

# Minority ethnic needs in Wales - a snapshot

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### Headnote

Over the past two decades, research has shown that factors such as 'race' and ethnicity, socio-economic status and geographic location impact on the level of access to information and treatment, as well as on the utilisation, experience and knowledge of mental health and social care provision. This paper by Roiyah SaltusBlackwood and Kalbir Kaur-Mann report on one aspect of a study to improve access to mental health information and care to targeted Black and minority ethnic (BME) groups living in an ethnically diverse city in Wales. The article presents the perceptions of the service users based on semi-structured interviews. The research literature used to develop the interview protocol was written largely in the context of England, not Wales. Drawing on this Wales-based study, the paper details the needs of BME service users that were highlighted, as well as outlining some specific issues facing those working in mental health in Wales

The World Health Organisation's definition of health is a state of complete mental, physical and social well being, rather than just the absence of disease. This insists that we understand health, illness and health care as socially mediated. Ahmad (1993) states it is, 'structured within social relationships,

shaped by historical developments and contemporary socioeconomic realities, and mediated through professional ideologies.' Moreover, demographic changes since the second half of the twentieth century have meant that healthcare and nursing practices in the UK have had to undergo significant change to address the needs of an increasingly diverse population. Linked to this is the need for nurses to work competently across all ethnic, class and religious groups - a duty of care that is now embedded in the national nursing code of professional practice (Nursing and Midwifery Council, 2002).

Over the past two decades, research has shown that factors such as 'race' and ethnicity, socio-economic status and geographic location impact on the level of access to mental health information and treatment, as well as on the utilisation, experience and knowledge of mental health and social care provision (Arai and Harding, 2002; Bhugra et al, 1997; Fernando et al, 1998; O'Connor and Nazroo, 2000; Sashidharan, 1993; Smaje, 1996). It is also increasingly evident from the research that how services are used and experienced by individuals from different ethnic groups is just as much a product of their own beliefs, needs and expectations as it is a product of the attitudes and perceptions of service providers (Nazroo 1997; Owens et al, 1991). Stereotypical views of BME people, racism, and cultural ignorance have been shown to undermine the way in which health and social care service providers assess and respond to minority ethnic patients and clients (Cochrane and Sashidharan, 1996; Curren, 1994).

Some, therefore, must struggle with a health and social care system that is not yet adequately equipped to respond to their needs, despite statutory obligations and legal requirements (Lloyd and Fuller, 2002). These disparities suggest that 'mainstream' mental health services may be failing to meet the needs of BME people, resulting in a spiral of disaffection, reluctance to seek help and readmission to hospital in times of crisis (Seeker and Harding, 2002). In a recent research publication on the perceptions of African and African-Caribbean service users by Keating et al (2002), this was explained as 'circles of fear', with staff members perceiving service users as potentially dangerous and service users perceiving services as harmful.

Over the last few years, socially ascribed differences such as 'race', ethnicity, and religion have become increasingly significant considerations for mental health practitioners, as well as health policy makers. Recent drivers include the Race Relations (Amendment) Act 2000, which insists that public authorities provide a quality of service to BME groups that does not exclude and

discriminate. Also important are recent publications such as *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England* (2003), *Delivering Race Equality: A Framework for Action* (2004) and, *Delivering Race Equality in mental health care: An action plan for reform inside and outside services* (2005). Together, these national policy documents aim to provide the framework for achieving equality of access, experience and outcomes to BME mental health service users in England.

In Wales, as with all public services in the UK, attempts are being made to critically appraise the National Health Service and work to ensure that a robust and responsive service is provided to all members of the population. According to the 2001 Census, the number of people from BME backgrounds in the UK was 4.6 million (7.9% of the total population). Out of a population of approximately 2.9 million people in Wales, in 2001, 2.1% (60,900) were from BME backgrounds. Since 1991, there have been increases in the proportion of African, Indian, Pakistani, Bangladeshi, and Chinese people living in Wales, as well as an increase in the number of people who classified themselves according to one of the mix ethnicity groups. BME groups were concentrated in the three largest urban cities: Swansea (2%), Newport (5%), and in Cardiff, (just over 8.5%).

Reducing inequalities in health and social care is one of the Welsh Assembly Government's priorities, with mental health being one of three top priorities. The challenge to modernise mental health services in Wales is great. In regards to the mental health services, the most recent Healthcare Commission inspection (previously the Commission for Health Improvement) (2004), stated that policy is less developed in Wales and moreover, services are less developed and that an older, more institutional model of care is prevalent. Added to this is the dearth of knowledge of the health needs of BME groups in general, and the mental health needs of BME groups in particular (Aspinall, 2003; Walters, 2004) Although there is anecdotal evidence to suggest that English-based studies have relevance in Wales, there remain major gaps in our knowledge of the mental health needs of BME people in Wales. The BE4 study was the first study in Wales since devolution that sought to examine, and provide a baseline of evidence of the mental health information and care needs of BME groups.

Aims of BE4 study

This paper reports on one aspect of a two-year study: the perceptions held by targeted BME services users (African, Caribbean, South and East Asian) in regard to key areas of their care and recovery pathways. The funding for the study was secured by a local mental health voluntary organisation which commissioned the University of Glamorgan to conduct the research, using an action research methodology. The wider aims of the BE4 study were as follows:

- \* To carry out a needs assessment in order to provide a baseline of evidence of the mental health and social care information and treatment needs of the target groups; and

- \* To identify gaps in access to service provision and care, making recommendations in how to develop a multi-agency, multi-sector, multi-professional practice framework.

#### Methodology and approach:

A qualitative approach was taken in order to explore, describe and develop an understanding of the experiences of a small sample of BME service users living in Wales. Approval to conduct this study was obtained from the local research ethics committee, the NHS Trust covering the area where the study was conducted, and the university research ethics committee. A letter of invitation and an information leaflet was provided for each potential participant detailing the aims of the study, what was to be required in terms of time commitment, and what was to happen to the data collected. In the leaflet it was also made clear that this study did not seek to affect the direct treatment of participants in any way and that participation was entirely voluntary. All participants were required to sign a consent form prior to the interview and were given two to three weeks to inform us that they wished to be part of the study.

The sample (Table 1) was purposive, with individuals being recruited by members of the local mental health teams and by mental health professionals working in the voluntary mental health sector. The inclusion and exclusion criteria reflected the aim to develop a sample of service users (n=12) with enduring mild to moderate mental health illnesses and who were living at home at the time of the interview.

An interview protocol was developed and was divided into a number of topics. The topics covered in the interviews were:

**Table 1. Service users who took part in the study (n = 12; women = 11; men = 1)**

<b>Self assigned ethnic group</b>	
Bangladeshi	3
Caribbean	3
Indian	2
Pakistani	2
Asian Welsh	1
Asian other	1
<b>Religion</b>	
Christian	3
Muslim	6
Hindu	1
Sikh	1
No information given	1
Number using services when interviewed	9
Use of interpreter during interview	1

\* Perceptions of health and mental health

\* Access to mental and social care information

\* Use, knowledge and experience of mental health services

\* Role of non-statutory services

## Analysis

BE4 staff conducted the interviews. The interviews were

tape recorded and transcribed verbatim (and, in one case, translated as well). Data analysis was conducted using an inductive approach: the constant comparative method (Maykut and Morehouse, 1994). Relevant themes within the text were gradually identified, compared and coded. Two members of the research team took part in the analysis of the data. The NVIVO computer software package was used to help in the coding process. The research literature and list of topics underpinning the interview schedule were used to help refine the themes. Several key themes emerged: 'assessment', 'the basics', 'discrimination and racism', 'models of care', 'relations with mental health professionals' and 'use of voluntary services'. Each theme is discussed below. Statements have been taken from interview data of the 12 service users. In presenting the findings, it is important to note one important limitation of this study: the small number of service users interviewed means that generalisations cannot be made. What the findings offer is a snapshot of evidence of the views and perceptions of BME services users in Wales that can be built on in future studies.

## Findings

### Assessment

The data revealed that by using models of assessment rooted solely in western concepts, the significance, role and importance of non-western ways of conceptualising and presenting illness will, at times, be missed. As one participant explained:

Yes, the assessments that were made of me...they acknowledged that I was different but they didn't go about seeing if they could find an Asian doctor you know, or somebody who could help me or support me you know, there was nothing, it was a case of: "Here it is, it is all white, you just happen to be here make the most of it".

It was also clear that perceptions of health and ill health impact on how one perceives the help given. For one participant her assessment and diagnosis (post natal depression) was not something that needed the care she was subsequently given.

As she explained:

'They told me.... it was called post-natal depression. In Asia...you could be cured a better way, natural things, herbal things... I think at that time I should have been treated the natural way, which is like with blessed water and stuff like that.'

'The basics' - food, personal space, and religion

Food, personal space, and religion were some of the basic considerations that were all in need of some level of re-dress as far as the service users that were interviewed were concerned. A common problem for those who has stayed in the local psychiatric hospitals was not having access to a range of halal or vegetarian food options, and also not being able to receive food from visiting family members. Personal space was another key issue, especially the need for same sex units, separate toilets and washing facilities. The lack of a prayer room at a local psychiatric hospital was, as one participant explained 'shocking...by now (they) should have had prayer rooms because...(there are) quite a lot of Muslim patients up there'. As this participant further stated, summing up the more general point of the need to get the 'basics' right:

'I would like to see a change...like hospitals...we have got mixed people in hospitals and I do admit that it is difficult trying to meet everyone's needs but needs as basic as food should be met...at least review it..things like that make

a difference.'

## Discrimination and racism

The experience of racism, both within and outside mental health services, was another theme that was explored with this group of mental health service users. Not all clients interviewed described experiencing racism while making use of primary and secondary care services. Those who did framed issues of personal (one-to-one) and organisational discriminatory practices in various ways. Recounting the experience of being in a local psychiatric ward in the early 1990s, one participant described the racism there as deep and pervasive:

Question: 'Right, is there any other of these cards that you think would apply to your own experience?'

'Well certainly racism, there are no two ways about it in the system.'

Question: 'In what sense?'

'In the sense that if it was up to the service provision in place I would probably be still in one of the wards. It just happened that I met this person who was looking at alternatives in mental health...There is an ignorance and because of that, racism, which I think is underpinning all of it...(If) racism was eradicated then perhaps these service providers would start looking at alternatives...its about tackling inequalities in health you know.'

For some, the issue was not racist behaviour or treatment, but rather dealing with the sense of not being understood as a result of ethnic, racial or religious difference. As one participant commented:

'They don't understand the cultural background, you know, the up bringing..'

As another participant stated: They just said they can't help me and my problem was cultural and that is why they couldn't help me...they said we haven't covered this ground before.'

## The importance of a range of models of care

It was also evident that faith-based treatments, such as faith-based counselling, were important to those who gained strength through prayer or elements of spirituality. Prayer for one participant was important, as 'prayer

gives you stimulation of mind...help us...you know, deal with our problems better'.

In terms of counselling, as another participant explained, speaking of the private treatment she secured through the help of a family friend:

'He had a great understanding of my insecurity and he understood particularly what it was like not being white and having the cultural and religious...I don't want to call it baggage because (that) is a very negative work, but you know, having, call it attributes if you like and being able to identify yourself as a human being who has got positive elements...all I was doing was looking at myself very negatively and the service providers, the psychiatric nurses, the doctors...their assessments of me were well you know "it is the way you are, it is the way you have lived your life, its your family"'

### Relationships with mental health and social care/welfare professionals

Of those interviewed, the majority felt that the interaction with members of the community mental health teams was useful and important. Explaining the help now received, one participant explained that 'Now I have got a different one (CPN) ...this one is different, she is okay but she is not as good as the first one I had but she still helps me ...'

Another participant stated that 'My CPN comes and visits me once a month and we have a chat about several things and how my health is at the moment and things like that so he gives me advice to overcome day to day problems...' Explaining her care plan, another participant, stated: 'I...see a psychiatrist every six months, but I get to see a CPN every month...at least you know that you are not being forgotten.'

### The role of voluntary mental health and social welfare services

The majority of those interviewed were aware of the community-based voluntary mental health services in operation locally and saw them as being places to 'go and talk and avoid isolationism...where you could walk in and gain support' or, in a similar vein, as another participant explained:

'They play a very important role I think because it is important that people who suffer from mental health have a place where they can go and feel safe and comfortable...They can just be themselves and be accepted...'

It was these services where the majority of those interviewed went to undertake personal development courses and have opportunities to meet with other service users. The importance of these activities, coupled with the limits of voluntary organisations because of funding restrictions and the frustration felt by service users was highlighted:

'What I would like is more activities in the day centre. At the moment I spend a lot of time sitting down drinking coffee and talking to other people who have mental health problems...Unfortunately the funding is so limited...that (name of organisation) is not able to pay for the tutors and instructors...who are able to give us information or organise any activity on a full time basis. Why can't ...black people with mental problems... (have) a group...?'

In regards to the befriending services provided by the only specialist BME mental health organisation in the city, one participant highlighted the need for interventions throughout the care pathway, stating that:

The befriending project, it doesn't give you therapy, or ways and means to overcome mental health. It is more about, to be quite frank, remaining in the system when (you) have got a befriending service but no access to counselling... therapy for BME people I would say is zero...(there is a need) to ensure that involvement develops into something which is more about not just befriending... a service that is going to deliver...in the sense (of) not as in befriending, but as a therapy (to enable people) to get better.'

## Discussion and conclusions

As the title of this paper suggests, the accounts of the experiences of BME service users in Wales described here provide a 'snapshot' of their views. The research was limited in scope to a small sample of people living in a city in Wales and their narratives are rooted in their encounters with locally-based statutory and voluntary mental health services. However, there are similarities in regards to the concerns BME mental health service users have in Wales and those highlighted in the body of research conducted in England and in other parts of the UK: the need for culturally appropriate assessment processes; services that can meet the needs of diverse ethnic groups; ongoing cases of individual or organisational racism and discrimination; and a lack of consistent and accessible recovery pathways. There are also similarities in regard to

pockets of best practice and levels of user satisfaction, notably in regards to community-based care (both within the voluntary and certain parts of the statutory sector).

From the findings of this study it is evident that there are barriers and issues that need to be tackled in regards to improving access to mental health information and appropriate treatment for those from BME backgrounds living in Wales. This can be best understood in the context of the current transformation of the statutory and non-statutory mental health service in Wales that has created pressures on the management and staff as old priorities shift to incorporate revised and new statutory priorities, care standards, and legal obligations. It is clear that this moment of change and transformation will need to be seen as providing welcome opportunities for re-ordering service priorities in the direction of greater responsiveness to the needs of a diverse population.

Another point to make is that unlike England, in Wales there has yet to be a national strategy or policy specifically intended to improve the mental health of minority ethnic groups or the care and treatment they receive from mental health services. Moreover, many of the policies driving greater equity of services and the delivery of more responsive mental health care for all the population that may emanate from key health bodies in England (outlined at the beginning of this article) have not been taken on board nor replicated in Wales. Thus, to date, health advocates, mental health practitioners, as well as managers and commissioners in Wales have no specific national policy documentation or long-term directives to use to underpin their funding allocation for new or enhanced services. Nor do they have to hand the sharp teeth of a specific national policy that most often underpins government priorities and funding commitments. Future research, as well as the development of policy on a local and regional level are needed in order to address the issues (and capture pockets of existing good practice) if the transformation currently underway in the integrated health and social care system in Wales is to truly become robust enough to appropriately address the needs of its increasingly diverse population.

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