diverse cymru
Promoting equality for all
Hyrwyddo cydraddoldeb i bawb

# Equality and Diversity Awareness Booklet:

## Black, Asian and Minority Ethnic Communities Mental Health Awareness Session

Barriers and issues for people from Black, Asian and Minority Ethnic backgrounds accessing mental health services

**The Impact of Unconscious Bias and Lack of Cultural Competence**

**Practical action is required to support the development of services in which staff are equipped to deliver culturally appropriate care tailored to individuals. This should take account of their ethnicity and the range of other factors that make individuals who they are, as well as challenge any assumptions that service users from Black, Asian and Minority Ethnic groups need the same care based on their race.**

Royal College of Psychiatrists

# Contents

# Introduction

As part of the way we are introducing the use of outcome tools into mental health and learning disability services we wanted to create an awareness within teams on broader aspects of their role focusing not just on clinical need, but on the unique personal experiences of the people they serve.

We can do this, in part, by considering the health inequalities that can arise between groups or populations from the sometimes unequal distribution of social, environmental and economic conditions within societies. These can determine the risk of people getting ill, their ability to prevent illness or opportunities to take action and/or access treatment when ill health occurs.

For us, one of the most important things we need to think about is how we ensure our services are culturally competent and how we can make reasonable adjustments, when necessary. Culturally competent services are those that respect the diversity in the service user population and are aware of cultural factors that can affect health and healthcare, such as language, communication styles, beliefs, attitudes and behaviours.

Diverse Cymru is a unique Welsh charity committed to supporting people faced with inequality and discrimination. They are specialists in providing equality and diversity consultancy/training courses and have been supporting our programme from the very beginning to assist us in making mental health services in Wales more equitable and unbiased.

This booklet[1] provides additional information to support the learning provided in the awareness video. We recommend that you use both resources available to support your learning, however, this does not cover the full extent of services offered by Diverse Cymru but is only an introduction to the learning that is available with them through their certification scheme.

1. It should be noted that except where terminology from the original external source has been used (such as Ethnic Minority), the booklet uses the term Black, Asian and Minority Ethnic throughout. Using this term to refer to for example, the African, Caribbean, Roma, Irish, Traveller and Eastern European communities, with particular regard to the perceived cultural differences of these groups.

# Module 1

## The Need

# Module 1 - The Need

Black, Asian and Minority Ethnic communities continue to experience inequalities within the U.K. mental health system despite major government policy initiatives.

Although Minority Ethnic inequalities in mental health services have been of concern for decades in the United Kingdom, a significant gap still exists between policies and methods of implementation.

There is therefore a need for action to better meet the needs of the Black, Asian and Minority Ethnic communities and to make the required changes to improve outcomes for members of those communities in the UK. Some of the specific needs to be addressed are that:

- In comparison to White people, more Black, Asian and Minority Ethnic people are diagnosed with mental health issues every year. Black, Asian and Minority Ethnic communities also face barriers accessing culturally appropriate services, including lack of cultural understanding, communication issues and where/how to seek help

- There is a recognised and acknowledged inequality in the services provided to Black, Asian and Minority Ethnic people accessing mental health services as compared to non-Black, Asian and Minority Ethnic service users. It is clear from the statistical and evidential information available this inequality leads to, for example, higher incidence rates of mental ill health and less pathways into mental healthcare, as

- Key factors in this inequality are the effects of unconscious bias and the lack of culturally competent services, for example Black men are often being perceived as being 'aggressive, bad, mad, dangerous', which leads to Black men being frequently over-represented within the mental health system, not listened to and not given equal access to mental health services

- Service providers need to work closely with people from Black, Asian and Minority Ethnic communities prior to service design and delivery. Information should be made available in appropriate languages to support understanding about their illnesses and how they can seek help.

# The Wales Research

Inservice users from Black and Minority Ethnic backgrounds in mental health services in Wales: a secondary analysis of the Count Me In Census, 2005–2010[2]

## Abstract

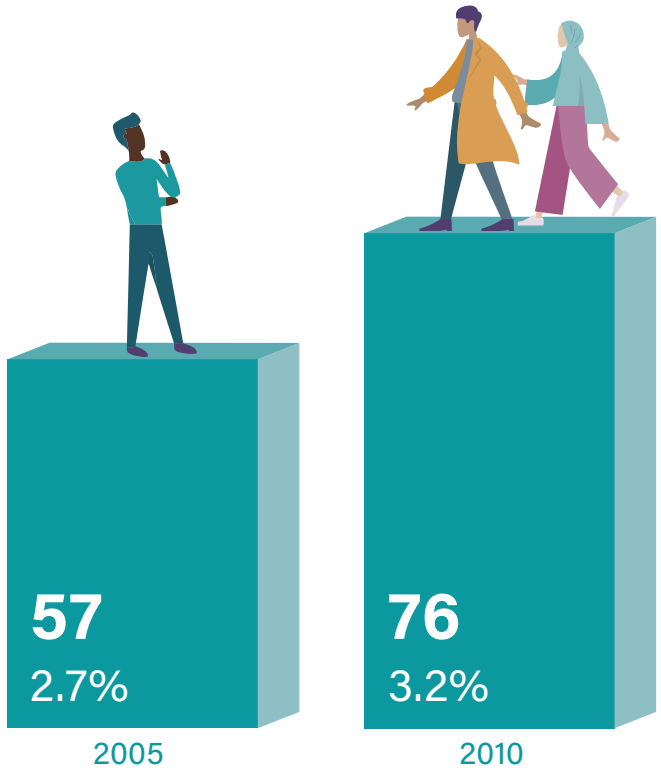
Count Me In was an annual census of mental health inservice users that was undertaken in England and Wales from 2005 to 2010. Apart from brief, unpublished commentaries by the Welsh Government, the data generated in Wales have received little attention and limited analysis.

This paper presents a secondary analysis of the census data, with a focus on mental health inservice users from Black, Asian and Minority Ethnic backgrounds in Wales.

Analyses focused on the number and characteristics of service users (age, gender, ethnicity, language and religion), the distribution of service users across Wales, sources of referral, detention status under the Mental Health Act 1983 on admission and length of stay from admission to census day.

The results revealed that the numbers of Black, Asian and Minority Ethnic service users from different ethnic groups fluctuated over the 6 years; it was difficult to identify any distinct pattern.

The number and proportion of Black, Asian and Minority Ethnic service users admitted to, or being supervised by, inservice user facilities increased year on year from 57 (2.7% of all service users) in 2005 to 76 (3.2%) in 2010. The three highest ethnic-group categories were 'Other', 'Black African' and 'Mixed Caribbean.' Racialised minorities in Wales were over-represented in inservice user mental healthcare, including compulsory detention. A consistently higher proportion of Black, Asian and Minority Ethnic people than White people in Wales were referred from the criminal justice system, while a consistently higher proportion of White people than Black, Asian and Minority Ethnic people were referred by GPs.




2. Dr Roiyah Saltus, PhD MA BA,Principal Research Fellow, University of South Wales, Pontypridd, Wales:Carmel Downes MSc Applied Social Research Methods BSocSc Research Assistant, University College Dublin, Dublin, Republic of Ireland:Paul Jarvis PhD PGCE BSc. Lecturer, University of South Wales, Pontypridd, Wales;Suzanne Duval Manager of Operations, Diverse Cymru, Cardiff, Wales. Full Analysis Details here.

## Summary

The paper provided a descriptive secondary analysis of the mental health data covering the 6 years during which the Count Me In census was conducted in Wales. From the paper's analysis, it was evident that much more work was needed to address mental health inequalities and inequities not only in Wales, but at a global level, not least in countries in Europe and in the USA where there are increasingly large and ethnically diverse populations. Of importance was the collation of statistical, as well as experiential empirical evidence and the development of policy that seeks to explore the social determinants of health and the structural inequalities that underpin people's health and wellbeing as manifested in the delivery and organisation of care, as well as in the individual and collective responses. In-depth exploration of care pathways remains another clear priority for research and policy, as do the recovery pathways taken or forged by people from racialised backgrounds.

# The Issues

## Ethnic inequalities in incidence rates and ethnic inequalities in pathways to care.

Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments. In general, people from Black, Asian and Minority Ethnic groups living in the UK are:

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

These differences may be explained by a number of factors, including poverty and racism. They may also be because mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-White British communities and meet their particular cultural and other needs.

It is likely therefore that mental health problems go unreported and untreated because people in some Ethnic Minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English.

It is not clear whether disparities in access to mental health services reflect variation in actual Black, Asian and Minority Ethnic mental health needs or are the product of institutional, cultural and/or socioeconomic exclusion factors, which disadvantage those from a Black, Asian and Minority Ethnic background. There is some evidence that excluded communities (often incorrectly referred to as '*hard-to-reach groups*'), including Black, Asian and Minority Ethnic groups, are less likely to obtain appropriate mental healthcare and may be disadvantaged either because they are unable to access services or because they receive inadequate help from services.

# The Disparities

## Community

### African-Caribbean people

African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. African-Caribbean people are also more likely to enter mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication rather than be offered talking treatments such as psychotherapy and are over-represented in high/medium secure units/ prisons. This may be because they are reluctant to engage with services and so are much more ill when they do. It may also be that services use more coercive approaches to treatment.

### Chinese people

There is very little knowledge of the extent of mental health problems in the Chinese community. It has been suggested that the close-knit family structure of the Chinese community provides strong support for its members. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help.

### Asian people

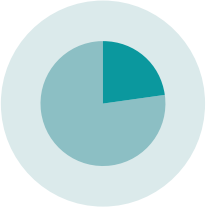
The statistics on the numbers of Asian people in the UK with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group. Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support. Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems. Research has suggested that Western approaches to mental health treatment are often unsuitable and culturally inappropriate to the needs of Asian communities. Asian people tend to view the individual in a holistic way, as a physical, emotional, mental and spiritual being.

### Irish people

Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular, they have higher rates of depression and alcohol problems and are at greater risk of suicide. These higher rates may, in part, be caused by social disadvantage among Irish people in the UK, including poor housing and social isolation. Despite these high rates, the particular needs of Irish people are rarely taken into account in planning and delivering mental health services.

# Mental Health and General Health

## Mental health



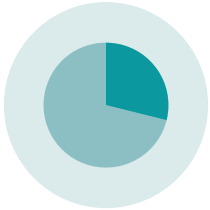
23% of inservice users in mental health services in England and Wales belonged to Black, Asian and Minority Ethnic groups.

The admission rate to mental health institutions for Black, Asian and Minority Ethnic people is 6 times higher than the average for other groups.

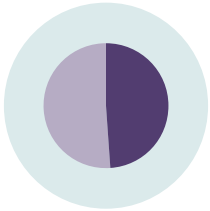
Black people are 40% more likely to be turned away when seeking help from mental health services.

Black African women who are asylum seekers are estimated to have a mortality rate of 7 times higher than for White women.

Black service users are more likely to be admitted to intensive care and secure services and be given higher doses of antipsychotic medication.



Black service users in mental health institutions are 29% more likely to be forcibly restrained.



Black service users in mental health institutions are 49% more likely to be placed in seclusion.

Black Caribbean young men are three times more likely to have been in contact with mental health services in the year before they died by suicide than their White counterparts and their suicides were more likely to be considered preventable.

### Diagnoses of schizophrenia are:

- Nearly 6 times higher in Black African people
- Nearly 6 times higher in 'other Black' people
- Over 3 times higher in mixed White and Black Caribbean people
- Nearly 4 times higher in 'foreign born' people broadly defined.

### Mood disorder is:

- Nearly 11 times more likely in mixed White and Black Caribbean people
- Nearly 7 times more likely in people of 'mixed' ethnicity
- Nearly 3.5 times more likely in Caribbean people
- Over 3.5 times more likely in African people.

### Pathways to care

Detention is:

- Nearly 4 times higher for Black people broadly defined
- Over 3.5 times higher for Caribbean people
- Over 3 times higher for African people.

### Forensic populations:

- 7.5 times more likely for Black British people
- Nearly 3 times more likely for Black people
- Just over 2.5 more likely for Caribbean people
- Nearly 3.5 more likely for African people.

### Police and Criminal Justice involvement is:

- Just over 2.5 times more likely for Black people broadly defined
- Over 2.5 times more likely for Black Caribbean people
- Nearly 2.5 times more likely for Black African people.

### GP involvement is:

- 0.71 times less likely for 'other White' population
- 0.67 time less likely for Black people broadly defined
- 0.57 times less likely for Black Caribbean people
- 0.61 times less likely for Black African people.

### General health:

- Infant mortality in England and Wales for children born to mothers from Pakistan is double the average than for White mothers
- Older Black, Asian and Minority Ethnic people have disproportionately low numbers who use community hospitals, older people's mental health services and access continuing healthcare funding
- Research in 2018 found that Black, Asian and Minority Ethnic health staff were almost twice as likely to be disciplined in comparison with White staff.

# Public Life

## Employment

- In 2017, applicants from Minority Ethnic backgrounds had to send 80% more applications to get a positive response from an employer than a White person of British origin
- Minority Ethnic applicants, including White minorities, had to send 60% more applications to get a positive response from an employer than a White person of British origin.

## Education

- Black, Asian and Minority Ethnic applicants to the most selective universities are less likely to receive offers, even when they may have the same grades as their White counterparts. While 8% of first year undergraduates were Black in 2016, they comprised just 1.5% of the intake at Cambridge University in the same year
- In academic attainment, only 56% of Black students achieve a First class honours degree or 2:1, compared to 80% of their White peers.

## Criminal Justice

- Despite making up just 14% of the population in 2017, Black, Asian and Minority Ethnic men and women make up 25% of prisoners, while over 40% of young people in custody are from Black, Asian and Minority Ethnic backgrounds
- Young Black people are nine times more likely to be locked up in England and Wales than their White peers
- Black people are more than twice as likely to die in police custody
- The proportion of Black people in prisons in England and Wales is more than in the US *(Black people make up 3% of population in England and Wales and 12% of the prison population, compared with 13% and 35% respectively, in the US).*

## Housing and Homelessness

- The Race Equality Foundation found in 2013 that overcrowding is most commonly experienced by Black African and Bangladeshi groups with just over a third of households living in overcrowded accommodation
- Black, Asian and Minority Ethnic groups are also more likely to experience homelessness. For example in Wolverhampton, in 2011, 26% of the population were from a Black, Asian and Minority Ethnic community, but these same communities made up about 40% of the homeless cases seen by the local authority.

## Poverty

- Throughout the UK, people from Black, Asian and Minority Ethnic groups are much more likely to be in poverty (i.e. an income of less than 60% of the median household income) than White British people
- In 2015, Pakistani and Bangladeshi communities were the most likely to be in 'persistent poverty', followed by Black African and Black Caribbean communities.

# The Barriers to Accessing Services

Although most mental health services are based and delivered in a community setting, little research has been conducted to understand the barriers faced by Black, Asian and Minority Ethnic communities to access appropriate services.

Perceptions of barriers to access can provide valuable evidence that may help to shape and drive changes within mental health services

Fear and dissatisfaction with services have been shown to play a significant part in Black people's interaction with mental health services. Over a decade ago, researchers identified 'circles of fear' that stop Black people from engaging with services, as mainstream services are experienced as inhumane, unhelpful and inappropriate. Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well-integrated with the community. As a consequence, Black, Asian and Minority Ethnic people come to services too late, when they are already in crisis, reinforcing the 'circles of fear.'

**Factors considered important barriers to accessing services include:**

- Lack of ability to effectively deliver healthcare services that meet the social, cultural, religious and linguistic needs of Black, Asian and Minority Ethnic individuals
- Lack of variation in clinical practice and service provision
- Lack of understanding of cultural models of illness
- Fear of stigma
- Perceived discrimination
- Barriers for appropriate communication
- Lack of understanding of the impact of differential treatment and how this can affect one's mental health and generate a crisis
- Lack of information and awareness of the mental health system, what it offers and how to access it.

**As a consequence, Black, Asian and Minority Ethnic individuals are often:**

- Viewed as bad, mad and dangerous
- More likely to be aggressive
- Over-diagnosed with schizophrenia and under-diagnosis with depression
- Not being heard or listened to.

# The Challenges

The key challenges, in terms of mental health issues and service delivery, faced by Black, Asian and Minority Ethnic people are:

**Social problems:**

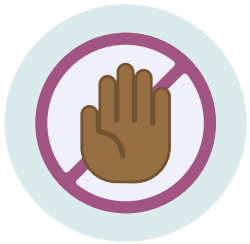
Racism, poverty, unemployment, poor housing, poor educational achievement

**Service provision which is inaccessible:**

Many Minority Ethnic workers are employed in shift work or in occupations which make it impossible for them to attend offices and meetings during conventional office hours.


**Language barriers:**

Majority of the British Ethnic Minority population were born in Britain, but we have a vulnerable minority who can only communicate in minority languages



**Minority ethnic community distrust of White agencies:**

Many Minority Ethnic people may see some organisations as White led with no concern for the interests of visible minorities.

**Lack of Black/Asian imagery:**

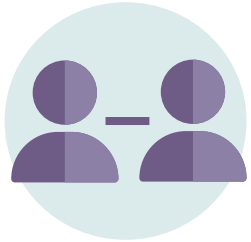
Many posters, leaflets and offices reflect only a mono-cultural society.

**Denial or fear of admitting need in the community:**

Certain problems are not admitted by some community leaders because their existence is not compatible with idealised views of what religious norms permit.

**Service staff ignorance of Minority Ethnic communities:**

Lack of adequate knowledge about minority cultures and an insensitive treatment of ethnic specific issues. For example, a lack of appreciation of the importance of religion in influencing social and health related behaviour.



**Making connections:**

Many service providers have small community work project teams and it is very important that they have the ability to form or join networks as this provides a means of exchanging experiences and needs with other teams. But in many cases, they do not make the right connections with Minority Ethnic communities.

**Lack of resources for positive outreach work:**

To provide additional or special services to attract or go out to Minority Ethnic groups is seen as needing to have or employing additional staff. This ignores principles of equity as well as need.

**Accessing communities:**

The process of making network connections with official or established groups should be distinguished from the issue of access to Minority Ethnic communities who are not always as established or integrated into local structures.

**A knowledge base:**

Service providers may not have adequate and appropriate information about Minority Ethnic service users. High quality information about a community is vital to assess need accurately and to shape services appropriately.

**Giving priority and adding value:**

There may be a problem for service providers to prioritise Minority Ethnic issues within a restricted budget, while ensuring that all communities feel that their needs are valued.

# Demography

## 2011 Census: Black, Asian and Minority Ethnic Communities Summary

| WALES: 2011 Census March 2011 | All categories: ethnic groups | White English Welsh Scottish Northern Irish British | White Irish | White Gypsy or Irish Traveller | White Other White | White All | Mixed multiple ethnic group White and Black Caribbean | Mixed multiple ethnic group White and Black African | Mixed multiple ethnic group White and Asian | Mixed multiple ethnic group Other Mixed | Asian Asian British Indian | Asian Asian British Pakistani | Asian Asian British Bangladeshi | Asian Asian British Chinese | Asian Asian British Other Asian | Black African Caribbean Black British African | Black African Caribbean Black British: Caribbean | Black African Caribbean Black British Other Black | Other ethnic group Arab | Other ethnic group Any other ethnic group | Ethnic Minorities All |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Local Authority Area** | nos. | % | % | % | % | % | % | % | % | % | % | % | % | % | % | % | % | % | % | % | |
| | 3,063,456 | 93.2 | 0.5 | 0.1 | 1.8 | 95.6 | 0.4 | 0.1 | 0.3 | 0.2 | 0.6 | 0.4 | 0.3 | 0.4 | 0.5 | 0.4 | 0.1 | 0.1 | 0.3 | 0.2 | 4.4 |
| **Isle of Anglesey** | 69,751 | 96.6 | 0.7 | 0.1 | 0.9 | 98.3 | 0.3 | 0.1 | 0.3 | 0.1 | 0.2 | 0.0 | 0.1 | 0.2 | 0.2 | 0.1 | 0.0 | 0.0 | 0.2 | 0.1 | 1.9 |
| **Gwynedd** | 121,874 | 94.4 | 0.5 | 0.1 | 1.5 | 96.5 | 0.2 | 0.1 | 0.3 | 0.2 | 0.4 | 0.2 | 0.1 | 0.7 | 0.3 | 0.2 | 0.1 | 0.0 | 0.6 | 0.1 | 3.5 |
| **Conwy** | 115,228 | 95.4 | 0.7 | 0.1 | 1.5 | 97.7 | 0.3 | 0.1 | 0.2 | 0.2 | 0.3 | 0.1 | 0.1 | 0.3 | 0.3 | 0.1 | 0.0 | 0.0 | 0.2 | 0.1 | 2.3 |
| **Denbighshire** | 93,734 | 95.6 | 0.6 | 0.0 | 1.2 | 97.4 | 0.3 | 0.1 | 0.3 | 0.2 | 0.3 | 0.2 | 0.1 | 0.4 | 0.6 | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 2.7 |
| **Flintshire** | 152,506 | 95.9 | 0.5 | 0.1 | 2.1 | 98.6 | 0.2 | 0.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.1 | 0.2 | 0.2 | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 1.6 |
| **Wrexham** | 134,844 | 93.1 | 0.4 | 0.1 | 3.4 | 97.0 | 0.2 | 0.1 | 0.2 | 0.2 | 0.6 | 0.1 | 0.2 | 0.3 | 0.5 | 0.4 | 0.0 | 0.0 | 0.1 | 0.1 | 3.0 |
| **Powys** | 132,976 | 96.1 | 0.4 | 0.1 | 1.8 | 98.4 | 0.2 | 0.1 | 0.2 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.6 | 0.0 | 0.1 | 0.0 | 0.0 | 0.1 | 1.7 |
| **Ceredigion** | 75,922 | 93.1 | 0.6 | 0.1 | 2.9 | 96.7 | 0.3 | 0.1 | 0.3 | 0.3 | 0.5 | 0.1 | 0.1 | 0.4 | 0.3 | 0.2 | 0.1 | 0.0 | 0.3 | 0.2 | 3.2 |
| **Pembrokeshire** | 122,439 | 95.6 | 0.7 | 0.4 | 1.4 | 98.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.3 | 0.1 | 0.1 | 0.2 | 0.4 | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 1.9 |
| **Carmarthenshire** | 183,777 | 95.5 | 0.4 | 0.2 | 2.0 | 98.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.3 | 0.1 | 0.1 | 0.2 | 0.4 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 2.1 |
| **Swansea** | 239,023 | 91.5 | 0.5 | 0.0 | 2.0 | 94.0 | 0.2 | 0.1 | 0.3 | 0.2 | 0.6 | 0.2 | 0.8 | 0.9 | 0.7 | 0.7 | 0.1 | 0.0 | 0.7 | 0.3 | 5.8 |
| **Neath Port Talbot** | 139,812 | 96.9 | 0.3 | 0.1 | 0.7 | 98.0 | 0.3 | 0.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.2 | 0.2 | 0.3 | 0.1 | 0.1 | 0.0 | 0.0 | 0.1 | 2.0 |
| **Bridgend** | 139,178 | 96.0 | 0.3 | 0.0 | 1.4 | 97.7 | 0.2 | 0.1 | 0.2 | 0.2 | 0.2 | 0.1 | 0.1 | 0.3 | 0.4 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 2.2 |
| **The Vale of Glamorgan** | 126,336 | 94.4 | 0.5 | 0.0 | 1.6 | 96.5 | 0.5 | 0.2 | 0.3 | 0.3 | 0.4 | 0.2 | 0.1 | 0.4 | 0.5 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 3.5 |
| **Cardiff** | 346,090 | 80.3 | 0.7 | 0.2 | 3.5 | 84.7 | 1.1 | 0.5 | 0.7 | 0.6 | 2.3 | 1.8 | 1.4 | 1.2 | 1.3 | 1.5 | 0.4 | 0.5 | 1.4 | 0.6 | 15.3 |
| **Rhondda Cynon Taf** | 234,410 | 96.3 | 0.2 | 0.0 | 0.8 | 97.3 | 0.2 | 0.1 | 0.2 | 0.1 | 0.3 | 0.1 | 0.0 | 0.5 | 0.4 | 0.5 | 0.0 | 0.0 | 0.1 | 0.1 | 2.6 |
| **Merthyr Tydfil** | 58,802 | 94.6 | 0.2 | 0.1 | 2.7 | 97.6 | 0.3 | 0.1 | 0.3 | 0.2 | 0.3 | 0.1 | 0.1 | 0.2 | 0.5 | 0.2 | 0.0 | 0.0 | 0.1 | 0.1 | 2.5 |
| **Caerphilly** | 178,806 | 97.3 | 0.2 | 0.0 | 0.8 | 98.3 | 0.3 | 0.1 | 0.2 | 0.2 | 0.2 | 0.1 | 0.0 | 0.3 | 0.2 | 0.1 | 0.1 | 0.0 | 0.0 | 0.1 | 1.9 |
| **Blaenau Gwent** | 69,814 | 97.3 | 0.1 | 0.1 | 0.9 | 98.4 | 0.2 | 0.1 | 0.2 | 0.1 | 0.3 | 0.1 | 0.0 | 0.2 | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 1.5 |
| **Torfaen** | 91,075 | 96.9 | 0.3 | 0.2 | 0.6 | 98.0 | 0.3 | 0.1 | 0.2 | 0.1 | 0.2 | 0.1 | 0.1 | 0.2 | 0.5 | 0.1 | 0.1 | 0.0 | 0.0 | 0.1 | 2.1 |
| **Monmouthshire** | 91,323 | 96.1 | 0.4 | 0.0 | 1.5 | 98.0 | 0.2 | 0.1 | 0.3 | 0.2 | 0.3 | 0.1 | 0.0 | 0.2 | 0.4 | 0.1 | 0.0 | 0.0 | 0.1 | 0.1 | 2.1 |
| **Newport** | 145,736 | 87.0 | 0.5 | 0.1 | 2.3 | 89.9 | 0.9 | 0.2 | 0.5 | 0.3 | 0.8 | 2.1 | 1.2 | 0.4 | 0.9 | 1.0 | 0.5 | 0.2 | 0.6 | 0.4 | 10.0 |

# Demography

## 2019: Ethnicity Summary – Welsh Government

| | White | Black, Asian and Minority Ethnic | | Black, Asian and Minority Ethnic % 2019 | Black, Asian and Minority Ethnic % 2011 |
|---|---|---|---|---|---|
| **Wales** | 2,954,600 | 153,300 | 3,109,300 | 4.9 | 4.4 |
| **Isle of Anglesey** | 69,300 | 300 | 69,600 | 0.4 | 1.9 |
| **Gwynedd** | 118,500 | 3,900 | 122,600 | 3.2 | 3.5 |
| **Conwy** | 112,800 | 1,800 | 114,600 | 1.6 | 2.3 |
| **Denbighshire** | 91,600 | 3,300 | 94,800 | 3.4 | 2.7 |
| **Flintshire** | 152,600 | 2,400 | 155,000 | 1.6 | 1.6 |
| **Wrexham** | 135,500 | 3,000 | 138,600 | 2.2 | 3.0 |
| **Powys** | 127,200 | 3,100 | 130,300 | 2.4 | 1.7 |
| **Ceredigion** | 73,000 | 2,000 | 75,300 | 2.7 | 3.2 |
| **Pembrokeshire** | 123,800 | 1,300 | 125,100 | 1.0 | 1.9 |
| **Carmarthenshire** | 177,600 | 5,500 | 183,200 | 3.0 | 2.1 |
| **Swansea** | 219,200 | 24,900 | 244,000 | 10.2 | 5.8 |
| **Neath Port Talbot** | 137,400 | 3,400 | 141,000 | 2.4 | 2.0 |
| **Bridgend** | 138,100 | 3,400 | 141,500 | 2.4 | 2.2 |
| **Vale of Glamorgan** | 122,700 | 4,200 | 126,900 | 3.3 | 3.5 |
| **Cardiff** | 309,100 | 57,400 | 366,800 | 15.7 | 15.3 |
| **Rhondda Cynon Taf** | 233,100 | 5,100 | 238,300 | 2.2 | 2.6 |
| **Merthyr Tydfil** | 57,700 | 1,700 | 59,400 | 2.9 | 2.5 |
| **Caerphilly** | 178,600 | 2,100 | 180,900 | 1.2 | 1.9 |
| **Blaenau Gwent** | 68,000 | 1,200 | 69,200 | 1.7 | 1.5 |
| **Torfaen** | 87,700 | 4,000 | 91,700 | 4.3 | 2.1 |
| **Monmouthshire** | 89,800 | 1,900 | 91,700 | 2.0 | 2.1 |
| **Newport** | 131,400 | 17,400 | 148,800 | 11.7 | 10.0 |

# Module 2

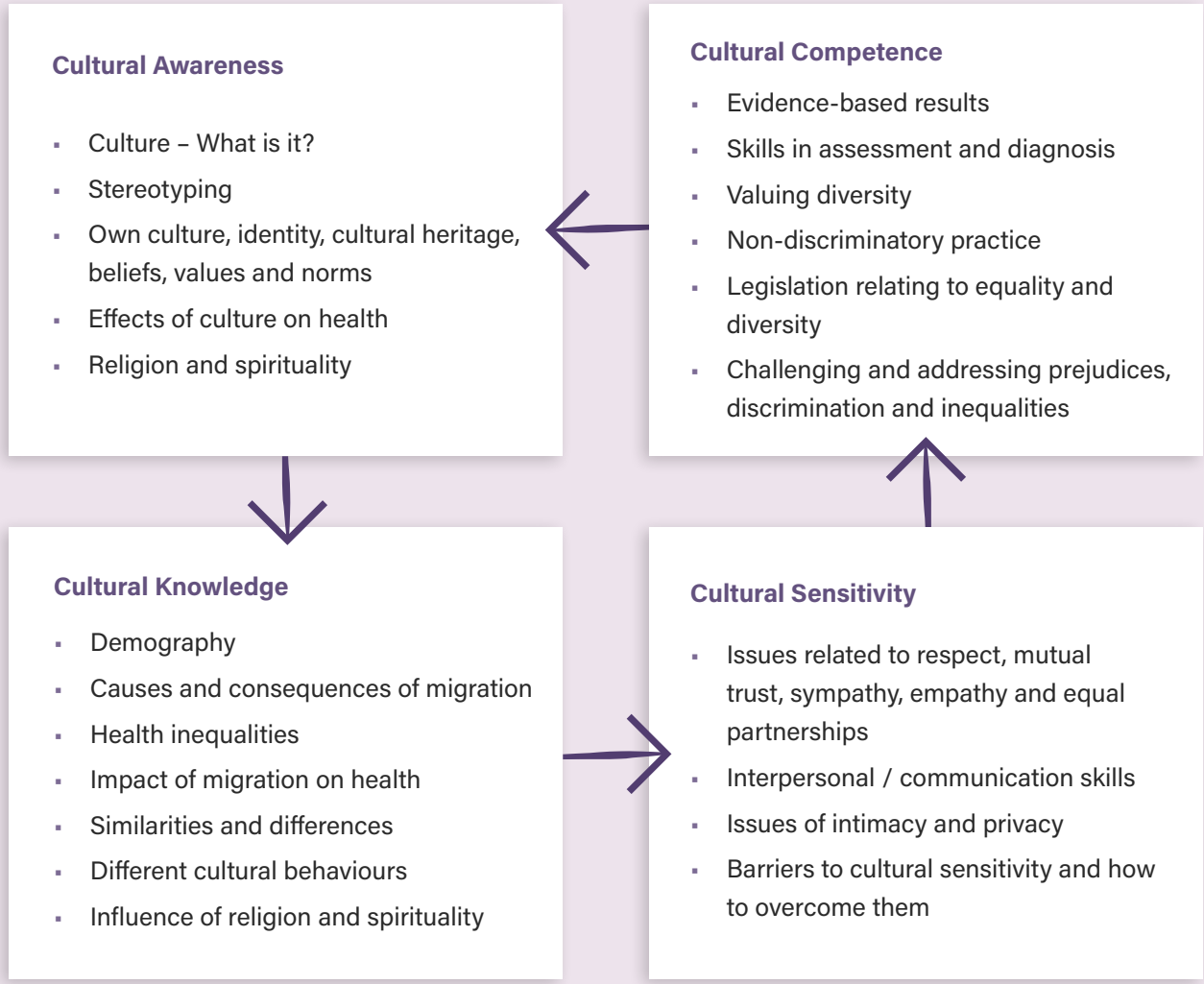
## What is Culture?

# Module 2 - What is Culture?

**Culture can be defined as:**

- The characteristics and knowledge of a particular group of people, encompassing language, religion, cuisine, social habits, music and arts. It is also defined as the 'way of life' of groups of people, meaning the way they do things, which incorporates an integrated pattern of human knowledge, belief and behaviour, relating to attitudes, values, morals, goals and customs shared by a particular group
- It is a filter through which people process their experiences and events of their lives
- It influences people's values, actions and expectations of themselves
- It impacts people's perceptions and expectations of others.

**Understanding and practicing cultural competence is often described as having 4 stages - awareness, knowledge, sensitivity and competence**



### Cultural Awareness

Cultural Awareness can be defined as someone's understanding of the differences between themselves and people from other countries or other backgrounds, especially differences in attitudes and values. It is also the foundation of communication and it involves the ability of standing back from ourselves and becoming aware of our own cultural values, beliefs and perceptions

### Cultural Knowledge

Cultural Knowledge is an important part of cultural competence. Culture specific knowledge refers to particular characteristics that belong generally to members of a certain culture, though not necessarily to every individual within that culture! It is also defined as all we know that characterises a particular culture and can include other information that can serve to explain why people are and behave in certain way

### Cultural Sensitivity

Cultural Sensitivity relies on a range of interpersonal and communication skills which can only be achieved if service users/clients are true partners. Thus, the foundation of cultural sensitivity is mutual trust, respect and empathy. It involves knowing that cultural differences as well as similarities exist, without assigning values, i.e., 'better or worse', 'right or wrong', to those cultural differences.

## Cultural Competence:

- Is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes?
- Is the ability to think, feel and act in ways that acknowledge, respect and built upon ethnic, socio-cultural and linguistic diversity?
- Research and experience are clear that the continued lack of cultural competence in service provision is due to a lack of understanding of cultural difference, reinforced by the impact of unconscious bias in workplace practice
- Practical action is therefore required to support the development of services in which staff are equipped to deliver culturally appropriate care tailored to individuals. This should take account of their ethnicity and the range of other factors that make individuals who they are, as well as challenge any unconscious bias assumptions that service users from Black, Asian and Minority Ethnic groups don't need the same care based on their race and culture
- Cultural competence means being equitable and non-discriminatory in your practice and behaviour
- It requires a balanced approach to others in which cultural identity and cultural context are taken into account
- Like competence in general, cultural competence is the responsibility of both the individual and the organisation.

There are, of course, strong professional and service reasons also for being culturally competent. To be culturally competent you and your practice must be:

- Person-centred
- Non-discriminatory
- Accessible to all
- Legally compliant and consider the equality impact of everything you do.

# The Need for Cultural Competence

The increasing diversity of the UK/Wales brings opportunities and challenges for healthcare providers, healthcare systems and policy makers to create and deliver culturally competent services.

Cultural competence is defined as the ability of providers and organisations to effectively deliver healthcare services that meet the social, cultural and linguistic needs of service users. A culturally competent healthcare system can help improve health outcomes, quality of care and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the healthcare system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to service user care.

No-one knows everything about every culture, let alone everybody within every culture, but by increasing your cultural competency, mistakes can be opportunities for learning and authentic human connection. Working with cultural competency at all levels of your practice, gaining insight into your own culture as well as others and using cultural bridging techniques will allow you to serve all service users with the best most equitable healthcare possible.

Cultural and linguistic competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups. To become culturally competent, a person should take stock of the culture, values and biases they have and how they shape their view of others. Evaluating your prejudices and preconceptions is an essential first step toward cultural competency. Secondly, a person must seek knowledge.

# Benefits and Challenges of Cultural Diversity in the Workplace

**Benefits:**

- Diverse cultural perspectives can inspire creativity and drive innovation
- Drawing from a culturally diverse talent pool allows an organisation to attract and retain the best talent
- A diverse skills base allows an organisation to offer a broader and more adaptable range of products and services
- Diverse teams are more productive and perform better
- Promotes greater opportunity for personal and professional growth.

**Challenges:**

- Colleagues from some cultures may be less likely to let their voices be heard
- Integration across multicultural teams can be difficult in the face of prejudice or negative cultural stereotypes
- Professional communication can be misinterpreted or difficult to understand across languages and cultures
- Different understandings of professional etiquette
- Conflicting working styles across teams.

Of course, as well as providing benefits, culturally diverse workplaces can present some issues that must be carefully managed too. Teams with individuals from multiple different cultural backgrounds can feel more difficult to work within, despite typically being more productive. This needs to be recognised, accommodated and accounted for.

# Managing Cultural Differences at Work

## Different Cultures

Employers should be mindful that their employees will often come from a broad range of backgrounds and may have different customs and values. Both employers and employees should be sensitive and respectful towards such differences. It is good practice for an employer to provide training for staff to establish a culture of respect in this area and provide an understanding of what constitutes acceptable and unacceptable behaviours.

# Module 3

## What is Unconscious Bias?

# Module 3 - What is Unconscious Bias?

## Definitions

- The inclinations, attitudes or stereotypes that affect our understanding, actions and decisions that form outside our own conscious awareness
- A kind of prejudice you have that you aren't aware of, that affects the kinds of impressions and conclusions that you reach automatically, without thinking
- The underlying, subconscious prejudices often referred to as people preferences, which affect everyone
- Associations between our attitudes to certain things and certain people that we are generally not aware of influenced by:
  - Nature – your physical environment and surroundings
  - Nurture – your upbringing
  - Experiences – your lived experiences.

## Considerations

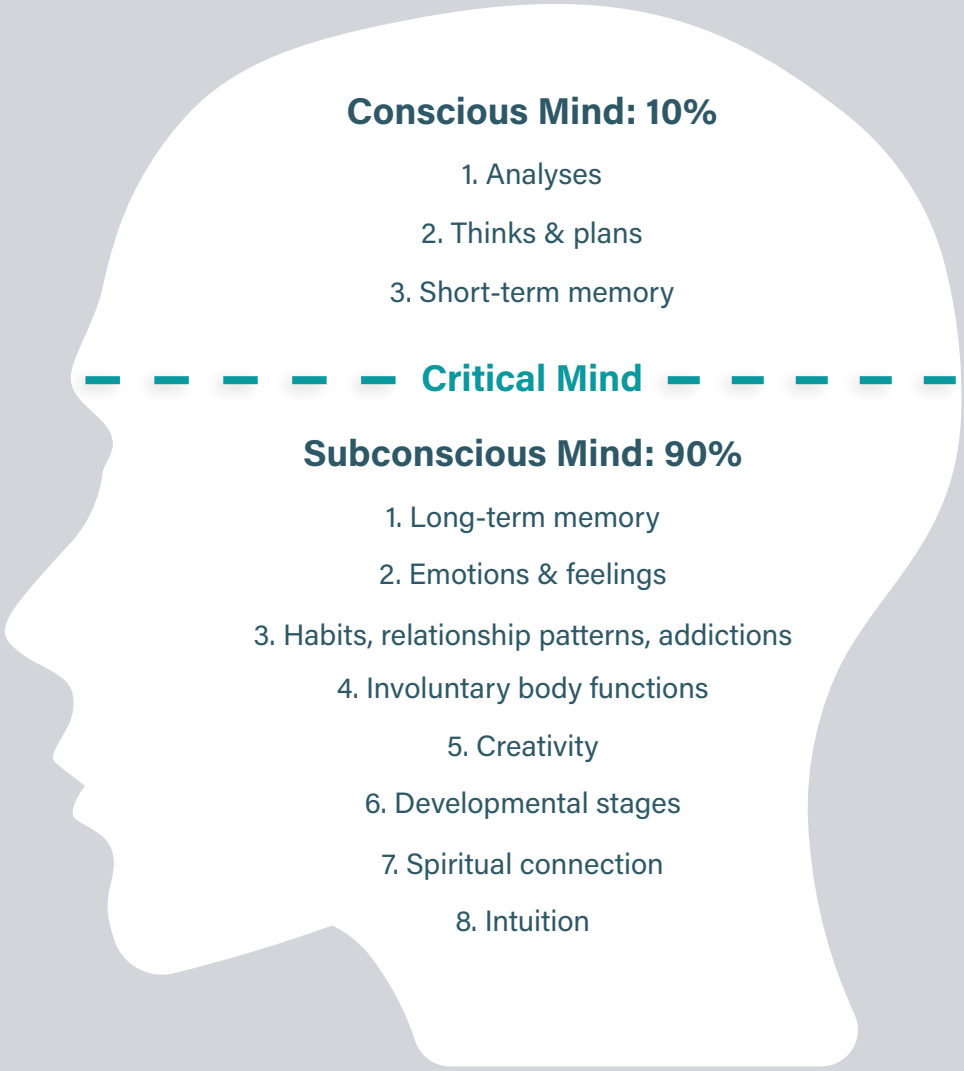
- Sometimes referred to as Unconscious Prejudice, Implicit Bias or Hidden Bias
- Unconscious Bias underlies many of our patterns of behaviour and can be **positive as well as negative**
- Traditional thought assumed that discrimination was conscious
- Now a vast body of research shows that this is not the case
- Stress or tiredness may increase the likelihood of decisions based on unconscious bias.

## Impact

- Unconscious bias can influence decisions in recruitment, promotion and service delivery. It could be discriminatory when unconscious bias relates to a protected characteristic
- Unconscious bias occurs when people favour others who look like them and/or share their values. For example, a person may be drawn to someone with a similar educational background, from the same area, or who is the same colour or ethnicity as them.

## Key Points

- It's natural - unconscious bias is a fact of life. Everyone has biases and can take them into the workplace
- It's unintended. Most of us are unaware of our unconscious bias - on a conscious level, most of us would say that we do not discriminate; our "hidden" brains may though
- You are not alone - we all suffer from having prejudices. They are simply mental shortcuts based on social norms and stereotypes. **However, just because you may possess hidden biases, prejudices, or stereotypes, does not mean that your practices are necessarily discriminatory**
- Most of us believe that we are ethical and unbiased - we imagine we're good decision makers, able to objectively size up things and reach a fair and rational conclusion that's in our and our organisation's best interests
- However, there is plenty of evidence that suggests that more subtle, covert types of discrimination do occur in our work and day to day life and more than two decades of research confirms that this is often the reality.



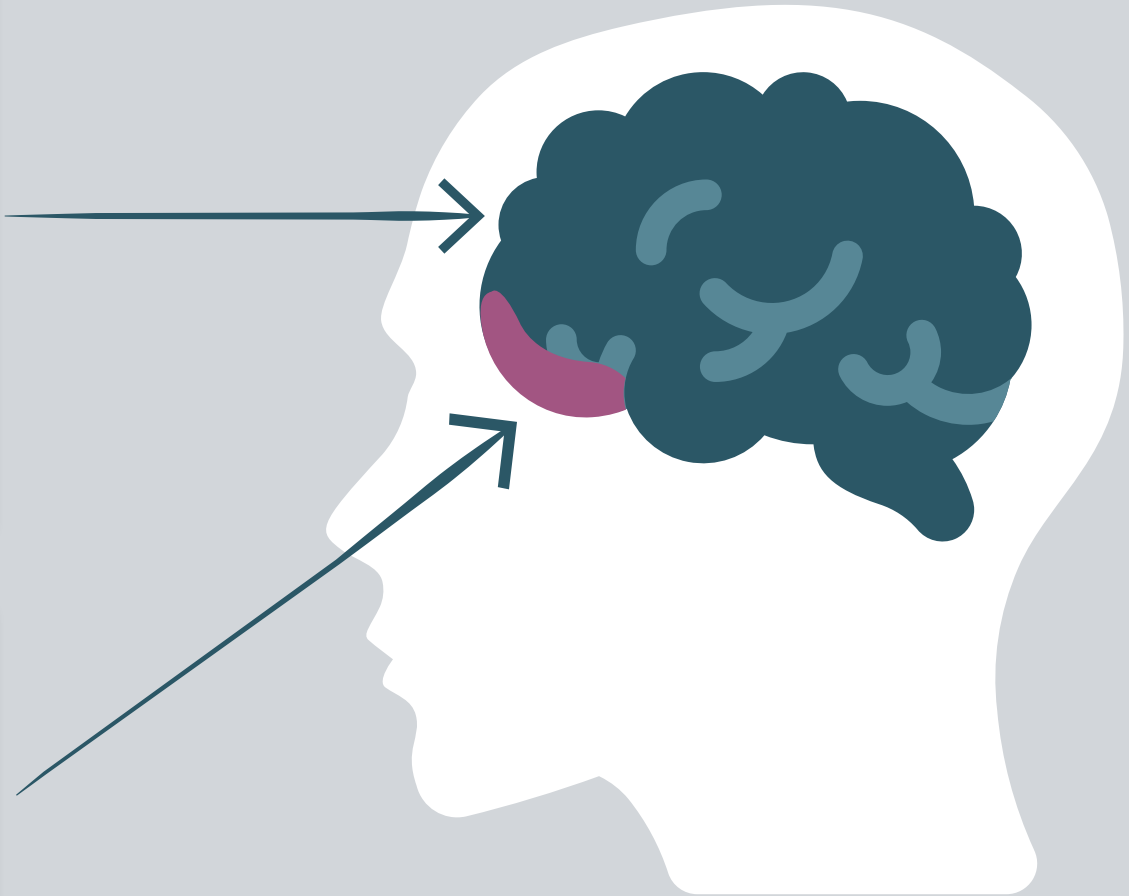
# The Human Mind

## The Subconscious Mind

- A host of brain functions, emotional responses, and cognitive processes that happen outside our conscious awareness but have a decisive effect on how we behave
- The hidden brain – takes over after the rules have been learned – automatic, fast, instant adjustments
- It can apply shortcuts to situations in which they don't work and sometimes applies rules to complex situations inappropriately.

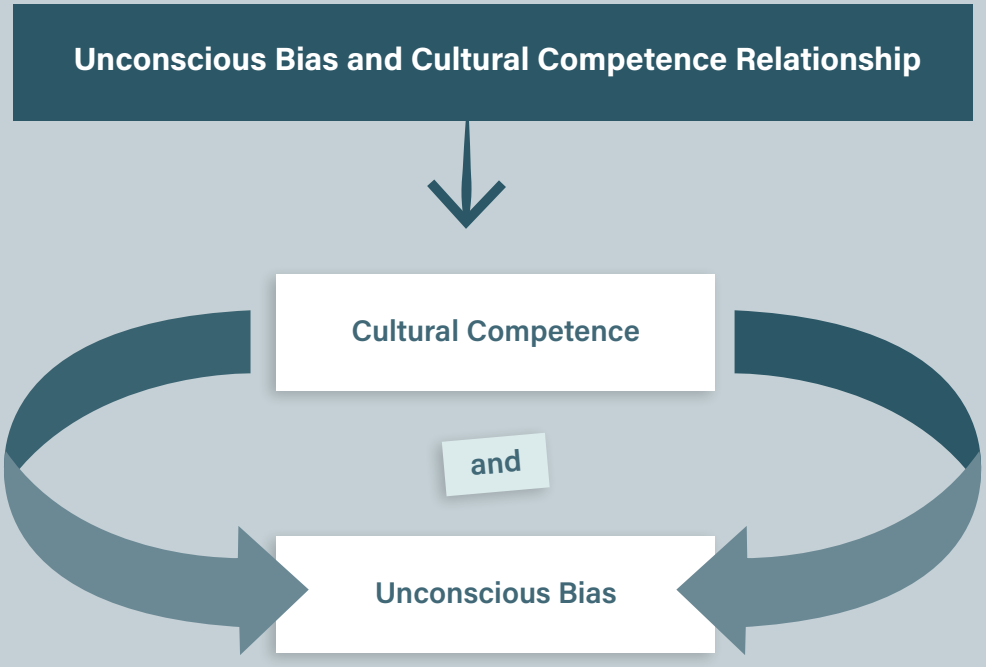
## The Conscious Mind

- Used for new situations – rational, careful, analytical, slow, deliberate, understands exceptions
- Not efficient to use this every time – exposed to 11 million pieces of information – can only process 40 at one time.



# Unconscious Bias Key Points

- Everyone has unconscious biases. The brain receives information all the time from our own experiences and what we read, hear or see in the media and from others. The brain uses shortcuts to speed up decision-making and unconscious bias is a by-product. There are times when this sort of quick decision making is useful, for example. if we are faced with a dangerous situation, however it is not a good way to make decisions when, for example, recruiting staff or delivering services
- Conscious thoughts are controlled and well-reasoned. Unconscious thoughts can be based on stereotypes and prejudices that we may not even realise we have. For example, stereotypes surrounding tattoos may subconsciously suggest to some people that a person is unlikely to conform and follow rules
- Many of our brain functions, emotional responses and cognitive processes fall outside of our conscious awareness
- We rely on stereotypes, even if we don't consciously believe in them
- Our brains are hardwired to make unconscious decisions
- We have to make decisions very quickly
- Direct link between our unconscious thinking, our actions and behaviour
- Unconscious bias may lead a person to act in a way that is at odds with their intentions
- Unconscious bias influences people subtly, not overtly. It derives much of its power from the fact that people are unaware of it.




**Linked but not the same thing**

**Culture is a Context of Unconscious Bias**

# Influences and Impact of Unconscious Bias

## Influences:

- Whom we employ
- How much we listen to people who are different
- How much we involve people who are different
- How we design services and projects
- How we interact with service users and stakeholders

## Impacts on:

- Recruitment
- Group work
- Allocation of roles/jobs
- Performance appraisals – marking/grading assessments
- Disciplinaries and grievances
- Appraisals
- Team building/bonding
- Service delivery/provision
- Team/individual working practices
- Responding to stakeholder complaints
- Leadership – management approaches
- Consultation and engagement

# Common Types of Unconscious Bias

## Affinity bias

Affinity bias refers to when you unconsciously prefer people who **share qualities with you or someone you like**. It occurs because your brain sees them as familiar and relatable and we all want to be around people we can relate to. For example, if an applicant went to the same school as you or they share similar hobbies, you are more likely to prefer them over other candidates. Affinity bias can cloud your judgement and attitudes to the way in which services are provided.

## Attribution bias

Attribution bias refers to **how you perceive your actions and those of others**. It stems from our brain's flawed ability to assess the reasons for certain behaviours – particularly those that lead to success and failure. We generally attribute our own accomplishments to our skill/personality and our failures to external factors – to hindrances that we believe are beyond our control. We are less likely to blame and find fault in ourselves. However, this perception often reverses when we view other people. When they do something successfully, we're more likely to consider them lucky or benefited by someone else and more likely to attribute their errors to poor capabilities or personal qualities. In providing services, this can skew your judgement and approach in the way in which services are provided.

## Beauty bias

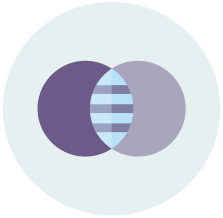
We all unconsciously notice people's appearances and associate it with their personality. Appearances are important, particularly in a workplace setting, as they reflect on professionalism and self-awareness. However, **many of us judge others too harshly based on their physical attractiveness**. It is unfair to think that a person does not make 'enough' of an effort with their appearance, or that they put in 'too much' effort. This can lead to assumptions about their personality and skills. You cannot assume that a person who dresses in a particular manner is an all-around organised person. The opposite could easily be true. Other times, you may unconsciously dislike certain features in a person. These may stem from a subconscious, stereotypical view of what a successful or friendly person looks like. These assumptions may cause unfairness in the way in which services are provided.

## Conformity bias

Conformity bias happens **when your views are swayed too much by those of other people**. It occurs because we all seek acceptance from others – we want to hold opinions and views that our community accepts. In service delivery, conformity bias is common. When a majority of the group shares an opinion for example about a particular culture, you usually decide to agree with them even if your original opinion differed. A unanimous view is less likely to come from a place of bias. However, **you should not let it prevent you from voicing your opinions and views**. Your opinions may draw attention to facts about judgements in the way in which services are provided that others do not notice.

## Confirmation bias

Confirmation bias refers to how people **primarily search for bits of evidence that back up their opinions**, rather than looking at the whole picture. It leads to selective observation, meaning you overlook other information and instead focus on things that fit your view. You may even reject new information that contradicts your initial evidence. Most people subconsciously slip into confirmation bias because they **seek confirmation that their initial assessment of a person is correct**. We even do it to back up other unconscious biases, so it is important to keep it in check. Otherwise, you fail to provide equitable services to, for example, those from a different cultural background, based on your faulty assessment.



## Contrast effect

This type of bias occurs when you assess two or more similar things/people and compare them with one another, rather than looking at each based on their own merits. The contrast effect is common in service delivery where it can make you judge individuals receiving a service differently based on your predefined assessment of those individuals. This can impact on your judgement and attitudes as to the way in which services are provided to each individual.

## Gender bias

Gender bias is simply a preference for one gender over the other. It often stems from our **deep-seated beliefs about gender roles and stereotypes**. For example, you may subconsciously think a man better fits a physically demanding job. In particular, gender bias occurs because we favour people that we can relate to, especially those of the same gender. We often connect with them more easily because of shared gender-specific physical and emotional experiences.

## Halo effect

The halo effect occurs when we **focus on one particularly great feature about a person**. You view everything about the person in a positive, 'halo' light, which makes you think they are more perfect than they are. Similar to affinity and confirmation bias, this makes us overlook other information. It skews our opinion of other aspects, including negative ones. In delivering services, you need to prevent the halo effect from blinding you in the way in which services are provided.

## Horns effect

The horns effect is the opposite of the halo effect: you **focus on one particularly negative feature about a person**, which may cloud your view of their needs. For example, if a person is from a cultural background that you have had a negative experience with, you need to avoid using a negative experience to define everyone of a similar cultural background.

# Implicit Association Test

The online Implicit Association Test (IAT), was designed to help test takers assess their unconscious biases.

Since it was launched in 1998, more than 6 million people have taken the test. The test assesses bias, based on how quickly the test taker pairs a face with a positive term and then compares it to how quickly the test taker responds to more difficult terms. There are 14 test modules in all.

**Click the title to go to each test.**

## Sexuality

Sexuality (Gay-Straight IAT). This IAT requires the ability to distinguish words and symbols representing gay and straight people. It often reveals an automatic preference for straight relative to gay people.

## Age

Age (Young-Old IAT). This IAT requires the ability to distinguish old from young faces. This test often indicates that people have automatic preference for young over old.

## Gender

Gender (Gender-Science IAT). This IAT often reveals a relative link between liberal arts and females and between science and males.

## Countries

Countries (UK-United States IAT). This IAT requires the ability to recognise photos of national leaders and other national icons. The results revealed by this test provide a new method of appraising nationalism.


## Weight

Weight (Fat-Thin IAT). This IAT requires the ability to distinguish faces of people who are obese and people who are thin. It often reveals an automatic preference for thin people relative to fat people.

## Skin-tone

Skin-tone (Light Skin-Dark Skin IAT). This IAT requires the ability to recognise light and dark-skinned faces. It often reveals an automatic preference for light-skin relative to dark-skin.

## Race

Race (Black-White IAT). This IAT requires the ability to distinguish faces of European and African origin. It indicates that most people have an automatic preference for White over Black.

# Module 4

## Good Practice Considerations

# Module 4 - Good Practice Considerations

What should good mental health services for people from Black, Asian and Minority Ethnic communities look like?

### Mental health promotion and raising awareness

Mental health promotion is an important component of strategies to encourage mental wellbeing and facilitate mental healthcare.

### Improving access and expanding the care pathway

There is good evidence that some Black, Asian and Minority Ethnic groups do not access specialist mental health services along conventional or planned pathways. Instead, these groups tend to follow more aversive care pathways into specialist care.

### Alternatives to coercive services and reducing detentions under the mental health act

Findings relating to the Mental Health Act and Count Me in Census show that Black people are more at risk of being detained under the Mental Health Act and more likely to be held in secure psychiatric care than any other ethnic groups.

### Improving cultural competence and appropriate specialist mental healthcare

An important issue reported by Black, Asian and Minority Ethnic communities is the disproportionate emphasis on control and coercion and the resulting 'circles of fear.'

### Support and advocacy

Service users, service users and carers from Black, Asian and Minority Ethnic backgrounds face particular difficulties in accessing and using support services over and above those faced by their White counterparts.

### Measuring and monitoring

Commissioning mental health services for Black, Asian and Minority Ethnic communities should be based on an assessment of local needs and on strong evidence.

### Improving choice and availability in service provision

Ethnic inequalities in mental health are a persistent and enduring problem, despite recent national initiatives set out to address this problem.

### Increasing the involvement of Black, Asian and Minority Ethnic Service Users and Investing in Black, Asian and Minority Ethnic User-Led Services

Black, Asian and Minority Ethnic service users continue to face barriers in participating in involvement initiatives. The idea that Black, Asian and Minority Ethnic service users are 'hard to reach' is still entrenched in organisational cultures and practices.

### Building on previous work

Unfortunately, previous recommendations in policy guidance have not been fully implemented.

# Possible Solutions to a Lack of Cultural Competence in the Workplace

How could we seek to involve Black, Asian and Minority Ethnic people in attempting to tackle the acknowledged problems?

**Reaching communities:** service providers need to seek the views of communities and act on their expressed concerns. Services and initiatives must be accessible, for example, taking into account suitable hours and transport availability.

**Gaining credibility:** the service provider's first task is to establish credibility among Minority Ethnic they wish to work with. They should have a commitment to working with Minority communities. They should have a good understanding of the issues facing Minority Ethnic communities. They should have an ability to listen positively to the needs of the Minority communities. Finally, they should have a willingness to take action on the concerns of that community.

**Involving target groups and communities:** there is a well-developed voluntary sector among Minority Ethnic communities, for example, religious, social organisations and campaigning bodies. Employing staff of Minority Ethnic origin may help services to gain the trust of and secure access to Minority Ethnic communities.

**Staff training/knowledge/skills:** many service providers are ignorant of Minority Ethnic cultures and community priorities. Staff need to understand the issues of concern to Minority Ethnic groups as well as having a grounding in specific cultural issues.

**Responding to diversity:** service providers should use materials which are not mono-cultural. Cultural diversity includes not only language, but religion, diet, identity, history and family organisation.

**Information gathering:** gather information about the area before you start. Look at the statistical data on the presence of Minority Ethnic populations before you take any action.

**Databases:** use only reliable data, assess your sources and use grass-roots information wherever possible. Maintain your databases on a long-term basis and be alert to trends and changes.

**Networks:** use existing networks, see allies working with Minority Ethnic groups in other fields, such as health promotion and community work.

**Sharing information and experience:** service providers should share ideas of good practice and solutions to difficulties. Use the resources and skills available in Minority Ethnic communities. Also, service providers should be prepared to accept different perspectives and to act on them by committing resources.

**Monitoring and evaluation:** service providers should set targets that reflect local needs and priorities. They should monitor activity and evaluate it, to be agreed standards. Remembering that minority groups also share common interests with the majority and do not only have special needs. Also, they should keep the Minority Ethnic communities informed of all their activities.

**Key Issues:** service providers need to understand the social history of Minority Ethnic communities of which racism is perhaps the greatest concern. While Minority Ethnic communities may have specific needs which should be met, all materials and strategies should reflect the existence of diversity in the population and should recognise that neither minority nor majority culture and society are static.

# The Challenges and Benefits of Cultural Competence

## Challenges

It is recognised that all mental health service providers are experiencing significant challenges in meeting the needs of their service users, often due to operating within tight financial constraints. The challenge facing mental health service providers has been further exasperated by sharp and ever-increasing demand for their services and the growing number of different cultures that need to be supported.

This growing number of different cultures, it is acknowledged, provides an additional challenge when dealing appropriately with the issues of 'Unconscious Bias' and 'Cultural Difference.'

In dealing with the issues of 'Unconscious Bias' and 'Cultural Difference', greater knowledge and understanding is essential. It is hoped that the Diverse Cymru Black, Asian and Minority Ethnic Awareness and Unconscious Bias awareness raising, toolkit, together with the Black, Asian and Minority Ethnic Mental Health Certification Scheme process will play a part in addressing and dealing with these challenges.

## Benefits

Culturally competent services produce numerous benefits for the organisation, its service users and the community, including:

### Social Benefits

- Increases mutual respect and understanding between service user and organisation Increases trust
- Promotes inclusion of all community members
- Increases community participation and involvement in health issues
- Assists service users and families in their care
- Promotes service user and family responsibilities for health.

### Health Benefits

- Improves service user data collection
- Increases preventive care by service users
- Reduces care disparities in the service user population
- Increases cost savings from a reduction in medical errors, number of treatments and legal costs
- Reduces the number of missed medical visits.

### Business Benefits

- Incorporates different perspectives, ideas and strategies into the decision-making process
- Decreases barriers that slow progress
- Encourages more effective embedding of equality and diversity within business as usual processes, leading to more effective compliance
- Improves efficiency of care services
- Increases the market share of the organisation.

Organisations that are culturally competent have improved health outcomes, increased respect and mutual understanding from service users and increased participation from the local community. Additionally, organisations that are culturally competent may have lower costs and fewer care disparities.

# How to Overcome Unconscious Bias and Improve Cultural Competence Practice

- Be aware of unconscious bias
- Don't rush decisions, rather, take your time and consider issues properly
- Justify decisions by evidence and record the reasons for your decisions, for example, during a recruitment exercise
- Try to work with a wider range of people and get to know them as individuals. This could include working with different teams or colleagues based in a different location
- Focus on the positive behaviour of people and not negative stereotypes
- Employers should implement policies and procedures which limit the influence of individual characteristics and preferences
- Recognise and acknowledge our own bias
- Take conscious action to reduce bias
- Regularly review and challenge ourselves
- Meet more people from communities and groups we have biases around
- See difference as an opportunity for learning and development
- Take our time to make decisions – fully assess each individual, separately
- Be impartial about facts, but understand feelings
- Use positive images and words
- Use clear, non-biased language
- Conduct self-assessment - taking an honest “look” into our unconscious
- Honestly explore values, beliefs and attitudes about others
- Non-defensively engage the entire organisation and the larger community in the self-assessment
- Consider whether workplace practice ensures equity in service delivery. Learning about Unconscious Bias and Cultural Competence
- Reframing from “discrimination” to focus on fair treatment and respect
- Embrace and utilise schemes such as the **Black, Asian and Minority Ethnic Mental Health Workplace Good Practice Certification Scheme**.

# The Black, Asian and Minority Ethnic Mental Health Workplace Good Practice Certification Scheme

## A Positive Way Forward to Achieving Cultural Competence

The scheme seeks to:

- Proactively address the inequality faced by Black, Asian and Minority Ethnic individuals using mental health services in Wales, recognising the importance of cultural sensitivity and cultural competence, in order to make a practical positive ongoing difference in the quality of mental health services that Black, Asian and Minority Ethnic individuals receive
- Be achieved through the provision of practical assistance to mental health organisations and practitioners to help them deliver excellent culturally sensitive and as a consequence, culturally competent mental health services to Black, Asian and Minority Ethnic individuals in Wales
- Take note of the issues related to the potential of unconscious bias, the scheme uses an evidence-based approach and will focus on supporting organisations/workplaces to effectively meet and respond to the needs of Black, Asian and Minority Ethnic mental health service users in a cost-effective way
- Provide Certification verification through an established accredited body, enabling organisations to incrementally work towards providing excellent practical culturally appropriate services
- Focus on supporting organisations to effectively meet and respond to the needs of Black, Asian and Minority Ethnic mental health service users in a cost and resource effective manner
- Provide organisations and practitioners with relevant techniques and interventions to deliver an effective culturally competent, service user-centred service.

# Five Assessment Areas and Four Levels of Attainment

| | Foundation | Developing | Competence | Excellence |
|---|---|---|---|---|
| | No clear or reliable Black, Asian and Minority Ethnic mental health evidence of good practice | Limited or informal Black, Asian and Minority Ethnic mental health evidence of good practice<br><br>Inconsistent Black, Asian and Minority Ethnic mental health evidence of good practice | Consistent and reliable Black, Asian and Minority Ethnic mental health good practice evidence<br><br>Able to demonstrate embedded Black, Asian and Minority Ethnic mental health good practice (minimum of 3 years)<br><br>Effective formalised Black, Asian and Minority Ethnic mental health processes and structures | Consistent and reliable evidence of best practice<br><br>Able to demonstrate embedded Black, Asian and Minority Ethnic mental health best practice (minimum of 3 years)<br><br>Effective formalised Black, Asian and Minority Ethnic mental health processes and structures |
| **Environment and Organisational Commitment** | The organisation's environment plays a critical role in determining how inclusive and welcoming the organisation's services are. Visible practical commitment particularly from senior managers is also vital if the organisation is serious in ensuring equitable services are provided. | | | |
| **Communication and Consultation** | A need for a continual two-way communication and consultation process. This involves the continual checking of how the other person has heard or understood what has been said. Also considering dialects/accents of the individuals' language. | | | |
| **Cultural Competence** | The ability to relate effectively to individuals from various groups and backgrounds. Culturally competent services respond to the unique needs of members of Black, Asian and Minority Ethnic populations. Services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention. | | | |
| **Professional Development** | Training which is imperative in order to develop the cultural capability of staff working with diverse cultural communities which will underpin the delivery of culturally capable services. Organisations need to be willing to challenge familiar ways of interacting and therefore, need to undertake ongoing proactive training and awareness raising. | | | |
| **Outcome and Engagement** | A need for effective monitoring and review, to ensure that services meet the needs and expectations of Black, Asian and Minority Ethnic people receiving services. The meaningful engagement of clients in designing, developing and delivering services involving families and the community. | | | |

# Publications

## Commission for Equality in Mental Health: Briefing

*Determinants of mental health - 21 January 2020*

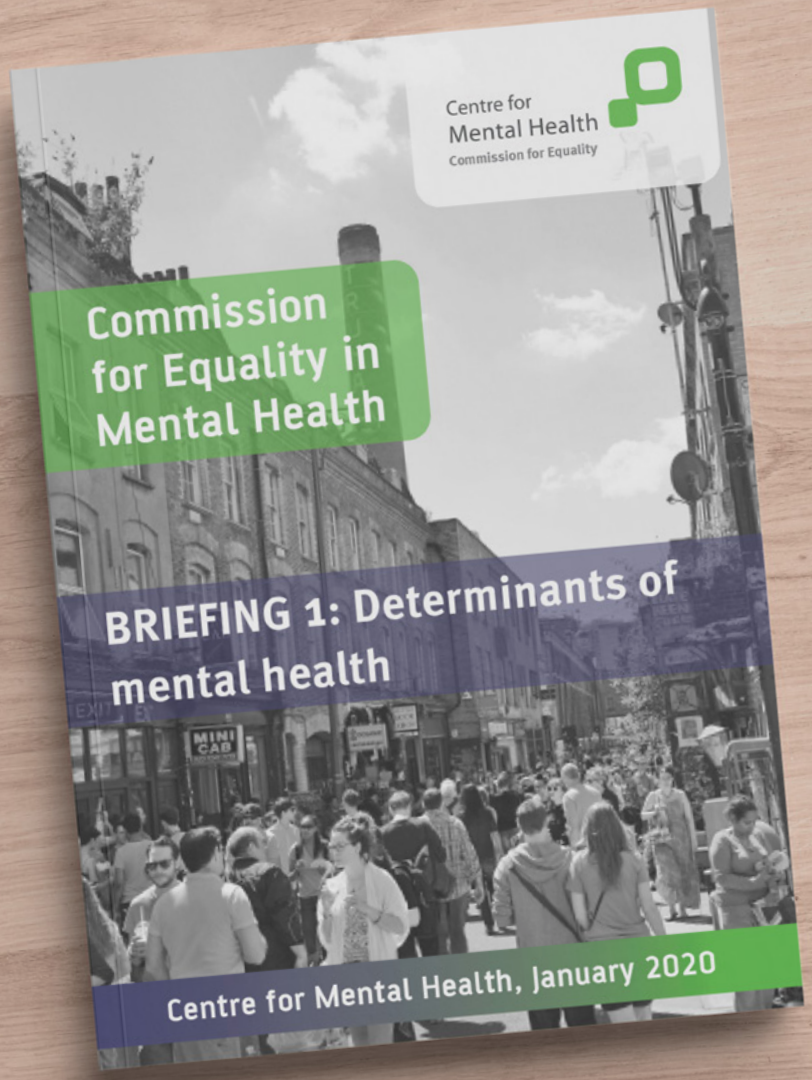
Why do some groups of people have a much higher risk of mental health difficulties and what can we do to reduce the disparities?

One in four of us will experience a mental health problem, but our chances of this are far from equal. There are many determinants in our lives which influence our mental health: from positive parenting and a safe place to live, to experiencing abuse or the impacts of austerity.

This first briefing from the Commission for Equality in Mental Health finds that mental health inequalities are closely linked to wider injustices in society. Inequalities in wealth, power and voice are linked to poorer mental health. Exclusion, discrimination, violence and insecurity all increase our risk of poor mental health and explain why some groups of people face markedly higher rates of mental ill health than others.

The briefing explores actions that can be taken, from communities and local services to national policies, to reduce mental health inequalities. They include action to reduce income inequality, housing insecurity and poor working conditions as well as changes to education and the provision of early years support to families.

See full briefing here.



# Summary

## Commission for Equality in Mental Health Briefing

Anyone can experience a mental health problem but our chances of having good or poor mental health are far from equal.

The Commission for Equality in Mental Health was set up by Centre for Mental Health to investigate inequalities in mental health in the UK and produce policy and practice proposals to tackle them. The Commission is seeking to understand why and how inequalities in mental health happen, what ways they manifest and most importantly, what can be done to prevent or mitigate them.

This briefing paper focuses on the unequal determinants of mental health. The determinants of mental health are the factors that influence our mental health throughout our lives.

All of us have multiple layers of identity and belong to communities of geography, gender, ethnicity, social class and many more and many of us experience forms of disadvantage resulting from poverty, homelessness, exclusion, discrimination or oppression. Many people have fewer choices, less of a voice, less power and fewer opportunities than others.

The determinants of mental health interact with these inequalities in ways that put some people at a far higher risk of poor mental health than others. For example:

- Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%
- Children and young people with a learning disability are three times more likely than average to have a mental health problem
- Men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk and are more likely than average to be diagnosed with schizophrenia
- 40% or more of people over the age of 85 and those in nursing homes have depression.

We have identified a range of suggestions from previous research and from our call for evidence about specific actions and approaches that could help to prevent, reduce or mitigate inequalities in the determinants of mental health. These include:

- Community-led peer support and social change movements
- Prioritising early years interventions, including parenting programmes
- A whole school approach to mental health with a focus on equality
- Action to increase the price and reduce the availability of alcohol
- Addressing income inequality, work insecurity and working conditions
- Improving housing quality and security and preventing homelessness.

The Commission will produce two further briefing papers, on access to support and on experiences of outcomes from services and a final report with recommendations for policy and practice in 2020.

# Communication Breakdown and Cultural Factors Create Barriers to Black, Asian and Minority Ethnic Groups Accessing Mental Health Services

A new study has found that members of Black, Asian and Minority Ethnic groups are facing barriers to mental health services because of a communication breakdown between healthcare users and providers.

Cultural factors, such as an inability to accept mental health problems and stigma, were also found to affect access to services. Use of mental health services also varies widely, with people from ethnic minorities less likely than their White British counterparts to contact their GP about mental health issues, be prescribed antidepressants or referred to specialist mental health services.

First, personal and environmental factors included a negative perception of and social stigma against, mental health, an inability to recognise and accept mental health problems, the positive impact of social networks, a reluctance to discuss psychological distress and seek help among men and cultural identity, along with financial factors.

Second, factors affecting the relationship between service user and health-care provider included the impact of long waiting times for initial assessment, language barriers, poor communication between service users and providers, inadequate recognition or response to mental health needs, imbalance of power and authority between service users and providers, cultural naivety, insensitivity and discrimination towards the needs of Black, Asian and Minority Ethnic service users and lack of awareness of different services among service users and providers.

**What are the problems of Black, Asian and Minority Ethnic carers?**

Carers may experience feelings of guilt, grief, loss or anger. Carers should take a break from caregiving to avoid becoming worn down. Support and respite care are available for carers and can provide comfort and practical assistance.

*"I didn't see myself as a carer, I just saw myself as a mum"*

*"The more we can share good experiences of what's worked for us... it's reassuring and you can get ideas you haven't thought about".*

Margaret cares for her husband, who has dementia. She talks about her husband's problems with swallowing and the importance of sharing experiences with other carers.

While Black, Asian and Minority Ethnic and White carers face similar difficulties in their caring role (namely high levels of stress and difficulties securing paid employment), Black, Asian and Minority Ethnic carers are known to experience unique challenges in accessing support services.

- Black, Asian and Minority Ethnic carers face particular difficulties in accessing and using support services, over and above those experienced by White carers
- Low uptake of services by Black, Asian and Minority Ethnic carers cannot be attributed to their lack of interest in receiving support. Many Black, Asian and Minority Ethnic carers are unaware of the services that exist to support them.

# References and Reading List

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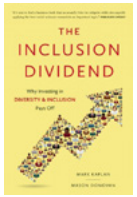
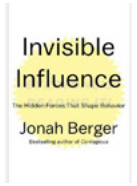
NeuroLogic: The Brain's Hidden Rationale Behind Our Irrational Behaviour

*Eliezer. J. Sternberg*



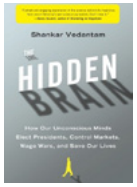

Inclusion Dividend: Why Investing in Diversity & Inclusion Pays Off

*Mark Kaplan*



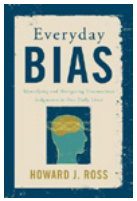

Invisible Influence: The Hidden Forces that Shape Behaviour

*Jonah Berger*



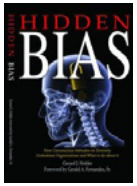

The Hidden Brain: How Our Unconscious Minds Elect Presidents, Control Markets, Wage Wars, and Save Our Lives

*Shankar Vedantam*




Everyday Bias: Identifying and Navigating Unconscious Judgments in Our Daily Lives

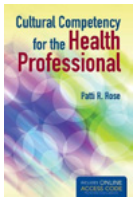
*Howard J. Ross*




Hidden Bias - How Unconscious Attitudes on Diversity Undermine Organizations and What to do about it

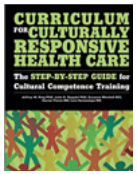
*Gerard J. Holder*

## Cultural Competency




Cultural Competency for Health Administration and Public Health

*Patti R. Rose*

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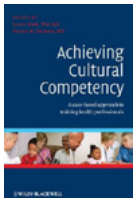
*Ring, J. et al.*

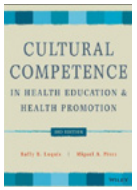

Diversity and Cultural Competence in Healthcare

*Janice L. Dreachslin; M. Jean Gilbert; Beverly Malone*




Achieving Cultural Competency

*Lisa Hark (Editor); Horace DeLisser (Editor)*

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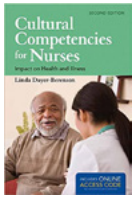
*Miguel A. Pérez; Raffy R. Luquis; Miguel A. Prez*

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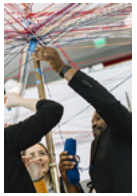
*Linda Dayer-Berenson*


Guide to Culturally Competent Healthcare

*Larry D. Purnell*



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*Hult Business School*

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