟ 2000 (Race Relations (Amendment) Act 2000) ਦੇ ਤਹਿਤ ਆਪਣੇ ਫ਼ਰਜ਼ ਪੂਰੇ ਕਰਨ ਵਿਚ ਮਦਦ ਦੇਵੇਗੀ।

ਡੀ ਆਰ ਈ ਦਾ ਉਦੇਸ਼ ਇਹ ਹੈ ਕਿ ਉਹ ਸੰਨ 2010 ਤਕ ਹੇਠ ਲਿਖੀਆਂ ਵੱਖ ਵੱਖ ਸ਼੍ਰੇਣੀਆਂ ਵਿਚ ਵੰਡੀ ਇਕ ਸਰਵਿਸ (ਸੇਵਾ) ਤਿਆਰ ਕਰੇਗੀ ਜਿਸ ਵਿਚ:

- ਬੀ ਐੱਮ ਈ ((BME) ਕਾਲੀਆਂ ਅਤੇ ਨਸਲੀ ਘੱਟ ਗਿਣਤੀ ਵਾਲੀਆਂ) ਕਮਿਉਨਿਟੀਆਂ ਅਤੇ ਹੋਰ ਸੇਵਾਵਾਂ ਵਰਤਣ ਵਾਲੇ ਲੋਕਾਂ ਨੂੰ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਰਤਣ ਬਾਰੇ ਘੱਟ ਚਿੰਤਾ ਜਾਂ ਡਰ ਹੋਵੇ;
- ਸੇਵਾਵਾਂ ਤੋਂ ਵੱਧ ਤੋਂ ਵੱਧ ਸਤੁੰਸ਼ਟੀ ਹੋਵੇ;
- ਬੀ ਐੱਮ ਈ ਕਮਿਉਨਿਟੀਆਂ ਤੋਂ ਘੱਟ ਲੋਕ ਮਾਨਸਿਕ ਰੋਗਾਂ ਦੀਆਂ ਇੰਨਪੇਸ਼ੈਂਟ ਯੂਨਿਟਾਂ ਵਿਚ ਦਾਖ਼ਲ ਹੋਣ;

- ਬੀ ਐੱਮ ਈ ਗਰੁੱਪਾਂ ਵਿਚਲੇ ਲੋਕਾਂ ਨੂੰ ਅੱਡ ਰੱਖਣ ਦੀ ਨੀਤੀ ਨੂੰ ਘਟਾਉਣਾ;
- ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਸਰੀਰਕ ਧੱਕੇਸ਼ਾਹੀ ਨਾਲ ਹੋਣ ਵਾਲੀਆਂ ਮੌਤਾਂ ਨੂੰ ਘਟਾਉਣਾ;
- ਬੀ ਐੱਮ ਈ ਦੇ ਵੱਧ ਤੋਂ ਵੱਧ ਸੇਵਾਵਾਂ ਵਰਤਣ ਵਾਲੇ ਲੋਕ ਨਿਰੋਗਤਾ ਦੀ ਖ਼ੁਦ ਰਿਪੋਰਟ ਰੱਖਣ ਵਾਲੀ ਸਟੇਜ ਤੇ ਪਹੁੰਚ ਸਕਣ;
- ਜੇਲ੍ਹਾਂ ਵਿਚ ਘੱਟ ਗਿਣਤੀ ਲੋਕਾਂ ਨਾਲ ਹੋ ਰਹੀ ਨਾ-ਬਰਾਬਰੀ ਨੂੰ ਘਟਾਉਣਾ;
- ਸਾਥੀਆਂ ਦੀ ਮਦਦ ਕਰਨ ਵਾਲੀਆਂ ਸੇਵਾਵਾਂ, ਮਨੋ-ਚਿਕਿਤਸਾ ਅਤੇ ਹੋਰ ਗੱਲਬਾਤ ਰਾਹੀਂ ਕਾਉਂਸਲਿੰਗ ਅਤੇ ਦਵਾਈਆਂ ਨਾਲ ਇਲਾਜ, ਜੋ ਕਿ ਸਭਿਆਚਾਰਕ ਤੌਰ 'ਤੇ ਸਹੀ ਅਤੇ ਪ੍ਰਭਾਵਸ਼ਾਲੀ ਹੋਣ, ਵਰਗੀਆਂ ਥੈਰੇਪੀਆਂ ਵਿਚ ਢੁੱਕਵਾਂ ਮੇਲ ਜੋਲ ਰੱਖਣਾ;
- ਬੀ ਐੱਮ ਈ ਕਮਿਉਨਿਟੀਆਂ ਅਤੇ ਬੀ ਐੱਮ ਈ ਸੇਵਾਵਾਂ ਵਰਤਣ ਵਾਲਿਆਂ ਨੂੰ ਪੇਸ਼ੇਵਾਰੀ ਮਹਾਰਤ ਦੀ ਸਿਖਲਾਈ ਦੇਣੀ, ਮਾਨਸਿਕ ਸਿਹਤ ਦੀ ਪਾਲਿਸੀ ਬਣਾਉਣ ਅਤੇ ਸੇਵਾਵਾਂ ਦੀ ਪਲੈਨਿੰਗ ਕਰਨ ਸਮੇਂ ਉਨ੍ਹਾਂ ਨੂੰ ਵੱਧ ਤੋਂ ਵੱਧ ਸ਼ਾਮਲ ਕਰਨਾ; ਅਤੇ
- ਅਜਿਹੀ ਵਰਕਫ਼ੋਰਸ ਅਤੇ ਸੰਸਥਾ ਤਿਆਰ ਕਰਨਾ ਜੋ ਬੀ ਐੱਮ ਈ ਕਮਿਉਨਿਟੀਆਂ ਦੇ ਲੋਕਾਂ ਨੂੰ ਸਹੀ ਅਤੇ ਜਵਾਬਦੇਹੀ ਢੰਗ ਨਾਲ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਦੇ ਸਕੇ।

ਇਕ ਨਵਾਂ ਬੀ ਐੱਮ ਈ ਮੈਂਟਲ ਹੈਲਥ ਪ੍ਰੋਗਰਾਮ ਬੋਰਡ, ਜੋ ਕਿ ਮੰਤਰੀਆਂ ਸਾਹਮਣੇ ਸਿੱਧਾ ਜਵਾਬਦੇਹ ਹੋਵੇਗਾ, ਡਿਪਾਰਟਮੈਂਟ ਆੱਫ਼ ਹੈਲਥ ਲਈ ਤਿਆਰ ਕੀਤਾ ਗਿਆ ਹੈ, ਜੋ ਇਸ ਐਕਸ਼ਨ (ਕਾਰਜਕਾਰੀ) ਪਲੈਨ ਅਤੇ ਬੀ ਐੱਮ ਈ ਦੇ ਵਿਸ਼ਾਲ ਮਾਨਸਿਕ ਸਿਹਤ ਪ੍ਰੋਗਰਾਮ 'ਤੇ ਨਿਗ਼ਰਾਨੀ ਰੱਖੇਗਾ। ਬੀ ਐੱਮ ਈ ਨੈਸ਼ਨਲ ਸਟੀਰਿੰਗ ਗਰੁੱਪ, ਜੋ ਕਿ ਮਨਿਸਟਰ ਆੱਫ਼ ਸਟੇਟ ਫ਼ਾਰ ਹੈਲਥ ਅਤੇ ਲੋਰਡ ਵਿਕਟਰ ਅਡੀਬੋਵੇਲ (ਚੀਫ਼ ਅਗ਼ਜੈਕਟਿਵ ਆੱਫ਼ ਟਰਨਿੰਗ ਪੁਆਇੰਟ) ਵਲੋਂ ਚੇਅਰ ਕੀਤਾ ਜਾਂਦਾ ਹੈ, ਇਸ ਨੂੰ ਸੂਚਿਤ ਕਰਦਾ ਰਹੇਗਾ।

ਪਲੈਨਿੰਗ ਅਤੇ ਪ੍ਰਬੰਧ ਕਰਨ ਅਤੇ ਮਾਨਸਿਕ ਸਿਹਤ ਸੇਵਾਵਾਂ ਦੇਣ ਵਾਲਿਆਂ ਲਈ ਡੀ ਆਰ ਈ ਨੂੰ ਲਾਗੂ ਕਰਨਾ ਇਕ ਅਤਿਅੰਤ ਜ਼ਰੂਰੀ ਕੰਮ ਹੋਵੇਗਾ। ਚੰਗੀ ਪ੍ਰੈਕਟਿਸ ਬਾਰੇ ਪਤਾ ਕਰਨ ਅਤੇ ਉਸ ਨੂੰ ਵਧਾਉਣ ਲਈ ਖ਼ਾਸ ਕਾਰਜ ਕੇਂਦਰ ਸਥਾਪਿਤ ਕੀਤੇ ਜਾਣਗੇ।

خلاصہ برائے نفاذ

ذہنی صحت کی دیکھ بھال میں نسلی مساوات کی فراہمی (ڈی آر ای۔ Delivering Race Equality in Mental Health Care (DRE)) ایک منصوبہ عمل ہے جس کا مقصد انگلستان میں بلیک اور اقلیتی نسلی حیثیت رکھنے والے تمام لوگوں کے لئے ذہنی صحت کی سروسوں میں مساوات قائم کرنا اور امتیازی سلوک سے نمٹنا ہے۔ ان میں آئرش یا بجیرہ روم کے ماخذ کے لوگ اور مشرقی یورپ کے پناہ گزین بھی آتے ہیں۔

اس پلان میں خاص طور پر تین کلیدی حالیہ مطبوعات سے استفادہ کیا گیا ہے:

- Inside Outside, Improving Mental Health Services for Black and Minority Ethnic Communities in England (*انگلستان میں بلیک اور اقلیتی نسلی کمیونٹیوں کے لئے ذہنی صحت کی سروسوں کو ہسپتال کے اندر اور باہر بہتر بنانا*)؛
- Delivering Race Equality: A Framework for Action (*نسلی مساوات کی فراہمی: عمل کے لئے ایک فریم ورک*)؛ اور
- ڈیوڈ بینیٹ کی موت پر خود مختار سطح پر تحقیقات (اگرچہ خود ڈی آر ای اس تحقیقات کی رپورٹ کا براہ راست جواب نہیں ہے)۔

ڈیوڈ بینیٹ ایک 38 سالہ افریقن کیریبئین مریض تھا، جو سٹاف کے قابو پانے کے بعد 30 اکتوبر 1998 کو درمیانی سطح کی حفاظت کے سائیکی ایٹرک یونٹ (طبی نفسیاتی علاج کے ہسپتال) میں انتقال کر گیا۔ ڈی آر ای کے علاوہ اس دستاویز میں ان تمام سفارشات کے جواب میں حکومت کا باضابطہ ردعمل ملتا ہے جو ڈیوڈ بینٹ کی موت کی تحقیقات کی رپورٹ میں کی گئی ہیں۔ یہ جوابات انتہائی مثبت ہیں اور، اگر انہیں ڈی آر ای میں بیان کردہ منصوبہ عمل کے ساتھ ملا کر دیکھا جائے، تو یہ ایک مربوط لائحہ عمل پیش کرتے ہیں جس کے ذریعہ ذہنی صحت کی سروس استعمال کرنے والے بلیک اور اقلیتی ماخذ کے لوگ اس سروس تک رسائی، اس کے تجربہ اور اس کے نتائج میں مساوات حاصل کر سکیں گے۔

یہ پروگرام تین ''تعمیری ستونوں'' پر قائم ہے، جن کی پہلی بار ڈی آر ای کے مشاورتی مسودہ میں تجویز کی گئی تھی:

- **زیادہ موزوں اور ہمدردانہ جوابی کارروائی کرنے والی سروسیں** - جن کا حصول تنظیموں اور ورک فورس کی ترقی، طبی سروسوں کی بہتری اور مخصوص گروپوں، جیسے عمر رسیدہ لوگوں، اسائلم کے درخواست گزاروں اور پناہ گزینوں، اور بچوں، کے لئے سروسوں کی بہتری کے عمل کے ذریعہ کیا جائے گا۔
- **کمیونٹی کی دلچسپی اور شرکت** - اس کی فراہمی زیادہ صحت مند کمیونٹیوں کے ذریعہ اور 500 نئے کمیونٹی ڈیولپمنٹ ورکروں کی مدد سے، سروسوں کی منصوبہ بندی کرنے میں کمیونٹیوں کو شریک کرنے کے عمل کے ذریعہ کی جائے گی۔
- **بہتر معلومات** - نسلیت کی بہتر مانیٹرنگ، معلومات اور اچھے دستور کے نمونوں کی بہتر تشہیر، کے ذریعہ، اور موثر سروسوں کے بارے میں علم کو بہتر بنانے کے ذریعہ۔ اس میں ذہنی صحت کے مریضوں کے بارے میں ایک نئی باقاعدہ رائے شماری شامل ہوگی۔

خود ڈی آر ای، صحت اور سماجی دیکھ بھال کے شعبوں میں مساوات قائم کرنے کے لئے عمل کے وسیع تر پروگرام کا محض ایک جزو ہے۔ مثال کے طور پر، نیشنل سٹینڈرڈز، لوکل ایکشن (*قومی معیارات، مقامی عمل*)، دیکھ بھال کے معیارات اور منصوبہ بندی کے لئے ڈیپارٹمنٹ کا موجودہ فریم ورک ہے۔ اس میں جن معیارات کو مرکزی حیثیت حاصل ہے ان میں یہ شامل ہیں:

- صحت کی دیکھ بھال کی تنظیموں پر لازم ہے کہ امتیازی سلوک کو چیلنج کریں، مساوات کو فروغ دیں اور انسانی حقوق کا احترام کریں ((C7(e))؛ اور

- تنظیموں پر لازم ہے کہ آبادی کے تمام ارکان کو اس قابل بنائیں کہ انہیں سروسوں تک مساویانہ رسائی حاصل ہو (C18)۔

ڈی آر ای این ایچ ایس میں سر نائجل کرسپ کے تیار کردہ نسلی مساوات کے دس نقاطی منصوبہ عمل پر عملدر آمد میں مدد دے گی، اور این ایچ ایس ٹرسٹوں کو نسلی تعلقات (ترمیم) کے قانون 2000 کے تحت ان کی ذمہ داریاں نبھانے میں بھی مدد دے گی۔

ڈی آر ای کا مطمح نظر یہ ہے کہ 2010 تک ایک ایسی سروس موجود ہوگی جس کی خصوصیات یہ ہوں گی:

- بی ایم ای کمیونٹیوں یعنی بلیک اینڈ مائنارٹی ایتھنک کمیونٹیوں اور سروس استعمال کرنے والوں میں ذہنی صحت کی سروسوں کے بارے میں پائے جانے والے خوف میں کمی؛
- سروسوں کے بارے میں اطمینان میں اضافہ؛
- سائیکی ایٹرک اِن پیشنٹ یونٹوں یعنی داخلی مریضوں کے طبی نفسیاتی علاج کے یونٹوں میں بی ایم ای کمیونٹیوں کے لوگوں کے داخلہ کی شرح میں کمی؛
- اِن پیشنٹ یونٹوں میں سروس استعمال کرنے والے بی ایم ای کمیونٹیوں سے تعلق رکھنے والے لوگوں کی جبری حراست کی غیر متناسب شرح میں کمی؛
- ایسے پر تشدد واقعات میں کمی جو ذہنی بیماری کے غیر تسلی بخش علاج میں ثانوی حیثیت رکھتے ہیں؛
- بی ایم ای کے گروپوں کے افراد کو تنہائی میں رکھنے کی کارروائی کے استعمال میں کمی؛
- ذہنی صحت کی سروسوں میں جسمانی مداخلت کے بعد اموات میں کمی؛
- بی ایم ای کے جو لوگ سروس استعمال کرتے ہیں ان میں سے از خود بحالی صحت کی رپورٹ کرنے کی منزل پر پہنچنے والے لوگوں کی تعداد میں اضافہ؛
- قید خانوں کی آبادیوں میں پائی جانے والی مختلف اقسام کی نسلی عدم مساوات میں کمی؛
- علاج کے موثر طریقوں کا زیادہ متوازن سلسلہ، جیسے پیئر سپورٹ سروسیں یعنی دوست احباب کی مدد کی سروسیں، سائیکو تھیراپی اور کاؤنسلنگ کے علاج، اور ان کے علاوہ دوائیوں کے ذریعہ علاج جو ثقافتی اعتبار سے مناسب اور موثر ہیں؛
- پیشہ وروں کی ٹریننگ میں، ذہنی صحت کی پالیسی کی تیاری اور ترقی میں، اور سروسوں کی منصوبہ بندی اور فراہمی میں، بی ایم ای کمیونٹیوں اور بی ایم ای کمیونٹیوں کے سروس استعمال کرنے والے لوگوں کے لئے زیادہ فعال کردار؛ اور
- ایسی ورک فورس اور تنظیم جو بی ایم ای کمیونٹیوں کو ایسی سروسیں فراہم کر سکیں جو مناسب اور زیادہ ہمدردانہ جوابی کارروائی کریں۔

اس عملی منصوبہ اور بی ایم ای کی ذہنی صحت کے وسیع تر پروگرام کی نگرانی کے لئے، ڈیپارٹمنٹ آف ہیلتھ میں بی ایم ای مینٹل ہیلتھ پروگرام بورڈ کے نام سے ایک نیا ادارہ قائم کیا گیا ہے، جو براہ راست منسٹروں کے سامنے جواب دہ ہے۔ یہ بی ایم ای نیشنل سٹیئرنگ گروپ کے زیر اثر ہوگا، جو منسٹر آف سٹیٹ فار ہیلتھ اور لارڈ وکٹر ایڈی بووالے (ادارہ ٹرننگ پوائنٹ کے چیف ایگزیکٹو) کی مشترکہ چیئر مینی میں کام کرتا ہے۔

ڈی آر ای پر عملدر آمد ہر اس شخص کے لئے فوری اہمیت کا حامل ہونا چاہئے جو ذہنی صحت کی دیکھ بھال کی منصوبہ بندی، اس کے انتظام یا اس کی فراہمی میں شریک ہے۔ دستور کے بہترین نمونوں کی نشاندہی اور انہیں عام کرنے میں مدد دینے پر مرکوز عملدر آمد کے مقامات قائم کئے جائیں گے۔

Foreword: John Reid MP, Secretary of State for Health

Racism or discrimination in any form have no place in modern society, and they certainly have no place in modern health or social care. David Bennett's death stands as a tragic reminder of what can happen if services fail to meet the needs of Black and minority ethnic (BME) communities and individuals. With this document we offer a clear way forward to equity for all in mental health care.

I am grateful to Sir John Blofeld and the other members of the independent inquiry panel for their thorough and helpful report on what happened to David Bennett. In this document we respond to all of the report's recommendations, but we also go further.

Shortly before the inquiry published its report, we launched a consultation document called *Delivering Race Equality: A Framework for Action* that made proposals for tackling the fundamental barriers to equality in mental health care. That framework has now been refined and finalised, thanks to those who responded to the consultation and to the group of leading experts in the field that Professor Kamlesh Patel, who is leading our programme of action, brought together to advise us.

What do we mean by race equality in mental health services? What exactly do I want *Delivering Race Equality* to deliver? Ultimately, just three things: equality of access, equality of experience and equality of outcome.

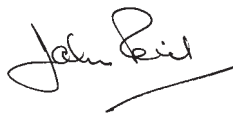
The obstacles facing us are not new. What is new is the level of determination to overcome them, and the resources backing up that determination. We are not starting from scratch – change is already on the way. For example, 80 community engagement projects are being planned, the recruitment of 500 community development workers has begun, new training for front-line staff is being designed, and from this year there will be an annual national census of all inpatients on ethnicity and mental health.

This also needs to be set in the context of our wider programme of work tackling inequalities in health and social care. The Chief Executive of the NHS, Sir Nigel Crisp, has launched a ten-point race equality action plan that challenges all NHS leaders to address race equality and the needs of BME communities in a systematic and professional way. In October 2004, I appointed the first Equality and Human Rights Director for the NHS, Surinder Sharma, and one of his priorities will be to promote Sir Nigel's plan.

The health and social care standards that we published last year in *National Standards, Local Action* require the NHS to deliver services in ways that challenge discrimination and promote equality of access. *Delivering Race Equality* is a blueprint for meeting those standards in mental health services for BME patients. I also believe that organisations that

fail to implement it will have difficulty demonstrating compliance with the Race Relations (Amendment) Act 2000.

Together, *Delivering Race Equality*, *Inside Outside* (published by the National Institute for Mental Health in England in March 2003) and the response to the David Bennett inquiry form a coherent and comprehensive action plan for eliminating discriminatory practice. Without it, many thousands of people will stay at risk of receiving a service that falls short of their needs.



John Reid

Foreword: Professor Kamlesh Patel OBE

Head of the Centre for Ethnicity and Health, University of Central Lancashire

National Director of the Department of Health Black and Minority Ethnic Mental Health Programme

Chair of the Department of Health Black and Minority Ethnic Mental Health Programme Board

Chair of the Mental Health Act Commission

Commissioner of the Healthcare Commission

There is discrimination, both direct and indirect, in mental health care. Just about everyone accepts that, and that the situation must change – quickly and permanently. What has been lacking is a comprehensive, credible programme of action for eliminating discrimination.

The case for change is well established and has been made many times before – including in the consultation version of *Delivering Race Equality* and before that in *Inside Outside* – and we do not repeat it here. However, we should acknowledge that progress does not just happen. The work could not have been done without the tireless efforts over the years of many, including Black and minority ethnic (BME) service users, their carers and families, those experienced in the field and mental health specialists – in particular Professor Sashi Sashidharan and Professor Suman Fernando.

Now we have the programme of action, founded on the three building blocks of:

- more appropriate and responsive services;
- increased community engagement; and
- better quality information, more intelligently used.

This document comprises the *DRE* action plan itself alongside the formal response to the findings of the independent inquiry into the death of David Bennett. While the action in *DRE* does not respond directly to the inquiry's specific recommendations, it does respond to the kind of failings in the care of BME mental health patients that had such a corrosive, and ultimately fatal, effect on David Bennett. *DRE* and the response to the independent inquiry are being published together to make it easier to see the complete picture of their approach to ending discrimination.

It is now over six years since David Bennett died. It would be wrong to say that there has been no progress since then, but no one can pretend that there has been enough. I hope that the actions in this document can help to make sure that this sort of tragedy is never repeated, and that they help many thousands of BME people with mental health problems to get the quality of care they need and are entitled to.

DRE is not about separate mental health services for BME communities. As the case of David Bennett demonstrates, it is not possible to adequately address improvements in access, experience and outcomes for BME service users without taking a comprehensive mainstream approach. We need equality for all ages, from childhood through to old age; we need it for women and men, and for particular groups such as refugees and asylum seekers.

DRE must be recognised as a living programme that will develop and change over time and will be integrated more fully into the wider programme of work on BME mental health. Similarly we will integrate that wider programme into the Department's (and the Government's) overarching strategies for tackling inequalities and social exclusion, especially Sir Nigel Crisp's race equality action plan.

I firmly believe that we have got the content of *DRE* about right. It has the potential to transform the care that BME patients receive from mental health services in this country. That is why I will stay deeply involved in leading this work, and will continue to chair the Department's BME Mental Health Programme Board.

It is the Board's job to oversee the whole BME mental health programme and make sure that the action needed at national level is taken. This includes, but is not restricted to, both *DRE* and the response to the independent inquiry into David Bennett's death, and will focus on making sure that action is implemented quickly and translates into better services for patients. Success also depends on local health and social care communities taking a positive and proactive approach to the action plan and making it happen.

I am determined to do all that I can to make *DRE* work, and I would not have agreed to take on the job unless I was optimistic about the outcome. Implementing *DRE* is in everyone's interest for all sorts of powerful reasons, and I know that we have the strong support of Ministers and top management. But implementation is not just in the hands of central and local government and the NHS – the independent sector has a pivotal role, both by providing culturally sensitive services itself and by passing on its expertise to the statutory sector.

I would like to thank everyone who put so much effort and expertise into advising us on *DRE* – all the members of the drafting group, advisers, Department of Health colleagues for their guidance, Lord Victor Adebowale for his ongoing support, and especially Dr Kwame McKenzie and Professor David Sallah for their detailed and invaluable work.

This document marks the first big step in a very challenging five-year programme of work. I am looking forward to it.

Kamlesh Patel

1. Introduction

Throughout this document the term 'Black and minority ethnic' (BME) is used to refer to all people of minority ethnic status in England. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants.

1.1 This document sets out a clear action plan for achieving equality and eradicating unlawful discrimination in mental health services in England.

1.2 It is the culmination of a process marked by three key documents published over the last two years. In chronological order they are:

- *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*[1] and its consultation responses;
- *Delivering Race Equality: A Framework for Action*[2] and its consultation responses; and
- the report of the independent inquiry into the death of David Bennett[3] (although *DRE* itself is not a direct response to the inquiry's report).

1.3 *DRE* was also designed to support mental health services' compliance with the Race Relations (Amendment) Act.

1.4 *Inside Outside* signalled reform of mental health care for BME communities. It was prepared by some of the leading experts in the field and was supported by widespread public consultation.[4] It identified three key objectives:

- to reduce and eliminate ethnic inequalities in mental health service experience and outcome;
- to develop the cultural capability of mental health services; and
- to engage the community and build capacity through community development workers.

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1 National Institute for Mental Health in England. *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*, March 2003.

2 Department of Health. *Delivering Race Equality: A Framework for Action*, October 2003.

3 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority. *Independent Inquiry into the Death of David Bennett*, Cambridge, December 2003.

4 NIMHE. *Real Voices: A Report on the Community Consultation to Inside Outside.* www.nimhe.org.uk/whatshapp/item_display_publications.asp?id=348

1.5 All three of those objectives are embedded in this action plan.

1.6 *Delivering Race Equality: A Framework for Action* proposed key strategic, whole-system responses to *Inside Outside* to implement the reform it signalled. It described three main building blocks, closely related to the objectives of *Inside Outside*, which now form the foundations of this action plan:

- the development of appropriate, sensitive and responsive services;
- the engagement of BME communities with service providers; and
- good quality, intelligently used information on the ethnic profile of local populations and of service users.

1.7 The report of the independent inquiry into the death of David Bennett made important recommendations about the way that mental health care is delivered to service users, especially those from BME communities. The recommendations also address wider issues such as the safe use of physical intervention in mental health settings. Like the rest of the action plan, the response to those recommendations is an integral part of the Department of Health's BME mental health programme. The report is described in more detail in Chapter 2.

1.8 Implementing the wider BME mental health programme is a task for the whole health and social care system. The independent sector already has a vital and leading role in providing culturally capable services to BME communities, and will be an invaluable source of experience and expertise for the statutory sector to draw on as it tackles inequalities in care.

1.9 After this introductory section, the document is divided into three main segments:

- **The Government's formal response to the recommendations of the independent inquiry into the death of David Bennett**
- **The DRE action plan for change in mental health services**
- **Next steps.**

Public consultation

Inside Outside

1.10 Responses to *Inside Outside* were published in *Real Voices*. Seventy-eight per cent of respondents felt that the principles of *Inside Outside* could deliver useful improvements to mental health care for BME communities.

1.11 They also made it clear that BME communities were dissatisfied with the quality of mental health care they receive. The main messages were that their care did not take account of respondents' values, and that mental health professionals needed training to deliver care in a culturally competent way.

1.12 The responses also helped to demonstrate the scale of the problem. Of those respondents with experience of mental health services, 49 per cent complained of discrimination, including 66 per cent of people of African and Caribbean origin, 49 per cent of those of South Asian origin, 45 per cent of those of Irish origin and 17 per cent of those of Chinese origin.

Delivering Race Equality

1.13 The launch of the *DRE* framework was also followed by an extensive consultation exercise and dialogue with the voluntary and community sector, as well as with those responsible for delivering change nationally and locally. The Department received over 150 responses from individuals, Royal Colleges, community organisations, campaigning groups and NHS organisations.

1.14 Much of the consultation feedback was positive. Patients and the public wanted to be reassured that, if they experience mental ill health, they will have access to a safe, clinically effective and recovery-enhancing environment that respects their language, cultural background, gender, age, sexual orientation, religious and spiritual beliefs and diverse values.

1.15 The Department of Health and the National Institute for Mental Health in England (NIMHE) want to thank all those who helped to identify oversights or misplaced emphasis in the *DRE* framework. We could not adopt all of the suggestions made, but the feedback has been invaluable in helping to draw up this action plan. For example, we have taken on board comments about:

- the role of community development workers;

- models of community engagement;
- asylum seekers and refugees;
- older people and children; and
- education and training in cultural competence.

1.16 The key criticisms raised in the feedback are summarised in the Annex, and complete responses will be made available on the Department of Health website.

The context, the vision: setting standards and changing values

1.17 This section:

- sets the *DRE* action plan in the context of some of the other work to improve equality of access to services, which support *DRE*'s objectives; and
- describes some of the characteristics of the service that *DRE*'s five-year programme of work should deliver.

The context

1.18 Equality in mental health services is not a new requirement. Many of the actions described in *DRE* have their roots in existing legislation, guidance or initiatives. Many are to be taken at national level, by the Government or other bodies. *DRE* pulls them all together, sets them in a mental health context, and adds the key, focused activity that is needed now to ensure rapid progress.

1.19 For example:

- The Race Relations (Amendment) Act 2000 requires organisations to publish race equality schemes. This leads directly to some important actions in *DRE*, including the production of active race equality and cultural capability frameworks, which will help to meet that requirement.
- The Healthcare Commission is proposing that NHS trusts should make public declarations on performance against core standards, which include equality of access to services. These declarations would have to include the views of service users and trusts' partners in the local health community, and would be verified by the Commission. The actions in *DRE* will help trusts to demonstrate that they are

reaching the core standards, for example by monitoring progress against their race equality frameworks.

1.20 All the actions in *DRE* will support trusts in implementing the 10-point plan for race equality in the NHS, published by Sir Nigel Crisp in February 2004.

National Standards, Local Action

1.21 *National Standards, Local Action* is the Department's health and social care standards and planning framework. It sets out:

- the framework for planning in the NHS and social services for 2005/06 to 2007/08; and
- the core and developmental standards that every organisation should reach in delivering NHS care.

1.22 The standards can only be achieved when they apply to all groups within our society, and the core standards are not optional – the Government has been clear that all NHS organisations must comply with them immediately. Those most relevant to this action plan are:

- that healthcare organisations must challenge discrimination, promote equality and respect human rights (standard C7(e)); and
- that organisations must enable all members of the population to access services equally (standard C18).

1.23 To meet those standards, local planning and target-setting will need to address inequalities and the needs of BME communities in particular.

1.24 Inspections through the Healthcare Commission (HC) and the Commission for Social Care Inspection (CSCI) will be a powerful driving force for change. The HC has said that in 2005/06 it will focus on performance against core standards. The inspections will be complemented by the collaboration between the Mental Health Act Commission, the HC and NIMHE to improve the information available on the care of BME groups.

The race equality action plan

1.25 In February 2004 Sir Nigel Crisp, the chief executive of the NHS, launched a 10-point action plan – a personal challenge to NHS leaders to give greater prominence to race equality as part of the drive to improve health. The aim is to make equality and diversity fundamental to all NHS strategies, and to address the needs of BME communities in a systematic and professional way. *DRE* will support implementation of the 10-point plan, just as the 10-point plan will support implementation of *DRE*.

1.26 The 10 points are:

Action	Responsibility
HEALTH SERVICES AND OUTCOMES	
1. STRATEGIC DIRECTION: Through the forthcoming planning guidance, embed race equality into future Local Delivery Plans to enable more personalised care, reduced chronic disease and health inequalities, increased capacity and community regeneration	DH and all NHS leaders with national and local partners
2. ALIGN INCENTIVES: Build race equality into the new standard and target-setting regime, into local performance-management systems and into the new inspection model	DH and all NHS leaders with national and local partners
3. DEVELOPMENT: Provide practical support to help NHS organisations make service improvements for people from ethnic minorities	NHS Top Team and Modernisation Agency
4. COMMUNICATIONS: Encourage fresh approaches to communications to engage people from ethnic minorities more effectively in improving outcomes	All NHS organisations and DH
5. PARTNERSHIPS: Work with other national and local agencies to promote the health and well-being of people from ethnic minority communities	DH and all NHS leaders in concert with national, regional and local partners

Action	Responsibility
DEVELOPING PEOPLE	
6. MENTORING: Senior leaders to show their commitment by offering personal mentorship to a member of staff from an ethnic minority	All senior leaders in DH and NHS
7. LEADERSHIP ACTION: Senior leaders to include a personal 'stretch' target on race equality in their 2004/05 objectives	NHS chairs and Chief Executives; DH Board members
8. EXPAND TRAINING, DEVELOPMENT AND CAREER OPPORTUNITIES: Enhance training for all staff in race equality issues. Develop more entry points for people from ethnic minorities to join the NHS and take up training. Improve access for BME staff to the full range of development programmes, support networks and professional training. Encourage appropriately qualified leaders from ethnic minorities in health and other sectors to consider and apply for executive positions	Local Workforce Development Confederations and HR networks, NHS Leadership Centre, NHS Institute for Learning, Skills and Innovation and other training providers
9. SYSTEMATIC TRACKING: Build systematic processes for tracking the career progression of staff from ethnic minorities, including local and national versions of the NHS Leaders scheme	All senior leaders and NHS Leadership Centre
10. CELEBRATE ACHIEVEMENTS: Acknowledge the contributions of all staff in tackling race inequalities and promote opportunities for staff from ethnic minorities to celebrate their contribution to the NHS	DH and all NHS leaders

1.27 An independent panel led by Trevor Phillips, Chair of the Commission for Racial Equality, is keeping the 10-point plan under review, providing advice and challenging the progress of the plan.

Race for Health

1.28 The Department of Health and Central Manchester Primary Care Trust are jointly sponsoring the Race for Health programme. The programme is funding and supporting 12 primary care trusts to help them transform the way that they commission and provide services, engage with local communities and partners, and

approach workforce matters, with the aim of ensuring better access to the NHS and better health outcomes for BME communities.

Race equality schemes

1.29 Orders issued under the Race Relations (Amendment) Act 2000 require all strategic health authorities, primary care trusts and NHS trusts to publish a race equality scheme explaining how they will:

- assess whether their functions and policies are relevant to race equality;
- monitor their policies for their impact on race equality;
- assess and consult on policies they are proposing to introduce;
- publish the results of their monitoring, assessments and consultations;
- make sure the public have access to the services and information they provide; and
- train their staff in the new duties.

The Mental Health Bill

1.30 The Government published a draft Mental Health Bill in September 2004. It represents the first major overhaul of legislation since the 1950s and is an integral part of the Government's strategy for improving mental health services for all. The Bill is currently being considered in Parliament by a pre-legislative scrutiny committee, which provides an opportunity for an informed consideration of the issues – taking the different perspectives into account – before the Bill is formally introduced. The Department will undertake a Race Impact Assessment on the draft Bill before it is formally introduced into Parliament.

The five-year vision

1.31 The aim of this action plan is to produce more equitable mental health care for BME groups. The plan has the potential to improve the care for any group affected by a disparity in health and healthcare, including BME older people, children and adolescents, and refugees and asylum seekers. It will take us further towards the core national standard of reduced inequalities in health and improved access to services.

1.32 If *DRE*, in conjunction with other reforms in health and social care, is successful then by 2010 we could have a service characterised by:

- less fear of mental health care and services among BME communities and BME service users;
- increased satisfaction with services;
- a reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units;
- a reduction in the disproportionate rates of compulsory detention of BME users in inpatient units;
- fewer violent incidents that are secondary to inadequate treatment of mental illness;
- a reduction in the use of seclusion in BME groups;
- the prevention of deaths in mental health services following physical intervention;
- an increase in the proportion of BME service users who feel they have recovered from their illness;
- a reduction in the proportion of prisoners from BME communities;
- a more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
- a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
- a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

2. The Government's response to the independent inquiry into the death of David Bennett

2.1 ***David Bennett, a 38-year-old African-Caribbean patient, died on 30 October 1998 in a medium secure psychiatric unit in Norwich after being restrained by staff for around 25 minutes.***

2.2 The report of the independent inquiry into his death was published on 12 February 2004. It can be seen in full at: www.nscha.nhs.uk/scripts/default.asp?site_id=117&id=11516

2.3 David Bennett had been treated for mental illness for 18 years. In 1985 he was diagnosed as suffering from schizophrenia. On the evening of 30 October 1998, Mr Bennett was involved in an incident with another patient at the Norvic Clinic in Norwich. Each man struck the other. Mr Bennett was then subjected to racist abuse. The inquiry believed that this was not the first occasion he had been subjected to racist abuse during his 18 years of treatment.

2.4 The two patients were separated and Mr Bennett was moved to another ward. There, he hit a nurse. He was then restrained by other nurses in a prone position for approximately 25 minutes. During the struggle he collapsed. Nursing staff and paramedics attempted to resuscitate him, but without success. He was taken to the Norfolk and Norwich University Hospital where he was pronounced dead.

2.5 The inquiry into David Bennett's death, which was chaired by Sir John Blofeld, was held in two parts. It examined the care and treatment received by Mr Bennett and, at the request of the Department of Health, a series of broader mental health issues.

2.6 The Government is grateful to Sir John, Professor David Sallah, Professor Sashi Sashidharan, Dr Richard Stone and Mrs Joyce Struthers for a thorough and helpful report. This is the Government's response to the specific recommendations made in the report. We share the objectives of those recommendations almost completely, and we are determined that those objectives will be met. In many cases the work has already begun; in others, the actions we and others will take are set out in the *DRE* action plan section of this document.

2.7 While this response is self-contained, it should not be seen in isolation from *DRE*. Together they represent a powerful action plan for tackling the failings in the system that led to David Bennett's death and that can still affect Black and minority ethnic (BME) patients.

2.8 In the inquiry report most of the recommendations were pulled together and numbered, but there were other significant recommendations within the main text. This response addresses the numbered recommendations in order, then the unnumbered ones.

Numbered recommendations

1. **All who work in mental health services should receive training in cultural awareness and sensitivity.**

2. **All managers and clinical staff, however senior or junior, should receive mandatory training in all aspects of cultural competency, awareness and sensitivity. This should include training to tackle overt and covert racism and institutional racism.**

3. **All training referred to in 1 and 2 above should be regularly updated.**

We accept these recommendations. Staff providing mental health services need the right training, supervision and leadership if they are to give all their patients culturally sensitive and safe care. This was reinforced in October 2003 with the publication of *Engaging and Changing* (a guide to effective policy for the care and treatment of detained BME patients) which includes guidance on the provision of culturally appropriate care and staff training.

NIMHE and the Sainsbury Centre for Mental Health (SCMH) have now developed ten Essential Shared Capabilities (ESC) that everyone working in mental health services should achieve during pre-qualification training. These include respecting diversity, and cultural competence will run throughout the training for the ESC programme.

Making sure that NHS staff have the skills, knowledge, attitudes and behaviours to provide services without discrimination to BME patients will also be a priority for the NHS Institute for Learning, Skills & Innovation (ILSI), starting with staff in mental health settings. NIMHE, SCMH and the NHS ILSI will collaborate on a training programme to run alongside ESC but focused specifically on race equality in mental health.

In addition to the ESC programme, *DRE* sets out in paragraphs 3.30 – 3.37 further action for delivering greater cultural capability in the NHS mental health workforce. This includes:

- mapping by NIMHE and SCMH of current education and training provision, to identify local initiatives and needs;
- a common skill-set for mental health practitioners, developed by NIMHE, that will include the need to take part in cultural capability training;
- work by NIMHE with the Training Organisation for Personal Social Services to help all professions to understand the racial and cultural needs of BME mental health service users;
- training for the new Support, Time and Recovery workers on the effects of racism and the cultural needs of service users and carers;
- the inclusion of cultural capability factors in inspections and performance indicators;
- review of service providers (including the independent sector) by primary care trusts (PCTs) and local authorities to make sure that national policies are implemented; and
- processes within PCTs and mental health trusts for planning and monitoring individuals' personal development, including cultural capability.

4. There should be ministerial acknowledgement of the presence of institutional racism in the mental health services and a commitment to eliminate it.

Racism, discrimination or harassment in any form are unacceptable and an affront to the core values of the NHS. In *DRE* we have been frank and open about the problems we face in NHS mental health care, which include both direct and indirect discrimination.

It is possible to hide behind the label of institutional racism – to confuse the act of recognising it with real action to reform services. If services are discriminatory, then ultimately the responsibility for solving the problem lies with everyone involved in planning, managing and providing the services.

The Government accepts its share of that responsibility and offers its support to those who must reshape front-line services. We have been clear about what we will do to root out and eliminate discrimination. The action *DRE* describes, such as making the workforce more culturally capable and strengthening the relationship

between service providers and local communities, has the power to create a new culture of non-discrimination that can improve practice and attitudes and produce equity.

DRE also lists clear examples of how the success of the programme can be judged – including reductions in the disproportionate rates of admission to inpatient units and compulsory detention, and a more balanced range of therapies for BME patients.

What matters most is implementing *DRE* and delivering its goals of equal access, equal experience and equal outcomes for BME patients. That is what the Government is committed to and what it, and the NHS, should be judged on.

5. There should be a National Director for Mental Health and Ethnicity similar to the appointment of other National Directors, appointed by the Secretary of State for Health to oversee the improvement of all aspects of mental health services in relation to the Black and minority ethnic communities.

We accept that strong, top-level national leadership is essential to improving services for BME communities and we believe we now have that leadership in place.

Professor Kamlesh Patel has agreed to lead the Department's programme of action and chair its BME Mental Health Programme Board, which will take continuing responsibility for delivery of the whole programme. Implementing both the response to the inquiry into the death of David Bennett and *DRE* will be a large and high-priority component of the board's work.

The board will be advised by the BME Mental Health National Steering Group, co-chaired by the Minister of State for Health and Lord Victor Adebowale, the chief executive of Turning Point.

We have also appointed Surinder Sharma as the first ever National Director for Equality and Human Rights in the NHS. Both he and Professor Patel are recognised leaders in their field. They will work with other key figures to drive forward the work and hold the NHS to account for progress.

Professor Louis Appleby, the National Director for Mental Health, sits on both the Programme Board and the National Steering Group. In a report published in December 2004 (*The National Service Framework for Mental Health – Five Years On*) he has made it clear that improving the patient experience and outcomes for BME patients is at the top of the national agenda for mental health services.

Paragraphs 3.13 – 3.18 of *DRE* go into more detail about respective roles and responsibilities, including those of the nine new regional race equality leads who have vital parts to play in leading NIMHE's BME work programme.

6. **All mental health services should set out a written policy dealing with racist abuse, which should be disseminated to all members of staff and displayed prominently in all public areas under their control. This policy should be strictly monitored and a written record kept of all incidents in breach of the policy. If any racist abuse takes place by anyone, including patients in a mental health setting, it should be addressed forthwith and appropriate sanctions applied.**

We accept this. Patients experiencing mental ill health need to know that they will be cared for in a safe environment that reflects their culture and needs. A senior manager in every organisation that provides services should take direct personal responsibility for delivering that environment.

The Department has already published guidance on local policies for dealing with harassment, most recently in October 2003 when NIMHE launched *Engaging and Changing*, a guide to effective care and treatment of BME detained mental health patients. Many of its principles, including those relating to racial abuse, also apply to patients who have not been detained.

That guidance is now reinforced and supplemented by *DRE*. Paragraphs 3.19 – 3.25 describe further arrangements and action necessary for dealing with racist abuse and harassment in NHS mental health settings, including:

- the need for health and social care organisations to have race equality and cultural capability frameworks in place and active;
- the need for chief executives to be directly accountable for these frameworks, and for the frameworks to be integral to the governance arrangements for their organisations;
- appraisal of these arrangements in the key performance indicators used by the inspection agencies; and
- external inspection, for example by the Healthcare Commission or the Mental Health Act Commission.

7. Every care programme approach (CPA) care plan should have a mandatory requirement to include appropriate details of each patient's ethnic origin and cultural needs.

We accept the need for all care plans to address ethnic, religious and cultural needs appropriately. This message was included in the most recent guidance on CPA and care management, and reinforced in *Engaging and Changing*, which looks specifically at the needs of detained BME patients. We will take every opportunity to reinforce that message but the guidance is not mandatory. The Department's BME Mental Health Programme Board will consider how these issues can be reflected in any revised Code of Practice under the draft Mental Health Bill.

The Royal College of Psychiatrists has begun a number of initiatives that are relevant to best practice in care planning to further develop the cultural capability of psychiatrists (see also the response to recommendation 15).

The national census of psychiatric inpatients that the Mental Health Act Commission, in partnership with NIMHE and the Healthcare Commission, will undertake during 2005 to record the self-identified ethnicity, languages and faith of all inpatients (including those in independent and secure facilities). The results will provide important data that can serve as a backdrop for qualitative analysis of BME service user experience.

8. The workforce in mental health services should be ethnically diverse. Where appropriate, active steps should be taken to recruit, retain and promote black and minority ethnic staff.

We accept this recommendation. The mental health workforce needs to become representative of the population at all levels. NHS employers and local authorities should demonstrate equality of opportunity, and if necessary actively encourage and support people from under-represented communities to join their workforce.

The Department has already issued guidance on best practice to achieve and support an ethnically diverse workforce: *Mental Health Services – Workforce Design and Development* (February 2003). This emphasises the importance of a workforce that includes all its local BME groups, and community development workers to build relationships with BME communities.

DRE now builds on this in paragraphs 3.26 – 3.29, with action including:

- implementation within mental health services of the 10-point National Action Plan on Leadership and Race Equality in the NHS;

- action by strategic health authorities, PCTs and local authorities to embed within mental health services the Department's guidance on BME staff networks (*Improving Working Lives: Black and Minority Ethnic Staff Networks*, July 2001);
- similar action to make sure *Mental Health Services – Workforce Design and Development* is implemented locally; and
- work between the Department and the Health for Asylum Seekers and Refugees Portal (HARP) to spread good practice on the employment in the NHS of refugees and overseas workers and consider the implications for mental health services of HARP's mapping of known initiatives.

To support this the NIMHE national workforce programme has also asked the University of Central Lancashire to examine the issues influencing recruitment and retention in the mental health field. Their report includes details of the issues affecting people from BME groups and examples of best practice.

9. Under no circumstances should any patient be restrained in a prone position for a longer period than three minutes.

We accept the need to ensure that any physical intervention is used only as a last resort, in the safest way possible and for the shortest period of time that is necessary for patient and staff safety. The challenge to mental health services is to make real changes that ensure the safety of patients, and to minimise the need for physical intervention by finding better ways to prevent and manage aggression.

To help meet that challenge NIMHE has begun working with the National Patient Safety Agency (NPSA) on a programme of work, including new guidance on the management of aggression for trainers and service providers to work to. It published interim guidance In February 2004 – *Developing Positive Practice Standards to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings*. Service providers are expected to follow this now. It includes:

- restraining patients on the floor, or in a prone position, only as a last resort;
- in settings where the use of restraint is foreseeable, having in place systems that ensure immediate access to medical or paramedical assistance;
- training in the risks associated with restraint and in life support skills;
- race and cultural awareness training for all staff;

- the responsibility of NHS trust boards to monitor the management of violence, including the use of physical interventions; and
- the importance of the prevention and de-escalation of potentially violent situations.

The National Institute for Clinical Excellence (NICE) is also preparing new guidance on the short-term management of violent behaviour in inpatient psychiatric settings – *The Short-Term Management of Violence (Disturbed Behaviour) in Inpatient Psychiatric Settings* – which is expected early in 2005. NIMHE will publish its definitive guidance later in the year, reflecting feedback on the interim version and the NICE guidance.

The definitive guidance will emphasise ethnicity and cultural issues as a core theme, and the development of that theme will be supported by a group representative of a wide range of cultural and ethnic backgrounds and in liaison with NIMHE race equality leads. The management of violence programme will report regularly to the Department's BME Mental Health Programme Board.

The existing Mental Health Act Code of Practice (19.12) is clear that any restraint should be used only for as long as is absolutely necessary and be sensitive to race and gender issues. The BME Mental Health Programme Board will consider how the issues can be reflected in any revised code.

The Royal College of Psychiatrists is updating its guidance on the management of disturbed and violent behaviour in psychiatric units. It will address issues of ethnicity.

Finally, the Department will continue to lead – and receive advice from – a cross-government expert group, involving other key stakeholders, looking at the safe management of aggression. The group's activity includes consideration of the relevant ethnic and cultural issues.

10. A national system of training in restraint and control should be established as soon as possible and, at any rate, within twelve months of the publication of this report.

We accept this in principle. The NIMHE/NPSA programme of work on the management of violence and aggression, described in the response to recommendation 9, includes the development of proposals for the accreditation and regulation of trainers and training programmes. Since training alone cannot deal with all the issues, accreditation will also take account of organisational systems and

leadership to ensure the provision of safe environments. These proposals are due to be finalised this year and will include reference to cultural sensitivity in training.

In January 2004 the programme established a consultancy and advice service for trusts, individuals and higher education institutions.

The NHS Security Management Service, in conjunction with NIMHE and other key stakeholders, is developing a training programme in non-physical intervention techniques for mental health service staff. It covers prevention and de-escalation, underpinned by a legal and ethical framework. The programme will be introduced early in 2005 and will form a mandatory foundation course before training in physical intervention skills.

11. The Department of Health should collate and publish annually statistics on the deaths of all psychiatric inpatients, which should include ethnicity.

We accept this in principle. One of the three main building blocks of the *DRE* action plan is better information about what is happening in the field, including better monitoring of ethnicity.

The Confidential Inquiry into Homicides and Suicides publishes reports every five years; the next is due in 2006. It has now been extended to cover all sudden, unexplained deaths in psychiatric units. It also collects information on recent use of restraint. In addition to the regular full reports a table will be published each year showing deaths by ethnicity and gender. The first report has been submitted to the Department and will be summarised on the Confidential Inquiry website at www.national-confidential-inquiry.ac.uk

The NPSA has established a system (the National Patient Safety Reporting and Learning System) for the notification of all patient safety incidents including deaths, and will publish reviews of key themes that arise from an analysis of the incidents reported.

Research is under way on the use of observation and engagement and adverse events in inpatient settings, and data on patients' ethnicity are being collected. The research is being organised by Professor Len Bowers of City and East London University.

Paragraphs 3.130 – 3.132 of *DRE* go into more detail.

12. All medical staff and registered nurses working in the mental health services should have mandatory first-aid training, including CPR training.

We accept that nursing and medical staff should have up-to-date resuscitation training. The interim guidance on the management of violence and aggression published by NIMHE in February 2004 states that all staff who may be involved in restraint must be trained in:

- basic life support skills (and attend annual updates);
- the physical risks associated with restraint, e.g. positional asphyxia, sudden collapse;
- recognising the conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and how to take appropriate action;
- the use of emergency equipment; and
- knowing how to summon appropriate assistance.

These points are expected to be reinforced in the forthcoming NICE guidance on the short-term management of violence in psychiatric inpatient settings described in the response to recommendation 9, and we will communicate the message clearly to mental health service providers.

The Resuscitation Council's guidelines provide a useful benchmark for services and make it clear that all hospital staff who have contact with patients should have regular training that is in line with their role and ability.

13. Records should be kept of all psychiatric units' use of control and restraint on patients. The Department of Health should audit the use of control and restraint.

We accept this. We recognise the importance of careful monitoring and management of the use of physical intervention as part of a wider strategy on managing violence in mental health settings.

NIMHE's interim guidance – *Developing Positive Practice Standards to Support the Safe and Therapeutic Management of Violence and Aggression in Mental Health Inpatient Settings* (February 2004) – is clear on the need for local monitoring of physical intervention, and trusts are expected to implement that guidance now. The definitive guidance to be published this year will include further advice on local data collection and good practice. The current Mental Health Act Code of Practice also states that every episode of intervention should be documented and reviewed.

To help establish a national picture this year's census of all psychiatric inpatients will include questions about the use of physical intervention, including seclusion. The census will be repeated in future years. Monitoring and managing physical intervention will also be a feature of the Focused Implementation Sites for the implementation of *DRE*.

14. There is an urgent need for a wide and informed debate on strategies for the care and management of patients suffering from schizophrenia who do not appear to be responding positively to medication and we recommend that the Department of Health monitor this debate in order to ensure that such strategies are translated into action at the earliest possible moment.

We accept this. The Royal College of Psychiatrists takes the lead on issues of clinical practice. The College is currently updating its guidance on the prescription of antipsychotic medication, and it will address issues of ethnicity. NICE has produced guidance on the management of schizophrenia – *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care* – which includes advice on the management of treatment-resistant disorders.

The Department will co-operate with the College on this and other issues affecting BME groups. It will monitor the debate and is developing information to support the commissioning of specialist mental health services, including services for people with treatment-resistant disorders. This information is due to be published this year.

15. All medical staff in mental health services should have training in the assessment of people from the Black and minority ethnic communities with special reference to the effects of racism upon their mental well-being.

We accept this. The response to recommendations 1 – 3 sets out comprehensive proposals for delivering a more culturally capable workforce in NHS mental health services.

In addition, this year's national census of psychiatric inpatients will help to identify ways in which services can be made more responsive and appropriate. The lessons will be incorporated into training programmes developed by NIMHE.

The Royal College of Psychiatrists has an important role. Its revised guidance on good psychiatric practice lists capability in anti-discriminatory practice and cultural capabilities among the basic skills that psychiatrists require. The College is

undertaking a number of initiatives to develop psychiatrists' cultural capability further:

- changes to its membership examinations curriculum and examination questions to include relevant and effective cultural capability questions;
- a cultural capability training manual for trainees; and
- encouraging College members to include cultural capability in their continuing professional development.

16. **All patients in the mental health services should be entitled to an independent NHS opinion from a second doctor of their choice, in order to review their diagnosis and/or care plan. If a patient, by reason of mental incapacity, is unable to make an informed decision, their family should be entitled to make it for them.**

We accept this in principle. The Department of Health's position is that accepting a patient's request for a second opinion is standard good practice, and a request should never be refused without good reason. Similarly, a request from a patient's family should be met as long as it does not conflict with the patient's interests.

DRE offers new support to BME patients seeking a second opinion. Paragraph 3.44 states that PCTs should make sure that BME service users and carers are aware of their choices in requesting a second opinion and are supported in making those choices.

Paragraph 3.63 describes proposals for a new independent mental health advocacy service for people detained under formal powers, which will offer patients help in understanding their treatment and their rights. The advocates will be drawn from a wide range of backgrounds to reflect the communities they work with, and it will be important that they are trained in cultural and diversity awareness.

In the particular instance of detention under the Mental Health Act, a patient cannot be given medication against their will without the authorisation of a second opinion doctor. Under the proposed Mental Health Bill, any detention beyond 28 days will be independently authorised by the Mental Health Tribunal, which will be advised by an independent medical expert.

The Royal College of Psychiatrists' revised guidance on good psychiatric practice states that psychiatrists should respect a patient's wish for a second opinion.

17. The question of detention in and treatment of patients in secure accommodation should be reconsidered in order to ensure that no patient is detained in such accommodation unless it is necessary, and that the period of each detention and the treatment be kept constantly under review.

We accept that patients should be cared for in the lowest level of security consistent with their needs and the need to protect others. Risk assessment and the development of risk management plans are integral to care planning. The regular review of care plans should include a review of the necessary level of security.

Paragraph 3.61 of *DRE* states that NIMHE will work with the Royal College of Psychiatrists and the Royal College of Nursing to make sure that clinical decisions about levels of restriction are kept under review.

The development of services in line with the National Service Framework for Mental Health (1999) and the NHS Plan is improving access to the most appropriate services in the most suitable settings. The development of assertive outreach and crisis resolution teams is also helping to reduce avoidable admissions. The NHS Plan includes a commitment to moving up to 400 inappropriately placed patients out of high-security hospitals and creating 200 long-term secure beds. The resulting service developments are helping to make sure that patients are accommodated in the level of security that is right for them at any given point in time.

The Royal College of Psychiatrists is updating its guidance on treatment in secure settings, and it will address issues of ethnicity.

The Department is funding research into alternatives to inpatient care that will collect data on ethnicity.

18. The Department of Health should examine, with the Department of Social Security, modifications to state financial assistance so that patients do not leave residential hospital care in order to obtain adequate financial assistance from the state.

We accept this in principle. Benefits such as Income Support, Incapacity Benefit or Housing Benefit are not downrated until a person has been a hospital inpatient for a year. The 52-week period must be continuous (unless the person is readmitted within 28 days of a previous stay in hospital, in which case the two periods are combined).

In 2002/03 (the last year for which we have figures) the mean length of stay of patients in mental illness specialties was 54 days, the median length of stay was

19 days, and only 1.7 per cent of discharged mental health inpatients had lengths of stay that exceeded 52 weeks. Nevertheless, the Department for Work and Pensions, with the Department of Health, will look at ways of focusing extra support if there is evidence that patients' recovery is being hampered by the existing provisions.

The Government is addressing wider issues arising from the benefits system. In June 2004 the Social Exclusion Unit (SEU), in partnership with NIMHE, published *Mental Health and Social Exclusion,* which addresses the impact of the benefits system on opportunities for social participation and access to services. The SEU has also published a related fact sheet – *Mental Health and Welfare Benefits* – aimed at service users and providers.

19. All psychiatric patients and their families should be made aware that patients can apply to move from one hospital to another for good reason, which would include such matters as easier access by their family, a greater ethnic mix, or a reasoned application to be treated by other doctors. All such applications should be recorded. They should not be refused without providing the applicant and their family with written reasons.

We accept this in principle. Every such request should be considered carefully and receive a reasoned response that takes into account the needs of the service user and their assessed best interests. A BME patient's wish to be closer to their family, or to be cared for in a more ethnically mixed environment, should be listened to, recorded and met unless there is a good reason not to meet it. It is good practice for refusal to be explained in writing.

These messages will be communicated and repeated over the coming months as *DRE* is implemented. The Race Relations (Amendment) Act and our agenda for greater patient choice in health care will both help to reinforce this.

DRE also includes action to enhance primary care and community care for mental health patients (paragraphs 3.46 – 3.57), helping to minimise the need for hospitalisation. Paragraphs 3.59 – 3.60 describe how volunteers from BME groups can help to befriend, support and advise inpatients, and states that wherever possible inpatients should have access to staff of the gender of their choice, a culturally appropriate environment and advocacy.

20. There is a need to review the procedures for internal inquiries by hospital trusts following the death of psychiatric patients, with emphasis on the need to provide appropriate care and support principally for the family of the deceased, but also for staff members.

We accept this. The Department has reviewed procedures for independent inquiries and will publish revised guidance this year.

In conjunction with this new guidance the NPSA will publish an information pack to help services establish investigations in the most effective way. This will include guidance on the provision of support and information to both the family of the deceased and staff members. It will recognise the importance of NHS trusts keeping family members informed and supported as fully and promptly as possible. Much of this guidance will be relevant in investigation of any patient safety incident, whether or not this leads to an independent investigation.

The NPSA is also rolling out training in root cause analysis, a technique for the conduct of investigations into patient safety incidents. This will help to develop a transparent and learning-oriented process for all investigations.

21. There is a need for medical personnel caring for detained patients to be made aware, through appropriate training, of the importance of not medicating patients outside the limits prescribed by law, and of the need for more regular and effective monitoring to support the work undertaken by the Mental Health Act Commission in this field.

We recognise and accept the responsibility of individual clinicians to act in the interests of their patients and to be aware of current guidance and best practice. The Department of Health will continue to work with the Royal College of Psychiatrists on key clinical issues affecting BME groups, including those related to prescribing.

Neither the Mental Health Act nor the draft Mental Health Bill prohibit doctors from prescribing beyond a product licence if it is in the patient's interest; but the NICE guidance is to keep dosages of antipsychotic drugs as low as possible, and that it is undesirable to use more than one at a time.

The Medicines and Healthcare products Regulatory Agency (MHRA) is an executive agency of the Department of Health. It protects and promotes public health and patient safety by ensuring that medicines are effective and safe and used safely. The MHRA continually reviews the safety of antipsychotic medicines and will take all necessary regulatory action to minimise any risks.

22. **It is vital to ensure that the findings and recommendations of this inquiry inform all relevant parties, including the developing black and minority ethnic mental health strategy.**

We accept this. The importance that the Government places on the inquiry's findings is reflected in the decision to publish the *DRE* action plan and our response to the inquiry together, and to make them available to everyone with an interest in planning and delivering services. The action arising from both components will form a coherent programme for improving mental health care for BME communities and others. The links between the two components will continue, as the Department's BME mental health programme board is responsible for overseeing the action arising from both.

Unnumbered recommendations

(a) **There should always be a fully equipped resuscitation trolley whenever a mentally ill patient is detained and people available at all times who are trained in the use of the equipment upon it.**

We accept the need for nursing and medical staff to have access to appropriate resuscitation equipment and will reiterate that message to service providers. This is likely to be reinforced in the forthcoming NICE guidance described in the response to recommendation 9.

The Resuscitation Council's guidelines provide a useful benchmark for services and state clearly that appropriate equipment should be available throughout the hospital.

(b) **The Inquiry notes that coroners make recommendations from time to time and proposes that those recommendations should be monitored and collated centrally.**

We accept the need for the system to be made more robust. In March 2004 the Government published *Reforming the Coroner and Death Certification Service – A Position Paper*. This proposes giving coroners new powers to undertake targeted further investigations (for example into deaths at a particular hospital or care home), and strengthening the lines of responsibility between coroners and agencies such as the Healthcare Commission and the Commission for Social Care Inspection.

(c) We recommend further research is necessary to find out why such a diagnosis (drug-induced psychosis) continues.

We accept this in principle. The issue of drug-induced psychosis is a complex one. We accept the importance of robust research to inform clinical practice and policy. Diagnosis is a matter of clinical judgement, and therefore the Royal College of Psychiatrists also has an interest in this area. The Department of Health will continue to work with the College on key clinical issues affecting BME groups, including those related to diagnosis.

Research indicates that some drugs, including cannabis, especially in high doses, can produce psychotic breakdown in individuals with no history of severe mental illness, and that symptoms of schizophrenia may be exacerbated by drug use in those with the illness. We recognise that while a direct causal link between early cannabis use and the later development of schizophrenia has not been proved conclusively, recent research shows a stronger association than was previously evident. The Department will ensure that research in this area is monitored and will listen to a range of external expert advisers.

Terms such as 'drug-induced psychosis' are agreed internationally to inform recognised classification systems, such as the World Health Organisation ICD-10 system. These systems assist clinicians in classifying disorders and provide guidance on distinguishing between drug-induced psychotic disorders and acute intoxication or schizophrenia, but the boundaries are not always clear-cut and clinical judgement is necessary. A classification such as 'cannabis-induced psychotic disorder' does not imply a particular pathophysiological mechanism and does not rule out a pre-existing vulnerability to psychosis. Classification systems are reviewed to reflect new evidence and understanding

Our responses to recommendations 1 – 3 and 15 address the need for all staff, including medical staff, working in mental health services to be trained in cultural capability, which has a bearing on issues of diagnosis.

(d) We recommend that there should always be a doctor in every place where a mentally ill patient is detained, or if that is not possible, foolproof arrangements should be in place twenty-four hours a day, that a doctor will attend within twenty minutes of any request by staff to do so.

We accept that appropriate medical cover is vital, and we will repeat that message to service providers, but precise arrangements must be decided locally in the light of local circumstances.

Individual commissioners and providers of services should make completely sure that appropriate medical cover is always available, and that there is a clear understanding about procedures for dealing with medical emergencies.

We believe it is also important to minimise the need for emergency medical intervention. The programme of work on the therapeutic management of violence and aggression (outlined in the response to recommendation 9) emphasises the prevention of violent incidents.

3. Delivering race equality – the action plan

3.1 This document is an action plan. It does not review the evidence of the need for action – this was set out clearly in *Inside Outside* and the *DRE* framework. It also supports the implementation of the ten-point race equality action plan for the NHS that Sir Nigel Crisp published in February 2004.

3.2 The two key components of implementation are the Black and minority ethnic (BME) mental health programme delivered by the National Institute for Mental Health in England (NIMHE) and the Department of Health's wider BME programme.

3.3 The action plan is in four parts. Parts one to three describe the action that needs to be taken around each of the three key building blocks identified in the *DRE* framework.

3.4 Each of parts one to three is summarised at the end in a table setting out the main headline objectives of the building block, and the actions needed to reach those objectives are divided into:

- existing requirements – action that organisations should be taking already to comply with legislation and existing guidance;
- 'working differently' – where existing activity needs to be done differently to be culturally sensitive, but not in ways that should impose a significant new burden;
- national action – what national bodies such as the Department of Health and NIMHE need to do to support reform; and
- new local action – what more is required locally to ensure rapid progress towards compliance with core standards and legislation.

3.5 Part four describes the next steps, including the governance framework, monitoring, and action needed to support the roll-out of the action plan.

Overview

The three building blocks

Appropriate and responsive services

3.6 To make sure that we improve the direct clinical care of all BME groups, we need action to:

- develop organisations so that they offer high quality, non-discriminatory and recovery-oriented healthcare;
- develop a workforce that can deliver equitable care to BME populations;
- improve clinical services for BME populations; and
- improve services for specific populations, including older people, asylum seekers and refugees, children and young people.

Engaged communities

3.7 The actions needed (inside and outside mental health services) to give BME communities genuine opportunities to influence mental health policy and provision, and to promote mental health and recovery, include action to:

- help build healthier communities; and
- engage communities, build capacity, deliver services and facilitate change in local mental health service economies.

Better information

3.8 To make sure that we have better information on service use and needs, and knowledge of recovery-enhancing environments and approaches, we need action to:

- improve the monitoring of ethnicity and mental health service use;
- improve the analysis and dissemination of information; and
- improve the knowledge available on effective services and evaluate the impact of this action plan.

Next steps

3.9 We need a performance framework that can deliver better and more culturally appropriate, clinically effective and recovery-oriented care for BME communities, as well as demonstrate how the different initiatives will produce those improvements.

3.10 Many different organisations will need to be involved in delivering the programme, reflecting the complex nature of mental health service development.

Appropriate and responsive services

3.11 The inequality in the treatment and outcome of mental illness for BME groups has already been well documented. Despite this, service development has been slow and erratic.

3.12 Equity in services requires widespread, co-ordinated change across the whole system of care. *DRE* pulls together policies, strategies, guidance and research and development projects produced by the different partners involved in the complex process of service delivery. Together they can deliver more appropriate and responsive services for BME communities.

Action to develop organisations

National leadership

3.13 Strong, committed and senior leadership is essential to the delivery of real and sustained reform. Sir Nigel Crisp, the Chief Executive of the NHS, is directing an overall national action plan on leadership and race equality. His message is clear – top leaders must take personal responsibility for achieving race equality.

3.14 That was reinforced by the appointment of Surinder Sharma as the first NHS Equality and Human Rights Director, to act as Sir Nigel's adviser and champion the equality agenda throughout the health service in England. A key element of his work will be to help the NHS tackle the disadvantage experienced by BME groups in accessing appropriate care.

3.15 Surinder Sharma and Louis Appleby, the National Director for Mental Health, will champion the modernisation of mental health services, including the system-wide changes needed to meet the needs of people from BME groups.

3.16 Professor Kamlesh Patel, the National Director of the Department of Health's BME Mental Health Programme, will lead the work. He will co-operate with the Commission for Racial Equality (CRE), the Healthcare Commission and other national organisations to raise the profile of the *DRE* action plan and support its implementation.

3.17 A new national director will manage NIMHE's extensive BME programme. The director will also lead in promoting BME issues across the Care Services Improvement Partnership, of which NIMHE will be a part from April 2005. This is a senior post that positions BME issues at the highest level of the organisation.

Regional leadership

3.18 New regional race equality leads will provide local leadership for the Department of Health and NIMHE BME programmes, including this action plan. They will develop and implement race equality within NIMHE and regional and local services, as well as providing leadership and mentoring to community development workers in their areas. They are accountable to the director of the NIMHE development centre in which they work and to the national director of the BME Mental Health Programme. Each of the eight NIMHE regions now employs a race equality lead, with two in London. They will have an important role in the selection of Focused Implementation Sites for *DRE* – work on this has already started in north-west England.

Racism, discrimination and harassment

(See also the response to recommendation 6 of the independent inquiry into the death of David Bennett – page 24.)

3.19 Discrimination in the NHS is unacceptable in any form – it contradicts the basic value of equity that the health service is built on. Everyone who experiences mental ill health is entitled to a safe and clinically effective, recovery-enhancing environment that respects their beliefs, culture, faith, spiritual needs, background and values.

3.20 Nevertheless, discrimination still exists. Failure to recognise and deal with racism, discrimination or harassment on any level is always a serious failing – and can have disastrous consequences. The inquiry into David Bennett's death shows how racial harassment contributed directly to the events leading to the tragic death of a young man in the care of the NHS.

3.21 Harassment can also be more subtle and not obviously linked with race or culture, but still needs to be tackled competently and with care. Local racial harassment policies should explicitly address how to manage staff-to-staff, service user-to-service user, staff-to-service user, and service user-to-staff incidents. The Department of Health guidance *No Secrets* sets out adult protection policies and procedures for vulnerable adults, including processes to address racism and racial harassment.[5]

5 www.dh.gov.uk/assetRoot/04/07/45/40/04074540.pdf

3.22 All NHS organisations and their management teams must comply with the Race Relations (Amendment) Act 2000 and other relevant legislation. This means that local managers need strong plans and policies to ensure compliance and maintain safe and healthy environments.

3.23 In particular, each organisation (and discrete components within organisations) must now have an active race equality and cultural capability framework and plans for action. These should be managed at a senior level – not left to subgroups that are too poorly resourced and weakly positioned to have an impact on the organisation. Chief executives are directly accountable for progress, and the plans should be integral to organisations' governance frameworks. NHS organisations are expected to review their existing race equality schemes and be ready to publish new ones by May 2005.

3.24 Key performance indicators used by the inspection agencies will reflect an appraisal of these procedures and practices. For example, do serious untoward incidents, violent incident reports and safety measures take into account possible racial and cultural issues? This kind of information should be available for external inspection, for example by the Healthcare Commission, the CRE or the Mental Health Act Commission.

3.25 The Healthcare Commission and the Commission for Social Care Inspection will develop arrangements for promoting safer inpatient and therapeutic environments for people with mental health problems.

Action to develop the workforce

3.26 A workforce needs the right skills before it can deliver equitable and effective care to all groups of society.

Recruiting and supporting a diverse workforce
(See also the response to recommendation 8 of the independent inquiry into the death of David Bennett – page 25.)

3.27 The workforce in mental health services, like that in other NHS and local authority services, should be representative of local BME groups. The NHS needs to demonstrate equality of opportunity to join its workforce, and to support people from under-represented communities through appropriate training and professional development programmes.[6]

6 Department of Health. *Mental Health Services – Workforce Design and Development: Best Practice Guidance*, February 2003.

3.28 Active and well-supported BME staff networks can help to address the social exclusion of BME communities and ensure that the people who are being encouraged to join service providers are not themselves disenfranchised and subject to discrimination. Primary care trusts (PCTs) and local authorities should integrate Department of Health guidance on BME staff networks, including expertise by experience, into mental health services.[7]

3.29 The Department will implement the national action plan on leadership and race equality in the NHS.[8] It will also work with the Health for Asylum Seekers and Refugees Portal (HARP) and other agencies to disseminate good practice in the employment of refugees and overseas workers in the NHS, and to consider the potential of HARP's mapping of recruitment initiatives for overseas/refugee health professionals.

Delivering a more culturally capable workforce
(See also the response to recommendations 1–3 of the independent inquiry into the death of David Bennett – page 21.)

3.30 *Inside Outside*, its consultation responses, the Mental Health Act Commission and the inquiry into David Bennett's death have all highlighted the need for improvements in the ability of mental health staff to deal with different racial and cultural groups.[9]

3.31 Nationally, NIMHE is working with the Sainsbury Centre for Mental Health (SCMH) to map current education and training provision for mental health services. This will identify training needs, good practice and positive local initiatives.

3.32 NIMHE will also develop a common skills set for mental health practitioners, including the need to be trained in cultural capability and to provide care in a culturally appropriate manner. NIMHE, with the Training Organisation for Personal Social Services, will work to ensure that all the involved professions understand the racial and cultural needs of people from BME communities. They will collaborate with professional bodies to establish a common framework of cultural capability that is feasible and clinically effective.

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7 Department of Health. *Improving Working Lives – Black and Minority Ethnic Staff Networks: Guidance,* July 2001.

8 NHS Modernisation Agency Leadership Centre. *Leadership and Race Equality – Mentoring Guidelines*, March 2004.

9 Sainsbury Centre for Mental Health. *National Visit 2: Improving Care for Detained Patients from Black and Minority Ethnic Communities*, April 2000.

3.33 The NHSU (which will become the NHS Institute for Learning, Skills and Innovation in 2005) will help to address learning needs. Its initial focus will be on:

- the 10 essential shared capabilities programme described below;
- a race equality and cultural capability programme; and
- workshops and toolkits that establish organisational readiness to deliver this type of training.

3.34 Locally, PCTs and local authorities should make sure that mental health service providers have identified the learning and development that all their staff – including the new support, time and recovery workers[10] and graduate and 'gateway' workers[11] – need to deliver a service in line with national policies. That could include training in the religious, cultural and linguistic requirements of people from BME groups, and in care and recovery planning, needs assessment, discharge planning and community engagement with BME communities.

3.35 Within mental health trusts and PCTs, professional bodies and governance structures should plan and manage individuals' personal progress towards cultural capability, for example through appraisal and continuing professional development.

3.36 To back all this up, strategic health authorities (SHAs) and the Healthcare Commission will ensure that cultural capability and race equality are reflected in performance indicators.

The 10 essential capabilities

3.37 Local cultural capability frameworks should complement the 10 essential capabilities for mental health practice launched in 2004 by the Department of Health. These capabilities, which strike a balance between value-based practice and evidence-based practice, are:

- working in partnership;
- understanding and respecting diversity;
- practising ethically;
- challenging inequality;

10 Department of Health. *Mental Health Policy Implementation Guide – Support, Time and Recovery (STR) Workers*, January 2003.

11 Department of Health. *Fast-forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers*, January 2003.

- promoting recovery;
- identifying people's needs and strengths;
- providing service user-centred care;
- making a difference;
- promoting safety and positive risk taking; and
- personal development and learning.[12]

Action to improve clinical services

3.38 Action is already being taken to improve the care of BME patients with mental health problems. The policies, strategies and guidance that are described or referred to in this document are all direct responses to the need for equity of specific populations.

Clinical governance

3.39 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. Local clinical governance arrangements therefore offer not only an opportunity to tackle inequalities but a framework for developing local improvement targets.

3.40 Organisations should have information capable of being analysed by ethnicity on factors such as admission rates, Mental Health Act orders, diagnosis, the use of seclusion, physical interventions and medication. If an organisation finds, for example, that average doses of anti-psychotic medication are higher for African-Caribbean men, or that novel anti-psychotic prescribing is lower, it should investigate why. If there is no clinical reason for the variation, then the organisation should act to reduce it.

Improving pathways to recovery

3.41 Ethnicity and culture need to be reflected in assessment, diagnosis, risk management and care planning, including decisions about the most appropriate location of care – it is common for BME communities to assume that their mental health care will be delivered by only specialist or inpatient mental health services.

12 Department of Health. *The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce*, August 2004. www.dh.gov.uk/assetRoot/04/08/71/70/04087170.pdf

3.42 Providing equitable care pathways means offering diverse routes to recovery, not just a single, predetermined pathway. More equitable pathways will improve inpatient, outpatient and community treatment environments. They include primary care, complementary treatment, and more flexibility in moving from the community to mental health care and back to the community.

3.43 To begin responding to these needs, NIMHE has commissioned a project on improving BME mental health care pathways. It will be carried out by the Centre for Health Improvements in Minority Ethnic Services (CHIMES), which is a collaboration between the Royal Free and University College Medical School and St Bartholomew's and The London School of Medicine at Queen Mary. The project will:

- demonstrate that pathways into mental health care can be modified by using local knowledge, peer support services, and voluntary sector expertise;
- identify and show how to overcome barriers to a care and recovery pathways approach;
- summarise a recommended learning process for trusts trying to improve pathways for BME groups;
- implement pathway interventions in four sites, bringing together all the elements of the programme in those sites;
- examine inpatient, community, voluntary sector, forensic and primary care interfaces; and
- use the information from the project, the experience of change management and the capacity generated to engage PCTs, SHAs, localities and the non-statutory sector in other sites.

3.44 Following guidance from the National Institute for Clinical Excellence, PCTs should help to establish agreements about pathways for individual service users by ensuring that service users and carers from BME communities are aware of, and supported in, their choices when seeking a second opinion on their diagnosis. (*See the response to recommendation 16 of the independent inquiry into the death of David Bennett – page 31.*)

3.45 The NIMHE/CHIMES project will offer whole system change. Other projects focus on specific treatment levels – community care, primary care, inpatients or forensic services. The following sections address each of these levels.

Community care

3.46 *Inside Outside* highlighted the independent sector's potential to help tackle inequalities of access, but the sector can still be neglected in commissioning processes.

3.47 The direct payment approach can help to fulfil the independent sector's potential and deliver more individual and culturally appropriate care provision. Direct payments allow individuals to pay for community care services that best meet their needs, and local authorities are now required to make direct payments to those who are eligible and want them.

3.48 The take-up of direct payments by people with mental health problems has been slow.[13] To respond, NIMHE will work with service providers to encourage more use of direct payments within BME communities.

3.49 NIMHE will co-operate with the independent sector to disseminate a new guide for BME service users and carers that highlights how direct payments can help to meet their needs. To support this, the Social Care Institute for Excellence will identify and disseminate good practice examples by the end of 2005.

3.50 By the end of 2005, the Department of Health will review the exclusion from direct payments of people absent from hospital on leave under section 17 of the Mental Health Act 1983.[14]

3.51 PCTs and local authorities, with NIMHE's support, should also review the implementation of existing guidance on community mental health teams[15] to make sure that they work in partnership with family members and other local agencies and involve them in discharge planning. Joint treatment approaches help to involve both inpatient and community staff and encourage continuity between the two sectors of care.

Primary care

3.52 Nine out of ten people with mental health problems are treated in primary care. This puts PCTs in a unique position to influence the delivery of services.

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13 Office of the Deputy Prime Minister. *Mental Health and Social Exclusion – Social Exclusion Unit Report*, June 2004.

14 Statutory Instrument 2003 No. 762. The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003.

15 Department of Health. *Mental Health Policy Implementation Guide – Community Mental Health Teams*, June 2002.

3.53 NIMHE will support PCTs in identifying practical steps to increase and encourage earlier access to care, including the appointment of community development workers. They, the new primary care mental health graduate workers/gateway workers and primary care mental health teams should help to create services that:

- promote culturally capable, non-discriminatory, primary care mental health services;
- build links with BME communities, including faith organisations, support networks, service users and carers;
- provide a choice of location to see professionals, including community settings; and
- provide information about sources of support, including appropriate national and local BME voluntary and community organisations.

3.54 PCTs should also review the potential of creating new pathways to referral, such as community self-referral points and confidential community helplines.

3.55 PCTs should make sure that carers, families or advocates of patients from BME groups are involved in care and recovery planning processes, and that plans include service users' perspectives of their needs. Everyone involved must take into account that decisions made during care planning can have a lifetime impact on the service user.

3.56 PCTs need to consider how their commissioning and inspection processes reflect the mental health modernisation programme. Frameworks for commissioning services should address how to ensure governance of best clinical practice in voluntary sector providers without constraining innovation, and how to encourage innovation in the statutory sector where safety and clinical effectiveness are the key commissioning priorities.

3.57 NIMHE and the National Primary Care Development Team will support local action by gathering and disseminating examples of good practice in access to primary care mental health services.

Inpatient care

3.58 The independent inquiry into the death of David Bennett demonstrated the need to improve acute inpatient services. PCTs and specialist mental health trusts should implement guidance on the modernisation of acute mental health care[16] in ways that provide responsive and appropriate services for people from BME groups.

16 Department of Health. *Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision*, April 2002.

3.59 Services cannot be responsive and appropriate unless the providers and commissioners of those services make sure that BME inpatients have access to:

- staff of the gender of their choice, wherever possible;
- accommodation, washing and living space facilities that take into account different cultural and gender definitions of ordinary social behaviour, dignity and respect; and
- culturally appropriate facilities relating to, for example, diet and personal hygiene.

3.60 To complement and enhance those services, PCTs and service providers should provide structured opportunities for appropriately trained, remunerated and supported people (including volunteers from BME groups and faith groups) to become involved on wards, for example as support, time and recovery workers[17] and by befriending and advising patients. Community development workers will also help to develop supportive links between inpatient wards and community organisations.

3.61 To help make sure that services for BME inpatients are appropriate, NIMHE will work with the Royal College of Psychiatrists, the Royal College of Nursing and others to ensure that clinicians carry out ongoing reviews to make sure that patients are cared for in the least restrictive environment that is consistent with their needs and safety.

3.62 Providers and commissioners should also make sure that there are culturally and linguistically appropriate independent advocacy services, if necessary using strategies such as joint commissioning to ensure adequate investment and coverage.

3.63 The draft Mental Health Bill (2004) provides for independent Mental Health Act advocacy to be available to everyone treated under powers of compulsory detention, and to the nominated person appointed to help them. The advocate will help patients (and nominated persons) to obtain and understand information about:

- their medical treatment;
- the legal authority under which they are detained;
- which requirements of the Act apply to their treatment; and
- their rights and how to exercise them – for example, by applying to the tribunal for discharge.

17 Department of Health. *Mental Health Policy Implementation Guide – Support, Time and Recovery (STR) Workers*, January 2003.

3.64 Patient Advice and Liaison Services, which are already established in all care trusts, should make sure they are linguistically and culturally equipped to provide advice on the independent advocacy and support services that are available locally.

3.65 In 2005, the Department for Constitutional Affairs and the Legal Services Commission will pilot new arrangements for the delivery of legal advice to people with mental health problems. This will concentrate on easier access to advice services (such as Citizens Advice Bureaux and law centres) both during a stay in hospital and in the community. The project will include a focus on the needs of users from BME groups.

3.66 The National Patient Safety Agency will support improvements to inpatient care with advice on creating a safer environment on acute psychiatric wards, helping to reduce the risk of suicide, self-harm, aggression, and sexual or racial harassment. *(See also the response to recommendations 9 and 10 of the independent inquiry into the death of David Bennett – page 26.)*

Forensic services

3.67 People from BME communities often follow more coercive and complex pathways to specialist care, including higher referral rates from the criminal justice system. Some BME communities have higher rates of initial contact with the police and other forensic services than the general population. However, this does not seem to be reflected in a higher incidence of violence before admission.

3.68 NIMHE will support the Association of Chief Police Officers (ACPO) in its review of post-qualification training in mental health. This will help to ensure that the training addresses racial and cultural capabilities. The review is expected to be completed in June 2006 and the roll-out of the training should begin by June 2007.

3.69 PCTs should develop plans, agreed with local criminal justice agencies and in consultation with local BME voluntary and community organisations, for early identification and diversion to mental health services from the criminal justice system. These diversion schemes will need to be culturally capable so as not to lead to discriminatory practice.

3.70 NIMHE will work with the Prison Service and others on implementing the national strategy for modernising mental health care in prisons[18] to ensure that it delivers results for all prisoners, including the 20 per cent from BME groups.

18 Department of Health, HM Prison Service, National Assembly for Wales. *Changing the Outlook – A Strategy for Developing and Modernising Mental Health Services in Prisons*, December 2001.

3.71 PCTs will ensure that, by the end of 2006, NHS mental health in-reach services are available in every prison (with 300 extra in-reach staff in addition to the 300 appointed by 2004).

3.72 The National Offender Management Service (NOMS), which brings together prison and probation services, will work with the Home Office, NIMHE and voluntary sector agencies such as Nacro to review the arrangements for releasing mentally disordered prisoners. NOMS will ensure that probation officers are trained in mental health awareness, building on the programme currently being delivered to prison staff.

Action to improve services for specific populations

3.73 *DRE* represents a very significant component of the Department of Health's wider programme of work on BME mental health issues, but it is only one component. The wider BME programme is itself part of wider programmes on inequalities and social exclusion within the Department and across government.

3.74 This action plan and other strategies for improving clinical care should make a positive difference for all BME groups. Nevertheless, there are groups who would benefit from additional programmes of work designed specifically around them. Further action is needed in these areas and the following sections mark only the start of a process of development that will form an important part of the BME mental health programme.

Refugees and asylum seekers

3.75 Refugees and asylum seekers face particular barriers to accessing and using mental health services. As well as experiencing the issues associated with the BME groups to which they belong, refugees have often been exposed to severe physical and psychological trauma as a result of war, imprisonment, torture or oppression. In their new host country they can then experience social isolation, homelessness, language difficulties, hostility and racism, all of which are strong predictors of poor mental health.

3.76 The Department is building on existing knowledge in this area by developing a resource pack linked to the equality framework. This will help service commissioners and health practitioners to meet the needs of refugees and asylum seekers.

3.77 NIMHE will ensure that the 80 community engagement projects that are part of its BME Mental Health Programme include projects for refugees and asylum seekers. NIMHE will also co-operate with HARP to ensure that services are aware of its new

mental health and well-being website, at www.mentalhealth.harpweb.org.uk, which was developed with funding from the Department. The site includes useful tools for health professionals and voluntary agencies who work with refugees and asylum seekers.

Older people

3.78 Older people can be marginalised in society, and older people from BME communities can face additional barriers to appropriate and effective services. Some of these barriers are specific to older people with mental health problems, others to the particular circumstances of minority groups.

3.79 For instance, some older people from BME groups have specific communication difficulties that limit the usefulness of written material in their own language. In addition, the higher risks of physical and mental health problems among specific racial and cultural groups requires more complex and seamless packages of care that address service users' needs holistically.

3.80 PCTs and local authorities should make sure that all mental health services take account of the language and interpretation needs of older people from BME groups.

3.81 Standard seven of the National Service Framework (NSF) for Older People requires PCTs to ensure that every general practice is using an agreed protocol to care for patients with depression or dementia. PCTs need to acquire BME age-specific expertise to help them develop services that are responsive and appropriate to the needs of older people from BME communities.

3.82 To support PCTs in this, NIMHE will work with organisations including the Policy Research Institute on Ageing and Ethnicity,[19] Age Concern and the Alzheimer's Disease Society to disseminate good practice in working with BME older people with dementia and other mental health problems, and with their carers.

Children and young people

3.83 Mainstream child and adolescent mental health services (CAMHS) are not meeting the needs of BME children and young people.[20] Not all CAMHS are commissioned with the needs of BME children and their families in mind. There are a number of issues, including a lack of basic ethnic monitoring data, a workforce that does not reflect the diversity of the population it serves, and a failure during assessment and treatment processes to meet the needs of a diverse population.

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19 www.priae.org/ (Patel N, Mirza N et al. *Dementia Matters – Ethnic Concerns*, 1999.)

20 Social Services Inspectorate, *Excellence not Excuses*.

3.84 Information from needs assessment is sparse, and the difficulties in producing good quality cross-cultural research brings into question the accuracy of available research data.[21,22,23]

3.85 The NSF for Children, Young People and Maternity Services (2004) includes a number of expectations and recommendations regarding the needs of BME communities, including refugees and asylum seekers. For example, standard nine makes specific recommendations on enhancing partnerships with BME groups.

3.86 The NSF will have a significant impact on the care of BME children and their families. In addition, NIMHE and the National CAMHS Support Service (NCSS) are working together on a number of key projects to bring about further change within child and adolescent mental health services.

3.87 Specific arrangements are necessary to address the needs of refugee and asylum seeking families, including children and young people. PCTs and local authorities should ensure that directories of services for BME groups are available to help children, young people and their families to receive appropriate support.

3.88 NIMHE and NCSS will support and promote good practice within CAMHS via their websites and through the use of the NIMHE Knowledge Community. They will identify a number of community development 'early implementer' sites across the country, which could employ BME community development workers to help bridge the gap between local CAMHS and the BME communities they are there to serve.

3.89 NIMHE will work with other partners in the statutory and non-statutory sectors to support mental health services in improving their ability to respond to the needs of this group.

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21 Bhopal R. 'Is Research into Ethnicity and Health Racist, Unsound, or Important Science?', 1997. *British Medical Journal*, 314: 1751.

22 Chatruvedi N. 'Ethnicity as an Epidemiological Determinant – Crudely Racist or Crucially Important?', 2001. *International Journal of Epidemiology*, 30: 925-7.

23 Ramcahndani P. 'The Epidemiology of Mental Health Problems in Children and Adolescents from Minority Ethnic Groups in the UK.' In Malek M and Joughin C (ed). *Mental Health Services for Minority Ethnic Children and Adolescents*, London: Jessica Kingsley, 2004.

Summary of actions for appropriate and responsive services

	Developing organisations	Developing the workforce	Improving clinical services	Improving services for specific populations
Existing requirements	Each organisation to have a race equality and cultural capability framework, managed at a senior level, including an effective harassment policy Updated race equality schemes to be ready for publishing by May 2005	All service planners and providers to receive training in cultural sensitivity, e.g. in religious and linguistic needs, care and recovery planning, needs assessment and community engagement PCTs, SHAs and LAs to implement DH guidance on the mental health workforce, including BME staff networks PCTs and LAs to ensure that service providers identify the training needs of their staff	PCTs and LAs to involve CMHTs in discharge planning, in partnership with families and other agencies PCTs to enhance and encourage earlier access to care PCTs to provide opportunities for BME involvement on wards, e.g. by befriending and advising patients PCTs to ensure that mental health in-reach services are available in all prisons	PCTs and LAs to review their implementation of standard seven of the NSF for Older People

	Developing organisations	Developing the workforce	Improving clinical services	Improving services for specific populations
Working differently		Within mental health trusts and PCTs, professional bodies and governance structures should plan and manage individuals' progress towards cultural capability	PCTs and mental health trusts to ensure that service users and carers are aware of their options in seeking a second clinical opinion PCTs and mental health trusts to ensure that carers, families and advocates are involved in care planning that is centred on the patient's needs PCTs to consider how their commissioning and inspection processes reflect mental heath modernisation objectives PALS to ensure that they are linguistically and culturally equipped	PCTs and LAs to ensure that services reflect the particular linguistic needs of older people from BME groups PCTs and service providers to have specific arrangements to meet the needs of refugee and asylum seeking families, including children and young people PCTs and LAs should provide directories of local services to help BME children and their families get access to support

	Developing organisations	Developing the workforce	Improving clinical services	Improving services for specific populations
National action	The National Director for Mental Health and the NHS Equality and Human Rights Director to champion reform The National Director of the BME Mental Health Programme to lead reform A national director to be appointed to manage the NIMHE BME programme NIMHE Race Equality Leads to provide regional leadership Inspection agencies' indicators to reflect local procedures and practice The Healthcare Commission to promote safer inpatient and therapeutic environments	DH to implement the national action plan on leadership and race equality DH to disseminate good practice on the employment of refugees and overseas workers NIMHE and SCMH to identify training needs and good practice NIMHE to develop a common skills set for mental health practitioners NIMHE and TOPSS to improve the understanding of BME issues among all the involved professions NHSU to develop a race equality and cultural capability programme	NIMHE to commission a project on improving BME mental health care pathways NIMHE and SCIE to disseminate guidance on direct payments for BME service users DH to review the exclusion from direct payments of people away from hospital on leave NIMHE and the National Primary Care Development Team to disseminate good practice in access to primary care mental health services The National Patient Safety Agency to issue advice on safer acute psychiatric wards DCA and the Legal Services Commission to pilot new arrangements for legal advice for people with mental health problems	DH to develop a resource pack on the needs of refugees and asylum seekers Community engagement pilot projects to include refugees and asylum seekers NIMHE and HARP to encourage the use of the new mental health and well-being website NIMHE to work with organisations such as PRIAE to disseminate good practice in caring for older BME people NIMHE and NCSS to promote good practice within BME CAMHS, and to identify community development 'early implementer' sites to bridge the gap between CAMHS and BME communities

	Developing organisations	Developing the workforce	Improving clinical services	Improving services for specific populations
National action *continued*			The draft Mental Health Bill to provide for independent advocacy to be available to everyone treated under powers of compulsory detention NIMHE to work with Royal Colleges and others to ensure that patients receive care in the least restrictive environment that is consistent with their needs NIMHE to support ACPO in its review of training in mental health NIMHE to work with the Prison Service on modernising mental health care in prisons NIMHE to work with NOMS, HO and Nacro to review arrangements for releasing mentally disordered prisoners	

	Developing organisations	Developing the workforce	Improving clinical services	Improving services for specific populations
New local action			**PCTs to seek new pathways to referral from BME communities** **Service providers to encourage more active take-up of direct payments within BME communities** **PCTs and service providers to ensure that BME inpatients have access to culturally appropriate facilities and services** **PCTs and service providers to ensure adequate provision of culturally appropriate independent advocacy** **PCTs to develop agreed plans for early diversion from the criminal justice system**	

Communities

3.90 Any initiative aimed at improving the healthcare experience of BME groups must recognise the leading role that BME communities themselves can play.

3.91 All communities have a role in preventing mental health problems and providing an environment where people who have become ill can recover and prosper. BME communities often have to go further, filling the gaps between their needs and NHS mental health service provision. Though sometimes under-resourced and poorly integrated into the wider mental health economy, the BME independent sector has continued to develop innovative services and has higher patient satisfaction ratings than statutory services.

3.92 The non-statutory and statutory sectors can learn much from each other. The statutory sector could improve access to appropriate mental health services by supporting non-statutory health providers as part of a mixed economy of service providers in a locality.

3.93 Integrating the experience, values, approaches and knowledge of the non-statutory sector into the whole system will help development both inside the mental health system and outside. This approach is integral to the establishment of Focused Implementation Sites for *DRE*, which will help to spread best practice on implementing change.

3.94 Creating a more mixed economy of mental health care depends on:

- capacity building in the non-statutory sector;
- better engagement of communities in commissioning processes;
- better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector; and
- sustainable support for effective services.

3.95 Statutory services need to involve BME communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services.[24] This is consistent with the Department's wider commitment to increasing the involvement of patients and the public in decision making, through structures such as Patients' Forums.

24 Glackin. *The Federation of Irish Societies' Health Impact Assessment of the Irish Voluntary Sector and the Partner Primary Care Trusts*, London Federation of Irish Societies, 2004.

Action to help build healthier communities

3.96 Prevention of mental illness becomes particularly important when there is a discrepancy between the rate of illness in one group and the rate of illness in another. Specific risk factors in BME groups – such as racism and school exclusion – have rarely been the target of mental health promotion activity.

3.97 Financial insecurity, unemployment and a poor built environment also have a negative impact on mental health and all disproportionately affect BME groups. It follows that action to mitigate those factors may decrease disparities in mental health. Schemes improving the inner city environment, such as neighbourhood renewal, or improved schools should also have positive effects on mental health.

3.98 However, targeted health promotion campaigns can still help to decrease disparities in mental health suffered by BME groups. To support this, in December 2004 NIMHE published *Celebrating our Cultures*, a comprehensive new toolkit that will be supported by training workshops in early 2005.[25]

3.99 In November 2004 the Department of Health published *Choosing Health*, the Government's strategy for improving health in England. It clearly reiterates:

- the Government's commitment to reducing health inequalities; and
- its commitment to the *DRE* action plan.

3.100 NIMHE has commissioned research on suicide in BME communities. It will be completed by the end of 2005 and will contribute to the National Suicide Prevention Strategy.

3.101 NIMHE is also co-ordinating a five-year plan to tackle stigma and discrimination. It will be implemented in co-operation with government departments, people with experience of mental health problems, and the voluntary sector. The plan will address issues of race and culture, providing a framework and materials to support local work.

Action to engage communities

3.102 There is a need for greater community participation in, and ownership of, mental health services. There also needs to be a multi-agency approach to commissioning and service delivery that strengthens partnerships between statutory and non-statutory providers.

25 National Institute for Mental Health in England. *Celebrating our Cultures: Guidelines for Mental Health Promotion with Black and Minority Ethnic Communities*, December 2004.

3.103 This means that the mental health system needs mechanisms that allow local populations to influence the way services are planned and delivered. To make full use of those mechanisms there needs to be greater awareness within BME groups of services that are available and how they can gain access to them.

Direct action on local planning and commissioning

3.104 Local information on ethnicity is not always available or used strategically if it is – for example to map representation, or for planning and commissioning more generally. There is often no overarching population needs assessment, and specific services for BME communities are not included in overall strategies.

3.105 Even where services are based on a high-quality needs assessment, the assessment should be re-examined regularly to discover whether changes in the local population require a change in service provision. This is an issue that particularly affects BME communities.

3.106 To address these issues PCTs and local authorities should:

- demonstrate that they are fulfilling their responsibility for using local demographic data;
- identify potential BME voluntary and community partners in providing local services;
- demonstrate that their strategic planning process and key joint planning groups consult, and are representative of, the BME voluntary and community sector and engage with service users and carers (and non-service users) from BME groups; and
- review current commissioning practices to ensure the full participation of BME voluntary and community organisations.

3.107 PCTs should ensure that appropriate practical support is available to BME voluntary and community organisations involved in commissioning and providing mental health services. This could include information, training opportunities, joint working and access to a liaison officer.

3.108 Local health agencies should form partnerships with diverse faith communities, providing a forum for discussion about mental health services. Guidance has been published by the Local Government Association and its partners.[26] PCTs should make sure that suitable local partnerships are in place.

26 Local Government Association. *Faith and Community*, 2002.

Community engagement scheme

3.109 PCTs that deliver services compatible with their responsibilities under the Race Relations (Amendment) Act will have their own community engagement strategies. NIMHE has developed its National Community Engagement Scheme to complement current PCT initiatives, not to replace them or to slow them down.

3.110 NIMHE will invest £2 million in the scheme, which will comprise about 80 projects run by non-statutory organisations across England over two years. They will help to build capacity in the non-statutory sector, develop partnerships between the non-statutory and statutory sectors, and offer new and innovative services that meet needs. They will aim to improve pathways to care and recovery, mental health awareness and satisfaction with care. As well as funding, projects will get support to develop their service, including a training package. The impact of the scheme and individual projects will be evaluated.

3.111 PCTs should ensure a multi-agency approach to community engagement, and integrate projects into key structures such as Local Implementation Teams, Local Strategic Partnerships and other relevant local activity – for example on regeneration, social inclusion, public health and community cohesion. There should be an emphasis on sustainability and support from the outset.

Community development workers

3.112 Changing the environment in which service planning is done may not by itself change service provision. Communities will need support in using the commissioning process so that their views are properly articulated and change is delivered.

3.113 Community development workers (CDWs) are a new type of NHS professional. They will support communities, build capacity within them, and ensure their views are represented in statutory sector reforms and plans.

3.114 PCTs will recruit 500 CDWs by 2006. They will have a number of roles, and detailed guidance has been published separately, but the key ones will be:

- providing support to non-statutory sector groups;
- identifying and accessing stakeholders;
- helping to articulate the needs and views of the communities they serve; and
- facilitating better communication and better pathways to recovery in the non-statutory and statutory sectors.

3.115 CDWs are crucial to promoting a community perspective in service development. They will facilitate the direction and nature of change in the statutory sector, as identified by the communities they serve, and help mental health services to bridge the gap between existing models of care and the values and needs of people from BME communities.

3.116 Each PCT and social services department will nominate a senior manager with whom CDWs will liaise, to make sure that knowledge and learning from communities is fully taken up within the organisation.

3.117 NIMHE will commission an evaluation of the work of CDWs.

Summary of actions for communities

	Building healthier communities	Engaging communities
Existing requirements		PCTs and LAs need to use local demographic data PCTs will recruit 500 community development workers
Working differently		PCTs and LAs should identify potential BME independent sector partners and learn from their experience and expertise PCTs and LAs should make sure that planning processes and groups represent and involve the BME independent sector and BME service users and carers PCTs should ensure a multi-agency approach and integrate projects into Local Implementation Teams, Local Strategic Partnerships and other local activity

	Building healthier communities	Engaging communities
National action	NIMHE has published *Celebrating our Cultures*, and will provide training workshops on mental health promotion within BME communities DH has published *Choosing Health*, reiterating its commitment to reducing health inequalities NIMHE has commissioned research on suicides in BME communities, which will contribute to the National Suicide Prevention Strategy NIMHE is co-ordinating a five-year plan to tackle stigma and discrimination	NIMHE will invest £2 million in a National Community Engagement Scheme NIMHE will commission evaluations of the National Community Engagement Scheme and the work of CDWs
New local action		**PCTs should ensure that appropriate support is available to BME community organisations involved in commissioning or providing services** **Local health agencies should form partnerships with diverse faith communities** **PCTs and social services departments should nominate a senior manager with whom CDWs will liaise**

Information, research and evaluation

3.118 Better quality, more intelligently used information is vital to improve services and equity in outcomes and to develop new strategies and services for mental health problems.

Ethnicity

3.119 High-quality data on ethnicity are essential for mental health service providers. It will help them to meet the statutory obligation under the Race Relations (Amendment) Act 2000 to monitor the impact of services on all ethnic groups. Despite that, there is clear evidence that the quality and comprehensiveness of ethnicity data collected in mental health services is inadequate.[27]

3.120 Ethnic monitoring has to be sensitive to local needs, and data collection must show relevance to local service development issues. For example, it should provide information on local white ethnic minority groups or different national and cultural groups of African origin.

Good practice

3.121 Information on areas of good practice is hard to come by. Better access to this sort of information will help the development of more appropriate and responsive services.

3.122 The Mental Health NSF and the National Suicide Prevention Strategy both identified the lack of good evidence of effective services and strategies as a barrier to improving the mental health of BME groups. This can be dealt with partly by improving access to, and dissemination of, existing good practice, but in some areas – such as the improvement of pathways to care and suicide prevention – more good quality research is needed.

Information for patients

3.123 Service users find it difficult to get the information they need to be partners in their own care and recovery. Access to information on available services, the efficacy of services and on patients' rights can be restricted by language difficulties or by the information not being made available in the right form or at the right time.

27 National Institute for Mental Health in England. *Engaging and Changing: Developing Effective Policy for the Care and Treatment of Black and Minority Ethnic Detained Patients*, October 2003.

Monitoring ethnicity and service use

3.124 The new projects cited in this action plan will be evaluated and the results disseminated quickly. The experience of BME service users will be surveyed across England annually and the information gathered will be used to inform service change.

3.125 To support planning the *Mental Health Minimum Data Set*,[28] which is used to gather information on local activity, includes an indicator on ethnicity.

3.126 NHS organisations responsible for commissioning and performance monitoring, and local authorities, should ensure that mental health services identify and record users' ethnicity (and other relevant data for the planning of care, such as religion, language, or gender). They should make sure that staff, users, carers and families understand the reasons for this and reassure them as to the confidentiality of information about individual service users. NIMHE has issued guidance.[29]

3.127 Commissioners and service providers should consider whether it would help local service development to monitor ethnicity in relation to specific aspects of treatment and care, for example:

- use of different categories of medication – novel antipsychotics, high dose prescribing, etc;
- admission rates to inpatient units, analysed by level of security;
- use of compulsion under the Mental Health Act 1983;
- inclusion of ethnicity and cultural needs in care planning;
- take-up of psychological therapies;
- rates of diagnosis, such as schizophrenia, drug-induced psychosis and co-morbid conditions; or
- user satisfaction with services.

3.128 A national mental health census will be carried out in 2005 jointly by the Mental Health Act Commission (MHAC), NIMHE and the Healthcare Commission (HC). It will cover all inpatients in mental health facilities and will:

28 NHS Information Authority. *Mental Health Minimum Data Set – Data Manual*, July 2001.

29 National Institute for Mental Health in England. *Engaging and Changing: Developing Effective Policy for the Care and Treatment of Black and Minority Ethnic Detained Patients*, October 2003.

- obtain robust baseline figures of the numbers of BME patients using mental health inpatient services;
- ensure that all mental health providers have accurate, comprehensive and sustainable ethnic assessment and record keeping in place that can provide a basis for high-quality data on the ethnicity of patients in all future data-gathering exercises;
- investigate the extent to which the providers, as perceived by patients and commissioners of care, have implemented culturally capable services with effective care planning and local evaluation influenced by information on patient ethnicity; and
- assess disparities in the use of the Mental Health Act, pathways to care and recovery, seclusion, and physical intervention for different cultural and BME groups.

3.129 From 2006 the Healthcare Commission will undertake the census annually and extend it to other patient groups.

Analysing and disseminating information

(See also the response to recommendation 11 of the independent inquiry into the death of David Bennett – page 28.)

3.130 The National Institute for Clinical Excellence (NICE) commissions the ongoing National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness.[30] Together with NIMHE, it disseminates to mental health services the emerging findings and lessons learned.

3.131 Its second five-year report will be published and disseminated in 2006. An annual table will be published recording the number of deaths, including information about ethnicity and gender.

3.132 The National Patient Safety Agency (NPSA) will also publish thematic reviews based on analyses of the data produced by the Confidential Inquiry.

Making knowledge available

3.133 Good information about services and ideas for service development may be difficult to find, making it harder to develop better mental health services.

30 National Institute for Clinical Excellence. *Safety First – Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness: Report 2001*. Department of Health, March 2001.

3.134 Older people, recent migrants, women from BME groups, and asylum seekers and refugees face particular problems in accessing mental health services and being involved in their planning. One key difficulty is language, but there are bigger problems for people from these communities who have additional communication difficulties, such as learning disabilities.

3.135 To address this, NIMHE is implementing a Knowledge Community project. This web-based project disseminates examples of evaluated good practice, including good practice in mental health services for people from BME groups. It will:

- support collaboration between people interested in improving mental health and mental health services; and
- build capacity within networks, offer value for money and choice in communication and knowledge sharing, and influence the way people with mental health needs are treated.

3.136 NHS Direct will provide a national interpretation and translation service (an NHS Plan commitment[31]). All NHS organisations will be able to access:

- a telephone-based interpretation service;
- a translation service – for the translation of documents, leaflets, websites, etc; and
- remote-based access to British Sign Language interpreters.

3.137 NIMHE has convened a national group (including NHS Direct, the National Register of Public Service Interpreters, clinicians and leading academics) to develop best practice guidance on interpreting, translation and communication support within mental health settings. This will build on Department of Health guidance on developing local communication support services and strategies,[32] and the *Strategic Health Authority Race Equality Guide 2004*. A report will be available in the spring of 2005.

3.138 NIMHE will also ensure that current guidance and good practice examples on the use of languages other than English are disseminated to mental health services.[33]

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31 Department of Health. *The NHS Plan – A Plan for Investment. A Plan for Reform*, 2000

32 Department of Health. *Guidance on Developing Local Communication Support Services and Strategies*, 2004

33 National Institute for Mental Health in England. *Engaging and Changing: Developing Effective Policy for the Care and Treatment of Black and Minority Ethnic Detained Patients*, October 2003.

3.139 Local health agencies should meet the existing requirement to make information on mental health services, including information for carers, accessible to all groups in the community. PCTs will retain responsibility for making information about local services accessible to all who need it.

Effective services and strategies

3.140 Work towards the elimination of inequalities and disparities in mental health services needs to be underpinned by an evidence base of effective approaches and interventions.

3.141 Services need to be more responsive to the needs of people from BME groups, but they also need to deliver positive health outcomes. An analysis in 2002 of project titles in the National Research Register showed that while only 1 per cent mentioned BME groups, 24 per cent of those involved mental health. Nevertheless, high quality research into the mental health care needs of BME groups has been a neglected area.[34]

3.142 The research governance framework for health and social care states:

> *"Research and those pursuing it should respect the diversity of human culture and conditions and take full account of ethnicity, gender, disability, age and sexual orientation in its design, undertaking and reporting. Researchers should take account of the multi-cultural nature of society. It is particularly important that the body of research evidence available to policy makers reflects the diversity of the population."*

3.143 The Department of Health encourages those commissioning or undertaking research to consider BME issues as an integral part of planning and delivery of programmes and projects.

3.144 NIMHE will increase the evidence base by commissioning research and evaluation, for example by continuing to support the Centre for Race and Ethnicity at the University of Warwick for a three-year period.

3.145 The Department and NIMHE will commission research to independently evaluate this action plan. The lessons learned will be disseminated quickly. In addition, research will be commissioned to evaluate the impact of the community pilot projects and the impact of community development workers (as part of a major research project on the impact of new developments in the mental health workforce).

34 Department of Health. *Strategic Reviews of Research and Development – Mental Health Main Report,* 2002.

Summary of actions for better information

	Monitoring ethnicity and service use	Analysing and disseminating information	Making knowledge available
Existing requirements			Local health agencies should meet the existing requirement to make information accessible to all groups within the community
Working differently			
National action	BME service users' experience will be surveyed annually and used to inform service change The MHAC, NIMHE and HC will carry out a national census of mental health inpatients in 2005. From 2006 it will be extended to other patient groups and carried out annually by the HC	The Confidential Inquiry into Suicide and Homicide by People with a Mental Illness will publish its second five-year report in 2006 NPSA will publish thematic reviews based on data from the Confidential Inquiry NICE will publish an annual table recording the number of deaths, including information on ethnicity	NIMHE is implementing a Knowledge Community project to disseminate evaluated good practice NHS Direct will provide a national interpretation service NIMHE has convened a national group to develop best practice guidance on interpreting and communication support in mental health settings, and will disseminate existing guidance to mental health services DH will encourage research that considers BME issues as an integral part of planning and delivery NIMHE will continue to increase the evidence base by commissioning research and evaluation

	Monitoring ethnicity and service use	Analysing and disseminating information	Making knowledge available
National action *continued*			DH and NIMHE have commissioned an independent evaluation of *DRE*
New local action	**Mental health services should record users' ethnicity, and other relevant data, such as religion and language, for planning care**		

4. Next steps

4.1 This action plan sets out a wide range of whole-system activity that can deliver real improvements to mental health care and reduce inequalities for Black and minority ethnic (BME) groups. It can only deliver those improvements if it is implemented effectively and as a priority.

4.2 This chapter describes:

- who will be involved in delivering the action plan;
- who will oversee its delivery; and
- the role of Focused Implementation Sites, which will develop the evidence base and facilitate the roll-out of the action plan.

Who is involved in delivery?

4.3 The action plan has specific governance arrangements within NIMHE and the Department of Health to make sure it is implemented. The lynchpin for this is the Department of Health's BME Mental Health Programme Board, chaired by Professor Kamlesh Patel.

4.4 This board will drive the development and delivery of the action plan and the response to the inquiry into the death of David Bennett, as well as taking responsibility for delivery of the wider BME mental health programme. It ensures formal accountability through the Department of Health and Government. It will co-ordinate and prioritise activity in the Department of Health, NIMHE, mental health services and other government departments so that changes set out in the action plan are delivered.

4.5 The board will be accountable to ministers through regular reports from the chair. It will seek advice from and report on progress to the BME National Steering Group, which is jointly chaired by the Minister of State for Health and Lord Victor Adebowale (chief executive of Turning Point).

4.6 The work of the board, the Department of Health and NIMHE will be undertaken in an open, transparent and accountable manner. The minutes of board meetings are published on the Department of Health website.

4.7 At local level all commissioning and provider units will be expected to take ownership of the action plan. The expertise and experience of the BME mental

health independent sector will be essential to successful implementation. Local decisions on priorities for change will need to be informed by:

- assessments of the needs of local communities and the challenges faced by organisations in meeting those needs fairly and equitably;
- the outcome of the Healthcare Commission's consultation exercise on how it will monitor compliance with core standards; and
- learning from Focused Implementation Sites.

How will progress be monitored?

4.8 Information available from the new national annual census of mental health patients will give providers and commissioners of services good-quality information on inequalities, which they can use to help deliver change. It will also allow year-on-year change in all provider units to be monitored, as will the regular Healthcare Commission inspections and surveys of mental health patient experience.

4.9 The Commission has said that in 2005/06 it will focus on performance against core standards, and has proposed a total of 18 'prompts' that it will use to check performance against the standards on equality of access and challenging discrimination.

Focused Implementation Sites

4.10 Focused implementation projects in sites across the country will help to demonstrate from the outset that change can be achieved.

4.11 The aim is to demonstrate that a whole-systems approach improves mental health services for BME groups, drawing on and adapting the 'collaborative' approach used successfully in other areas of healthcare. This means that Focused Implementation Sites will facilitate and guide change, not directly impose it in a top-down, 'one size fits all' fashion.

4.12 They will also:

- provide leadership and raise the profile of the BME programme;
- develop strategic partnerships between key organisations to lever investment and build capacity;

- directly and quickly improve mental health services for BME populations; and
- build capacity and intelligence that will facilitate further change.

4.13 The performance of the Focused Implementation Sites will be evaluated, but that does not mean that national implementation should be delayed until then. Implementation needs to begin everywhere now but, as it emerges, the experience of the sites will feed into and inform implementation by, for example:

- generating extra information on practical steps towards delivering appropriate and responsive services;
- further developing the knowledge base on the effectiveness of the action plan;
- developing more capacity to drive change across England;
- offering co-ordinated, whole systems care with fidelity to the action plan model; and
- building managerial capacity that will become available to others who are rolling out the action plan.

Deploying the action plan in the Focused Implementation Sites

4.14 The support available to the Focused Implementation Sites will include:

Information

- Sites will be able to use the national census in addition to other local strategies to benchmark their services.
- They can use Mentality's training in the development of a health promotion strategy for BME groups.
- They will be offered support to deploy the BME suicide prevention section of the National Suicide Prevention Strategy, which is being developed for this action plan.

Clinical services

- Help will be available to improve individual skills and organisational cultural competence by using a cultural capability and value-based practice developed by NIMHE and the Sainsbury Centre for Mental Health, with the NHSU.
- Support and advice will be offered on how care and recovery pathways for BME groups can be diversified and developed.

Commissioning

- There will be consultancy input on pathways to recovery to improve liaison between statutory providers and their communities.
- Community engagement projects in evaluation areas will support the practical application of changes in commissioning.

Local support

- There will be strategic support for local managers from NIMHE Development Centre Race Equality Leads and local community development workers.

Choosing sites

4.15 The criteria and process for selecting Focused Implementation Sites are being finalised, but the process will be led by NIMHE in consultation with other local agencies. A number of factors will determine which areas are selected, including the following:

- Localities should be at different stages of race equality (as measured using the criteria developed for benchmarking by the University of Central Lancashire).
- If a Strategic Health Authority (SHA) has urban and rural areas, at least one of the localities should be rural.
- Demographic information for the localities, to ensure that they represent the main BME groups in the SHAs.

4.16 Areas already taking action include Greater Manchester, which has begun to cement strategic partnerships and increase capacity ready to implement *DRE*.

Annex: Summary of critical responses to the *DRE* framework

On the basis of the published policy documents the commitment to produce actual impact on service users' experiences and outcomes was not evident. For example, there was very little attention in *DRE* to show how services might improve and how clinical practice would change, with too much emphasis on collecting information. This would not produce change.

- The voluntary sector's role was significant but not sufficiently clear.
- Service users and informed professionals should be involved in changing service delivery, research and development, and in training the workforce.
- Community engagement and community development were distinct processes, and the roles of community development workers and race equality leads were not clearly delineated. Clarity was needed about how these processes and new roles would complement each other and how they would enhance the quality and effectiveness of care.
- BME as a term did not address the numerous groups who might not be included in any programme of activity, for example, mixed-race people, white minorities, or white communities with distinct cultural lifestyles based on religion, ethnicity, language, age, gender or sexual identity.
- Blaming the communities by suggesting they needed to be more engaged did not recognise how engaged the communities were with mental health issues.
- BME communities had distinct illness models, philosophies of illness and mind, and real fears about the safety and the therapeutic qualities of the care they received.
- Cultural competence or capability was a sophisticated process that really needed radical reform in training, in continuing professional development, and in the way organisations undertook their roles. It was not a toolkit, a quick fix, or an accredited training course that only practitioners or only white people needed.
- Racism in society, in the NHS, and in mental health services had to be tackled alongside any equalities agenda.
- Institutional racism in psychiatric, psychological, nursing and social work practice was neglected.
- Equalities should include attention to other socially excluded groups who suffered prejudicial treatment and were likely to suffer a higher risk of mental health problems alongside poorer access to culturally appropriate and clinically effective care.

- Mental health promotion, improved well-being, and recovery paradigms offered more effective public health and health service solutions that focused on strengths, prevention alongside treatment, and promotion of optimism and hope whilst attacking professional pessimism about prognosis.
- There were no clear targets, and the processes necessary to bring about change were not adequately described for all stakeholders to optimise their contributions.
- Leaders of NHS and social care organisations, alongside managers and practitioners, had to be held to account. There had to be clear targets and monitoring processes.
- Using the term 'race' might mislead us collectively into thinking 'race' exists.
- *Inside Outside* and *Delivering Race Equality* were intended as landmark documents, but there was little that was directly cross-referenced and built from one policy to the other. This in itself would not help bring about sustained change and might reflect how institutionalised processes hindered improvements for Black and minority ethnic groups.
- Consultations were not published in a timely manner, and seemed not to contribute to the developments in the programme, some of which appeared to emerge from nowhere, and without clear evidence of impact. Likewise some elements of the programme had been initiated and are unlikely to change, whilst others, clearly necessary, were not being implemented promptly.
- Omissions: the police, forensic sectors, asylum seekers and refugees, older people, children and adolescents.
- Leadership and accountability for the programme were needed, with transparency in decision-making and leadership appointments.

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