

**East Midlands Focus Implementation Site
Review 31st October & 1st November 2006**

31st October 2006
Leicester/shire & Northampton
To be held at
The Peepul Centre
Orchardson Avenue,
Leicester,
LE4 6DP

1st November 2006
Derby/shire, Nottingham/shire & Lincolnshire
To be held at
Westminster House,
Porchester Road,
Nottingham

Important Information

Welcome to the East Midlands.

In order to make your visit coordinated and as smooth running as possible can we suggest that you take time to read the following advice.

Some practical advice, most people will be travelling some distance to get to Leicester for the evening of the 30th October 2006. I would advise you to keep the afternoon of the 30th October 2006 free to allow for travel, as the two days will require long periods of concentration and considerations of complex agendas.

The review panel may wish to have a briefing meeting late afternoon on the 30th October 2006.

Evening of 30th October 2006.

Please be advised and book accommodation at Belmont House Hotel, Leicester (Tuesday 30th October 2006)

A special rate of £87.00 Bed & Breakfast has been negotiated; just inform them you are from the NHS. There is a free hotel car park attached to the hotel.

Details for the hotel can be viewed below.

We hope that you will be able to join us, FIS leads, Leicester and Northampton and the Race Equality Lead for an evening meal.

Rendezvous time for dinner 7.30pmish.

Historic Belmont House Hotel



Belmont House was built in the 1860's and was part of the speculative development of New Walk. One hundred and thirty years later the excellent proportions and graceful elegance of the buildings form an integral part of this lovely Victorian conservation area. Originally known as Queen's Walk, New Walk was laid out in 1785 and runs along one of the most beautiful stretches of Leicester. For over 200 years, this scenic walkway has been designated strictly for pedestrian use connecting the town with the former racecourse, now Victoria Park.

The Hotel has been owned by the Bowie Family for over 70 years, following a tradition founded on the principals of great service, comfort and style – qualities that have been maintained and built upon by the current owners.

Over the years many changes have been made to the fabric of the hotel, but always with a sympathetic eye to the style and elegance of the building. The hotel now has 77 bedrooms all individually designed to offer our guests a touch of luxury. Good food is provided from our award winning kitchen, in either the Cherry Restaurant or Bowies, Bar Restaurant. But the heart of the hotel is Jamie's Lounge Bar, by day, a meeting place for light bites, coffee or a refreshing glass of wine. By night, a relaxing rendezvous where guests and friends gather to wind down after the day's business.

Whatever the reason for staying in Leicester, taking time to enjoy its many attractions is well worth its while. Just a stroll down the New Walk takes you to the centre of Leicester with its myriad of shops. Take a wander through the historic 1,000 market with its hustle and bustle or choose the elegant St Martins, with its coffee shops and fashion houses.

And getting here couldn't be easier

Best Western Belmont House Hotel, De Montfort Street, Leicester, Leicestershire, LE1 7GR

Tel: (0116) 254 4773 Fax: (0116) 247 0804

email: info@belmonthotel.co.uk

web: www.belmonthotel.co.uk

Please allow 1.5 hrs to travel by car to Nottingham from Leicester.

Maps will be provided to assist you all.

**Please be advised and book accommodation at Jury's Inn Nottingham
(Wednesday 31st October 2006)**

A special rate of £80.00 Bed & Breakfast has been negotiated; just inform them you are from the NHS. There is a car park opposite the hotel, Homes Place.

Details for the hotel can be viewed below.

Jury's Inn Nottingham ***

Waterfront Plaza, Station Street, Nottingham, UK, NG2 3BJ

Tel: +44(0)115 901 6700 Fax: +44 (0)115 901 6777

Jury's Inn Nottingham is ideally situated on Station Street in the heart of the city centre. It offers the perfect solution to your accommodation requirements. Only minutes away from all business, shopping, cultural and entertainment districts, this Nottingham hotel is the ideal base to enjoy this vibrant city.

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31st October 2006
Leicester

Venue: The Peepul Centre
Orchardson Avenue, Leicester, LE4 6DP
0116 266 7673
10am – 4pm

A G E N D A

- | | | |
|-----------|--|-----------------------------------|
| 10.00 | Coffee | |
| 10.30 | <u>Welcome</u> and setting the Scene | TBA |
| 10.45 | <u>Overview from SHA</u> | TBA |
| 11.00 | <u>Introduction to LLR</u> | Wal Holynski/
Meena Ackbarally |
| 11.30 | <u>Value Added grant –
progress/challenges</u> | Meena Ackbarally/
Ballu Patel |
| 12.00 | <u>Progress in Service Delivery</u> | Noreen Young |
| 12.30 | <u>Review team questions</u> | |
| 100 -200 | <u>Lunch and tour of Peepuls centre</u> | |
| 2.00 | Recap from morning session | Meena Ackbarally |
| 2.15-3.15 | Community development workers
progress challenges and aspirations | Naim razak/
Rachana Vyas |
| 3.15 | Questions | |
| | Break with refreshments | |
| | Review team to formulate their
questions | |
| 16.00 | Finish | |

1st November 2006
Nottingham

Trent Focussed Implementation Site
Review Day 1 November 2006, 10am – 4pm

Westminster House, Porchester Road, Nottingham

A G E N D A

- **Welcome and introductions** **George Hind**
- **Introduction to the Trent FIS area** **George Hind**
- **Local information and demographics**
 - **Karen Austin – Lincolnshire**
 - **James Fleet – Nottinghamshire**
 - **Ruth Sargent – Derbyshire**
- **Tea/coffee break**
- **Community Development Workers – updates from local commissioners**
 - **????????? – Nottinghamshire**
 - **Ruth Sargent – Derbyshire**
 - **Allan Kitt – Lincolnshire**
- **Lunch break**
- **Local action plans/steering group updates**
 - **????????? – Derbyshire**
 - **Kate Truscott – Lincolnshire**
 - **????????? – Nottinghamshire**
- **Value added project updates**
 - **Jeanne Bain/Karen Austin – Lincolnshire**
 - **????????? – Nottinghamshire**
 - **????????? – Derbyshire**
- **Tea/coffee**
- **Community Engagement Programme**
 - **Nasreen Aktar – programme overview**
 - **????????? – Karma Nirvana**
 - **April Spence/Karen Austin – Morton Hall prison**
- **Conclusions and farewells – Asha Day**

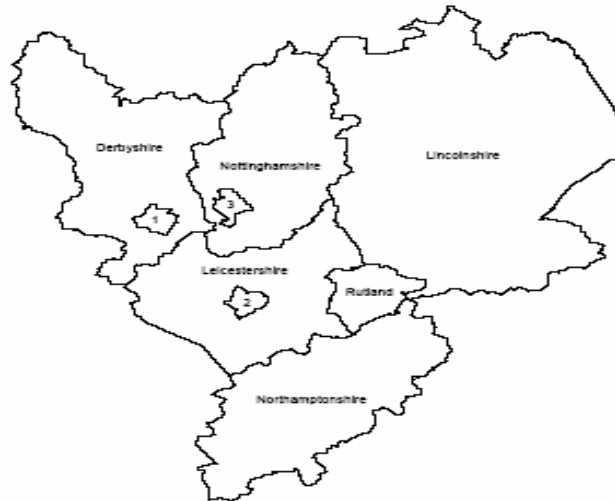
EAST MIDLANDS KEY CONTACTS

<p>Asha Day Associate Director/Regional Race Equality Lead CSIP East Midlands Telephone: 01623 812 942 Mobile:07766026679 Email: asha.day@eastmidlands.csip.nhs.uk</p>	<p>Ruth Sargent, Derbyshire Dales and South Derbyshire Primary Care Trust Park Hill, Hilton Road, Egginton, Derbyshire, DE65 6GU. 01283 731300 Mobile 07717702159</p> <p>Also at Central Derby PCT Tel :01332 203102 Ruth.sargent@centralderby-pct.nhs.uk</p>
<p>Meena Ackbarally Eastern Leicester PCT Enkalon House 92 Regent Road Leicester LE1 7 PE Tel : 0116 2951429 Email: meena.ackbarally@elpct.nhs.uk</p>	<p>James Fleet Nottinghamshire healthcare NHS Trust Duncan Macmillan House Porchester Road, Mapperley Nottingham NG3 6AA Tel: 0115 969 1300 x 40664 James.Fleet@nottshc.nhs.uk</p>
<p>Ann Crowder Northamptonshire Healthcare Sudborough House St Mary's Hospital London Road Kettering Northants NN15 7PW Tel : 01536 494 790 Ann.Crowder@nht.northants.nhs.uk</p>	<p>Karen Austin Lincolnshire Partnership NHS Trust Unit 2 Oak House Witham Park Waterside South Lincoln LN5 7FB Tel: 01522 582954 Fax: 01522 582960 karen.austin@lpt.nhs.uk</p>

An Overview of the East Midlands

1.1 The counties and unitary authorities¹ of the East Midlands

- 1 Derby
- 2 Leicester
- 3 Nottingham



*1 Boundaries as at 1 April 1998. See Notes and Definitions.
Source: Office for National Statistics*

The demography of the East Midlands

1. Introduction

This section of the Evidence Base provides a portrait of the demographic characteristics of the East Midlands region. It comments on population structure in terms of age, gender and ethnicity, and analyses historic trends and forecast population growth.

2. Population structure

The population of the East Midlands, totalling 4.3 million people, is similar in structure to the English average. Eighteen percent of East Midlands residents are in the school age group, 63.1% are in the working age group and 18.9% are of pensionable age.

There are distinct differences within the region. The south of the region and the main towns and cities have higher proportions of the population in the working age group, whilst the more rural parts of the region have higher proportions in the pensionable age group.

The proportion of people who identified themselves as belonging to an ethnic minority group in the 2001 Census was lower in the East Midlands than the English average, at 9% compared to 13%.

3. Population living in urban and rural areas

The East Midlands is the third most rural region in England, with 29.5% of the total population resident in rural settlements, over 10 percentage points higher than the English average of 19.4%.

Almost 70% of people in the East Midlands live in settlements of greater than 10,000 people. This is lower than the English average.

4. Population trends

Between 1994 and 2004, the East Midlands population grew at a greater rate than the English average, increasing by 5.1% compared to 3.9%. This growth significantly exceeded that of the other northern and midlands regions, but was less than the growth in southern regions.

The 8.8% growth in the pensionable age group in the East Midlands was the second largest of all regions, behind the East of England. The working age group in the region also grew at an above average rate.

Sub-regionally, Rutland experienced the largest population growth in this period, whilst both Nottingham and Leicester Cities experienced overall population decline.

TABLE 2**Population by ethnic group: April 2001, number and percentages**

		East Midlands		England
		Number	%	%
White	White British	3,807,731	91.3	87.0
	White Irish	35,478	0.9	1.3
	Other White	57,171	1.4	2.7
Mixed	White & Black Caribbean	20,658	0.5	0.5
	White & Black African	3,426	0.1	0.2
	White & Asian	11,176	0.3	0.4
	Other Mixed	7,879	0.2	0.3
Asian	Indian	122,346	2.9	2.1
	Pakistani	27,829	0.7	1.4
	Bangladeshi	6,922	0.2	0.6
	Other Asian	11,815	0.3	0.5
Black	Black Caribbean	26,684	0.6	1.1
	Black African	9,167	0.2	1.0
	Other Black	3,628	0.1	0.2
Chinese		12,910	0.3	0.5
Other Ethnic Group		7,353	0.2	0.4
Total for all minority ethnic groups		364,442	8.7	13.0

Source: ONS Crown Copyright, '2001 Census', from NOMIS, 10th February, 2006

emda: The East Midlands in 2006

2.3 Ethnicity

Ethnicity data are sourced from the 2001 Census. Respondents were asked to state what they considered their ethnic grouping to be. The question asked in 2001 was more extensive than that asked in 1991, and included a 'Mixed' category for the first time:

- In the East Midlands 364,442 people, or 9% of the population, classified themselves as coming from an ethnic minority background in 2001 (Table 2);⁵
- This proportion is below the English average of 13%, but is very similar to the South East, the East of England and the North West, where between 8% and 9% of the population in each case classified themselves as belonging to an ethnic minority group;
- London has a much larger proportion, with 40% of its population classified as other than White British. The West Midlands also has a larger proportion, at 14%. Both the North East and the South West have smaller proportions, with 4% and 5% of their respective populations consisting of minority ethnic groups;
- Residents of Indian origin make up the single largest ethnic minority group in the East Midlands, accounting for almost 3% of the total population, compared to 2% in England, followed by people of 'other White' background and 'White Irish'. Most other ethnic minority groups account for a smaller proportion than in England as a whole, with the Bangladeshi population accounting for a smaller proportion than in all regions except the South West.

Count me in: the National Mental Health and Learning Disability Ethnicity Census

East Midlands Region Headlines from 2005

- o 33,828 patient/service user records in 212 NHS and private sector organisations in England & Wales (3,158 patients in providers within East Midlands GOR)
- o 98.7% ethnic origin recorded
- o Overall 79% (80.6%) of inpatients were White British, and 19% (17.1%) were from Black and minority ethnic groups
- o 70% of Black and minority ethnic in patients were in just 23 organisations.
- o 184 out of 212 organisations had less than 50 black and minority inpatients

Patient ethnicity 2005 Census (percentages)

Categories	England and Wales	*East Midlands GOR (Total 3,158 patients)
British	79.20%	80.6%
Irish	2.20%	2.1%
Other White	3.10%	2.2%
White and Black Caribbean	0.80%	0.9%
White and Black African	0.20%	0.2%
White and Asian	0.30%	0.5%
Other mixed	0.50%	0.9%
Indian	1.30%	1.9%
Pakistani	1%	0.9%
Bangladeshi	0.50%	0.2%
Other Asian	0.80%	0.5%
Caribbean	4.10%	4.3%
African	1.90%	1.4%
Other Black	1.70%	0.5%
Chinese	0.20%	0.1%
Other	1.10%	0.6%
Not stated	1.20%	1.6%
TOTAL		99.3%

***Local data: ethnicity of inpatients / patient numbers**

NHS Trusts in East Midlands

(NB. GOR totals also include patients in 16 independent providers)

Trust	White	BME
Nottinghamshire Healthcare	806	218
Leicestershire Partnership	439	103
Derbyshire Mental Health Services	362	45
Lincolnshire Partnership	255	8
Northamptonshire Healthcare	143	40
Chesterfield, North Eastern Derbyshire and High peak and Dales PCTs (3)	73	2
Total NHS MH inpatients	2078 (83%)	416 (17%)

East Midlands Regional FIS Steering Group

Membership

Professor C. Steel, Director CSIP East midlands, Chair

Ms. Asha Day Regional Race Equality Lead

FIS Leads:

Ms. Meena Ackbarally

Mr. James Fleet

Ms. Ann Crowder

Ms. Karen Austin

Ms. Ruth Sargent

Other FIS Representatives

Mr. S. Edgeley, Derbyshire Mental Health Trust

Mr. S. Fawcett, Leicestershire Partnership NHS Trust

SHA

Mr. George Hind

Voluntary Sector*

Mr. Al Khalifa

Government Office*

Awaiting for name of new representative

Academic*

Professor Dr. Mark Johnson, Mary Seacole
Research Centre, De Montfort University. Leicester,

User*

Clr. Ms. Manjua Sood also representative of Multi Faith Forum, Leicester

* Denotes non NHS

Terms of Reference

East Midlands Regional Focused Implementation Site (FIS) Steering Group

Aim: The aim of the Steering Group is to work at a strategic level with a focus on setting standards, benchmarking, and sharing information and resources, supporting the successful delivery of the programme.

The Group will also provide a link to the NIMHE BME Programme (nationally) by sharing and discussing national developments and the implications for these in the East Midlands.

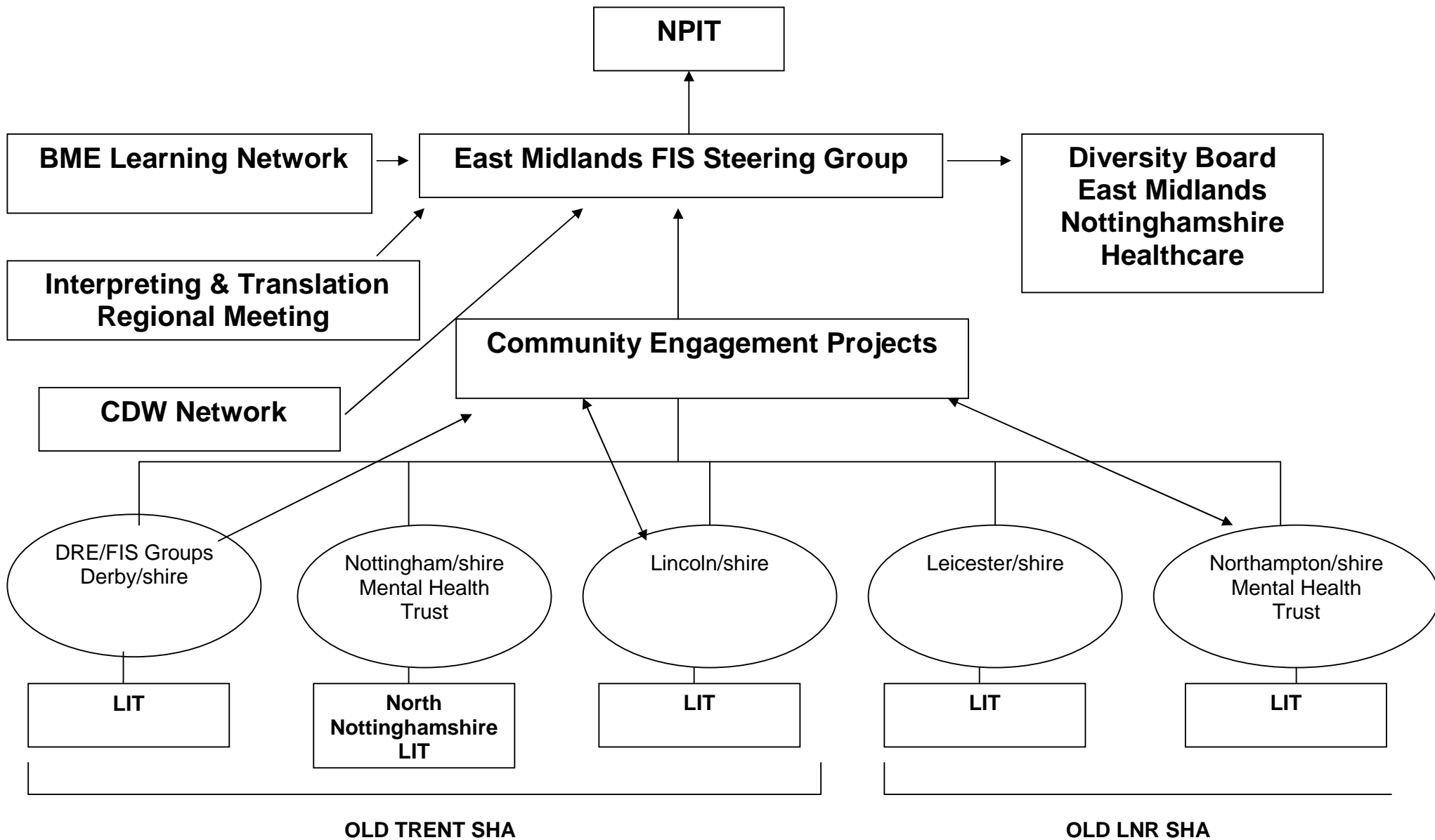
Objective: The East Midlands FIS Steering Group exists to ensure that a collaborative and informed approach is taken between all stakeholders in order to deliver the DRE Action Plan.

Responsibilities

Review the local implementation of the FIS in East Midlands ensuring use of evidence based data and intelligence / relevant information.

1. Sharing Information and good practice - the Steering Group will ensure the dissemination and promotion of good practice across all East Midlands FIS. Especially when the practice is deemed to contribute to the more effective delivery of DRE.
2. Setting Priorities for the East Midlands - the Steering Group will ensure to look at emerging issues from DRE Action plans and local FIS experience. Any common themes arising from these issues will be brought to the attention of the NIMHE BME Programme and local / regional FIS Steering Groups.
3. Strengthening services through:
 - Identifying creative joint solutions to local difficulties,
 - Supporting effective communication systems,
 - Harnessing the strengths of the voluntary and statutory sectors and their stakeholders.

As a part of the strategic role for the East Midlands FIS Steering Group we will ensure to develop benchmarks upon which we can judge our own progress against the 12 characteristics of DRE by setting clear and achievable benchmarks that everyone can participate in achieving across the East Midlands.



Date of Review: 31st October 2
1st November 2006

Trent SHA FIS Area

Value Added Grants

Trent SHA

Delivering Race Equality in Mental Health Care

Focused Implementation Site - Added Value Grant Form

Title of activity:

BME Voluntary Sector Capacity-building project
Communication and Access to mental health services
Culture and Spirituality

Description of the activity in no more than 250 words:

The proposed project will provide support and capacity-building within the BME and mental health voluntary sector in Trent in the following ways:

- Review the existing infrastructure within the BME voluntary sector in order to scope their capacity to support the development of culturally appropriate mental health services
- Provide a 'health check' for both the BME and mental health voluntary sector in order to help them to develop and improve sustainable services
- Identify and start to develop training and support packages for identified groups in order to fill such gaps as may be identified
- To scope any need for development of the BME service user movement and propose local solutions
- Support a BME voluntary sector organisation (or organisations) to engage with existing BME service users and staff to generate a picture of the BME experience of mental health services in Trent and make recommendations on areas for improvement including but not limited to
 - Communication
 - Control and restraint
 - Suitability of service received

Communication and Access

- Identify providers of interpreting and translating services
- Identify and/or develop models of interpreting services for mental health service users

Culture and Spirituality

- Scope 'spiritual' groups within the 3 locality area
- Identify local 'cultural' groups and begin to develop best practice guidance
- Identify how mental health services can address spiritual needs of BME patients

Please explain how this activity will enhance the delivery of the DRE Action Plan:

- A whole system approach to delivering mental health services to BME communities
- Reduced fear of services among BME communities;
- Increased satisfaction with services;
- A reduction in the rate of admission of people from BME communities to inpatient units;
- A reduction in the use of seclusion in BME groups;
- 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 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 planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities

Anticipated outcomes:

- Increased capacity within the BME voluntary sector to provide infrastructure support to other voluntary organisations providing mental health services to the BME community
- Improved understanding of BME issues within the mental health voluntary sector
- Increased confidence in the local bme community in mental health services

Date of Review: 31st October 2006 /
1st November 2006

- Real partnership and collaboration between the voluntary and statutory health sector

Justification for the amount:

- Consultancy payment to BME voluntary organisation to carry out scoping exercises and ‘health checks’
- Training courses to be developed and carried out in 3 localities
- Payment for service users’ time
- Production and dissemination of final report
- Hospitality and Venue costs for community engagement

Grand Total £50,000.00

Derby/shire DRE/FIS Health Economy

Delivering Race Equality-A Framework for action

Draft terms of reference for the Derbyshire steering group

Membership of the group

The group will consist of representatives from:

- Derby Millennium Network
- North Derbyshire BEM community
- Mental Health Voluntary sector
- Derby City Mental Health Partnership
- Derbyshire Mental Health Confederation
- Mental Health Trust Diversity lead
- Mental health commissioners
- Housing agency

Remit of the group

The group will meet to ensure a co-ordinated strategy and implementation plan to meet the requirements set out in the document “Delivering Race Equality”. The group will ensure that the development follows the national requirements and reflects the needs of the different communities in Derbyshire.

Frequency of meetings

The group will meet monthly.

Terms of reference

1. To consider how Government requirements will be met and ensure that developments are in line with the available information on best practice.
2. To consider the impact of development on other parts of the mental health service, and report to the Strategic Commissioning Group (SCG) to ensure a whole systems approach.
3. To develop a detailed implementation plan based on a gap analysis and seek to secure necessary funding.
4. To report to the SCG, as required but on at least a six monthly basis
5. To guide and support the development of services, including securing resources and professional co-operation within the wider service.
6. To organise an annual/bi-annual meeting of the wider reference group, specifically seeking the involvement of black and ethnic minority communities.

To monitor the impact of developments.

Derbyshire Race Equality Steering Group

Delivering Race Equality Action Plan

BETTER QUALITY AND MORE INTELLIGENTLY-USED INFORMATION

Those responsible for planning, delivering and monitoring services, both to individuals and collectively, need to ensure that good quality data on ethnicity is comprehensively collected and intelligently used. This is considered essential if services are to be able to meet their legal obligation under the RR(A)A 2000 to monitor the impact of services on all racial groups.

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
1. Ensure that service users' ethnicity (and gender and other relevant data) is identified and recorded.	Voluntary Sector DMHT Local Authorities Commissioners		Ensure recording of ethnicity, gender and other relevant information continues to be built into information management system.	Rubina Reza Clive Bull Stephen Edgeley	DMHST Action Plan within HR Strategy. CPA Audit Reports Healthcare Commission Performance Indicator on Ethnicity Recording.
2. Ensure staff, patients and their relatives/carers understand the importance of ethnicity data for improving services.	Voluntary Sector DMHT Local Authorities Commissioners	This issue is addressed in CPA training and staff should address the issue sensitively with service users and carers, however no co-ordinated approach to inform/educate users and carers.	Ensure that the issue is addressed at the next consultation event. Develop health promotion strategies. Ensure standards in the cultural competency checklist relating to training are covered by all provider organisations	Clive Bull Stephen Edgeley	Consultation Event minutes and papers. Training Records.
3. Map ethnic information throughout care pathways to inform decisions about appropriate treatment/services.	Voluntary Sector DMHT Local Authorities Commissioners	Specific care pathways work has mapped ethnic data Diversity posts in specialist teams	Ensure all care pathways work highlights ethnic information and addresses outliers. Evaluate roles alongside Community Development Workers roles.	Clive Bull Stephen Edgeley	Care Pathways
4. Gather local demographic data and conduct with communities needs assessments, including understanding how different cultures within the area regard mental ill health.	Voluntary Sector DMHT Local Authorities Commissioners	Currently commissioned mapping of BME community groups, via LINKS and DMN Health Equity audit in the City	Mapping completed. Gather Public Health demographic data together	PCT Diversity Schemes DMN Commissioners Public Health	DRE Report
5. Use ethnic data strategically to map representation and plan services designed around these different needs/ understandings. Derbyshire Voice and DMN to work together in developing service user representation in planning processes	Derbyshire Millennium Network	Population information used to highlight need in City. Housing scheme for black and African Caribbean community developed. Support worker for Asian Women commissioned. Community Development Workers in post.	Pull together voluntary sector info through SLA monitoring, into an overview position (links to number 1 above)	Trust Business Units Stephen Edgeley	Service Plans

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
6. Monitor local services for impact on different racial groups using outcome and performance indicator data. Mechanisms might include monitoring of local delivery plans, SSD annual user surveys and development of local benchmarking	Lead Commissioners		Support User Focused Monitoring to see if impact on racial groups can be built into their analysis and whether it is possible to build a specific ethnicity element into their programme of activity. Develop programme for measuring satisfaction with services	Clive Bull Stephen Edgeley	UFM Reports

APPROPRIATE AND RESPONSIVE SERVICES

It is a legal requirement that staff are trained on the general duty under the RR(A)A 2000 to promote race equality and good race relations and to eliminate unlawful racial discrimination. It is considered essential that the extent to which mental health services are appropriate and responsive to the needs and wishes of Black and minority ethnic communities be considered as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups. The Act requires that remedial action be taken where adverse and unjustifiable impact is identified.

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
7. Each organisation to have a race equality and cultural capability framework including an effective harassment policy	Voluntary Sector DMHT Local Authorities Commissioners		Create Race Equality and Cultural Capability Framework and Harassment Policy.	Clive Bull Stephen Edgeley	Harassment Policy
8. Make workforce representative of the community it serves. (a) PCT's. (b) Local Authority. (c) DMHT. (d) DMN.	Voluntary Sector DMHT Local Authorities Commissioners		Trust monitors workforce profile and Recruitment and Selection Data on quarterly basis to compare with the local population. Continued monitoring by Diversity Board and development of initiatives to address areas of under-representation within professions and grades. Include as part of SLA monitoring requirements	Clive Bull Stephen Edgeley	Workforce Map
9. Assess individual and organisational learning/development needs. (a) PCT's. (b) Local Authority. (c) DMHT. (d) DMN.	Voluntary Sector DMHT Local Authorities Commissioners		Collation and analysis of training needs and commissioning/development of training. IPR/PDP implemented across the Trust. Monitored and collated by Training and Development Department as Trust Identification of Training Needs.	Clive Bull Stephen Edgeley	Training Needs Analysis Training Programme
10. All service planners and providers to receive training in cultural sensitivity	DMHT Local Authorities Commissioners		Produce and deliver cultural sensitivity training programme.	Clive Bull Stephen Edgeley	Cultural Sensitivity Training Programme and Attendance Records
11. Implement DH guidance on the mental health workforce, including BME staff networks.				Clive Bull Stephen Edgeley	
12. Ensure that service providers identify the training needs of staff.				Clive Bull Stephen Edgeley	
13. Governance structures to plan and manage individuals progress towards cultural capability.				Clive Bull Stephen Edgeley	

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
14. Promote and enable staff to undertake training on RR(A)A 2000 general duty.	Voluntary Sector DMHT Local Authorities Commissioners	Diversity Awareness included as part of both the Induction and Mandatory Training Programmes	Development/Purchase and implementation of eLearning Diversity Package	Clive Bull Stephen Edgeley	Diversity eLearning Package. Trust RES Learning and Innovation Strategy Training Records.
15. Develop benchmarks and monitor progress on appropriateness and responsiveness of services, look for outliers and take action as appropriate.	Voluntary Sector DMHT Local Authorities Commissioners	Rethink have a well developed checklist regarding cultural competency of its workers. They have agreed that other organisations can use it, ensuring that Rethink is credited. What training is available in the PCTs and is it available to non-PCT staff? Need to ensure it is a standard item in SLA monitoring	Steering group to commission further work to develop benchmarks and scope to develop a toolkit and training and development pack		Cultural Competency Benchmarks. Cultural Sensitivity Toolkit and Training and Development Pack.

INCREASED COMMUNITY ENGAGEMENT

It is a legal requirement that services make information available to and consult all racial groups. Those responsible for planning and delivering services need therefore to involve and build a partnership with Black and minority ethnic communities, with progress assessed by those responsible for monitoring services.

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
16. Ensure information on services, including information for carers, is made accessible to the local community, in forms which take into account issues such as literacy levels.	DMHT Local Authorities	DMHST is ensuring that all information is available electronically in different languages and in audio. Social services leaflets produced in main 6 languages	Consider the production of a leaflet/poster advertising the availability of the service in the main 6 languages.	Mark Thaxter	Multilingual Leaflets and Posters
17. Support the community engagement process of recruiting and developing Black and minority ethnic Community Development workers	Lead commissioners	Mapping of community services completed. Plans developed to appoint CDWs feeding into LDP and Local authority budget plans. Two new workers appointed Sept 05	Implement plans when approval is given	Clive Bull Stephen Edgeley	Job descriptions of BME CDW's and service map.
18. Ensure there is sufficient support to BME organisations involved in commissioning and providing services.					
19. Integrate consultation with and representation of Black and minority ethnic VCS specialist services, community and faith groups into the strategic planning process and key joint planning groups.	Voluntary sector Forum Derbyshire Millennium Network	Steering group set up, with built in 6 monthly wider consultation as sub group of the strategic commissioning group. Voluntary sector mental health forum established, encourage greater participation by BME groups	CDWs to encourage involvement in planning processes to work with Derbyshire Voice		
20. Put in place robust mechanisms to ensure this representation is underpinned by consultation and engagement with the wider local Black and minority ethnic community.	DRE Steering Group	Annual consultation event agreed, 1 st held Jan 04, 2 nd held 23 rd November 2004, 3 rd held 8 th November 2005. Ensure Annual event is planned and encourage wide representation and attendance, monitoring the representation and planning. Issue of service user involvement in the steering group to be addressed.			

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
21. Develop benchmarks of and monitor progress on community engagement, referring to relevant local government targets/activity. Account should be taken of local councils' responsibility to maximise the impact of initiatives and synergy across activities.	RS to check	Check with LAs re LSPs. Links to 10 above. Explore the potential of using the City Community Network to link to LSPs.			

IMPROVING CLINICAL SERVICES WITHIN DERBYSHIRE MENTAL HEALTH TRUST

SUICIDE It is considered essential that to meet the key national target on suicide reduction those responsible For planning and delivering services address the high suicide risk of vulnerable groups, including young women born in India/East Africa and Irish-born men.

PATHWAYS TO CARE It is considered essential that those responsible for monitoring local services monitor the pathways into and out of care of Black and minority ethnic groups, particularly African and African-Caribbean men, with the objective of making these less aversive in nature, as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups, with remedial action taken where adverse and unjustifiable impact is identified

ACUTE INPATIENT FACILITIES It is considered essential that those responsible for planning and delivering acute services ensure they are appropriate and responsive to the needs and wishes of Black and minority ethnic patients and are more effective in their treatment, with progress assessed by those responsible for monitoring services, as part of fulfilling the RR(A)A 2000 requirement on assessing the impact of services on all racial groups, with remedial action taken where adverse and unjustifiable impact is identified

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
			22. To enhance and encourage earlier access to care.	Diversity Board/ Business Units	
			23. To provide opportunities for BME involvement on wards.	Diversity Board/ Business Units	
			24. To ensure in-reach into prisons.	Diversity Board/ Business Units	Prison Inreach Service Specification.
			25. Ensure that service users and carers are aware of their options in seeking a second clinical opinion.	Diversity Board/ Business Units	
			26. Ensure that families and advocates are involved in care planning that is centred on patients needs.	Diversity Board/ Business Units	
			27. Consider how commissioning and inspection processes reflect mental health modernisation objectives.	Diversity Board/ Business Units	
			28. PALS to ensure that they are linguistically and culturally equipped.	Diversity Board/ Business Units	
			29. To seek new pathways to referral from BME communities.	Diversity Board/ Business Units	
			30. Reduce the disproportionate rate of admission of people from BME communities.	Diversity Board/ Business Units	

Key Actions by Level 1 DRE Steering Group	Area and Lead	Evidence at Level 1	Key Actions by Level 2 Derbyshire Mental Health	Area and Lead	Evidence at Level 2
			31. Reduce the disproportionate rate of compulsory detention.	Diversity Board/ Business Units	
			32. Reduce the rate of violent incidents that are secondary to inadequate treatment.	Diversity Board/ Business Units	
			33. Reduce the use of seclusion in BME groups.	Diversity Board/ Business Units	
			34. Develop a more balanced range of effective therapies that are culturally appropriate and effective.	Diversity Board/ Business Units	
			35. Develop support services for carers.	Diversity Board/ Business Units	
			36. To encourage more take up of direct payments within BME communities.	Diversity Board/ Business Units	
			37. Ensure BME inpatients have access to culturally appropriate facilities and services.	Diversity Board/ Business Units	
			38. Ensure adequate provision of culturally appropriate independent advocacy.	Diversity Board/ Business Units	
			39. To develop plans for early diversion from criminal justice system.	Diversity Board/ Business Units	

National Mental Health & Ethnicity Census Report May 2005

The National Mental Health & Ethnicity census was completed on the 31st of March 05. It provides a snapshot view of the 407 inpatients on our wards on the day of the census.

Table 1: Ethnic Category breakdown of inpatients included in the census

Ethnic Category	No. of Patients	Percentage
A British (White)	352	86.5%
Z Not stated	10	2.5%
M Caribbean (Black or Black British)	9	2.2%
C Any other white background (White)	8	2.0%
H Indian (Asian or Asian British)	8	2.0%
B Irish (White)	7	1.7%
N African (Black or Black British)	4	1.0%
D White & Black Caribbean (Mixed)	2	0.5%
J Pakistani (Asian or Asian British)	2	0.5%
R Chinese (other ethnic groups)	2	0.5%
F White & Asian (Mixed)	1	0.2%
L Any other asian background (Asian or Asian British)	1	0.2%
S Any other ethnic group	1	0.2%
Total	407	100.0%

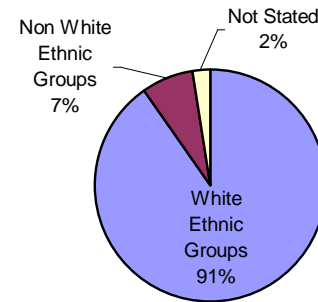


Figure 1: Ethnic Category Breakdown

% of patients with an ethnic category recorded	97.5%
% patients without an ethnic category recorded	2.5%

The 'White' ethnic groups (White British, Irish and any other white background) together accounted for 91% of inpatients. All other ethnic backgrounds or 'Non White' ethnic groups accounted for 7%

Table 2: The way ethnic category was recorded

National and local guidance recommends patient self assessment of ethnicity, with a relative or carer doing this on the patients' behalf if they are unable to self assess. Staff should not assess patient ethnicity.

Way Ethnicity Assessed	No. of Patients	Percentage
Self Assessment	343	84.3%
Assessment by Staff (exceptional case)	14	3.4%
Assessment by Relative	15	3.7%
Not Assessed	35	8.6%
Total	407	100.0%

Where the relationship between ethnicity and some of the recorded criteria are presented in this analysis, the small numbers of ethnic minority groups at the local level do not allow any conclusions to be drawn

Table 3: Religion and Language Breakdown

2.9% of the inpatient population spoke a language other than English

Language	No. of Patients	Percentage
English	395	97.1%
Any other language	4	1.0%
Hindi	2	0.5%
Polish	2	0.5%
Punjabi	2	0.5%
French	1	0.2%
Mandarin	1	0.2%
Total	407	100.0%

Religion	No. of Patients	Percentage
Church of England	240	59.0%
No religious group	68	16.7%
Other Christian	28	6.9%
Roman Catholic	27	6.6%
Other Protestant	14	3.4%
Any other religion	9	2.2%
Atheist/Agnostic	5	1.2%
Sikh	5	1.2%
Buddhist	3	0.7%
Orthodox Christian	2	0.5%
Muslim	2	0.5%
Hindu	2	0.5%
Jewish	1	0.2%
Rastafarian	1	0.2%
Total	407	100.0%

Table 4: Referral Source of Admission

Referral	No. of Patients	Percentage
GP	40	9.8%
Self	13	3.2%
LA Social Services	7	1.7%
A&E Department	25	6.1%
Police	17	4.2%
Other Clinical Specialty	171	42.0%
Carer	3	0.7%
Courts	3	0.7%
Medium Security	2	0.5%
Other	106	26.0%
Temporary Transfer from Mental Health Unit	13	3.2%
Permanent Transfer from Mental Health Unit	7	1.7%
Total	407	100.0%

Table 5: Whether patients are known to be asylum seekers and ethnic background of known asylum seekers

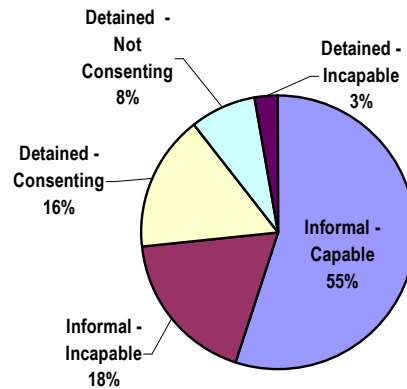
Asylum Seeker	No. of Patients	Percentage	Ethnic Category of Known Asylum Seeker
No	398	97.8%	M Caribbean (Black or Black British)
Yes	4	1.0%	N African (Black or Black British)
Not Known	5	1.2%	R Chinese (other ethnic groups)
Total	407	100.0%	S Any other ethnic group

Figure 2: Consent Status Breakdown

73% of inpatients were informal detained

61% of detained patients were consenting, incapable

Overall 21% of patients were incapable



admissions and 27% formally

29% not consenting and 10%

(both informal and detained)

Table 6: Consent Status and Relationship

with Ethnic Category

Ethnic Category	Informal		Detained		
	Capable	Incapable	Consenting	Not Consenting	Incapable
A British (White)	201	63	54	25	9
B Irish (White)	4	1	2		
C Any other white background (White)	5	1	1		1
D White & Black Caribbean (Mixed)	1		1		
F White & Asian (Mixed)			1		
H Indian (Asian or Asian British)	2		2	4	
J Pakistani (Asian or Asian British)	2				
L Any other asian background (Asian or Asian British)			1		
M Caribbean (Black or Black British)	4	1	1	2	1
N African (Black or Black British)	2		2		
R Chinese (other ethnic groups)	2				
S Any other ethnic group				1	
Z Not stated	1	8	1		
Total	224	74	66	32	11

Table 6.1: Consent Status and Relationship between White and Non White categories

Ethnic Category	Informal		Detained			Total
	Capable	Incapable	Consenting	Not Consenting	Incapable	
White (A+B+C)	210	65	57	25	10	367
Non White (D+F+H+J+L+M+N+R+S)	13	1	8	7	1	30

74.9% (275) of the 'White' ethnic groups were informally admitted compared to 46.7% (14) of the 'Non White' categories

25.1% (92) of the 'White' ethnic groups were formally detained compared to 53.3% (16) of the 'Non White' categories

Of the patients who were detained - 27.2% (25 out of 92) of the 'White' ethnic groups were 'Not Consenting' inpatients compared to 43.8% (7 out of 16) of the 'Non White' categories that were 'Not Consenting'

Table 7: Legal Status on Admission and on Census Day

Legal Status	On Admission	On Census
Informal	248	297
Section 2	46	19
Section 3	88	77
Section 5.2	10	2
Section 37/41	7	5
Section 37	1	2
Section 47	1	
Section 48/49	2	3
Section 135	2	
Section 136	2	
Criminal Proceedings (Insanity) Act		2
Total	407	407

Table 8: PCT (Commissioning Body) and Relationship between Ethnic Category

Ethnic Category	5AL	5EA	5ED	5EG	5ER	5EV	5EX	5H7	5HN	5JC	5ML	Total
A British (White)	88	40	49	28	32	2	69	30	10	3	1	352
B Irish (White)	5						2					7
C Any other white background (White)	1	1			1	1	2	1		1		8
D White & Black Caribbean (Mixed)	2											2
F White & Asian (Mixed)											1	1
H Indian (Asian or Asian British)	6						2					8
J Pakistani (Asian or Asian British)	2											2
L Any other asian background (Asian or Asian British)		1										1
M Caribbean (Black or Black British)	7		1				1					9
N African (Black or Black British)	3						1					4
R Chinese (other ethnic groups)	2											2
S Any other ethnic group	1											1
Z Not stated	6		1		2		1					10
Total	123	42	51	28	35	3	78	31	10	4	2	407

Table 8.1 PCT (Commissioning Body) Organisation Code

5AL	CENTRAL DERBY PCT
5EA	CHESTERFIELD PCT
5ED	AMBER VALLEY PCT
5EG	NORTH EASTERN DERBYSHIRE PCT
5ER	EREWASH PCT
5EV	BROXTOWE AND HUCKNALL PCT
5EX	GREATER DERBY PCT
5H7	DERBYSHIRE DALES AND SOUTH DERBYSHIRE PCT
5HN	HIGH PEAK AND DALES PCT
5JC	CHARNWOOD & NW LEICESTERSHIRE PCT
5ML	EAST STAFFORDSHIRE PCT

Table 9: CPA level of Inpatients by Wards

Patients are not given a CPA level until the pre-discharge Multidisciplinary meeting. As a result, 47.9% of patients did not have a CPA level recorded on census day. 52.1% had a known CPA level quite likely from previous episodes of care.

Ward	Neither CPA nor SAP	Standard	Enhanced	Total No. patient
Audrey House			9	9
Beresford	11	5		16
Cherry Tree Close	14	3		17
Cobden Road			5	5
Edale	6	5		11
I C U – A			8	8
I C U – B			11	11
Lathkil	16	5		21
MB UNIT DCGH	1		1	2
Monsal CB Unit			6	6
Morton Ward	26			26
PICU	2			2
Pleasley	16		3	19
Tansley	5	3	22	30
Ward 12 DRI	9	3	1	13
Ward 14 DRI	9	7		16
Ward 28 DCGH	17	2		19
Ward 29 DCGH	13	5		18
Ward 32 DCGH	7	8	8	23
Ward 33 DCGH	6	16	8	30
Ward 34 DCGH	3	6	16	25
Ward 35 DCGH	4	5	18	27
Ward 36 DCGH	12	18		30
Wirksworth	12	2		14
Woodside Ward	6	3		9
Total	195	96	116	407
% CPA level	47.9%	23.6%	28.5%	100.0%

Table 9.1: CPA level and Relationship with Ethnic Category

Ethnic Category	CPA Level			Total No. patient
	Neither CPA nor SAP	Standard	Enhanced	
A British (White)	170	84	98	352
B Irish (White)	2	1	4	7
C Any other white background (White)	5	2	1	8
D White & Black Caribbean (Mixed)		1	1	2
F White & Asian (Mixed)			1	1
H Indian (Asian or Asian British)	2	1	5	8
J Pakistani (Asian or Asian British)	1	1		2
L Any other asian background (Asian or Asian British)	1			1
M Caribbean (Black or Black British)	4	1	4	9
N African (Black or Black British)	1	1	2	4
R Chinese (other ethnic groups)	2	1		3
Z Not stated	7	3		10
Total	195	96	116	407

Tables 10, 11 & 12 relate to patients' incidents recorded only within the last three months for patients with longer inpatient stays

No patients of an ethnic minority group had incidents of recorded injury, seclusion or control and restraint

Table 10: Whether patients had any incidents of injury recorded and the ethnic background of those with recorded injury

Any Recorded Injury	No. of Patients	Percentage	Ethnic Category of patients with recorded injury	No. of Patients
No	345	84.8%	A British (White)	37
Yes	42	10.3%	B Irish (White)	1
Not Known	20	4.9%	Z Not stated	4
Total	407	100.0%	Total	42

Table 11: Whether patients had any incidents of background of those with recorded seclusion

Ethnic Category	Number of Incidents of Seclusion	
	One	Two
A British (White)	5	1
Z Not stated	1	
Total	6	1

seclusion recorded and the ethnic

Patients with episodes of seclusion recorded 7 (1.7%)
 Patients with no episodes of seclusion recorded 400 (98.3%)

Table 12: Whether patients had any incidents of control & restraint recorded and the ethnic background of those with recorded control & restraint

Patients with episodes of control & restraint recorded 12 (2.9%)
 Patients with no episodes of control & restraint recorded 395 (97.1%)

Recorded Number of Incidents of Control and Restraint	Ethnic Category		Total
	A British (White)	Z Not stated	
One	7	1	8
Two	1		1
Three	2		2
Five	1		1
Total	11	1	12

REPORT FOR MENTAL HEALTH STRATEGIC COMMISSIONING GROUP-MAY 2006

Delivering Race Equality Sub Group

Background

SCG is reminded that the DRE sub group was formed following the DOH publication of the DRE consultation document in 2003. In June 2005 the DOH published the final DRE document which 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".

Update of progress

Action Plan

The action plan has been updated to reflect the outcomes in the DRE document. The following gives a brief update of some of the key areas of the plan.

Focused Implementation Site

Derbyshire was successful in becoming part of the Trent Focused Implementation Site (FIS). FIS are a new National initiative to rapidly improve services in mental healthcare for black and minority ethnic (BME) and excluded groups. FIS will work across a whole system in implementing 'Delivering Race Equality in Mental Healthcare' (DH 2005) with the aim of achieving the five year vision stated in the report.

Derbyshire's role is to focus on Culture and Spirituality. We have agreed to:

- Scope 'spiritual' groups within the 3 locality areas
- Identify local 'cultural' groups and begin to develop best practice guidance
- **Identify how mental health services can address spiritual needs of BME patients**

To date the Mental Health Trust have developed a reference guide 'Meeting the religious, spiritual and cultural needs of service users' for staff. The guide will be shared across the health community in Trent for all staff working in mental health services.

User Focused Monitoring (UFM) will be engaged to assess the impact of the guide.

Community Development Workers (CDWs)

The workforce target for Derbyshire is that we will have 9 CDWs by December 2006. There is 1 existing CDW in Chesterfield, Derby Millennium Network have been commissioned to provide 2 CDWs. The workers have been in post since September 05. Although DMN are a Derby based organisation their brief is to work across Derbyshire recognising that initially the concentration of work will be in the City whilst networking with groups that are county based. There are plans for an additional post by September 06. It is likely that the steering group will recommend that the post is based with the Gypsy Liaison service in Matlock.

This will give us 4 workers, which means we will miss the target of 9 by 5 posts. DMN and the North Derbyshire Voluntary Sector Service are working on a plan to ensure that the posts we do have and any future posts we can secure will work together as a coherent 'virtual' team, even if they are based with different organisations.

The existing CDWs have started to make close working links across organisations to support BME service users and communities. They are working to set up specific user and carer support groups and to raise mental health awareness with BME communities. They are also offering a one to one service for people in mainstream mental health services.

Making Space who are providing a carer support service for derby and Derbyshire have designated one of the Derby posts for BME carers. They will be working closely with DMN in providing the service.

Annual Stakeholder Event

The third annual event was held in November 05. The event was attended by 80+ people from organisations across Derbyshire. It was an extremely successful event, comprising; national speakers, including The National Director for DRE, workshops and dance and music performances from community groups. The hard work that DMN and the CDWs put into the event was evident in both the attendance and the content of the day. This year's event is planned for World Mental Health day on the 10th October.

Health Equity Audit

Derby City PCTs Public Health Directorate is undertaking a health equity audit. The audit comprises; a literature search, data analysis using Mental Health Trust data, focus groups and UFM interviews. The DMN based CDWs will be helping to conduct interviews.

Wider engagement

The steering group have been grappling for some time with the issue of how to engage with other organisations such as the Police and criminal justice services, Housing organisations. It is recognised that LSPs are probably the bodies we need to engage with. We are working on a proposal that is realistic in terms of time commitment for both ourselves and the LSPs. This may be a proposal for an annual diversity/bi-annual meeting with leads from each LSP.

R.Sargent
May 2006

DERBY/SHIRE DRE/FIS Agenda - SWOT Analysis

<p>Strengths</p> <p>Partnership working across statutory, voluntary and community sector.</p> <p>Community engagement through consultation events and work of Derby Millennium Network</p> <p>Steering Group as sub group of Strategic Commissioning Group with 2x annual reporting requirement</p> <p>Trust diversity Network and plans to develop specialist post</p> <p>Specialist work within the Trust</p> <p>Community engagement projects</p>	<p>Weaknesses (needs)</p> <p>Links to non health partners</p> <p>Influencing broader community strategic agenda</p> <p>Disciplined monitoring of action plan</p> <p>Capacity</p> <p>Use of information</p>
<p>Opportunities</p> <p>More focussed action planning and follow through</p> <p>Experience has relevance beyond mental health</p>	<p>Threats</p> <p>Capacity to follow through</p> <p>Lack of strategic influence</p> <p>Funding gap</p>

NEW BOOKLET FOR RELIGIOUS SPIRITUAL NEEDS

See Appendix 1

Community Engagement Projects

Derby Millennium Network:

DMN is a lead BME voluntary community sector agency, supporting the needs and issues facing the Black and Minority Ethnic and Diverse communities in Derby. DMN are working and engaging on a wide range of strategic, policy making, grass roots, and community based agenda's. DMN are an umbrella organisation and have membership from both community groups and individuals in Derby. DMN have procured a BME health and social care partnership officer, BME capacity building officer, BME cluster development worker and two Mental Health community development workers. DMN also have a one stop BME health and wellbeing centre in Derby.

Project Focus: The group intends to carry out research on the mental health experiences of over 18's, Black and Asian service users and carers, in order to make recommendations for cultural competence in the mental health services in the Derby city area. They will also carry out research with mental health service providers.

The group intends to develop a structured questionnaire for use with service users, carers and service providers, in order to help design the questionnaire, the group will have direct input from users, carers, and providers by having consultations meetings with them. The group intends to complete 100 questionnaires in total, and hold three focus groups, which will be split between the target research communities.

All the interviews will be conducted on a one to one basis, with two researchers present; interviews will be recorded if consent is given. The focus groups will be split as follows, Mental health service providers/professionals, carers, mixed gender service users, and female only service users.

Services users and carers will be accessed through publicity, community development worker, informal networks, and existing mental health support groups.

The group have completed a detailed time line for the duration of the project, which they will revisit and revise as necessary on an ongoing basis. Researchers have also made a start on completing the UCLan ethics proforma, and have started to draft informed consent/information sheet for the questionnaires and focus groups. The Group have also devised an information leaflet about the project, the primary aim of which is to hand out at local events to raise profile of the project. The group have also attended Uclan Mental Health 1 and 2 workshops, and Research workshops 1, 2 and 3.

A training package for the research team has been devised by the researchers in conjunction with the REL, CDW and steering group members. The research team will have a training presentation once a month in their team meetings, areas identified for presentation are : An overview of the mental health system, The National Health service and related organisations (which will include the following topics, commissioning of mental health service, monitoring/performance management, and the local mental health implementation team), History of mental health and ethnicity, The mental health act and other related legislation (Human rights act, Race Relations (Amendment) Act), Most common mental health diagnosis within BME communities (Bi Polar disorder, Schizophrenia, personality disorder and depression), The role of the Community Development Worker and the Delivering Race Equality Action Plan, and the mental health act ethnicity census. The first of these presentations has taken place which was the overview of the mental health system. Presentations will be carried out by steering group members, REL, CDW's and other relevant professionals.

The group will also be attending and displaying a stand about the project at: *The mental health and media, developing an East Midlands co-ordinated campaign event* on the 14th September

2006, an event which is organised by East Midland CSIP. Some members of the team will also be attending the: *Mental Capacity Act regional launch* on the 6th September 2006, which is being held by CSIP West Midlands. The lead researcher will also be supporting the CDW by co-facilitating a workshop around community engagement with users and carers at an event that is taking place on the 10th October 2006, hosted by Derby PCT titled : *Beyond consultation towards community engagement*.

The person co-ordinating the project from DMN, has gone on to secure a position as FIS coordinator for NIMHE East Midlands, and will be supporting the project, in his new capacity, he already has a good relationship with the researchers and the project, and his new position will further enhance the partnership working.

Presentations about the progress of the project have been made to the LIT, and DRE boards and written updates will be sent to these boards at regular intervals, which will be included in the minutes of the meetings.

Research Team: A team of ten researchers have been recruited to undertake the work, all the researchers are from the Derby area, and come from diverse range of backgrounds. All have some experience as service users and/or carers. The researchers are a mix of male and female from African Caribbean, and South Asian backgrounds. The research team are also from various faith backgrounds, and speak a number of languages between them.

“The workshops were fantastic, I was really nervous about them, but the atmosphere was great“ (Researcher, DMN)

Steering Group: The first two steering group meeting has taken place, meetings will be held on a 6 weekly basis, in between meetings the members are available via email, if they are needed to comment on anything. The steering group is made up of members from Rethink- supported lodgings for BME service users, Derbyshire carers association, Derbyshire mind, African Caribbean mental health group, Derby central and greater PCT (commissioner for mental health services, senior cultural diversity specialist, PALS manager), Asian women’s mental health group, specialist registrar – public health, senior lecturer Derby university, ward 35 psychiatric acute unit, African Caribbean service user, Asian service user, REL and SW. The steering group are clear about their role in relation to the project, and will support the research team by providing support and guidance throughout the lifetime of the project, they will also share their area of expertise as relevant to the research, members will also comment on research tools, final report, and other information related to the project. Members of the steering group will also raise awareness of the project via there own networks, and will help to identify placements/shadowing opportunities for researchers.

Completed Community Engagement Project

Karma Nirvana - Derby

Focus of the work:

Mental health needs of South Asian women re-settling in Derby following Domestic Violence.

Researchers:

Four women – two were former service users. One has since gained employment and one has taken up a Foundation Degree

Methods:

Questionnaires focus groups and case studies.

Sample:

Questionnaires were completed with 30 women aged 18-49. Most were aged between 25 and 39. Two thirds were Pakistani; one third was Indian. Most were British Citizens, although a third were born outside of the UK. Two thirds of the sample was Muslim; one third was Sikh. Nearly one third of the sample were unable to either speak or write in English. Generally respondents were more likely to be verbally fluent in any language than they were to be literate in it.

In addition five of the women agreed to take part in a focus group.

Key findings:

Over a third of the sample reported forced marriages.

Over two thirds reported domestic violence.

Lack of independence was also reported as an issue by a third of the sample.

There was a considerable delay between being the victim of domestic violence and seeking help

Feelings of shame, stigma, and isolation and fear of re-percussion were greatest barriers to seeking help. Financial dependency was also an issue.

Lack of contact and separation from family contributed to feelings of sadness and depression for around one third of the sample each.

Depression, stress, fear and loneliness were common amongst the sample – only half had ever sort any help with any of these feelings however, mainly because people didn't know that help might be available or where to go

Broader issues such as housing and community safety have a significant impact on mental well-being. This is particularly so within the context of racism and community cohesion or poor community relations.

There was a considerable desire to develop personally amongst the sample (e.g. through education)

Key things people wanted:

Understanding of South Asian culture and family issues from people they sort help from.
Help to overcome feelings of shame and isolation
A greater range of help – someone to talk to who would understand – counsellors from minority ethnic backgrounds.
Projects aimed at mental well-being and inclusion

Recommendations:

Well-publicised easy access services – publicity aimed at South Asian women
Training for people in a range of generic and specialist services around the specific needs of working with South Asian women and domestic violence/forced marriage – looking out for it, knowing what to do, awareness of issues such as family and honour
Availability of broader range of services (i.e. social inclusion – beyond medication)
Specific needs of South Asian women who have escaped domestic violence and/or forced marriages (e.g. around dependency and confidence)

Since Completion of report

- Group have had a private launch of the report to the steering group.
- Official launch of the report is being planned in January (where the group hope Baroness Scotland), will attend.
- Since the inception of the project one of the researchers has gone onto full time in employment, one has gone back to undertake a degree in community development and regeneration and the University of Derby, and two are in the process of applying for the Community development workers posts in Derby.
- The lead researcher has also taken part as a member of the Fis review panel that was undertaken in the South East.
- A working group of all the key stakeholders is in the process of being set up, to take forward the recommendations of the report.
- The group have presented their work to a number of regional forums and conferences.
- All four of the researchers have gained the University certificate in community research and Mental Health.

**Delivering Race Equality-Focused Implementation Site (Value added Grant)
update August 2006
Derbyshire Focused Implementation Site**

Introduction

Derbyshire is part of the Trent Focused Implementation Site (FIS). The Derbyshire DRE steering group is working to implement all areas of the action plan to deliver against the desired outcomes detailed on page 19. However, as part of the Trent FIS it was agreed that the area of work that Derbyshire would contribute was in developing approaches towards ensuring that spirituality was addressed as part of the care planning process. Therefore this report concentrates on that area of work with some obvious overlaps and references to other areas of activity that are inter-related.

Progress

Derbyshire Mental Health Trust has developed a guidance document in meeting the religious, spiritual and cultural needs of patients.

This has been adopted across the organisation and has been used to underpin the assessment of patient needs.

Increased access to spiritual leaders from the community has been established complimented by the appointment of two posts to reflect both the higher population of Sikh and Muslim faiths within Derby.

Recognition has been given to limitation of guidance and further work is underway both in educating staff in cultural awareness and proactively ensuring documentation reflects the required assessment of needs.

An independent audit of the guidance and its impact in service delivery is to take place in the autumn.

The CSIP lead on spirituality, Peter Gilbert, has been consulted and kept informed of progress.

The guidance has been widely distributed within the Trust and shared nationally with other providers of mental health care.

Training

To date the Value Added Grant has not been committed.

The plan is to commission User Focused Monitoring (UFM) to undertake a piece of work to assess the impact the new guidance has had on the experience of BME Groups of mental health services.

User Focused Monitoring is an approach to evaluating services that was developed by the Sainsbury Centre for Mental Health. A group of service users are trained to develop an evaluation project for a specific service area and undertake interviews of other service user analyse the findings and develop an action plan.

Discussions have been held with the UFM group in Derbyshire and they are keen to participate in this work. They do acknowledge that they are a predominately white group of people and will need assistance to recruit new interviewers from BME communities.

Either by good fortune or by good planning the Community Engagement Project recently agreed to be carried out at Derby Millennium Network has identified up to 20 people from BME communities, with experience of mental health services, that are interested in being involved in research and evaluation. Work is taking place to form a collaboration between these two areas of work.

Delivering Race Equality-Focused Implementation Site (Value added Grant) update August 2006.

It is planned that the Value Added Grant will be used to:

- i. Add to the budget of the Community Engagement Project to enable it to support a greater number of researchers.
- ii. Commission a UFM project focused on the impact of the spirituality guidance
- iii. Fund an event to enable wider dissemination of information about the DRE work being undertaken in Derbyshire

Ruth Sargent (Chair) On behalf of the DRE steering group

August 2006

Lincolnshire - Morton Hall Prison Project:

HMP Morton Hall is situated in rural Lincolnshire and is a designated foreign national prison catering for an average of between 70-80% BME prisoners. The prison has a high proportion of women from BME communities (most notably African/Caribbean women), in a county with a small BME population and growing African and Caribbean community. Many of these women are imprisoned for drug trafficking offences and are a long way from their home and families

Project Focus: To develop and improve understanding of the Mental Health support needs of BME women in Morton Hall prison, initially this was going to be primarily women from the African and Caribbean sub continent, as this is the group that has an over representation in the women prisoners population at Morton Hall, but this may change to include Eastern European women prisoners. The research focus will be finalised at a meeting due to be held on 16/09/06 between UClan, REL, NIMHE prisons lead and the prison governor.

Enhanced security clearances have been approved for the UClan SW and coordinator, UClan teaching staff, and other personnel still awaiting clearances.

Time line for the duration of the project has been developed by the coordinator, and coordinator has also made a start on completing UClan ethics proforma, and local prisons ethics form. Also a start has been made on developing an informed consent/information sheet.

Meeting on the 16/09/06 took place to clarify a number of issues: research focus, payment amount to prisoners and ethics. At the meeting it was agreed that research focus would be dependent on majority ethnic background of prisoners. The prisoners will also be paid twenty pounds per week to work on the research. Workshops will be delivered in the prison to the prisoners, and have been scheduled for late November (for Mental Health 1 and 2), and early October for (Research 1,2, and 3), with the final two workshops taking place in Mid January (Research 4 and 5). Lead researcher will be attending Lit and DRE meetings in November to update them on project progression, and written updates will be sent in a regular basis to be included with the minutes.

Research Team: The coordinator has been recruited from the outside, and she will be the lead researcher working with the women in the prison, and coordinating the project. An attempt has also been made to recruit the women prisoners at Morton Hall. A flyer/notice was sent out giving details about the project, and asking interested women to apply. The response rate was very low, and the women that were interested did not fit the criteria (i.e. women from the African and Caribbean sub continent). However a follow up to the recruitment, where the coordinator had a walk around with a prison officer to raise profile of the project was very encouraging, with a number of women expressing an interest in taking part. The prison governor has agreed to 5 women prisoners taking part in the project and workshops. An open recruitment event will take place in early October, where prisoners will be invited to an open event, so that they may find out in detail what the project is about.

Steering Group: The first steering group meeting has taken place, all meetings will be held at the prison. Steering group members have been given access to attend these meetings by the prison governor. Once the prison researchers are recruited an individual from the research team will also be invited to sit in the steering group. The steering group consists of REL, SW, NIMHE East Midlands prisons lead, Lincolnshire NHS partnership Trust, Morton Hall staff (Governor/Deputy, head of Healthcare, and research), Commissioner Mental health services Lincolnshire PCT, Voice East Midlands. A discussion also took place at the steering group about some members of the steering group attending the UClan workshops; this is further being discussed and considered.

Focused Implementation Site Action Plan

Delivering Race Equality

October 2006 - 2008

Introduction

Delivering Race Equality in Mental Health Care: An Action Plan for reform inside and outside services is a comprehensive and results-orientated programme for tackling racial inequality in Mental Health Care.

Nottinghamshire Healthcare signed up in 2005 to become one of the first national Focused Implementation Sites (FIS) for Delivering Race Equality (*DRE*). Seventeen Focused Implementation Sites have been established in liaison with Strategic Health Authorities across the country. As a FIS site, the Trust is required to identify best practice and demonstrate focused and accelerated progress towards achievement of the Department of Health's vision for improving the provision of services to Black and Minority Ethnic communities.

Delivering Race Equality in Mental Health Care (DRE)

DRE is an action plan for 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. The action plan draws on three recent publications:

- 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, a 38-year-old African Caribbean patient who died on 30th October 1998 in a medium secure psychiatric unit after being restrained by staff.

The DRE programme is based on three building blocks:

- *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 Community Development Workers nationally.
- *Better information* – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services.

The vision for DRE is that by 2010 services will be characterised by:

1. less fear of mental health services among BME communities and service users;
2. increased satisfaction with services;
3. a reduction in the rate of admission of people from BME communities to psychiatric inpatient units;
4. a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;
5. fewer violent incidents that are secondary to inadequate treatment of mental illness;
6. a reduction in the use of seclusion in BME groups;
7. the prevention of deaths in mental health services following physical intervention;
8. more BME service users reaching self-reported states of recovery;
9. a reduction in the ethnic disparities found in prison populations;
10. 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;
11. 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

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

The FIS Action Plan aims to secure quantifiable improvements in the services provided to BME communities, in line with these key service delivery outcomes.

The key principles set out within the Trust's FIS Action plan has been developed through by multi-professional Steering Group, following a robust baseline activity and information evaluation process, which was fully be a multi-professional Steering Group.

Executive Sponsor: Rachel Munton - Executive Director of Nursing and Allied Health Professionals

Lead Manager: James Fleet – Corporate Personnel Manager

The FIS Action Plan has been compiled with the significant contributions of Michelle Johnson (Equality Adviser – Local Services), Zulfkar Hussain (Clinical Nurse Specialist – Asian Services) and Steph Palmerone (Associate Director of Strategic Planning & Modernisation).

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
<i>Monitoring</i>				
1. Analyse BME service user representation within clinical services (refer to 2005 census data)	1,8	Directorate Information Analysts	Quarterly reporting to Equality Committee	December 2006
2. Establish baseline of BME community's perception of mental health services.	1	Involvement Team Audit Team PALS Complaints Department	Quarterly reporting to Equality Committee	January 2007
3. Conduct annual Trust wide satisfaction surveys of all care groups, inpatient and community services.	2,8	Applied Informatics	Annual report to Equality Committee	January 2007
4. Analyse admission and readmission rates and take action to address disproportionate BME admission rates.	3,8	Applied Information Team Head of Performance (Forensic) Trust Performance Lead	Quarterly reporting to Equality Committee Balanced Scorecard for AMH Trust Performance Reports	December 2006
5. Analyse source of referrals leading to admissions and take steps to reduce disproportionate rates.	3	Directorate Management Teams Applied Informatics Directorate	Quarterly reporting to Equality Committee Directorate Clinical	February 2007

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
		Equality Leads	Governance Groups	
6. Collate and analyse compulsory detention data.	4	Information Governance and Mental Health Lead – Joy Fisher Social Services Directorate	Quarterly reporting to Equality Committee	December 2006
7. Analyse data on violent incidents involving BME service users.	5	Health Informatics Service – Geoff Clements	Quarterly reporting to Equality Committee	From December 2006
8. Monitor complaints and serious untoward incidents by ethnic category.	5	Clinical Governance Lead Complaints Lead Risk Management Lead	Quarterly reporting to Equality Committee Directorate Clinical Governance Groups Serious Clinical Incident Review Group Trust-wide Clinical Governance Committee	January 2007
9. Monitor staff access to regular updated MVA, cultural and racial awareness training.	5,7	Workforce Development (Denise Harrison) MVA Training Teams	Quarterly reporting to Equality Committee	December 2006
10. Monitor use of seclusion for BME service users	6	Health Informatics Service – Geoff Clements	Quarterly reports to Directorate Clinical Governance	January 2007

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
			Committees	
11. Monitor data for BME service users who become prisoners whilst receiving psychiatric care.	9	CPA Department – Mark Varney Directorate Management Teams	Quarterly reporting to Equality Committee	December 2006
12. Monitor and report on the availability of and access to culturally specific therapies, support and social inclusion.	10	Directorate Management Teams Directorate Equality Leads		
13. Analyse and monitor BME service user involvement and volunteer recruitment across directorates.	10,11	Voluntary Services Department – Diane Bown Involvement Team – Paul Sanguinazzi	Quarterly reporting to Equality Committee	December 2006
14. Identify lessons learnt from deaths in care using the 'root cause analysis' technique.	7	Trust Risk Manager – Jane Craig	Governance and Risk Assessment Committee Quarterly reporting to Equality Committee	January 2007
15. Ensure appropriate representation on RCA panels, e.g. clinical, MVA department etc.	7	Clinical Governance – John Gibbon	Trust wide & Directorate Clinical Governance Committees	January 2007

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
<i>Community Engagement</i>				
16. Engage with BME communities to establish activities aimed at de-stigmatising mental health services.	1	Involvement Team – Paul Sanguinazzi	Quarterly reporting to Equality Committee	March 2007
17. Identify at least 2 community de-stigmatising activities for inclusion in annual directorate business plans.	1	General Managers	Trust Business Plan Review Patient and Public Annual Survey	March 2007
18. Develop focused interventions linked with community development workers (CDW) within those geographical areas where rates are disproportionate.	3	Directorate Management Teams Clinical Directors	Trust wide HR Performance Reports	January 2007
19. Involve BME services in key local directorate forums and in developing and delivering Trust training initiatives.	11	Involvement Team – Paul Sanguinazzi	Quarterly reporting to Equality Committee	December 2006
20. Development of a pilot engagement scheme to assess and support the needs of African Caribbean patients at initial assessment and admission on acute wards.	11	Corporate Personnel Manager – James Fleet Head of Involvement – Paul Sanguinazzi.	End of project report to Equality Committee	October 2006

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
<i>Communication & Policy</i>				
21. Identify safe alternatives to seclusion.	6,7	Clinical Directors Clinical Nurse Specialists	New procedures through ELC Equality Committee	October 2006
22. Compile registers of focused directorate activity and community engagement for BME service users based on lead, shared and partnership responsible levels.	1	Directorate Managers Communications Team – Julie Grant	Local Equality Forums Quarterly reporting to Equality Committee	December 2006
23. Build BME focused activity into business plans.	1	Head of Business Planning – Barrie Humphriss	Corporate and local business plans	March 2007
24. Review physical intervention guidelines in keeping with RCA recommendations and amend as appropriate.	7	MVA Training Teams	Trust wide and Directorate Clinical Governance Committees	January 2007
25. Develop guidance on the provision of support and information to the family of the deceased and staff.	7	Trust Risk Manager – Jane Craig	Governance and Risk Management Committee Quarterly reporting to Equality Committee	December 2006

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
<i>Performance Management</i>				
26. Integrate satisfaction survey recommendations into directorate business plans, PADS and Trust-wide objectives	2	Head of Business Planning Head of Workforce Development Head of Performance	Quarterly business plans PADS	Ongoing
27. Implement care pathways that reflect ethnicity and culture in assessment, diagnosis, risk assessment and care planning.	12	Directorate Managers Directorate Equality Leads	Quarterly reporting to Equality Committee	March 2007
28. Develop specific targets for reduction of compulsory admissions	4	Medical Director Performance Team		March 2007
29. Include targets to reduce seclusion in business plan outcomes.	6	Health Informatics Service – Geoff Clements Head of Business Planning	Directorate Clinical Governance Committees	January 2007
30. Conduct Equality Impact Assessments (EIAs) to inform and guide service reviews across all care streams.	10	Corporate Personnel Manager – James Fleet	Annual report the Equality Committee	December 2006

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
Workforce				
31. Use workforce data/applied information to target focused recruitment activity of underrepresented BME communities, in partnership with local authorities and other agencies.	12	Head of Workforce Development – Lindsey Wallis Corporate Personnel Manager – James Fleet E-Learning Lead – John Clarke	Quarterly reporting to Equality Committee	January 2007
32. Provide all medical and clinical staff with cultural and racial awareness training and integrate such training into the continuing professional development process.	12,5,6	Head of Workforce Development Corporate Personnel Manager Clinical Directors	Quarterly reporting to Equality Committee	January 2007
33. Review training and development programmes and evaluate the impact in relation to BME focused services.	2	Head of Workforce & Organisation Development Corporate Personnel Manager Associate Nursing Directors	Performance reporting to Trust Board ELC	January 2007
34. Assess cultural sensitivity and appropriateness of MVA training.	5	Head of Workforce & Organisation Development Clinical Directors Associate Nursing Directors	Quarterly reporting to Equality Committee Governance and Risk Management Committee	January 2007
35. Establish criteria to assess cultural competence and evaluate this	8	Corporate Personnel Manager	Quarterly reporting to Equality	January 2007

ACTIONS	RELEVANT OUTCOME	LEADS	PERFORMANCE REPORTING	TIMESCALE
across the workforce.		Head of Workforce & Organisation Development	Committee	

Nottinghamshire Healthcare



NHS Trust



AmaaniTallawah
PEACE AND IMPRESSIVE STRENGTH

PILOT FOR

“AFRICAN CARIBBEAN COMMUNITY
ENGAGEMENT”

Amaani Tallawah supports and promotes the well-being of African Caribbean people who use mental health services in Nottingham. Services provided include floating tenancy support, drop-in services, advocacy, provision of relevant information and education and awareness of issues relating to mental health.

The points below set out a jointly developed proposal, between the Trust and Amaani Tallawah which aims to address a clearly identified need by the African Caribbean service user population within the Trust's Adult Mental Health (City) in-patient wards.

This proposal has been developed in line with the specific Delivering Race Equality (DRE) Focused Implementation Site - Value Added Grant requirements and focuses on 'communication and access to support' for BME service users.

Supporting African Caribbean Community Engagement with Mental Health Services

The proposal:

1. Amaani Tallawah will provide two Community Engagement workers to set up a weekly two hour surgery on:
 - a) Ward A42 at Queens Medical Centre
 - b) Lady Middleton Ward at Highbury Hospital
 - c) Lister Ward at Duncan Macmillan House
2. This pilot scheme will run for six months, (26 weeks), from week commencing 8 January 2007 to week ending 7 July 2007.
3. The aims of this scheme is to offer a focused clinical service to African Caribbean patients on these acute wards by supporting them through their in-patient care, identifying their specific cultural, clinical and social needs in order that more effective culturally sensitive support and intervention is provided to these patients in the rehabilitation and recovery process.

A holistic support network will be provided, where users can access support with housing, finance, medication etc

The presence of the Amaani Tallawah Community Engagement workers on the wards will give Service Users the opportunity to make links with a service they feel they can trust and have confidence in. We hope to build a rapport with patients and provide them with a sensitive service

4. This pilot programme will deliver key lessons, information and best practice insight into delivering the quantifiable service improvements benefits identified within ***Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services (DRE)***.

The key outcomes of this pilot project will be:

- a) A smoother transition through in-patient care back into the community for African Caribbean patients
- b) A reduction in re-admissions to the wards of African Caribbean patients

- c) A reduction in referrals to secondary services (CMHT's) of African Caribbean patients
 - d) Service Users will have confidence to contact services earlier when in crisis
 - e) Amaani Tallawah will receive recognition and be consulted for initial assessments
5. Amaani Tallawah will provide research information, recommendations and have consultation with the Trust in order to plan a way forward.

Projected Costs

2 x Community Engagement Workers

Hourly rate	£10.1665 x 15hrs per week each	
Travel expenses/Parking	£390 per 26 weeks	
Administration/running costs	£250 per 26 weeks	
Produce a final report	£300	
	
Total		£8,870.

Community Development Workers

Trent

CDWs at August 2006

Area	Target	Actual
East Midlands Target	38	5
Derby/shire	9	3
Derby	6	2
North Derbyshire	3	1
Nottingham/shire	9	2
North Notts	3	2
Nottingham City + South	6	0
Lincolnshire	6	0
Leicester/shire	9	0
Leicester	5	0
Leicestershire	4	0
Northamptonshire	5	0

Leicestershire, Rutland and Northamptonshire SHA

**Delivering Race Equality in Mental Health Care
LNR Focused Implementation Site - Added Value Grant Form**

Title of activity:

LNR – Value Added Grant

1. Engaging with communities, service users and carers to provide genuine opportunities to influence mental health policy, commissioning and provision.
2. Development of Coping Strategies to deal with life challenges through Mental Health Coaching

Description of the activity in no more than 250 words:

1. Engaging with communities, service users and carers to provide genuine opportunities to influence mental health policy, commissioning and provision. This will be achieved through undertaking the following:

User led validation of baseline assessment and local DRE action plan.

- Training and support for users, carers and members of the community to enable them to engage with communities to validate the baseline assessment and actions needed to address issues.
- Events to facilitate the above
- Material/Information/Resources to engage

User led audit and review of services

- Provide training, expenses, resources needed to enable users, carers and community members to engage effectively within processes informing commissioning, planning, delivery of services and review of mental health services. This would be through voluntary sector organisations and community groups.

Commissioning Framework Tool/Mechanism

- The above activities will feed into the development of a robust commissioning tool that enables the effective engagement of users, carers and the community. The local FIS group will establish a reference group to be a critical friend to commissioners of mental health.

2. Development of Coping Strategies through Mental Health Coaching

Coaching, is a modern and rapidly growing method for helping others to improve and develop new skills, find personal success, achieve aims and manage life changes. There is considerable potential for utilising coaching in mental health. Coaching unlocks a person's potential to maximise their own performance. In Leicestershire, the BME communities have identified the need for culturally appropriate, non-medical interventions to help cope with life challenges. This is at a stage that would help prevent the situation from deteriorating to the extent that medical help is needed.

The activity that is proposed is to train 3 individuals in coaching for mental health. Once trained they will utilise the peer group education model which has been successfully implemented and mainstreamed within ELPCT. This model will coach individuals who have not yet entered mental health services at the primary care level, but prevent them from doing so through enabling them to deal with life challenges.

Please explain how this activity will enhance the delivery of the DRE Action Plan:

Once the activities have been undertaken and fully implemented, the delivery of the DRE action plan will be enhanced through enabling us to effectively monitor the implementation of the action plan at the ground level and within the communities.

The activities will help to ensure that there is engagement at all levels throughout the delivery of the DRE action plan and other mental health planning, commissioning and review processes.

Anticipated outcomes:

- Engagement throughout commissioning cycle
- Increased trust within the community leading to less fear of mental health services amongst BME communities
- Increased satisfaction and less fear of services
- A more active role for BME communities and BME service users in the planning and provision of services

Justification for the amount:

1. Engaging with communities, service users and carers to provide genuine opportunities to influence mental health policy, commissioning and provision - £30,000

- User led validation of baseline assessment and local DRE action plan – £10,000
- User led audit and review of services - £20,000

2. Development of Coping Strategies through Mental Health Coaching - £20,000

- Training of coaches who will in turn train community coaches
- Community coaches in the community
- Training materials and resources
- Promotion and raising awareness

*Amounts include marketing and awareness raising within BME communities using local community media networks.

Community Development Workers

LNR

CDWs at August 2006

Area	Target	Actual
East Midlands Target	38	5
Derby/shire	9	3
Derby	6	2
North Derbyshire	3	1
Nottingham/shire	9	2
North Notts	3	2
Nottingham City + South	6	0
Lincolnshire	6	0
Leicester/shire	9	0
Leicester	5	0
Leicestershire	4	0
Northamptonshire	5	0

**Delivering Race Equality in Mental Health Care Action Plan
Leicester, Leicestershire and Rutland**

Building Block One: Appropriate and Responsive Services – To make sure we improve the clinical care of all BME groups

Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress - Sept 2006
1. To achieve appropriate and responsive services	Baseline assessment of need is being finalised. This will be informed by National work.	(a) To develop a shared understanding of 'appropriate and responsive' services for our local population through working in partnership with users, carers, providers and commissioners.	Time and capacity of current leads to go through information properly.	Meena Ackbarally, ELPCT	Numbers 1, 2, 10	Completed
		(b) Draw key themes from local evidence underpinned by national research, models and tools as a baseline assessment		Shabana Janjua, ELPCT		Completed
		(e) Train service users to lead the baseline		Training material, trainer		Review feasibility of this methodology

		<p>assessment validation process.</p> <p>(c) To utilise commissioning as a lever to deliver responsive service</p> <p>(d) To raise awareness of FIS and DRE and its implications to MHIP Steering Group, LIT, PEC's, Boards and LA equivalent</p>			<p>Number11</p>	<p>Validation Exercise completed with recommendation reflecting the DRE characteristics</p> <p>Commissioning Strategy to be completed by December 06 with an evaluation of the process used Reference group with users and carers to act as a critical friend</p> <p>Completed</p>
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2. Benchmark services against the outcomes from the baseline assessment		(a) Develop a methodology to carrying out bench marking.	Financial	- Clinical Governance Forum - LA audit - BME census	Number1, 2 , 10	Complete by Nov.06
Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress – Sept 2006
1. To work towards a workforce that is representative of the BME population	Integrated work plan being developed by the LIT	(a) Carry out an analysis of the current workforce to determine BME representation (b) Ensure work force plan addresses issues of representation at every level and grade within		WDC	Number 12 which will have a positive effect on a number of other characteristics	To be reviewed in the context of SHA organisational changes

		<p>organisations</p> <p>(c) Explore with Chief Execs to include workforce representation as part of objective setting for Directors as per Nigel Crisp's 10 point action plan</p>				
2. To assess individual and organisation's learning and development needs	Training needs analysis to take place in 05/06 Knowledge and Skills Framework (KSF) to be implemented across NHS as part of Agenda For Change. Race for Health	<p>(a) Ensure the training needs analysis to take place address DRE issues and Person Centred Planning</p> <p>(b) Ensure</p>	Resources agreed for TNA- Worker to be employed.	Integrated Training group WDC		<p>Completed</p> <p>Using quality element of SLA to drive this through performance management.</p>

		<p>appropriate mechanisms with KSF are in place to achieve gateway for equality by staff groups at all levels.</p> <p>(c) Appropriate and consistent training to be provided taking into account (a) and (b) above.</p>				<p>Process will be evaluated by Jan 07.</p> <p>LPT(provider) undertaking this with support from FIS Site. Will utilise CD developed with Demontfort University as part of Race for Health Initiative</p>
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Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress - Sept 2006
1. Engage clinicians at every level of FIS delivery	(a) Some clinicians are willing to be involved, however engagement is ad hoc.	Psychiatrists on steering group. Engage clinicians throughout the MHIP process and local DRE FIS Steering Group and the baseline assessment validation road shows		PCT's and LPT	All except 8 and 12	Psychiatrist and GP identified November 06
Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress - Sept 2006
1. CAMHS	CAMHS BME Strategy is complete and being implemented.				Number 1 and 8	CDW in post raising awareness through media,community events PDSA to be used to evaluate Jan07

Building Block Two: Engaged Communities –To give BME communities genuine opportunities to influence mental health policy and provision, and to promote mental health recovery (inside and outside mental health services)

Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress - Sept 2006
<p>1. To ensure that information on services and access is available in appropriate formats, languages and locations for users and carers.</p>	<p>LAMP Directory currently provides information online around local services.</p>	<p>(a) Test out accessibility of LAMP website with BME communities to determine its user friendliness.</p> <p>(b) Provide information in community settings, GP Practices, LPT Settings.</p> <p>(c) Provide information in appropriate formats and in different languages.</p>		<p>Commissioners, LAMP, Service providers.</p>	<p>Number 1</p>	<p>CAHMS have identified a lack of information and leaflets ect are being funded by FIS</p> <p>CDWs have attended and provided information at a number of community events</p> <p>CPA info is being updated, inc. making it available from GPs; design of new leaflet has</p>

		<p>(d) Ensure there is library of resources (MH Promotion) presence at key community events.</p> <p>(e) LAMP SLA to specify what information is to be available, to whom and where. Commissioners to agree format of review.</p>				<p>involved consultation with BME groups</p> <p>Carers Resource Pack has been translated into main South Asian languages</p> <p>Subgroup of Standard One Group is currently working on this Validation Exercise has identified need for improvement Commissioners will address this through SLA which is currently being reviewed. Changes to be implemented by Jan.07</p>
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Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress – September 2006
<p>1. To fast track employment of Community Development Workers as part of being an Early Implementer Site.</p>	<p>There are financial restraints. Consultation documents nearly ready. One adult mental health CDW and 1 WTE CAMHS CDW in place currently against target of 9. Explore joint funding possibilities with Voluntary Sector.</p>	<p>(a) Participation in national CDW Early Implementer Site</p> <p>(b) Paper to LIT and their PCTs for decision.</p> <p>© Agree a model for implementation and a timeline for phased implementation</p>			<p>Will impact on all of the characteristics</p>	<p>A subgroup of the FIS steering worked up a model in 05. CEs through the LIT agreed for this to be tendered. In the process of tendering. Expressions of interest have been received from 16 organisations both local and national. PQQ awaited</p>
<p>2. BME Voluntary Sector, community and faith groups' input into FIS</p>	<p>No BME representative on LIT. Need to put BME mental health barrier on LSP agenda. Connect with council of faith LPT review</p>	<p>(a) To initiate a dialogue with faith groups</p> <p>(b) To ensure LIT has effective BME representation</p> <p>© Remove barriers preventing meaningful</p>				<p>Faith Groups contacted dialogue to engage creatively</p> <p>Developing a model with users carers to ensure LIT has</p>

	internal arrangements regarding Diversity group including external BME representation.	engagement at meetings.				<p>meaningful BME representation. model to be presented to LIT in Dec06</p> <p>Cards system and Jargon busting initiative being implemented and piloted at Steering Group meeting</p>
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3. Building Block Three: Better Information – To make sure that we have better information on service use and needs, and knowledge of recovery-enhancing environments and approaches

Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress – September 2006
<p>1. Ensure all organisations have agreed ethnicity monitoring categories to enable a consistent approach.</p>	<p>Most organisations use the census categories. However the categories are too broad and ethnic monitoring does not give additional information on culture/religion.</p>	<p>(a) Map out findings and bench mark against national BME Census trends. Use data to influence commissioning intentions.</p>			<p>Will impact on all of the characteristics</p>	<p>Data collection from providers is being addressed through the Sla Cluster meetings</p>
<p>2. To ensure ethnicity recording is embedded in each organisation's culture</p>	<p>Think it is good but need to audit. Check complete consistency</p>	<p>(a) Recording this data should be mandatory, include in SLA's. (b)To provide training for staff to understand the importance of recording this information and the benefits of having this knowledge in order to deliver</p>				<p>Already included in City Council SLAs and Care First data capture – ethnicity, gender, religion. Reporting on ethnicity and gender good. Reporting on religion variable.</p>

		<p>appropriate and responsive services</p> <p>© Ensure data recorded is wider than ethnicity and encompasses religion, culture, language etc.</p>				
3. Obtain High-quality data on ethnicity that is sensitive to local needs, and reflects all ethnic minority groups		<p>(a) Improve data captured by LPT and PCTs. Improve BME data within Minimum Data Set e.g. ethnicity, religion, language, or gender</p> <p>(b) Build on good practice in Local Authorities</p>				
4. Meet the statutory obligation under the Race Relations (Amendment) Act 2000 to monitor the impact of services on all ethnic groups.		<p>(a) Obtain BME service user views regarding services they receive in order to inform future planning and improve engagement. Areas to gather data in include:</p> <ul style="list-style-type: none"> - Inpatient 				<p>City Council have contracted Akwaaba Ayeh to carry out a time-limited consultation with carers from African and Caribbean communities, focusing on these</p>

		<ul style="list-style-type: none"> - Use of Mental Health Act - CPA - Take-up of psychological therapies - Rates of diagnosis 				<p>communities' over-representation in MHA stats</p> <p>Use of Mental health Act done in 2003 will be used as a baseline to see if there has been positive changes. Work to be completed March 07</p>
5. Promote inclusion of ethnicity and cultural needs in care planning		(a) Link with the CPA Supervisory Group to include section on care planning that takes into account ethnicity culture				Review status in Dec 06
Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress – September 2006
1. Provide information to users, carers and staff regarding interpreting services		(c) Link to CPA Supervisory Group to include section re interpreting in local Procedures				

Local Aims	Local Position	Action	Resources	Local Responsibility	DRE Key Characteristics	Progress – June 2006
1. Obtain BME service user views re services they receive in order to inform future planning and improve engagement		(a) Service User questionnaires (b) Focus Groups © Feedback from Voluntary Sector providers to BME communities				Some one-off consultations happening. Needs to be embedded into regular feedback – e.g. LPT Patient Survey to make more effort to reach BME service users
2. Provide information to users and carers regarding mental health services with particular reference to local socially inclusive provision		(a) Link with community groups (b) Service user/carers information leaflets				Carers Resource Pack has been translated Leaflets for CHAMS being produced following request from community
3. Reduce stigma relating to mental illness in BME communities		(a) Link with community leaders (b) Provide information and education to community groups				Several awareness raising events have been undertaken by the CDWS

APPENDIX OF DRE KEY CHARACTERISTICS

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

1. Less fear of mental health care and services among BME communities and BME service users
2. Increased satisfaction with services
3. A reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units
4. A reduction in the disproportionate rates of compulsory detention of BME users in inpatient units
5. Fewer violent incidents that are secondary to inadequate treatment of mental illness
6. A reduction in the use of seclusion in BME groups
7. The prevention of deaths in mental health services following physical intervention
8. An increase in the proportion of BME service users who feel they have recovered from their illness
9. A reduction in the proportion of prisoners from BME communities
10. 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
11. 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
12. A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities

Base line Data Report

This report sets out the current available data in Leicestershire Leicester Rutland. Work is in progress to analyse these in relation to the 12 characteristics for successfully delivering race equality within the context of the validation exercise and will ultimately inform the commissioning strategy. Currently this report presents a collation of available evidence.

Population Profile Leicestershire

The County's population of 615,000 is forecast to increase by 4% in the next ten years. Although the County is mostly rural, nearly half the population live in market towns, or urban areas close to Leicester. Leicestershire is rich in the diversity of its people and its resources.

In the early 1970's there was immigration to Loughborough of people of Bangladeshi and Gujurati origin. More recently there has been movement out of the city of Leicester into Leicestershire, particularly into the districts of Oadby & Wigston, Blaby and the southern part of Charnwood Borough. These areas have the highest proportions and numbers of people from minority ethnic communities in the County. The districts of North West Leicestershire and Melton have the lowest proportions and numbers.

Black and minority ethnic groups make up 7.25% of the County's population, compared to 3.4% in 1991. Of these 5.29% are of Black or Asian origin while among the white minority groups there are significant communities of Irish and Eastern European origin, as well as groups of Gypsies and Travellers, refugees and asylum seekers.

The age structure of minority ethnic groups in Leicestershire is more youthful than the white population. One in 14 of the minority ethnic population is of pensionable age, compared to a fifth of the white population.

In the Census 74% of people stated they were Christian, 2% Hindu, 0.8% Muslim, 0.8% Sikh, 0.1% Buddhist, 0.1% Jewish, 15% said they had no religion and 7% chose not to answer the question.

Population Profile Leicester

Leicester City has a total population of 326,981 and is characterised by inner city areas of great cultural diversity, mainly in the North and East of Leicester. There are large council estates in the West and South with mainly white residents. There are also pockets of affluent suburban areas. In the main this would suggest a significantly high level of deprivation, which would normally give rise to higher than average use of services, especially mental health services.

There is also a large asylum seeker population in Leicester with some services being developed to meet the needs of this diverse population.

Other Supporting Documents

The two following documents are a table of ethnic split in the city and county and Mental Health Act statistics for 2003. As a FIS we will be mapping this against 05/06 data and develop actions to deliver DRE characteristic number 4

M Ackbarally

Appendix One

SWOT Analysis of LLR FIS

<p style="text-align: center;">STRENGTHS</p> <ul style="list-style-type: none"> → Innovation, energy, talent, commitment → Performance monitored by LIT → Experience of Redesign and a 'can do culture' → Learning from Race for Health → Community willing to engage → Experience of Community development approach → Using Commissioning as a lever 	<p style="text-align: center;">WEAKNESSES</p> <ul style="list-style-type: none"> → Haven't unlocked full workforce potential → Relatively new organisations → Communication to all parts → Tribalism/organisational traditions → Capacity and funding issues in black voluntary sector → Lack of adequate data → Insufficient capacity
<p style="text-align: center;">OPPORTUNITIES</p> <ul style="list-style-type: none"> → Making an economic case for delivering race equality in mental health → Financial constraints forcing service redesign and creation of plurality in markets → To restore credibility with BME communities → Be a catalyst for clinicians to explore and move towards a social model of care → Practice based commissioning → Developing innovative models of mentoring and coaching 	<p style="text-align: center;">THREATS</p> <ul style="list-style-type: none"> → Competing priorities → Inability to demonstrate economic value → Financial position of local health community → Reinforcing communities mistrust in statutory organisations → Black organisation not achieve a niche in the third sector market

**PERCENTAGE OF PEOPLE IN ETHNIC GROUPS
(by PCT with national and regional comparators)**

LOCALITY	Base Population	WHITE			MIXED			
		British	Irish	Other White	White & Black	White & Black African	White & Asian	Other Mixed
England	49,138,831	86.99%	1.27%	2.66%	0.47%	0.16%	0.37%	0.31%
East Midlands	4,172,174	91.26%	0.85%	1.37%	0.50%	0.08%	0.27%	0.19%
Trent StHA	2,599,080	93.96%	0.73%	1.21%	0.49%	0.07%	0.22%	0.16%
LNR	1,517,463	86.50%	1.06%	1.63%	0.51%	0.10%	0.35%	0.24%
Melton Rutland Harb	140,910	95.23%	0.72%	1.48%	0.24%	0.04%	0.23%	0.13%
Leicester City West	110,739	83.05%	1.58%	1.90%	1.34%	0.21%	0.54%	0.38%
Eastern Leicester	169,182	45.80%	1.09%	2.11%	0.80%	0.18%	0.78%	0.47%
Hinckley and Bosworth	115,258	96.66%	0.52%	0.89%	0.20%	0.04%	0.22%	0.13%
Charnwood and NWL	229,537	92.33%	0.66%	1.44%	0.23%	0.06%	0.29%	0.17%
South Leics	158,436	88.98%	0.76%	1.29%	0.36%	0.07%	0.34%	0.17%

LOCALITY	ASIAN or ASIAN BRITISH				BLACK or BLACK BRITISH			CHINESE or OTHER	
	Indian	Pakistani	Banglades	Other Asian	Caribbean	African	Other Black	Chinese	Other ethnic
England	2.09%	1.44%	0.56%	0.48%	1.14%	0.97%	0.19%	0.45%	0.44%
East Midlands	2.93%	0.67%	0.17%	0.28%	0.64%	0.22%	0.09%	0.31%	0.18%
Trent StHA	0.91%	0.82%	0.05%	0.14%	0.62%	0.12%	0.08%	0.27%	0.16%
LNR	6.51%	0.42%	0.36%	0.54%	0.70%	0.40%	0.10%	0.38%	0.21%
Melton Rutland Harb	1.19%	0.07%	0.02%	0.13%	0.14%	0.04%	0.03%	0.22%	0.09%
Leicester City West	6.97%	0.38%	0.07%	0.60%	1.33%	0.82%	0.16%	0.48%	0.20%
Eastern Leicester	38.02%	2.28%	1.09%	2.87%	1.86%	1.49%	0.22%	0.53%	0.40%
Hinckley and Bosworth	0.69%	0.09%	0.03%	0.13%	0.09%	0.02%	0.01%	0.19%	0.09%
Charnwood and NWL	2.90%	0.08%	0.55%	0.25%	0.11%	0.16%	0.02%	0.50%	0.26%
South Leics	5.97%	0.36%	0.04%	0.52%	0.40%	0.15%	0.05%	0.41%	0.14%

Source – East Midlands Public Health Observatory – based on 2001 Census Data

Analysis of Assessments under the Mental Health Act in Leicester in 2003

Introduction

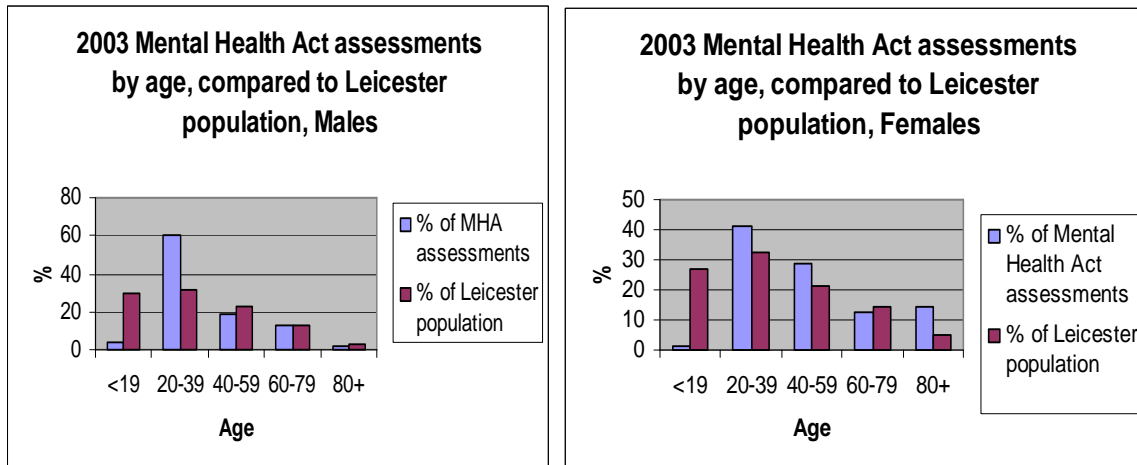
Monitoring forms are completed by Approved Social Workers in Leicester when they are asked to carry out an assessment under the 1983 Mental Health Act. This document sets out the main findings from this monitoring during the period January to December 2003. Full sets of data are available from Kala Subbuswamy (subbk002@leicester.gov.uk or (0116) 225 4768).

Analysis of assessments

Overall, 382 monitoring forms were available for analysis. These were analysed by age, gender and ethnicity and these figures compared to population figures from the 2001 Census.

Gender

43.6% of all the Mental Health Act assessments analysed were carried out on women, compared to 56.4% on men. Women comprised 51.8% of the total Leicester population in the 2001 Census, and men comprised 48.2%.



Key findings:

There are very few assessments for people aged under 19 years

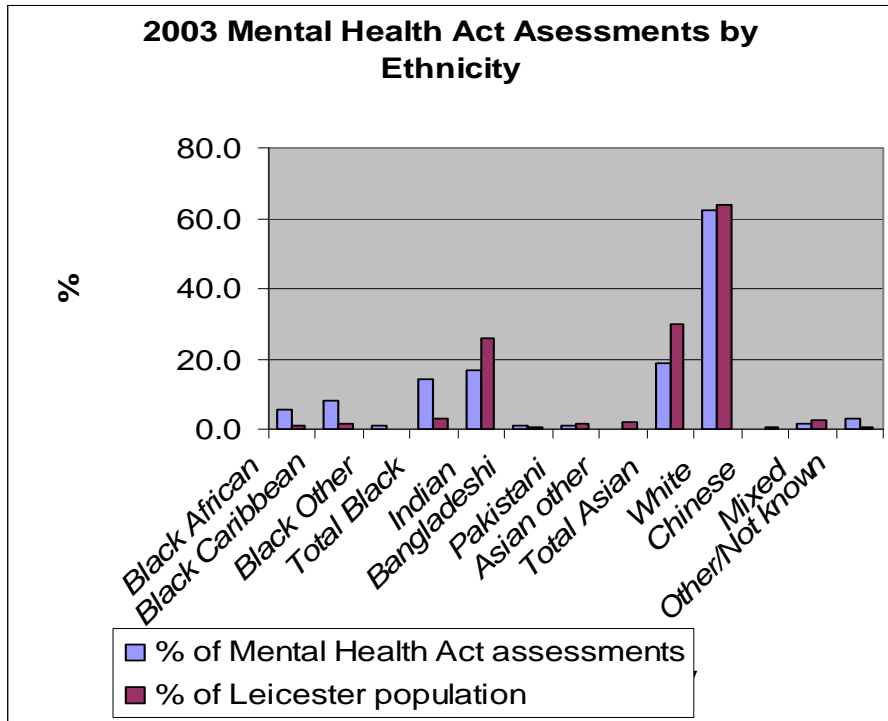
Men aged 20-39 years are particularly over-represented in Mental Health Assessments, making up about 30% of the male population, but over 60% of assessments

There is also an over-representation of women aged over 80 years

Ethnicity

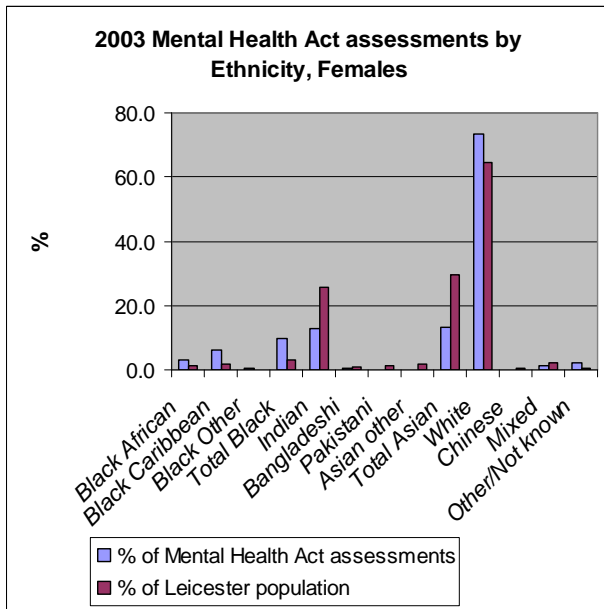
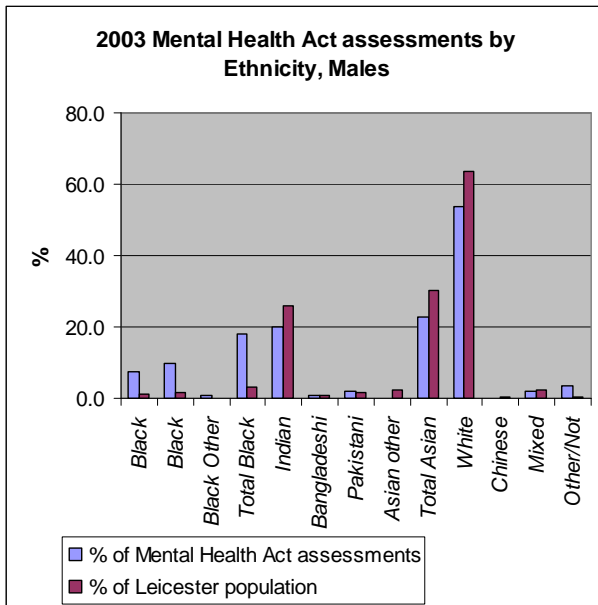
Initial analysis shows over-representation of people from all the Black communities – Black Caribbean, Black African and Black Other in 2003 Mental Health Act Assessments.

There is under-representation of all the Asian communities.



Breaking the figures down by ethnicity and gender shows this same pattern for both men and women, but Black men are particularly over-represented, making up over 18% of male assessments but only 3% of the male population in Leicester. Assessments of Black women make up almost 10% of female assessments, compared to 3% of the female population.

Asian women are particularly under-represented in terms of Mental Health Act assessments.



Due to the small numbers in certain categories, further analysis of assessments was confined to people aged 20 years and over, and based on grouping ethnicities as White, Asian, Black and Other.

Ethnicity, gender and age

Breaking down assessments into 20-39 years, 40-59 years, and 60+ years, and analysing these by ethnicity and gender, shows that:

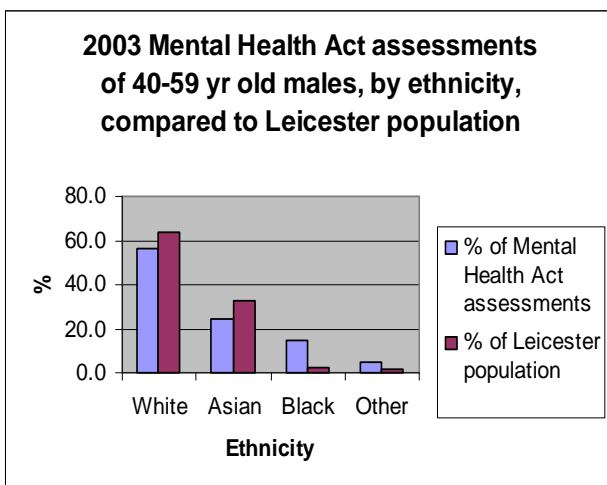
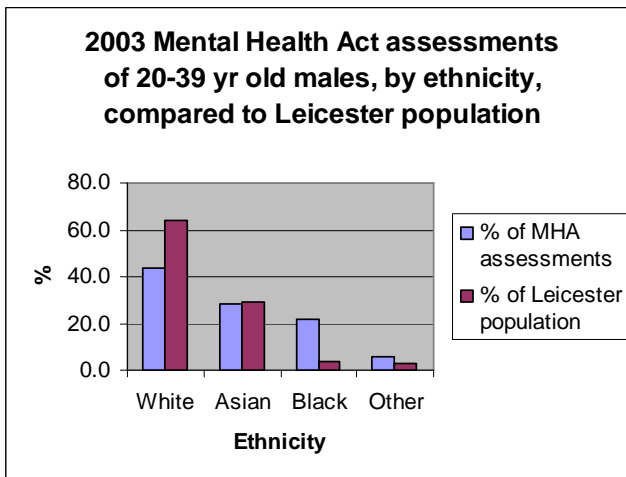
The over-representation of Black men and Black women in Mental Health Act assessments occurs across all adult age groups.

The under-representation of Asian women is particularly marked for women aged between over 40 to 59 years.

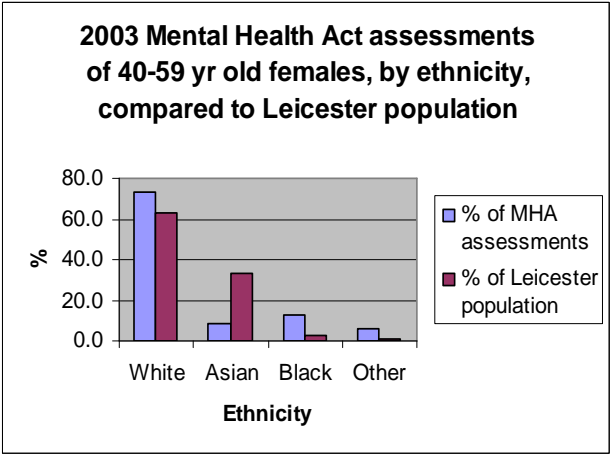
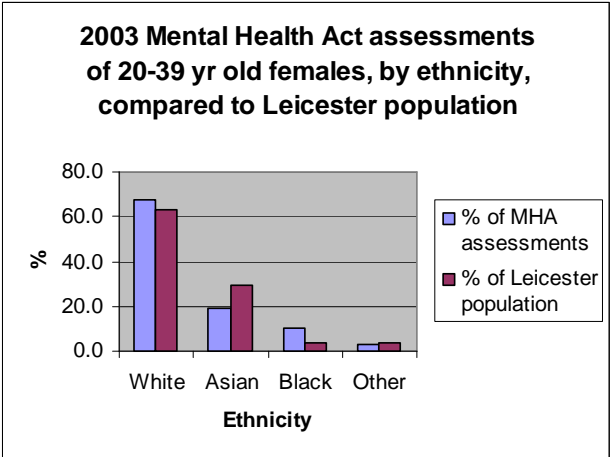
Asian men in the 40-59 year group are slightly under-represented in assessments, but in other age groups show neither over or under-representation.

White men in the 20-39 year group are under-represented in assessments.

Men

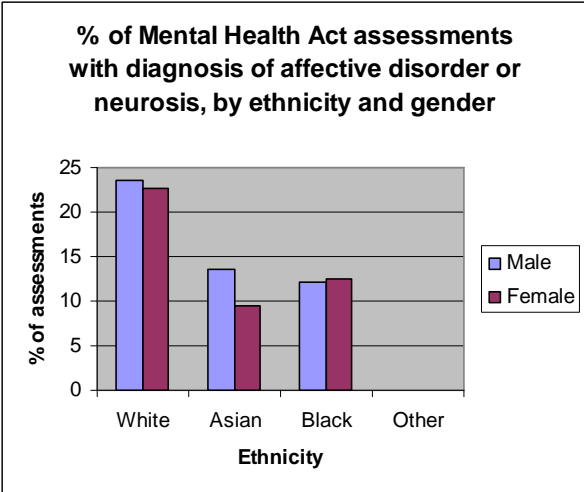
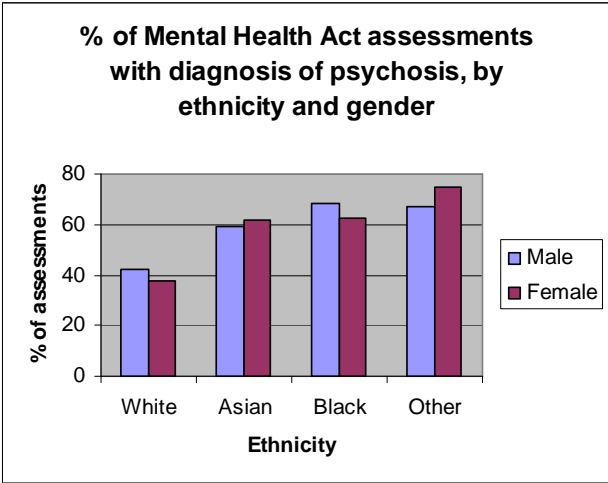


Women



Diagnosis and ethnicity

Compared to the White population, a higher percentage of people from Asian, Black and Other communities who received Mental Health Act assessments in 2003 had a diagnosis of psychosis. A lower percentage from these communities had a diagnosis of affective disorder or neurosis, compared to those from White communities.



People from Black communities who received assessments were over-represented in diagnoses of affective disorder/neuroses, but particularly in diagnoses of psychosis. Black communities made up 3% of the Leicester population in the 2001 Census, but Black men made up 25% of male Mental Health Act assessments with diagnoses of psychosis. The corresponding figure for Black women was 14.5%.

Table 1: 2003 Mental Health Act assessments with diagnosis of psychosis, by ethnicity and gender, compared to ethnicity and gender breakdowns of Leicester population

Men	% of psychosis diagnoses	% of Leicester population		Women	% of psychosis diagnoses	% of Leicester population
White	44.6	63.3		White	62.3	64.3
Asian	23.2	30.4		Asian	18.8	29.5
Black	25	3.0		Black	14.5	3.1
Other	7.1	3.3		Other	4.3	3.1

The figures for psychosis are especially striking when compared to estimated prevalence of psychosis for adults in different communities, based on figures from the Department of Health study, Ethnic Minority Psychiatric Illness Rates in the Community (Sproston & Nazroo, 2002).

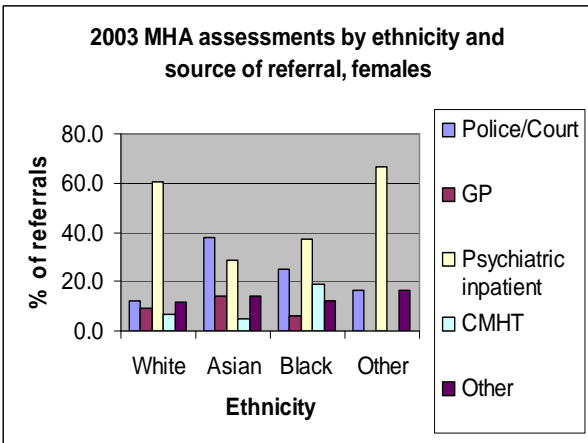
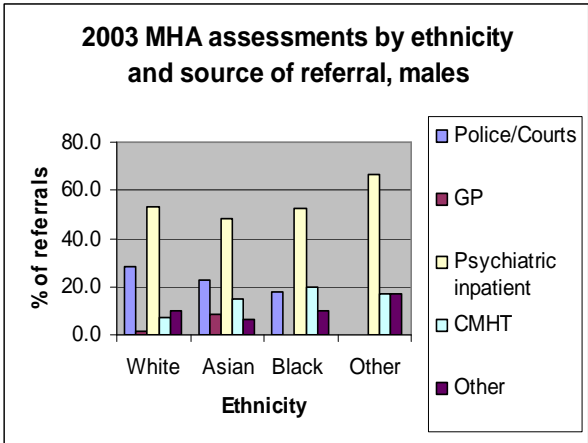
Table 2: Number of Mental Health Act assessments in each community with diagnosis of psychosis, compared to estimated prevalence of psychosis in different communities

	Estimated number experiencing psychosis in a year in Leicester			Number of Mental Health Act assessments with diagnosis of psychosis			% of assessments divided by estimated prevalence		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
White	622	467	1089	50	43	93	8.0%	9.2%	8.5%
Asian	265	393	658	26	13	39	9.8%	3.3%	5.9%
Black	50	59	109	28	10	38	56.0%	16.9%	34.9%
Other	26	29	55	8	3	11	30.8%	10.3%	20.0%

The current analysis does not allow us to say how many assessments are of different individuals and how many relate to the same individual receiving multiple assessments. If all the assessments are of different individuals this means that over a third of Black adults estimated to have psychosis received a Mental Health Act assessment in 2003, compared to around 6-8% in the White and Asian communities. If there are mostly multiple assessments, Black individuals with psychosis are receiving many more assessments in a year than individuals in the other communities. In either situation, Black people with psychosis are being failed by the system. Figures for Other communities also seem high, but the small numbers and lack of data on which to base estimates of prevalence make this an unreliable finding.

Source of referral

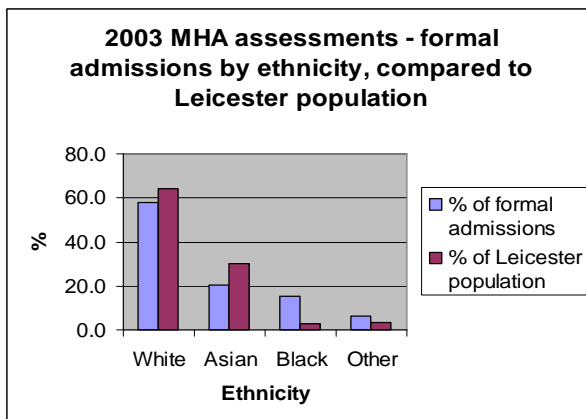
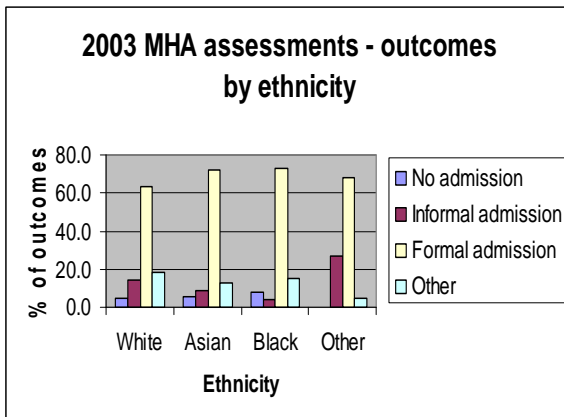
Patterns for source of referral are similar across all ethnic groups for men, with the majority of referrals coming from psychiatric inpatient settings. For women, the picture is more mixed, as shown below. However, the small numbers in some categories make it difficult to draw firm conclusions.



Analysis of outcomes of assessments

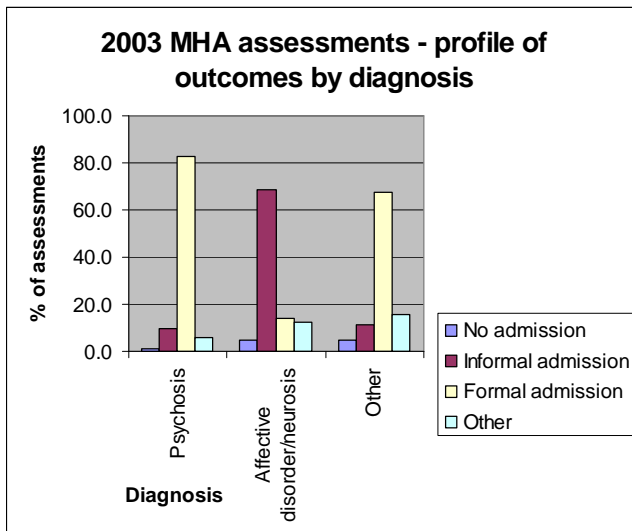
By ethnicity

Outcomes show the same pattern across all the ethnic groups, with the vast majority of assessments (63-73%) ending in formal admission under the Mental Health Act. However, due to the inequalities in assessments initially as shown above, Black communities were strongly over-represented in formal admissions in 2003, compared to their levels in the population, and Asian communities were under-represented, although less strongly.



By diagnosis

Outcomes are strongly linked to diagnosis. Over 85% of assessments of those diagnosed as having psychosis ended in formal admission, compared to only 14% of assessments of those diagnosed as having affective disorder or neurosis. For other diagnoses, 68% ended in formal admission.



The current analysis was unable to explore whether this pattern was different for different ethnic groups, but this analysis could be carried out.

Conclusions

The most significant finding, and the finding that gives rise to most cause for concern is the strong over-representation of Black communities in Mental Health Act Assessments and as a result, in formal admissions or 'sectioning'. This finding replicates local findings for previous years (Appendix A), and this is an issue that clearly needs to be addressed to ensure equity for people from Black communities living in Leicester. The current analysis also indicates a link with diagnoses of psychoses.

The under-representation of Asian men and especially women may be a result of individuals and communities having the capacity to cope with mental health needs. However, particularly in light of suggestions from other areas nationally of relatively high numbers of Asian women self-harming and committing suicide (Bird & Faulkner, 2000), this issue should be explored further.

Recommendations

- That this report is shared with the City Approved Social Worker (ASW) group
- That these findings be reported to the City Mental Health Strategy Team, Local Implementation Team and the mental health Race Equality Group for agreement on future action
- That these findings are shared with the Early Intervention in Psychosis service to explore how they could influence the development and work of the service

References

Bird, L. & Faulkner, A. (2000) Suicide and Self-Harm. Mental Health Foundation

Sproston, K. & Nazroo, J. (2002) Ethnic Minority Psychiatric Illness Rates in the Community. Department of Health

Appendix A

Table 1: Number of Mental Health Act Assessments carried out, by ethnicity and by gender, during 1998, 2001, and 2001/2002

	Number of MHA assessments carried out			Population in Leicester, 2001 census
	1.1.98 – 31.12.98	2001 (limited data available)	1.7.2001 – 30.6.2002	
Total	364	100	300	279,921
By Ethnicity				
Black	33 (9.1%)	17 (17.0%)	31 (10.3%)	8,595 (3.1%)
Asian	45 (12.4%)	12 (12.0%)	42 (14.0%)	85,177 (30.4%)
White	274 (75.3%)	68 (68.0%)	190 (63.3%)	178,739 (63.4%)
Dual heritage		2 (2.0%)	10 (3.3%)	6,506 (2.3%)
Other (Not known/Other ethnic group)	12 (3.3%)	1 (1.0%)	27 (9.0%)	904 (0.3%)
By Gender				
Male	N/a	60 (60.0%)	142 (47.3%)	134,782 (48.2%)
Female	N/a	40 (40.0%)	153 (51.0%)	145,139 (51.8%)
Not known	N/a	0	5 (1.7%)	

Table 2: Compulsory admissions, by ethnicity, 1998 and 2001/2002

	Jan. 1998 – Dec. 1998		July 2001 – June 2002		Total Population Leicester, 2001 census
	Total no. of assessments (% of total admissions)	No. of compulsory admissions (% of total compulsory admissions)	Total no. of assessments (% of total admissions)	No. of compulsory admissions (% of total compulsory admissions)	
Total	364	277	300	216	279,921
Black	33 (9.1%)	29 (10.5%)	31 (10.3%)	19 (8.8%)	8,595 (3.1%)
Asian	45 (12.4%)	35 (12.6%)	42 (14.0%)	27 (12.5%)	85,177 (30.4%)
White	274 (75.3%)	205 (74.0%)	190 (63.3%)	133 (61.6%)	178,739 (63.4%)
Dual heritage	N/a	N/a	10 (3.3%)	9 (4.2%)	6,506 (2.3%)
Not known/Other	12 (3.3%)	8 (2.9%)	27 (9.0%)	28 (13.0%)	904 (0.3%)

Follow-up work – November 2005

49 forms (monitoring and pro-formas) looked at – all those identified as from African-Caribbean backgrounds.

38 separate individuals were identified: 29 (76%) who had only had one assessment in 2003; 9 (24%) who had had more than one assessment.

Therefore, we can say that more individuals from African-Caribbean communities received Mental Health Act assessments that would be expected from population figures. The over-representation finding is not explained by repeated assessments of a small number of individuals.

7 individuals were identified as Somali.

Northamptonshire DRE/FIS Agenda

Completed Community Engagement Project

Count Us In – Northamptonshire Irish Support Group

Focus of the work:

Mental health service needs and experiences of 1st generation Irish community. To gain better information about the issues facing the community so that more appropriate and responsive services could be developed.

Researchers:

Team of 3. All were of Irish decent. Two were from a nursing background. Two had research backgrounds.

Methods:

Questionnaire. Three quarters were self completed. The remainder were carried out by interview (either face to face or over the phone).

Sample:

Poor response rate – only 27 in total. Most were over 50 (n=21). Nearly all had lived in the UK for 6 or more years – most for 20+ years. A quarter were British citizens.

Key findings:

In terms of awareness – respondents seemed most aware of mental health problems related to depression and schizophrenia.
48% of the sample had experienced mental health problems – although most of this related to the experience of others (e.g. family, friends). 92% of these said they had sort help; 35% rated the help they received as poor; 41% felt they had not been treated fairly. There was a general criticism that treatment appeared to be limited to 'pills' whereas people felt that having someone to talk to and listen to them was most important. There was a general sense that being Irish meant you were likely to be treated less favourably than others, although this didn't appear to stop people accessing services. There was a general sense that Irish people were likely to get worse care within a mental health service than they were within a general health service. There was generally good awareness amongst respondents of the links between alcohol and mental. GP's were likely to be the first point of contact for most people seeking help.

Key things people wanted:

Services that demonstrated an understanding of Irish history and culture.

Recommendations:

More proactive inclusion of Irish issues on the BME agenda

Community Development workers with a focus on the Irish Community.

Training and awareness raising for all healthcare staff about the needs of the Irish community. GP's are particularly key as they are likely to be the first point of contact for many people seeking help.

That ethnic monitoring information is better used to inform the development of services for Irish communities.

More work needed in relation to (a) alcohol and (b) specific groups of Irish people such as travellers, second generation, mental health service users.

Since completion of the report

- The launch of the report is due to take place on the 30th November. Mary Tilki, chair of the federation of Irish societies will be a key note speaker at the event.
- The lead researcher has gone onto secure employment with the organisation as a community development worker.
- Two of the other researchers have gone onto further part time education.
- One of the researchers has gained the University certificate in community research and Mental Health.
- The group have presented their work at an international Mental Health seminar in London.
- A working implementation group will be set up to take the recommendations of the report forward.
- The group have received further funding from the PCT to do health events in Northampton.

Value Added Value Grant Spend: Northamptonshire

Total budget
£5,500

Monies spent
£5,250

The majority (£5,00) has been spent on direct grants to community groups (see attached letter that went to a wide range of local BME groups)

We had a great response and had 8 successful applications (and one that was too late)

The following asked and received £ 500 pounds for each organisation

- * Northants Black History Group - to stage two Reminiscence workshops with African Caribbean MH Service Users (awaiting write up)
- * Northampton Irish Support Group -to stage a Mental Well being day for the Irish Community on the 28th September
- * Synergy Forum - to undertake first stage of work to consult with communities to provide culturally sensitive MH projects in the Northants African Community, (feedback asked for)
- * KRISP - to stage a multi cultural event in Kettering in July and raise profile of MH services (broad event which helped to improve local contacts and networks)
- * Northants Somali Forum -to stage an event to raise awareness/promote of mental well being (dates to be confirmed)
- * Northampton Bangladeshi Association -health event held including promoting mental well being in the community (event held- write up awaited)
And to the following we awarded £1,000 each
- * Dostiyo - Asian Women's Organisation to fund respite care for older Asian women with dementia and depression (ongoing work this year)(awaiting write up)
- * Wellingborough Black Consortium -to stage two events , one for the African Caribbean community (Sept 16th) and one for the Asian Community (Sept 4th)on mental health issues - supported by the local CMHT

We also spent £25 on an NHT - Gypsies and Travellers Awareness raising session

Northants Healthcare NHS Trust

Submission Form for Small Grants for BME Community Organisations to promote
 Mental Well-Being (April 2006)

NAME OF ORGANISATION:	
AIMS OF ORGANISATION:	
CONTACT DETAILS:	
NAME:	
POSITION IN ORGANISATION:	
ADDRESS:	
TELEPHONE:	
EMAIL:	
GENERAL INFORMATION:	

<i>Do you have Charitable Status?</i>	
<i>What parts of the county do you cover?</i>	
<i>What do you currently provide for Mental Health Service Users (do not worry if there is nothing currently)</i>	

If you were successful in your bid, how would you use the money?

How would you measure your successes?

Who will be the person responsible for overseeing the use of the grant?

Please explain the amount you are bidding for and exact details how it will be used (eg £50 for child care, £500 for holding an event for BME group on stress management in June 2006) and make clear your priorities (this is only a small budget and will need to be divided between community groups, so please be realistic).

WE UNDERSTAND THE TERMS OF AND CONDITIONS IF WE ARE OFFERED A GRANT AND AGREED THAT OUR OUTCOMES:

- **WILL POSITIVELY PROMOTE THE MENTAL WELL BEING OF BLACK AND MINORITY ETHNIC (INCLUDING TRAVELLERS AND GYPSIES) COMMUNITIES OR INDIVIDUALS WHO USE MENTAL HEALTH SERVICES (OR SHOULD BE USING MENTAL HEALTH SERVICES)**
- **WE ARE A BONA-FIDE ORGANISATION WITH RULES/TERMS OF REFERENCE, MANAGEMENT COMMITTEE AND MEMBERS**
- **AND/OR WILL PROMOTE COMMUNITY ENGAGEMENT WITH MENTAL HEALTH SERVICES**
- **THAT THE OUTCOMES WILL NOT DISCRIMINATE AGAINST ANY PARTICULAR GROUPS OR INDIVIDUALS AND WILL POSITIVELY PROMOTE THE NEEDS OF WOMEN, DISABLED AND DISADVANTAGED GROUPS AND INDIVIDUALS**
- **WE AGREE TO SUBMIT A SHORT WRITTEN REPORT TO NHT IN SEPTEMBER/OCTOBER TO OUTLINE OUR PROGRESS AND A FINAL BRIEF REPORT ONCE THE PROJECT IS COMPLETED.**

SIGNED:		POSITION IN ORGANISATION:	
ORGANISATION CHAIRS SIGNATURE:			
ORGANISATION TREASURERS SIGNATURE:			

S/a:ac.grant1

Northampton DRE/FIS Agenda - SWOT Analysis

<p>Strengths</p> <ul style="list-style-type: none"> -Support for the CDW posts has always been there from the provider Trust and Commissioners and the LIT are now fully behind this development. -We have had time to build local networks to ensure that community groups can be fully involved in the development, consultation and commissioning process. Some may even be in a position to manage these posts. -We have a clear LIT plan in place that all stakeholders are signed up to. This will ensure that the LIT can ensure the quality of the commissioning process. 	<p>Weaknesses (needs)</p> <ul style="list-style-type: none"> - The funds are not there as yet and rely on the decommissioning of other services and other reductions elsewhere in the provider Trust. Major consultation exercise in place to be completed by the end of October when final decisions will be made by commissioners. - Time delay has led to slight distrust in some community groups. - Delay in setting up the FIS Steering Group as reluctance to commit to it till finance sorted, so work has been led by one person in the provider Trust, alongside NIMHE/CSIP.
<p>Opportunities</p> <ul style="list-style-type: none"> - Great opportunity to get it right for local BME community who are now more ready and keen to engage in this in a meaningful way -We know who needs to form the FIS Steering Group and who is committed to it -There is now a greater understanding of the CDW's in the community, and with providers, commissioners and other stakeholders and so the LIT will be supportive of the work of the CDW's . 	<p>Threats</p> <p>As the finance is dependant on the decommissioning of other services that</p> <ul style="list-style-type: none"> (A) the two will be seen as the same thing – IE proposal to close African Caribbean Day Centre (which provides a direct drop in and out reach service using STR and Social Worker posts) and fund the CDW's (which is a very different role operating in a very different environment) (B) as the release of the funding for the CDW's is dependant on savings elsewhere any changes to the final outcome following consultation may mean resources are not provided for the CDW's even if there is broad support for them (C) The BME community groups may consider that we have "robbed Peter to pay Paul "

Appendix 1

NEW BOOKLET FOR RELIGIOUS SPIRITUAL NEEDS

Appendix 2

DERBY/SHIRE

Community Development Worker Job Description and Person Specification

Job Title: Community Development Worker for the Black and Minority Ethnic Community - Mental Health

Department/Section:

- Health and Social Care Division, Derby Millennium Network

Reports to:

- Health and Social Care Partnership Officer, Derby Millennium Network – line management
- BME Project Officer – Derbyshire Mental Health Services Trust – specialist supervision

Accountable to:

- Delivering Race Equality Steering Group

Salary Range:

(Rates from 1 April 05)

- NJC Scale Points 26 to 31 - £20,295 to £24,000

Scale 6 Point 26 to Scale 6 Point 28 (£20,295 to £21,654) – unqualified

Scale SO1 Point 29 to Scale S01 Point 31 (£22,512 to £24,000) – qualified NVQ Level 3 Health and Social Care

Hours of work:

37.5 per week full-time. Role will include some weekend and evening work.

Location of the job:

- Based at Rosehill Business Centre, Normanton Road, Derby

Travel:

- Physically able to travel throughout Derbyshire as part of the role (not necessarily a car driver)

Management Responsibilities:

- Responsible for monitoring project budget and delivering service in line with budget.

Management Areas & Key Relationships. Links with:

- GP Practices, Social Services and mainstream , BME voluntary service providers and user and carer groups
- Links with mainstream mental health services and other service development areas as well as public health and Primary Care services
- Work with Mental Health Services Trust BME Project Officer and mental health specific roles within the BME community.

- To link with the DMN Health and Social Care BME Cluster/Network
- To link with the Southern Derbyshire Voluntary Sector Mental Health Forum
- Other key agencies identified within the course of the work

Job Purpose/Summary

The post will operate within the following broad themes:

- Support Local Service Delivery
- Work across PCT's to cover diverse and dispersed communities
- To review current services, identify gaps in service provision from BME service providers, improve the capacity of BME organisations to deliver services which meet the needs of the BME communities that they serve
- To give advice and support to PCT's on migrant and refugee health issues
- Ongoing identification, quantification and needs assessment of vulnerable groups, currently asylum seekers, refugees and other migrant ethnic minority groups
- Facilitation of access to health services for vulnerable groups such as asylum seekers, refugees and other migrant ethnic minority communities
- Providing information and facilitating delivery of appropriate training for health professionals and community groups including cultural awareness, issues specific to the communities being served and general issues on asylum seekers and refugees
- Information sharing and collaboration between health, social services and voluntary sector with influence of strategic change when appropriate
- Encouraging use of integrated interpreting service project in service delivery including primary care and contributing to their review
- Mental Health Promotion and anti-stigma work in BME communities
- To flexibly work/adapt local strategies to improve services for BME communities
- To review current services within the statutory and voluntary sector, to identify needs and ensure the development of new and innovative approaches which will improve culturally and linguistically sensitive services that improve access In order to provide effective support, treatment and care and deliver better mental health outcomes for people from the BME community
- To include BME advocacy, cultural awareness, gender sensitive services and dual diagnosis (mental health and drug and alcohol problems), services for elders.
- To work in partnership with statutory providers, independent organisations, religious leaders and communities to support the development and provision of an integrated service that brings together opportunities for improved health, social care, housing, income, work and leisure to meet the needs of people with mental health problems in the BME community
- To work with staff in the Trusts and other provider organisations to provide leadership, to enable the development of knowledgeable staff within the service that have training, skills and attitudes to gain the confidence, respect and trust of the BME community
- To work in partnership with statutory providers, independent organisations, religious leaders and communities to support BME mental health service providers and the statutory sector to facilitate innovations in service and improve service delivery to BME communities

Person Specification:

Essential –

Good general education and a demonstrable ability to learn and apply knowledge

- Ability to communicate clearly, both verbally and in writing
- Flexible approach and ability to work independently and on own initiative
- Effective communication skills, both written and verbal
- Ability to deal with complex issues facing vulnerable groups in the community
- Good organisational and interpersonal skills

Experience:

Essential -

- At least 2 years experience working with or for communities, either in the voluntary or statutory sector, including experience of working with the community groups relevant to the post or equivalent real life experience
- Experience of facilitating the delivery of training and making information available to a range of professionals
- Experience of working collaboratively with a range of agencies
- Carrying out needs assessment within communities and preparing action plans, which identify priorities and risks

Desirable –

- Experience of working with people who may be experiencing negative change or reacting to life events

Knowledge:

Essential -

- Demonstrate knowledge of the community groups relevant to the post, including excellent awareness of cultural, social and health issues in Derby and Derbyshire
- Knowledge of statutory health and social care services, including primary care
- Understanding of public health issues
- Knowledge of community support and development

Desirable –

- Demonstrate knowledge of any languages spoken by the various community groups relevant to the post (where applicable)
- An informed and practical view of the role of a health advocate, including the public/health promotion aspects of the post

Specific Expertise:**Skills:****Essential -**

- The ability to work with a range of people in different settings, including professionals from statutory and voluntary organisations and members of the public
- Ability to work independently and organise own workload
- Ability to work across a range of organisations and stakeholders

Desirable –

- Experience of using IT (word processing, e-mail and the internet) – desirable
- Language skills?

Education and Training:

- Identify learning needs and undertake agreed training and development in connection with the role
- Help design, deliver and evaluate training on BME issues, service provision and developments
- Develop awareness of the benefits and requirements of supervision, both line management and specialist supervision