Institution: Queen Mary University of London (QMUL)

Unit of Assessment: A2 (Public Health, Health Services Research and Primary Care)

Title of case study: Understanding and addressing ethnic inequalities in mental health

1. Summary of the impact

Research by Bhui 1996-2013 showed striking differences by ethnic group in diagnosis and management of mental health disorders due to a complex interplay of socio-cultural factors and different perspectives of patients and professionals. Impacts included: [a] the development and implementation of a UK-wide mental health policy 'Delivering Race Equality'; [b] a national training and workforce development programme that shifted the conceptual paradigm from the cultural competencies of individuals to system-wide intervention (called 'cultural consultation'); [c] service development research 'Enhancing Pathways into Care' (EPIC) to implement findings and draw lessons across four NHS Trusts; [d] incorporation of research findings into national and international guidelines, and influence on mental health legislation and policy; and [e] a new phase of research on implementing findings.

2. Underpinning research

Common mental disorders affect one in six adults in UK and cause significant morbidity. Psychotic disorders affect one in 100 but are more disabling and have greater risk of disability, social exclusion, self-harm, suicide and contact with specialist psychiatric services. Diagnosis and management of mental health conditions vary by ethnicity. Since the mid-1990s Professor Kamaldeep Bhui's team have conducted research at Queen Mary on cross-cultural psychiatry aiming to identify and explore these ethnic differences and ensure that patients receive best care and achieve optimum outcome whatever their ethnic group, social class, language, culture or religion. The research can be divided into four broad groups:

2a: Descriptive epidemiology (research conducted 1996-98). Prof Bhui showed that Black Caribbean people were more likely than Whites to enter care through forensic and psychiatric routes, more likely to be detained under the Mental Health Act, and more likely to be diverted to hospital from prisons, suggesting that their illness was less likely to be noticed by police or courts [1]. His team also showed that South Asians are less likely to be referred to specialist psychiatric care, despite seeing their GPs more often than other ethnic groups for all health problems [2]. These findings were partly, but not fully, explained by differing expressions of distress as well as different thresholds (irrespective of GP ethnicity) for recognition of common mental disorders [2].

2b: Systematic review of compulsory detention (2001-02). A systematic review of 38 papers and meta-analysis of 13 suitable studies quantified the excess detentions (odds ratio for being compulsorily detained under mental health legislation if Black vs White = 4.3) [3].

2c: Quantitative surveys of socio-cultural determinants of mental health inequalities (2001-08). Bhui et al undertook a series of surveys of discrimination / work stress and common mental disorders, of which one secondary analysis showed that discrimination was an important risk factor for common mental disorders [4]. Other studies implicated explanatory models and coping; and socio-economic risk factors of common mental disorders [4]. This involved developing and validating new survey instruments (eg the Barts Explanatory Model Interview) [5].

2d. Analysis of national suicide statistics by ethnic group (2006-07). Bhui led a national evaluation of suicide and ethnicity [6] that documented a highly significant excess of suicide in young (13-24 year old) black Caribbean and African men compared to white British men of the same age. These findings were evident in both community and inpatient settings. The team also showed that, in contrast to previous studies, South Asian women did not have significantly higher rates of suicide. In a report to the Department of Health, the team demonstrated a near-absence of community-based suicide prevention initiatives, and notably none aimed at high-risk Black men.

Queen Mary researchers included Professors Bhui, Stansfeld, Priebe, and Feder and Hull.

3. References to the research

Six papers listed of 40 relevant from this group (Queen Mary researchers in **bold**):

1. **Bhui K**, Brown P, Hardie T, Watson JP, Parrott J. African-Caribbean men remanded to Brixton Prison. Psychiatric and forensic characteristics and outcome of final court appearance. *British Journal of Psychiatry* 1998; 172: 337-44.

2. **Bhui K**, Bhugra D, Goldberg D, Dunn G, Desai M. Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychological Medicine* 2001; 31: 815-25.

3. **Bhui K**, **Stansfeld S**, **Hull S**, **Priebe S**, Mole F, **Feder G**. Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. *British Journal of Psychiatry* 2003; 182: 105-16.

4. **Bhui K**, **Stansfeld S**, McKenzie K, Karlsen S, Nazroo J, Weich S. Racial/ethnic discrimination and common mental disorders among workers: findings from the EMPIRIC Study of Ethnic Minority Groups in the United Kingdom. *American Journal of Public Health*. 2005; 95: 496-501.

5. **Bhui K**, Rüdell K, **Priebe S**. Assessing explanatory models for common mental disorders. *Journal of Clinical Psychiatry* 2006 67: 964-71.

6. **Bhui K**, McKenzie K. Rates and risk factors by ethnic group for suicides within a year of contact with mental health services in England and Wales. *Psychiatric Services* 2008;59:414-6.

4. Details of the impact

4a. Informing public and professional debate on a sensitive issue

The findings emerged in the context of some high-profile deaths of Black men in UK psychiatric hospitals, and raised awareness of ethnic inequalities in mental health. Prior to this research, the prevailing paradigm for explaining these inequalities was 'racism'. Not only was this an inaccurate interpretation of the evidence; it also diverted policy attention into simplistic solutions (eg tick-lists of 'cultural competencies' in which staff would need to be trained), and to undermine efforts of NHS organisations and staff to provide effective and personalized care taking account of culture. Research in Queen Mary has steadily shifted this paradigm towards more nuanced and socio-culturally informed perspectives. For example, the excess of compulsory detentions of Black men for psychosis may be due in small part to 'racism' or 'cultural stereotyping', but a full explanation must include other interacting variables, including poverty; educational background; stress and discrimination in the workplace; cross-cultural differences in expressions of distress; differences in family support and help-seeking behaviour; and medication adherence. The findings of this research and evaluation of the national programme [7] led to the recognition among policymakers that solutions must go beyond a behaviourist emphasis on 'racial awareness' to embrace organisational and systemic changes as well as personal culture and poor cultures of care.

4b. Informing and developing national legislation and policy (includes):

- Revisions to the **Mental Health Bill 2006.** This research was reviewed and evidence taken when the new bill was being developed. The findings, cited in the consultation documents [8], helped halt legislation that was feared to risk greater ethnic inequalities in use of the Mental Health Act. The final Bill was modified in a way that was unlikely to further increase inequalities in detention, and further research is investigating what explains increasing levels of compulsory detention in hospital in all groups, and the persistent excess among black patients.

- Prof Bhui was invited to draft national policy in 1999-2004; this work produced a **5 year plan** ('Delivering Race Equality 2005-2010' [9]) incorporating new service models, training and further research. Many impacts resulted from this policy in 2008-13. In many localities, communities had a greater say in local services and were more engaged with NHS services by informing the implementation of the Race Relations Amendment Act and by promoting more sophisticated models of workforce development to meet the needs of culturally diverse populations. Most importantly, every trust was charged with improving their delivery of care to minority ethnic groups and to show this in inspections to the Regulator. Other impacts include:

- Prof Bhui co-authored a report to the Department of Health on suicides in Black and Minority Ethnic (BME) groups [10], contributing to the emphasis in the newly launched (Sept 2012) **National Suicide Prevention Strategy and to the work of the 2006 strategy** as part of the 'Delivering Race Equality' programme.

- A national **Race Equality & Cultural Competence** programme (RECC) was mandated for all mental health professionals, driven by strategic health authorities (SHAs) [11]. It led to inclusion of training by the Care Quality Commission in a race impact assessments of SHAs.
- **Five hundred 'race equality leads'**, a new workforce, were introduced nationally requiring each Strategic Health Authority to develop an action plan [12].
- As part of developing a competent and informed workforce to reduce inequalities, with pump-priming funds from Department of Health, Bhui set up an MSc in 2002 (plus Certificate and Diploma) in **Transcultural Mental Health**, delivered in an innovative online format to 80 students annually, now drawn from over 38 countries. This course has recently been extended with new pathways in **Psychological Therapies,** and **Mental Health & Law** [13].

4c. Informing and developing national and international guidelines

This work has been cited by, and strongly influenced, guidelines by the National Institute of Health and Clinical Excellence on schizophrenia, for which Bhui chaired the access and engagement panel [14]; the World Psychiatric Association Guidelines on Mental Health of Migrants [15]; European Union Guidelines on Healthcare of migrants: EU-COST action [16]; and European Psychiatric Association guidelines on Public Mental Health [17].

4d: Implementing and evaluating new care pathways in the NHS

The action research project led by Queen Mary (2005-2007) 'Enhancing Pathways Into Care' (EPIC) in four NHS trusts illustrated a range of ways of changing pathways into care and engaging hard-to-reach groups to improve access, often through partnerships between voluntary and statutory sector agencies [18]. For example, a Pakistani Muslim Centre developed a joint assessment protocol with an early intervention team in order to improve access to psychiatric care for women from this otherwise isolated population. In one site (Sheffield) local audits showed a small reduction in the average duration of admissions among Black people. The evaluation showed clinical leadership, transformational leadership and cultural confidence were key ingredients to the genuine change in services. The graph below (from a peer-reviewed publication in *Transcultural Psychiatry*) shows one example of reduction in average length of stay in Black patients on admissions on wards in Sheffield in a participating unit in the EPIC project in 2005-7.
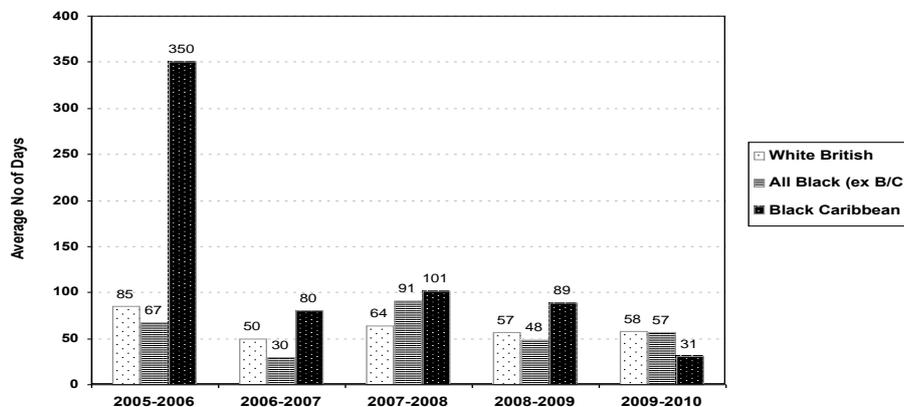
4e: Informing and influencing training and workforce development

The Queen Mary team were commissioned by NHS Tower Hamlets (£450K) to provide the **Cultural Consultation Service** to address intersectional inequalities arising in clinical practice. Bhui set this up to provide individual staff training in holistic, socio-culturally informed care as well as organisational and system-level support and guidance to NHS organisations seeking to reduce inequalities in mental health service provision [19]. This is built on anthropological understandings of culture, which notes the significance of beliefs, arts, laws, morals and behaviours found in all ethnic groups. The model uses patient and staff narratives of care as the basis for intervention alongside ethnographic research methods for evaluation. The team imported and adapted a Canadian model to provide a new service, including in-service workforce development by teaching staff how to use a cultural formulation, and addressing commissioning, management and team influences. This and the narrative approach permitted more negotiated care plans for patients who were disengaging or stuck in assertive outreach or other specialist psychiatric teams. The service also included organizational analyses to assist the services and teams to adapt their ways of working to reduce inequalities. Bhui led an audit of this service showing over 900 contacts, and that cultural competency of staff improved [20]. Among a small sample of complex patients (n=36)

needing specialist and in-depth work, there were significant cost savings (£18K total) at three month follow up. Patient functioning improved and trends showed fewer unmet needs.

4f: Informing further research

The overall picture nationally from the Care Quality Commission is that despite an evidence-based intervention based on this research, there has been no *overall* reduction in ethnic inequalities in detentions, ie that dramatic improvements in some areas (see graph above) are counterbalanced by worsening inequalities in other areas. This has prompted new collaborative NIHR-funded research studies to explore variations in compulsory admissions across the country [21]. Hypotheses include various geographical factors and social determinants of health.

4g: Oral and written evidence to Home Office and Government: Bhui's team undertook research on Khat (widely used in some minority ethnic groups and linked to mental health problems) and presented the case for it being made illegal [22].

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5. Sources to corroborate the impact

7. National Institute of Mental Health England 2003: 'Inside Outside: Improving Mental Health Services for BME Communities in England' (includes 27 references to Queen Mary research) Inside Outside: Improving mental health services for BME communities in England.

8. Mental Health Bill 2006. Hansard record of Queen Mary research being discussed in House of Lords debate on this Bill: www.theyworkforyou.com/lords/?id=2006-11-28c.679.2&s=Bhui#g704.0

9. Department of Health and National Mental Health Development Unit. 'Delivering Race Equality in Mental Health Care: A Review' 2009 (www.nmhdu.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf, see page 11) includes EPIC evaluation lead by Bhui: www.wolfson.qmul.ac.uk/psychiatry/epic

10. National Mental Health Development Unit: 'Suicide Prevention for BME Groups in England' 2006: www.nmhdu.org.uk/silo/files/suicide-prevention-for-bme-groups-in-england.pdf

11. Race Equality and Cultural Competence programme (RECC), see 'Delivering Race Equality in Mental Health Care: A Review' 2009: www.nmhdu.org.uk/silo/files/delivering-race-equality-in-mental-health-care-a-review.pdf

12. Ministerial statement announcing 500 community development workers as race equality leads: www.publications.parliament.uk/pa/cm200405/cmhansrd/vo050111/wmstext/50111m01.htm

13. Training courses: www.wolfson.qmul.ac.uk/psychiatry/courses/ and www.qmul.ac.uk/events/items/2012/83195.html

14. NICE Guideline on Schizophrenia (updated 2010) www.nice.org.uk/CG82 See pages 9,10,11 and 30. Bhui et al, 2007 cited here has been accessed 28,648 times.

15. World Psychiatric Association guidance on caring for migrants with mental health needs. Bhugra, Gupta, Bhui *et al*, *World Psychiatry* 2011 10: 2-10. www.wpanet.org/detail.php?section_id=7&content_id=895

16. European Union Guidelines on Healthcare of migrants: EU-COST action: www.cost.eu/domains_actions/isch/Actions/IS0603?management

17. Campion J, **Bhui** K, Bhugra D. European Psychiatric Association (EPA) guidance on prevention of mental disorders. *European Psychiatry* 2012; 27: 68-80.

18. Reports on EPIC project. All papers listed here: www.wolfson.qmul.ac.uk/psychiatry/epic/epicppublications.html, published in: *International Review of Psychiatry* 2009; 21: 425-6, 450-9, 460-4, 465-471, 482-5. By Bhui, Moffatt, McKenzie, Sass: www.wolfson.qmul.ac.uk/psychiatry/epic/epicevaluation.html

19. Cultural Consultation website www.culturalconsultation.org

20. Audit of Cultural Consultation Service. http://www.culturalconsultation.org.uk/wp-content/uploads/2013/10/CCS-Final-report.pdf [available in archive]

21. www.netscc.ac.uk/hsdr/projdetails.php?ref=10-1011-70

22. Advisory Committee on Drug Misuse: Khat: A review of its potential harms to the individual and communities in the UK. www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/ACMD-khat-report-2013/report-2013?view=Binary