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Specialist Services for Minority Ethnic Groups?

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ABSTRACT

This paper considers the advantages and disadvantages of special mental health services specifically for black and ethnic minority patients. The diversity of the population of black and ethnic minorities is discussed alongside the dynamic demographic re-structuring of such groups. The influence of culture, race and ethnicity on the process of acculturation adds to the complexity of health beliefs and help seeking patterns amongst any single ethnic, cultural or religious group.

Culturally specific services are established in the United States. In the UK the voluntary sector supply special services and these are considered as an attractive and affective means of engaging and treating those who otherwise would not seek help in the statutory sector because of ethnic and cultural barriers. Such an approach might improve engagement of patients who report that existing services are culturally unattractive or insensitive to their distress. The call for specialist services challenges the status quo of service provision for black and ethnic minorities, and potentiates ethnic, cultural, linguistic and religious matching where service users feel this to be beneficial. Some research suggests concordance of value orientations between service users and health professionals is critical. Specific services will help the service user feel understood as the providers will be informed of the service user’s cultural beliefs and values.

In the UK there have been no well established or sustainable services, and none which have been evaluated for clinical efficacy, sustainability and economic viability. Distinct cultural, religious, ethnic and racial groups might emphasise quite different demographic variables as the foundations of their distinct identity. The special provision of services to each of these potential groups on the basis of preferred identity does not guarantee improved outcome, satisfaction or cost efficiency. Specialist services models can work with statutory sector services in many ways, but there will be variations in lines of accountability, funding, and ideology. If specialist services became a reality, and work in isolation from the statutory sector, this might increase marginalisation, and will lead to the fragmentation of generic mental health services.

We outline the benefits of special services as an interim measure towards the development of comprehensive multi-culturally effective generic mental health services. We anticipate that the best treatment models will involve a full range of independent and voluntary providers with effective working relationships with the statutory sector in order to optimise benefit to black and ethnic minority patients. The barriers to health working alliances necessary to achieve a multi-culturally competent service can not be underestimated; these and ethical dilemmas in achieving this outcome are discussed.
Introduction

Britain is a multi-cultural society. Public services have a duty to promote physical and psychological well-being among all members of a culturally diverse population. There has been evidence of poorer mental health service provision, service use, outcome and satisfaction among some minority groups for some years.\textsuperscript{1,2,3,4} Yet communities have not seen changes in practice that have satisfied them. This has led to a palpable mistrust of the services by some ethnic groups. Calls for special services rather than improvement of existing services come in this context of a breakdown of trust. There have been no scientific evaluations of special service models in countries where these are available, nor indeed a full conceptualisation of how such services might function in harmony with other generic services. The thorny issues surrounding economic feasibility and ethical dilemmas have not been fully considered. In this discussion paper we look at the arguments for and against psychiatric services especially geared towards minority ethnic groups.

We acknowledge that any health service response, alone, may not decrease disparities in morbidity and mortality if these are caused by the social context within which minorities live.\textsuperscript{5} Discrimination and institutional racism are pervasive forces throughout society and part of the web of causation that generates mistrust, and compounds the reported disparities in health between ethnic groups in the UK.\textsuperscript{6} A more fundamental and wide-based approach based on preventing ill-health and promoting healthier communities will be required to counter these.\textsuperscript{7} The development of services that are effective for a culturally diverse population is an important part of such a wide-based response.

The population context

Minority ethnic groups make up 6\% of the population in England and Wales.\textsuperscript{8} They are concentrated in cities. Most of the research work in this field has concentrated on the larger groups such as those of African, African-Caribbean and South Asian origin. It is accepted that the Irish are the largest ethnic minority group in the UK and have specific needs that are rarely researched or met.\textsuperscript{9} Some refugees leave behind them political torment and traumatic emigration that leads to significant and specific health needs.\textsuperscript{10} Other neglected minorities include Chinese and Vietnamese communities.

There exists a great deal of cultural diversity both between and within the minority ethnic groups in the UK. For instance, those entering the UK from the
Caribbean and the Indian subcontinent on the basis of the UK's economic needs in the 1950s and 1960s contrast with the people entering the UK by mass political exodus from East Africa nearly 20 years later. The economic migrant labourer, by virtue of the needs of the recruiters and the employers, were healthy whereas the mass exodus included large numbers without any clear screening for health status. Within ethnic groups specific groups differ in their educational achievement. This has implications for their capacity to escape poverty and make economic gains, to use health promotion strategies and to articulate their concerns about services if these appear to have a detrimental or unhelpful impact on health status. This process of changing social status, and improving educational and professional achievement over the generations is a part of the acculturative process which tends to contribute to distress itself.

Mental health and illness in minority ethnic groups has not been investigated as thoroughly as in the majority community. There have been some epidemiological studies. These have shown high levels of distress among minority ethnic groups, that GPs are more likely to miss depression when people from minority ethnic groups present to their surgeries, that there are high levels of suicidal ideation and higher suicide rates among Asian women and young black men. The rates of schizophrenia and mania in the African and African-Caribbean population are higher than in other groups.

The mental health needs of primary migrants differ from those of their children and grandchildren. Those born and brought up in the UK are likely to have been exposed to specific risk factors to which their parents were not exposed. Health beliefs, although nearer to those of the host population, are still likely to differ among second and subsequent generations because of the exposure to parental beliefs and cultural lifestyles. This makes for a dynamic and persistently changing profile of ethnic minorities. The inclusion of socially excluded groups who are not usually considered as 'ethnic' minorities, for example, the Irish, Scottish or people from Eastern Europe, must also be given attention in the re-conceptualisation of a sustainable and comprehensive service.

**The service context**

The dominant model for community psychiatric services in the UK advocates that services be based on an assessment of the aggregated needs of the local population. If services are already in place, these should be modified on the basis of systematic and regular needs assessment. Such a model draws on the local UK experience. One of the facets to be borne in mind is the
socio-economic and political commitment to properly fund the infrastructure of health services. This requires adequate funding of a range of clinical professionals necessary for each sub-speciality within the health care system and the continuing robust evaluation of services. Regrettably, the NHS is unlikely to increase its budget in real terms and the UK spends less per head of population on health than most European countries. Therefore, service improvements will need to be free of additional costs, or to be funded from savings that emerge from more effective and efficient service. Any service solution must therefore adhere to this reality, albeit an undesirable one.

It is important to remember that services can be acceptable only if they are set up at a local level with clear dialogue with the local community. Taking into account public dissatisfaction is an essential first step. A mixture of public and private service provisions will contribute different facets to the delivery of psychiatric services, and the responsibilities of each of these sectors, and of patients will need careful delineation. Furthermore, patient representatives should comprehensively represent the full diversity of potential patients. It is all too easy for specific individuals, who appear to represent black and ethnic minorities, to become the main and only point of consultation with communities. This further compounds social exclusion by assuming that the 'take me to your leader syndrome' can be a legitimate form of consultation. Social exclusion is all too easily established, but counteracting it is much harder and should be an active and pro-active process.

The GP is the first port of call and occupies a gate-keeper role to secondary services. GPs, through PCGs, will be increasingly important purchasers of health care. This system has been chosen because the GP's role as gatekeeper, as a custodian of longitudinal and cross sectional information on patient's health-well-being and socio-economic situation, is paramount to the cost-effectiveness of the NHS. The fact that patients with psychiatric problems may by-pass the GP, that GPs may not be sympathetic to psychiatric problems among ethnic minorities, that GPs may not be skilled in dealing with them or that GPs may not be seen as part of, or representative of, the trusted community are seen as problems that need to be remedied through better training. The cultural differences in help seeking, the expression of distress and the impact of specific 'model' services require more attention.

Retention of staff in psychiatry is poor, burn-out among professionals is high, and recruitment to inner-city community teams is difficult. Discrimination on entry into medical school means that certain minority groups are poorly represented among doctors and it will take many years to
redress the balance. Similar investigation of other professions and their representability of local populations is necessary.

In the traditional model of service provision, before the ‘user movement’ gathered momentum, individuals had little choice, and despite their grievances, which went unexpressed, they gratefully accepted whatever was offered, believing it to be all that could be offered. This was always compounded by a humble belief that professionals were far better qualified to know about illness, disease and its treatment; and of course the professions are informed about the pharmacology of drug treatments, and the scientific basis upon which treatments are efficacious, but satisfaction and a knowledge that one’s problems are understood are also part of a broader strategy of healing. Such considerations are rarely accommodated in a service development strategy.

What is a special service?

The term ‘special services’ requires careful definition. As an appealing concept to redress inequalities, its use is subject to generalisation (Box 1).

**Box 1: Definitions of Specialist Services**

A. Entirely separate funding, and separate operational procedures, with differing lines of accountability.

B. Funded by the same source as generic mental health services, but allowed to exist as a separate contractor to deliver services to specialist groups. Accountability to the funder, but otherwise lines of accountability are separate.

C. Funded by the same source, but required to work in conjunction with generic mental health services with clear lines of accountability to funders, with the option of various degrees of shared accountability with generic services. This imposes a duty to develop an effective interface between providers irrespective of their ideology.

D. Funding by a single source, but imposing responsibility on generic mental health services to ensure high quality care for all groups by sub-contracting to a variety of providers, and specifying a detailed service level agreement. However, this approach may place constraints on the innovative potential of culturally specific providers. Yet in an adverse economic climate this appears to be the only financially viable option which sustains good practice in the voluntary and independent sector. This approach also leads to the development of expertise in the statutory sector through partnerships and cross-organisation training and practice development.
The British experience to date has been to nurture models A, and B, in the voluntary sector on the assumption that this fulfils identical obligations and responsibilities as models C and D. Thus model A represents entirely separate services funded by non-health service funds; most of the voluntary is funded in this manner. Model B represents voluntary and independent providers who have been successful in attracting some funding from the health authority or local authority, yet their day to day procedures are different and unique. C is clearly a more 'equal' partnership where service model B becomes more efficient with shared lines of accountability and shared goals. Model D represents a mature and truly effective mosaic of existing high quality providers working in conjunction with the statutory sector. This helps the statutory sector develop the expertise to work with culturally diverse populations through partnerships with a range of independent and voluntary organisations that have the expertise. The tensions of developing an effective voluntary sector and moving to integration with the statutory sector have been investigated.  

It is notable that whilst we examine the varieties of specialist services, and the difficulties of implementing any ideal 'model' service, there remains a need to consider culturally competent generic mental health services that include a proper admixture of skills and expertise. The ability to work with difference and diversity is an important core professional skill for all delivering services in the future. A culturally competent generic mental health service might be the most economic option, and may well be the only workable option in a society that is becoming increasingly socially, culturally and economically diverse. An economic as well as clinical outcome evaluation has not been conducted on specialist services. Though in the US some African-American led services provide primary care, secondary care, housing and rehabilitation this has not yet been attempted in the UK. Where service provision requires the integration of so many forms of intervention, can specialist services ever be viable and effective in the UK context?
The Arguments For Special Services

There are suggestions that special and separate services for black and ethnic minority individuals could improve up-take of services, satisfaction with services, the quality of services and clinical outcomes. Special services are appealing as one approach to address an imbalance of priorities which would otherwise persist. Resources are seen to be dedicated to a group that protests about exclusion.

Specialist services become a place where skills are nurtured and more extensive services developed. A further advantage is that the attractiveness of psychiatric services, which to the lay person are generally shrouded in mystery and stigma, must increase if the values heralded by a service are consistent with those of the black and ethnic minority populations. Community confidence and trust in the image of a service as well as its actual interventions are important for an effective treatment alliance. Racial, ethnic and possibly cultural matching of the individual patient and therapist may be achievable. The broad arguments in favour of separate services are listed:

1. A knowledge of cultural factors, language, cultural taboos, rites of passage etc. are greatly improved. The staff are thus able to deal with problems with a clear understanding of the cultural factors thereby making it likely that patients and their carers will find their needs met, and feel understood by the professional. This will reduce the need for interpreters and 'culture brokers' and less time required to conduct, a competent assessment.

2. Better understanding of needs: Therapists and patient from same minority groups can encourage an earlier establishment of trust. This is especially crucial where a specific black or ethnic minority group have unique political histories, distinct languages and adverse circumstances that are condu-cive to the generation of mistrust.

3. Some research suggests that where therapists are of the same ethnic background as patients, this reduces the drop-out rates after initial assessment. There is no research evidence that outcome varies in these settings. However, in early stages of therapeutic interactions such contact may be crucial to successfully engage patients.
4. As a result of feeling or being understood the expectation is that the patient is more receptively engaged and will benefit from the service. This understanding relies not only on language spoken but also on understanding of concepts about mental illness. **Satisfaction** is associated more with concordance of explanatory models of patient and professional rather than ethnicity."

5. Where patient and professional share understanding, a more accurate assessment ensues. If the staff and the patients are able to communicate effectively, and not misread or misinterpret behavioural and **linguistic** cues, the needs of patients can be understood and addressed appropriately.

6. **Women** only services have been recommended and **successfully** used to increase uptake in different parts of the world. Such an approach suggests that women may feel safe and protected in women only settings. In some cultural groups women only services, or specific women only areas create a culturally congruent treatment environment.
The Arguments Against Specialist Services

There is no clear documented research showing benefits in the UK. Qualitative evaluations of voluntary sector provision are common, but the sustainability of the service remains in question. The pattern so far is that such specialist services, and these are usually restricted to the voluntary sector, are set up on ‘soft’ budgets and are rarely sustainable. In practice budgets are rarely set to allow time for service development, evaluation, teaching or training. Ethnic matching of individuals and their therapists could be taken to its logical extreme where only specific needs can be catered for by a generic service, and each sub-group might be conceptualised to require very specific services where religion, language, ethnic group and health beliefs are matched. Of course the resources to fully meet the needs of every sub-group by the use of a multitude of smaller services are not available. Another ethical dilemma is that if such specialists erroneously claim separate services to best meet the needs of ethnic minorities, by doing so, barriers to the development of fully competent generic services are reinforced. Such an ideology appears counterproductive to those working towards integration and towards improving the quality of generic mental health services for all populations. The broad arguments against separate services are:

1. The chief reason against separate services is the marginalisation of such services and their staff by generic services. Such feelings of marginalisation can also lead the majority group to feel that minority groups are given special resources. Positive discrimination is not advocated by all, and certainly is not welcomed by all black and ethnic minority groups.

2. By allowing the development of such services the majority community and staff from these groups may feel that they have done their duty and do not need to learn anything about the minority groups, their culture, their needs or management. The majority community, and generic services, may feel 'proud' and satisfied to have done the needful without taking any responsibility for ongoing improvement or delivery of services to black and ethnic minority groups. Yet, black and ethnic minorities will continue to find themselves in contact with the statutory services. Thus the aim to improve generic services for all cultural groups is compromised.

3. There is some research evidence that suggests that ethnic matching does not improve the long-term outcome of patients. Ethnic matching taken to its logical extreme may prove to be extremely expensive for the services.
4. In the **extreme** situations in settings and catchment areas where there may be more than one minority ethnic groups means that there may well be several separate services thereby contributing to a isolation and fragmentation of services where fragmentation is already a **major** problem in all services.

5. A separate service may induce a sense of envy, and yet it may be **seen as an inferior** service* Patients may be 'dumped' by virtue of their ethnic group even if their needs are not likely to be met in these settings. In addition, **marginalisation** may affect resources and inappropriate referrals will increase pressure on the special service if it is seen as a magical panacea to a **complex** problem.
A Way Forward

There are no comprehensive specialist statutory services in existence in the UK. The discussion is usually centred around specific services and their relationship to the NHS, or if such a relationship should exist at all. From an economic perspective, it is hard to argue against the need for some co-ordination of services. Moreover, Government policy is for integration of services of health and social services as a way of decreasing cost and preventing fragmentation of care. The need for quality assurance and the duplication of this in separate streams of accountability are required, but this does place a question on the long-term prospects of continued funding of a type A and B service. Type A and B services have the confidence and trust of the public.

These qualities are desirable for all services. Separate services achieve this by being especially familiar with cultural knowledge, and being perceived to be a place of comfort and care and not coercion. We advocate a move away from reliance on services of type A and B, which are mainly separate services with specialist skills, but with a limited funding and limited capacity to sustain a service. Such services have usually filled a gap in services. We advocate a move towards service models C & D. This involves harnessing high quality specialist services and considering them to be part of a comprehensive service with statutory and voluntary provider units that have overcome the problems of integration. These include financial competition, conflicting value orientations, professional backgrounds, personalities and personal views about race, culture and mental illness.

The capacity to resolve conflicts is essential, and bad experiences of collaboration where legislation and funding are used to articulate a power relationship are detrimental. Performance and quality criteria may prioritise different activities.

A Role for the Voluntary Sector

Hence the voluntary and independent providers have emerged in response to a crisis in statutory sector provision. Voluntary and statutory providers are diverse in their functions and are not easily grouped and treated identically. The qualities and problems of the voluntary sector are listed in Box 2. Some providers specialise in one group of patients only.
Box 2: Voluntary & Independent Providers: qualities and problems

**PROBLEMS**
- Limited fulling-service provision and evaluation expected on limited budget
- Marginalised
- Staff removed from traditional career paths, hence ongoing training interrupted
- Poor management
- Luck of experience in evaluation of service
- Powerless, compared to influence of statutory sector.

**QUALITIES**
- Smaller, more informal and personal service
- Cultural knowledge
- Flexible working patterns
- Socio-centric models of work
- Culturally congruent models of healing
- Culturally congruent models of being and relating to people
- Linguistic competence where English is not first language
- Do not suggest treatments or interventions which are known to violate belief systems.

A great deal of the debate surrounding the provision of services for black and ethnic minority patients continues not to specify the role of the voluntary and independent sector in a comprehensive service. It is now clearly established that black and ethnic minority patients are dissatisfied with generic services, and this might explain their poorer engagement with statutory service providers. The over representation of black and ethnic minority patients in forensic services, and dissatisfaction of those admitted under the powers of the mental health act, especially in subsequent rather than first generation, might also reflect this core dissatisfaction and lack of trust following a first admission. Nonetheless, patients with mental illness, even if they are dissatisfied with the mental health services, are unable to choose another service or other groups of professionals. They know that at times of crisis they are entirely dependent on their local service, regardless of their reservations about its structure, ideology or professional expertise. They will tolerate professionalis lack of cultural awareness, and even ignorance about
their cultural priorities, responsibilities and models of restitution. They have to trust in what they are given because there is no alternative.¹⁶

The limited experiences so far reported of voluntary and independent providers are favourable.²⁸ ³⁴ Some voluntary and independent organisations insist that statutory organisations can never meet the needs of black and ethnic minority patients as their level of attention to detail and training is a constant problem.³⁴ In particular smaller independent organisations that serve one or two cultural, or linguistic or national groups, appear to be able to provide a level of satisfaction to patients that statutory providers can not replicate, simply because of the numbers of such distinct cultural, linguistic and national groups.

**Developing Culturally Competent Mental Health Services.**

Government encouraged the development of the voluntary and independent sector in order to discover models of good practice which it hoped could be generalised. It was envisaged that statutory services could then learn the lessons and modify service structures and clinical practice in order to offer the best care to all its population (a move from model A to model D, and a shift from the voluntary to the statutory). Alas, statutory services have not learnt the lessons nor has practice been substantially modified. This was partly due to the rapid series of organisational and legislative changes that detracted attention away from services for black and ethnic minority groups. Partly, it was, and is still, due to inertia in institutionalised practice and management.

Statutory services tend to ignore the continuity of the person’s sense of self and identity which is, of course, disrupted or modified but not replaced by mental illness. Those who adhere to the disease model tend to ignore the illness model in which the disease process has a social context which has an impact on the disease. A disease therefore has a social course as well as a pathological course. Acknowledgement of this is vital if the current dissatisfaction with psychiatric services is to be understood and the move towards more wide-based community and holistic approaches to care are to be assessed properly.

Black and ethnic minorities as well as the public, regardless of cultural and ethnic origins, have more socio-centric lay understandings of mental illness. It is on these that they draw to make sense of illness, and it is on these that they draw when they seek help and enter into a therapeutic relationship. Where professionals are ignorant about these lay conceptualisations of health,
illness and restitution, there is a tendency to fall back upon only the disease model, which although useful, is limited and never does justice to the totality of a patient's illness experience.

This is where specialist expertise in the form of the voluntary and independent sector makes a significant contribution that is entirely consistent with government policy, namely to have a multi-disciplinary and public perspective in the development of services, interventions and professional training. The voluntary and independent sector have specialist expertise in cultural knowledge and beliefs. Statutory service workers do not routinely acquire this unless trained specifically in the culture of interest. This sharing of belief systems between professional and service user is not total, but relatively better than occurs in statutory services. Added to this, 'community' participation itself has been shown to be good for the health of minority ethnic groups.73

Professional values of the multi-disciplinary team and the public's perspectives each contribute to a debate on which no consensus emerges. Some focus on resources alone, wishing a separate service to be developed for each cultural group, others expect specialist services which serve groups of ethnic minorities who have shared values and beliefs. Thus in South London, Turkish Muslims were seen in a service that was developed for Indian Sub-continent Muslims because their religious beliefs were understood. They preferred this than going to a service where non-Muslims were seen despite there being considerable language differences between Indian sub-continent Muslims and Turkish Muslims. Some argue for total integration, envisaging a statutory service that can meet the needs of all cultural groups, but the reality is that attention to core knowledge about each cultural group is difficult to generate and retain within teams, especially if professionals feel such knowledge to be superfluous in a disease based approach to the treatment of illness.38
Conclusions

Hence the debate should centre not around whether voluntary independent providers can provide a high quality service; they can. Nor should it be one focused on a separate service for all black and ethnic minority groups. This is not viable, or desirable and certainly not ethically advisable in a multicultural society. The debate therefore should be one of how existing specialist providers, voluntary and independent sector, can survive and contribute to the care offered to black and ethnic minority groups, and how the statutory sector can adopt the 'active ingredients' and 'successful components' of the voluntary sector. This requires the formation of partnerships and business dyads.

Yet, the development of healthy working alliances, and where appropriate, integration of services with very different ideologies is notoriously difficult. As the variety of black and ethnic minority groups have unique profiles of acculturation and proficiency in using existing services, it is not unexpected that service adequacy for each cultural group is at quite different developmental stages. In the face of inadequate services in the short term, the use of independent specially commissioned services (model A, or B) whilst models C and D are developed seems opportune. In the long term some dependence on the voluntary and independent providers will be essential. The statutory sector has to develop and retain core professional skills and knowledge. This can only flourish if there is an ‘organisational capacity’ to develop a multi-culturally competent generic mental health service. This must be motivated by commitment at all levels.
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References


