



The Costs of Race Inequality

The results of SCMH research and analysis, presented clearly and concisely to inform and influence policy and practice.

The Sainsbury Centre for Mental Health (SCMH) is funded by the Gatsby Charitable Foundation to improve quality of life for people in the UK with severe mental health problems.

SCMH works to influence policy and improve practice in public services through research, analysis and development. It is affiliated to the Institute of Psychiatry at King's College, London.

Introduction

Research has repeatedly shown that there are major differences in the way that Black African and Caribbean people come into contact with mental health services and in the benefit they derive from them, compared with the rest of the population. The need to address disparities in access, experience and outcomes is recognised in the Government's five-year action plan, *Delivering Race Equality in Mental Health Care* (DRE, Department of Health, 2005a).

This paper seeks to strengthen and support the case for action set out in DRE by developing the hypothesis that better mental health services for Black people could yield a double benefit: improved outcomes and lower financial costs. In other words, there may be a business case for change as well as the acknowledged health and equity case.

Further research on the costs and effectiveness of better ways of providing mental health care for Black people is needed to substantiate this hypothesis in detail and the present analysis should be regarded as primarily illustrative. It is nevertheless clear, even on the basis of the limited calculations presented here, that the potential scope for re-allocating resources in beneficial ways is very substantial.

Background

The analysis starts from the established research evidence (best summarised in Bhui *et al.*, 2003) on differences in the use of mental health services between Black people and their White counterparts. This shows, for example, that Black people are often reluctant to engage with mainstream mental health services and do so only at times of crisis or breakdown. Delays in seeking help can create new risks, such as involvement of the police or use of the Mental Health Act, and lead to disproportionately high rates of hospital inpatient admission, compulsory admission, admission to intensive care and secure services and use of seclusion and restraint in all types of hospital. Not surprisingly, such patterns of service use are negatively experienced and associated with poor outcomes, as measured for example by high rates of relapse and re-admission. In turn, these adverse consequences reinforce the mistrust of mainstream services that is the initial cause of delayed engagement.

Breaking the Circles of Fear (SCMH, 2002) looked into the relationship between African and Caribbean people and mental health services. The report confirmed previous quantitative findings in relation to the over-representation of African and Caribbean people in mental health services. It also highlighted:

- ❖ High concentrations of African and Caribbean people within inpatient, acute and secure treatment settings
- ❖ Limited involvement of primary care and a lack of community-based crisis care
- ❖ People coming into contact with services via the criminal justice system
- ❖ Poor levels of engagement and satisfaction
- ❖ Questionable attributions of risk to Black service users
- ❖ High levels of fear among Black service users of both mental health professionals and of statutory services
- ❖ A related high level of fear among mental health professionals in relation to the risks posed by Black service users
- ❖ Alienation and lack of involvement of Black carers.

A notable feature of the patterns of service use described in *Breaking the Circles of Fear* (SCMH, 2002) is that they entail the over-representation of Black people in high-cost services, particularly hospital inpatient care. This raises the possibility that a shift towards a more representative pattern of care among this group might not only improve outcomes but also save expenditure, by reducing the demand for high-cost services.

While previous research has noted the over-representation of Black service users in costly forms of care it has not explored the financial implications in any detail. On a wider front, some studies have been undertaken in the US focusing upon how much economic activity is lost through racism and disadvantage (Brimmer, 1993), including calculations of the amount of GDP lost through the imprisonment of large sections of the African American male community. However we found no examples in the UK of analyses of the differential costs of mental health service delivery to disadvantaged groups.

The main aim of the present paper is to make a start on filling this gap, in particular by setting out some quantitative estimates of:

- (i) costed care pathways, comparing Black and White service users; and
- (ii) the potential to spend public money on mental health care differently if the quantity and mix of services used by Black people were more in line with those of their White counterparts.

The analysis of costs and savings relates to London only. This is partly for reasons of data availability but also because the study is confined to the use of mental health services by Black African and Caribbean people (rather than all Black and minority ethnic communities), as issues of unequal access and outcomes in mental health care are known to be particularly serious for this group; and more than 70% of all Black African and Caribbean people in England live in the capital.

Acknowledgements

Grateful acknowledgement is made to four mental health trusts in London which have provided detailed patient-based information on service use by ethnicity, as used in the construction of costed care pathways. These are: Barnet, Enfield and Haringey Mental Health NHS Trust; Camden and Islington Mental Health and Social Care Trust; Central and North West London Mental Health NHS Trust; and South London and the Maudsley NHS Trust. Thanks are also due to the Healthcare Commission and Mental Health Act Commission for making available data for London from the *Count Me In* census of inpatients in mental health hospitals undertaken in March 2005.

Service use by ethnicity

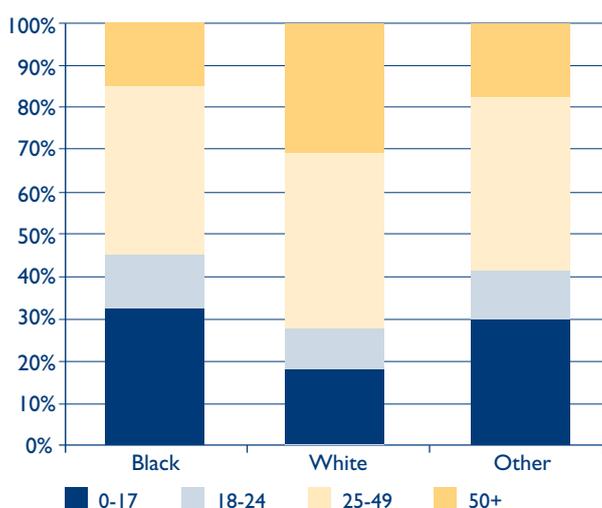
For the purpose of this study, London's population has been divided into three broad 'ethnic groupings': Black, White and Other. As shown in Table 1, more detailed breakdowns are possible but combining the figures into the three larger groupings gives larger sample sizes, providing findings that are more viable and robust in comparison to those based on smaller groups. It also reflects the differences in mental health care use described in the *Count Me In* census (in which Black African, Caribbean and mixed groups were consistently different to all other ethnic groups, [Healthcare Commission, 2005]) and ensures that confidentiality is preserved should the number of people using more specialist services be so small as to make patient identification possible.

Table I: Breakdown of London population by ethnicity

Category	Ethnic group as cited in 2001 Census	Proportion of London population	
Black	Black or Black British: Black Caribbean	4.79%	12.4%
	Black or Black British: Black African	5.28%	
	Black or Black British: Other Black	0.84%	
	Mixed: White and Black Caribbean	0.99%	
	Mixed: White and Black African	0.48%	
White	White: British	59.79%	71.1%
	White: Irish	3.07%	
	White Other: White	8.29%	
Other	Mixed: White and Asian	0.84%	16.5%
	Mixed: Other Mixed	0.85%	
	Asian or Asian British: Indian	6.09%	
	Asian or Asian British: Pakistani	1.99%	
	Asian or Asian British: Bangladeshi	2.15%	
	Asian or Asian British: Other Asian	1.86%	
	Chinese	1.12%	
	Other Ethnic Group	1.58%	

A study of relevant census data showed that working age adults comprised about half of each of the three groupings. There are, however, major differences between the Black and White groupings in the relative numbers of children and older adults. The age bands in Figure 1 reflect those used in the *Count Me In* data and highlight this difference.

Figure 1: London population by ethnicity and age



Sources of data

In order to study use of secondary mental health services we relied on two sources. The first was the *Count Me In* census (Healthcare Commission,

2005) of people using inpatient mental health services on 31 March 2005. This census is one of the building blocks of the Government’s plan to tackle inequalities in access and outcomes for mental health service users from Black and minority ethnic (BME) communities (Department of Health, 2005a). It provides accurate information on patient ethnicity, and some NHS mental health trusts are already using this information to review and plan services.

The second source we used was a subset of data from the Mental Health Minimum Data Set (MHMDS), a nationally defined framework of data on adult mental health service users. Each record in the dataset describes a Mental Health Care Spell – that is, the whole period in which an individual is looked after by a provider of specialist mental health services from initial referral to final discharge. Data for secondary mental health service use between April 2004 and March 2005 was provided by four London NHS trusts, three of which provided information on both inpatient and community services, while one provided data only on inpatient services.

The main reason for using two overlapping datasets was to ensure that the data we used was as rich as possible. Though the quality of the data is getting better by the day, data collection for the MHMDS is still in its early stages and it is not always complete. This is particularly true with regard to data items such as ethnicity, which may be considered ‘non-essential’ by some. As the focus of the *Count Me In* census was on ethnicity, data

collection was more rigorous regarding this aspect, with only 0.8% of cases in the ‘Not Stated’ category.

In addition to being a form of cross-checking, the *Count Me In* census includes data on aspects of inpatient care, such as the use of seclusion and restraint, which are not available via the MHMDS. The MHMDS, however, contains important information about the use of community mental health services, which are excluded from *Count Me In*, so both are needed to get a fuller picture of the actual numbers and costs involved.

There are certain caveats regarding the data and subsequent analysis, which should be clarified at the outset:

1. The figures used in the analysis have not been adjusted to take into account factors which might cause differences in the prevalence of mental illness by ethnicity. It is known that many Black and minority ethnic groups suffer disadvantages relating to housing, employment, income and other socio-economic variables, all of which may be associated with higher levels of mental illness. The information used in this study was not sufficiently detailed to account, or standardise, for these variables.
2. The *Count Me In* data is for all people using inpatient services in London, not just those who are resident in the capital. This is because patient postcodes are incompletely coded and do not always reflect their place of residence. The data may therefore include people being treated in London even though they are resident elsewhere.

The *Count Me In* data on psychiatric inpatients that was made available for this study groups together people over the age of 65 with those aged 50-65. Because the focus of our study is on adults of working age, an adjustment to exclude those aged 65+ was made in the analysis of costs and expenditure savings and this may introduce a small margin of error.
3. Data from the MHMDS is of limited quality and completeness. For about a third of all the people using mental health services, ethnicity was either not recorded or ‘Not Stated’. (This figure varied from one trust to another and was greatly reduced for inpatient services.)

Where such discrepancies were noted, people in the ‘Not Stated’ category were allocated to our three ethnic categories pro rata, i.e. in the same proportion as observed in that particular service user group (e.g. inpatients, people seen by CMHTs etc.). Results based on these calculations are referred to as ‘adjusted’.

4. Another area where there was a marked lack of recorded data was with regard to diagnosis. On the whole, less than a third of the cases had a recorded International Classification of Diseases (ICD) code. This made it impossible to conduct any sort of analysis regarding differences in symptoms or diagnosis.

Adult mental health service use

The combined population of the catchment areas of the four trusts that provided data for our study makes up approximately 43% of the total population of London and includes 60% of the Black population. Table 2 provides a breakdown of the population split by ethnicity.

Table 2: Comparison of the sample and all-London populations

Ethnic grouping	Population of the four trusts' catchment areas	Total London population	% of London population in trust catchment areas
Black	528,701	887,959	60%
White	2,078,136	5,103,203	41%
Other	472,637	1,180,929	40%
Total	3,079,474	7,172,091	43%

The age distribution of population by ethnicity was compared to the overall London distribution cited earlier and was not significantly different. In order to concentrate on working age adults only, all service users who did not fall into the 16-65 age band were, as far as possible, excluded from the MHMDS.

Figure 2 shows the ethnicity of working age adults using secondary mental health services of any kind provided by our four trusts. Figure 3 indicates the number of adults per 100,000 of each grouping who use these services. They indicate that a Black person is around 1.6 times more likely to come into contact with mental health services in London than a White person.

Figure 2: Mental health service users in the sample trusts by ethnic grouping (working age adults)

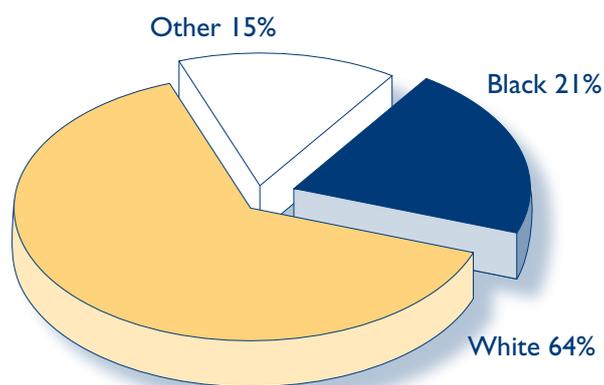
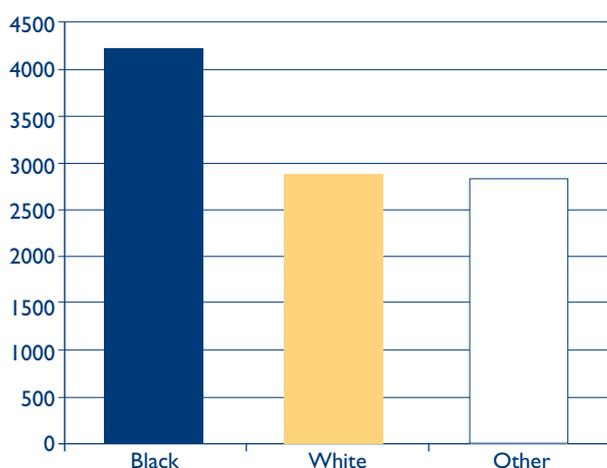


Figure 3: Numbers of people using mental health services in the sample trusts per 100,000 local population of each ethnic grouping (working age adults)



Inpatient service use

Looking at inpatient care alone, we found that a Black person is 2.9 times more likely to be in hospital than a White person, as can be seen from an analysis of the *Count Me In* data for London. Figure 4 compares the proportion of inpatients in London in each ethnic grouping to their total representation in the population. Figure 5 shows the number of inpatients in each group per 100,000 adults in London's population.

Figure 4: Proportions of psychiatric inpatients and population of each ethnic grouping in London (all adults over 18)

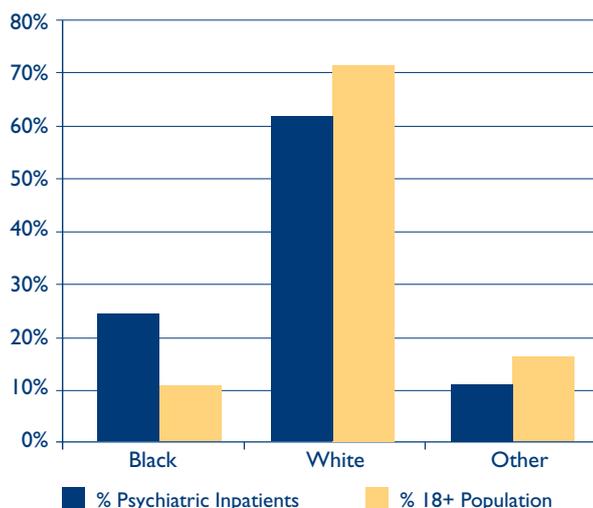
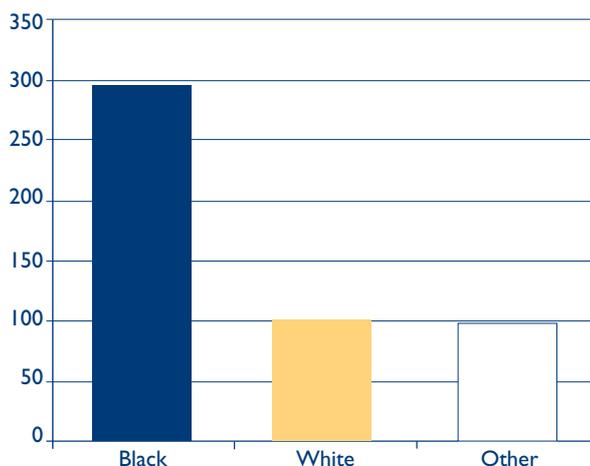
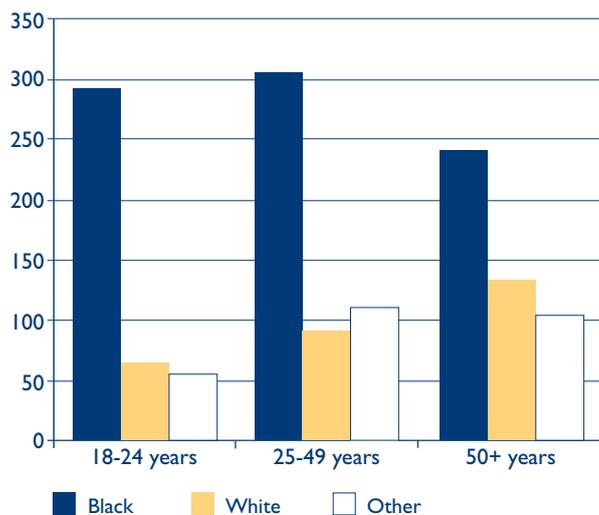


Figure 5: Number of inpatients per 100,000 of each ethnic grouping in London (all adults over 18)



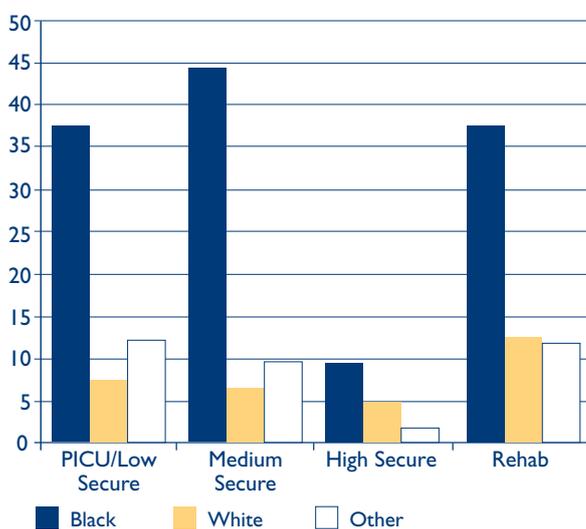
If the data is broken down by age group, it is evident that disparities are greater among younger adults than their older counterparts, as shown in Figure 6.

Figure 6: Inpatients per 100,000 population in London by age and ethnicity



A young Black person between the ages of 18 and 24 and living in London is four times more likely to be an inpatient on a psychiatric ward than a White person of the same age. For people aged between 25 and 49 the multiple falls to 3.5, while Black people over the age of 50 are just under twice as likely to be inpatients as their White counterparts.

Figure 7: Inpatients per 100,000 population in London (all adults over 18)



Not only is the number of Black people using inpatient services in London proportionately much higher than among White people, the former also tend to be more likely to have been referred to hospital by the police or courts rather than by their GP. This is shown in Figure 8.

Figure 8: Sources of referral in London

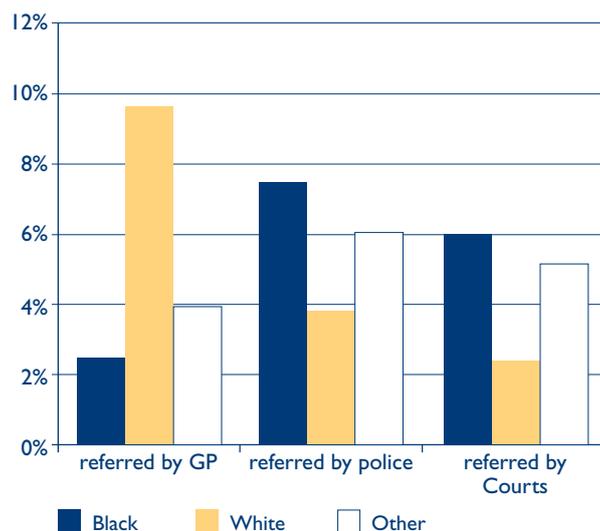
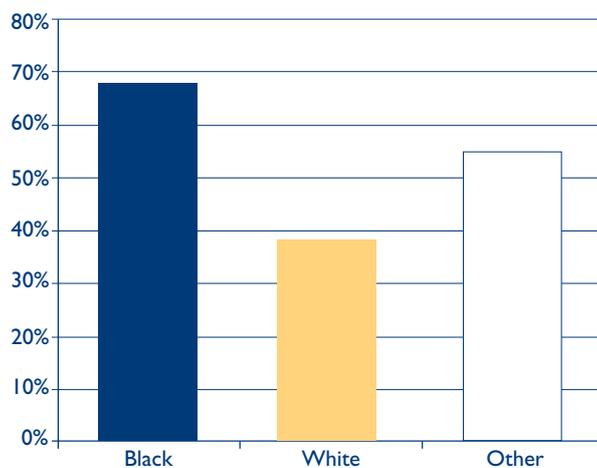


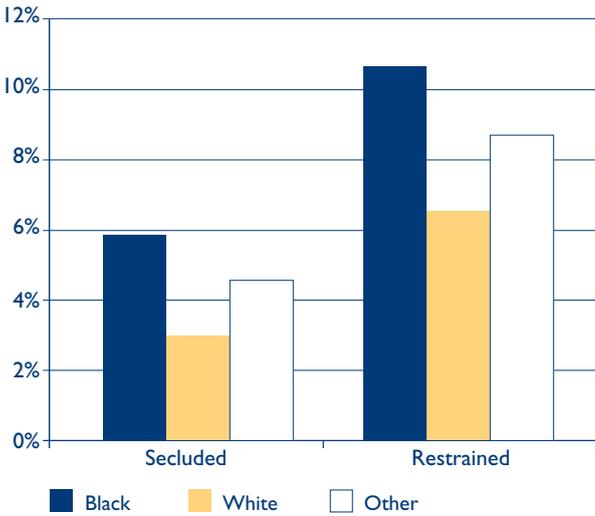
Figure 9 shows that Black people are nearly twice as likely as White people to have been admitted to hospital compulsorily under a section of the Mental Health Act.

Figure 9: Admissions under the Mental Health Act in London



The *Count Me In* census collected data on seclusion and incidents involving the control and restraint of inpatients during their time in hospital, or within the last three months if their stay was longer. Periods of seclusion for inpatients happened if they were placed, at any time and for any duration, alone in an area with the door(s) shut so that they could not leave freely. In the three months prior to the census, 3% of inpatients had experienced one or more periods of seclusion. Overall, 8% of inpatients had experienced one or more incidents of control and restraint. As can be seen from Figure 10, Black people are more likely to experience one or more incidents of seclusion and/or restraint than White patients.

Figure 10: Use of seclusion and restraint in London



Community service use

Information provided by the sample trusts has been analysed for three types of community-based provision (contacts with community mental health teams [CMHTs], crisis resolution teams and assertive outreach teams). Figures 11-13 show how the caseloads of these teams are broken down by ethnic grouping. The over-representation of Black people is most pronounced in the case of assertive outreach.

Figure 11: Community mental health team caseloads in the sample trusts by ethnic grouping (working age adults)

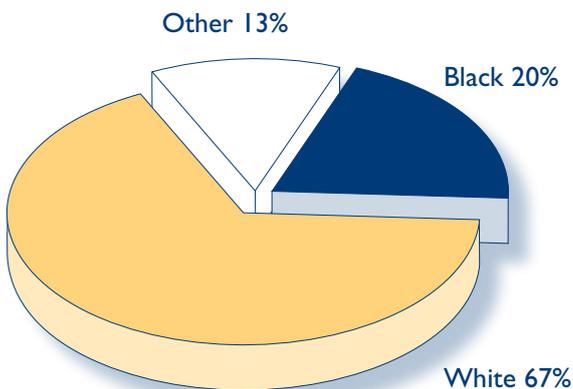


Figure 12: Crisis resolution team caseloads in the sample trusts by ethnic grouping (working age adults)

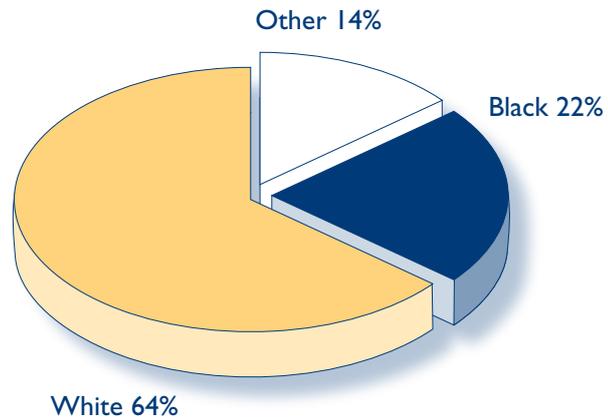
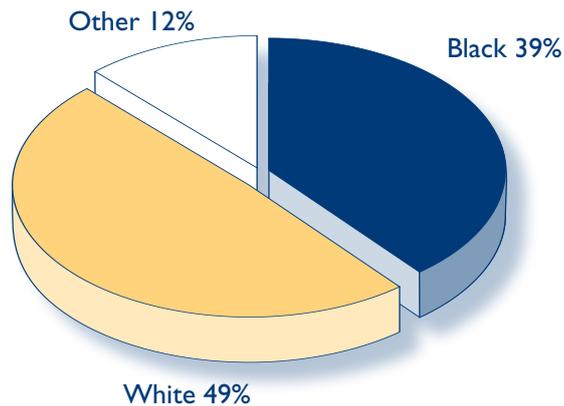
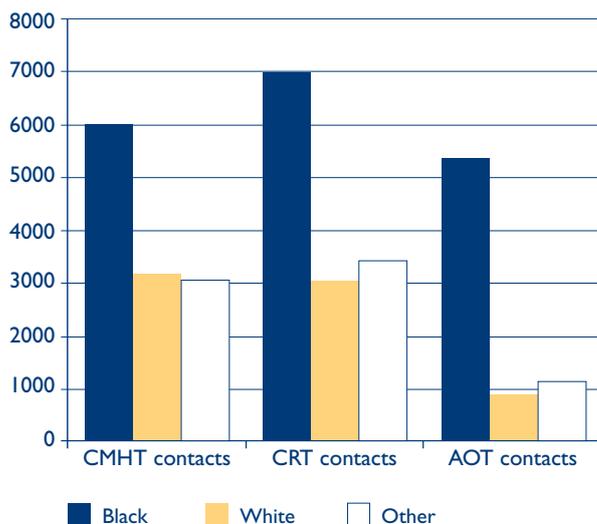


Figure 13: Assertive outreach team caseloads in the sample trusts by ethnic grouping (working age adults)



Differences in service use are more apparent if the total number of contacts per year are depicted per 100,000 population. Black people in the catchment areas of the sample trusts have nearly twice as many CMHT contacts per head of population as their White counterparts. This increases to six times as many contacts with assertive outreach services (Figure 14).

Figure 14: Community service use in the sample trusts per 100,000 population of each ethnic grouping (working age adults)



Costs and expenditure

The previous section has confirmed the finding of earlier research that there are clear differences between Black and White populations in their respective patterns of mental health service use. The present section combines this evidence with information on unit costs and expenditure on mental health care in London in order to explore the financial consequences of these variations.

Two forms of analysis are presented. The first covers the costs of care pathways (the journeys through care that people take), comparing average or representative Black and White service users. The second presents an estimate of the scope for using money in different ways if the quantity and mix of services used by Black people in London could be brought closer in line with those observed among other ethnic groupings in the capital.

The figures used here represent a theoretical maximum sum that could be reallocated if service use among Black people was equal to that of other Londoners. It is of course unlikely that this would

be either feasible or desirable, certainly in the short or medium term. It is, however, indicative of the scale of change that could be achieved over time by reinvesting funds in more appropriate and acceptable services.

Care pathways

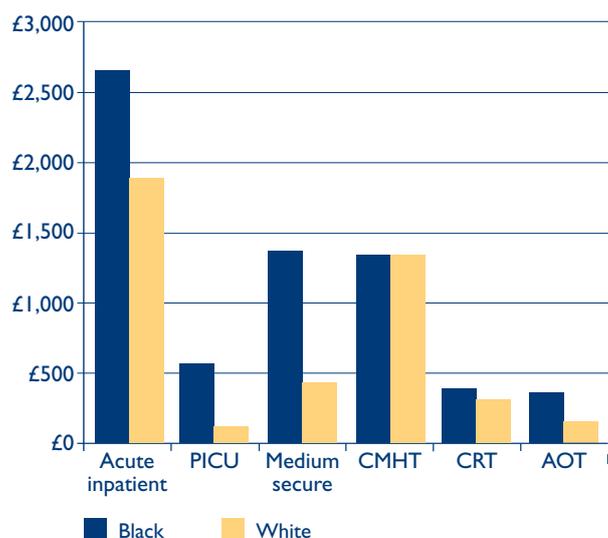
The costed care pathways set out below are based on the anonymised data for service use, broken down by ethnicity, provided by the four London trusts which participated in this study. This information covers six services. Three of these are hospital-based (numbers of occupied bed-days in adult acute care, local psychiatric intensive care units and medium secure units) and three of them are community-based (contacts with community mental health teams, crisis resolution teams and assertive outreach teams).

We estimated costed care pathways based on this information in three main stages:

- i. for each of the six services, a measure of the volume of activity was calculated per average service user of each ethnic grouping (Black, White, Other). This shows, for example, that an average or representative service user among all Black people who came into contact with the mental health services of the four trusts in 2004/05 had 10.9 days of care in an acute inpatient ward in that year, whereas among all White service users the corresponding figure was 7.6 days.
- ii. an appropriate unit cost was applied to each measure of service volume, so as to give an estimate of expenditure on each of the six services per average user. This shows, for example, that the 10.9 days of acute inpatient care occupied by a representative Black service user in 2004/05 had a cost of £2,660, while the 7.6 days occupied by a representative White service user had a cost of £1,854. The unit costs are London-wide averages and were derived from a number of sources, including the Reference Costs for all hospital inpatient services published annually by the Department of Health (2005b).
- iii. Finally, the expenditure figures were aggregated across the six services, so as to give an estimate of the total cost of service use per average or representative user in each ethnic group.

The total average annual cost per Black service user is £6,539, compared with £4,132 per White service user. A breakdown of these figures by service type is summarised in Figure 15.

Figure 15: Annual costs of mental health services in London per service user (working age adults)



A number of points may be noted. First, the total cost of services for an average Black service user was 58% higher than the corresponding cost for an average White user. Second, more than half of this difference is accounted for by higher spending on psychiatric intensive care unit (PICU) and medium secure care among Black service users. And third, although less important in absolute terms, there is also a large proportionate difference between Black and White service users in average expenditure per head on contacts with assertive outreach teams. All of these findings are consistent with the research evidence that Black people disproportionately come into contact with mental health services via adversarial or crisis-related routes.

The scope for changing spending patterns

The second question to be analysed in this section focuses on how much public spending on mental health services in London might be used differently if expenditure on care were more similar – relative to population size – for Black and White people. Two factors determine the size of this potential saving: first, the difference in average spending per service user in the two groups, as analysed above; and second, differences in the relative numbers of Black and White people who come into contact with mental health services.

Dealing first with the scope for reallocating inpatient expenditure, it is estimated that total spending on all forms of psychiatric inpatient care for working-age adults in London in 2004/05 amounted to £473.8 million. This represented 24.2% of inpatient spending in England as a whole, a much higher share than might be expected on the

basis of population numbers, as London accounts for just 15.5% of the national total. London has about 45% more beds per 1,000 population than the national average and unit costs are also higher.

Table 3, based on the *Count Me In* census and on DH Reference Cost data, gives a detailed breakdown of the expenditure of £473.8 million by type of inpatient ward and by ethnicity.

Table 3: Cost of inpatient services for each ethnic grouping in London (working age adults)

Inpatient expenditure, 2004/05, £ million				
	Black	White	Other	Total
Acute	55.0	162.6	32.6	250.2
Rehabilitation	13.4	32.0	6.2	51.6
PICU + low secure	25.8	33.6	11.7	71.1
Medium secure	29.8	28.5	9.0	67.3
High secure	6.6	25.1	1.9	33.6
All	130.6	281.8	61.4	473.8

Total spending on inpatient care for Black people was 2.4 times higher than would be predicted purely on the basis of relative population numbers. The scale of relative overspending was particularly pronounced in the case of medium secure, intensive care (PICU) and low secure services, but even for care in acute wards spending on Black people was nearly twice the expected level.

If this overspending could be eliminated so that expenditure on inpatient care per head of population was the same for Black adults as the London average, the total reduction in spending would amount to £76.2 million. This figure would be £85.7 million if levels of service use were the same as for White people.

Less comprehensive information is available on the scope for savings on community services. We have used data on relevant services (contacts with CMHTs, CRTs and AOTs) provided by three of the four London trusts participating in this study. We estimate that, in London as a whole, total expenditure on these services amounted to £198.4 million. An estimated breakdown of this expenditure by ethnic group is shown in Table 4.

Table 4: Cost of community services for each ethnic grouping in London (working age adults)

Expenditure on community services, 2004/05, £ million				
	Black	White	Other	Total
CMHTs	28.8	98.6	18.9	146.3
CRTs	6.4	18.4	4.1	28.9
AOTs	9.1	11.3	2.8	23.2
All	44.3	128.3	25.8	198.4

Spending on these services among the Black population is about twice as high as might be expected on the basis of population numbers, with the relative overspending being particularly pronounced in the case of contacts with assertive outreach teams.

If combined spending per head on these community services were the same for Black people as the London average, the saving in expenditure would be £21.4 million. The scope for reallocation rises to £23.8 million if spending per head for Black people were the same as for their White counterparts.

Bringing together inpatient and community services, the overall scale of savings that could be spent on different kinds of services for Black people in London amounts to between £97.6 million and £109.5 million. This corresponds to between 9.1% and 10.2% of total expenditure on all mental health services for working age adults in London in 2004/05.

One important observation may be noted. Per head of population, combined spending on inpatient and community services as just described was about 170% higher in the Black population than in the White population. About a third of this difference can be attributed directly to higher spending per service user (i.e. the 58% difference in costs per average or representative service user), leaving the remainder to be attributed to differences in the relative numbers of people in the Black and White populations who use mental health services. In explaining higher levels of spending, the over-representation of Black people in all forms of secondary or specialist mental health care is therefore more important in quantitative terms than variations between Black and White people in the costs of care per individual service user.

Implications

Key findings

Concerns expressed in the research literature about care pathways (Bhugra, 2004; Bhui *et al.*, 2003; Morgan *et al.*, 2005) are confirmed in our analysis. The proportion of Black people being seen by secondary mental health services is much higher than for White people. Again reflecting earlier studies (e.g. Browne, 1997), Black people are more likely to have been referred to inpatient services by the police or the courts rather than their GP. They are also more likely to be secluded or physically restrained than their White counterparts: an issue that was amply highlighted in the inquiry into the death of David Bennett during a control and restraint procedure at the medium secure unit in Norwich (Blofeld, 2003). The most significant difference in service use emerged in our analysis of psychiatric intensive care and medium secure units. In these sectors, Black people were seven times more likely to be admitted than their White counterparts.

One aspect emerged in our analysis that is not highlighted in the research literature: the over-representation of black people in *community* mental health services. Our analysis showed that Black adults were nearly twice as likely to have contact with a community mental health team and six times as likely to be referred to an assertive outreach service as their White counterparts.

Understanding over-representation

An important conclusion of our study is that Black people appear to be over-represented across the spectrum of secondary mental health services, community as well as hospital-based. A key question that follows is: why? Is this higher level of provision related to a real excess of mental illness in the Black community?

It has been pointed out (Sharpley *et al.*, 2001) that this question has been addressed in recent years by recourse to four main hypotheses: misdiagnosis, biological, social and psychological.

In relation to misdiagnosis, the studies cited by Sharpley *et al.* “provide no evidence” that psychiatrists discriminate by ethnicity in their diagnosis of schizophrenia.

With regard to a biological predisposition to schizophrenia, the evidence is largely negative. Studies have found lower rates of schizophrenia in Jamaica than in Caribbean immigrants to the UK (Hickling and Rodgers-Johnson, 1995) and noted “strong environmental factors acting on second

generation African Caribbeans” (Sharpley *et al.*). The implication of these studies is that social and environmental factors, not genetics, are behind the differences in diagnosis.

Social hypotheses, including ‘urban effects’ of inner city deprivation and social disadvantage were also reviewed by Sharpley *et al.* (2001). Issues such as poor housing, isolation and exposure to racism (what Sashidharan (1993) termed the ‘ethnic vulnerability hypothesis’) were also considered. Yet it was noted that UK-resident South Asian communities are also subject to many of these same factors but rates of psychosis in these groups are not so high.

Finally, ‘psychological factors’ were also considered. These include an adverse interpretation of life events and different ‘attribution styles’. In other words, people who attribute adverse life events to external factors rather than themselves may be predisposed to schizophrenia. However, researchers have concluded that this “cannot be seen as an explanation for increased rates [of schizophrenia] per se. The problem is not in individuals but the wider social forces acting on those communities” (Sharpley *et al.*, 2001).

The implication of these reviews is that no simple reason explains why African and Caribbean people are disproportionately diagnosed with schizophrenia. And we are yet to understand what other factors might be involved, such as dual diagnosis, homelessness or a lack of appropriate move-on accommodation in the capital with its consequent effect on lengths of hospital stay. In the meantime, it is vital that where discrimination does exist it is tackled and more appropriate services are developed as alternatives to existing patterns of provision.

The Delivering Race Equality programme

The Department of Health’s (2005a) *Delivering Race Equality* programme makes it clear that discrimination in mental health treatment is unacceptable and a priority for action. In it, the Government has committed itself to an ambitious five year plan which includes:

- ❖ reducing the rate of admission of people from BME communities to psychiatric inpatient units
- ❖ reducing the disproportionate rates of compulsory detention of BME service users in inpatient units
- ❖ reducing the use of seclusion in BME groups
- ❖ preventing deaths in mental health services following physical intervention.

However, it is unlikely that the vision behind this plan can be achieved if we do not learn more about the precise mechanisms that cause clinicians and other decision-makers to continue to attribute such high levels of risk to African and Caribbean people. And there is an urgent need to address the failure of people and their communities to engage with primary care services before a crisis point is reached. Investment is needed in testing service models that will turn around this cycle of negative engagement. This must involve great value being placed on the important contribution of the Black voluntary sector.

The role of the voluntary sector

The Mayor of London (2005) has argued that many voluntary services are capable of delivering services that satisfy the requirements of safety and security, both for the individual service user and the wider community, while also enjoying a high level of service user satisfaction and engagement and costing a fraction of what it takes to run statutory inpatient services. Christie (2003) and Fernando (2006) also highlight the valuable contribution that Black voluntary organisations are making to service provision.

Much more work is needed on such comparisons, particularly evaluating how risk is managed in the community. This could mean offering more capacity development in the Black voluntary sector to enable organisations to play a greater role in the commissioning process.

Commissioning for race equality

We believe that this study should be the first step in a much larger series of studies into the relationship between economics and service delivery. It is applicable to other service areas within the NHS and it may also be relevant in other fields of social care as well.

The Department of Health’s (2005c) *Delivering a Patient-led NHS* promises a new environment for the NHS in which patient need is paramount and GPs have a lead role in commissioning. The policy also promises greater choice for patients and a wider diversity of providers. One implication of our study is the need to establish models of good practice in mental health service commissioning. Commissioners have a key role to play by ensuring they only purchase services that perform well in relation to such factors as service user satisfaction, risk management and re-admission rates.

There may well be a need for more precise contracts with providers which include equality issues as well as cost-effectiveness. Therefore it

would also be logically necessary to consider and set out the circumstances in which services could be de-commissioned on the basis of equality issues.

Information would appear to be key to this investment. The Government has acknowledged information as one of its 'building blocks' in the DRE programme. Yet the NHS currently has few intelligent information systems that give comprehensive activity data on service take-up by ethnicity, let alone related unit costs. The problems of data quality and availability were only too clear during the course of the present study and it is for this reason that we have included a 'workbook' as an appendix to enable trusts to perform this type of analysis for themselves.

The way forward

So what would a model of good practice look like? As Fernando (2006) notes, "no clear-cut single good practice model for multi-cultural service provision has emerged in the UK". An important first step to improved service provision is engaging with service users. In a review of voluntary sector services that have been successful in engaging Black service users, Christie (2003) identified a number of recommendations for good practice:

- ❖ Working in partnership
- ❖ The role of advocacy in securing people's rights
- ❖ Suitable premises
- ❖ Empowering service users
- ❖ Retaining a focus on core activities
- ❖ Strategies for preventing people from unnecessarily entering the statutory mental health system
- ❖ Cultural sensitivity
- ❖ Tackling culture-specific fear and anxiety about mental illness
- ❖ Outreach work to engage positively with people
- ❖ Involving families and the community in care
- ❖ Creating organisations with a sense of Black identity.

Many of the voluntary sector agencies that have provided such service elements have not had sufficient opportunities to influence the process of commissioning and statutory service provision. More work is needed to enable them to make a more significant contribution.

Yet there are positive signs that some NHS bodies are now making significant progress. On the basis of the interim findings of this study, Camden & Islington Mental Health and Social Care Trust has begun to invest in a service specifically designed to change pathways for African and Caribbean people. We hope that many more similar examples will follow.

South London and the Maudsley NHS Trust also has a number of initiatives to improve its relationship with local African and Caribbean communities such as the Cares of Life project in Southwark, which works with local Black churches, voluntary organisations and youth groups, and the SPEKTRA cultural consultation and mediation service in Lambeth.

The scope for spending money differently that this paper has highlighted is considerable. However, it must be noted that new, more appropriate, services need to be developed *before* funds can be released from those in which Black people are currently over-represented. In the light of the financial difficulties many NHS mental health trusts are now reporting, achieving the level of reallocation we have suggested will be an uphill task, requiring the full support of commissioners and of government. It cannot be achieved simply by disinvesting in existing service provision without first creating a radical transformation in the range of services on offer to Black people in London.

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Appendix: Workbook

One of the main aims of providing a workbook is to enable NHS organisations and others to perform analyses such as those described in this paper independently, as a regular form of audit for the services they provide. Audits are an important means of getting an up to date view of services and an easy means of tracking trends and changes in service provision / use. In addition to being a check on how services are being provided across different ethnic groups, the data could also provide the basis for more detailed academic research into the reasons why there are such great discrepancies in service use.

In order to perform the calculations the MHMDS can be ‘queried directly’ or a subset of the data can be used. A finite time period should be chosen and data extracted, based on one line for every person seen by the services during that time period. Each row, or client record, should include as much demographic data as possible such as age, sex, ethnicity etc. and a data field for all secondary services used during the specified time period. On this basis service users can be grouped and their service use compared in order to highlight differences or similarities.

Cases where ethnicity has not been stated or recorded may be apportioned to ethnic groups on the basis of recorded service use, as can be seen in the example in Table 5.

Table 5: Pro rata distribution of people whose ethnicity is ‘Not Stated’

	Adults using mental health services	Service use by ethnicity excl. ‘Not Stated’	‘Not Stated’ apportioned by service use	Adjusted no. of service users
Black	9896	22.7%	4919	14815
White	27123	62.3%	13483	40606
Other	6526	15.0%	3244	9770
‘Not Stated’	21647			
Total	65192	100.0%	21647	65192

Once data on service use has been apportioned by ethnicity, further analyses can be performed regarding average use. There are a number of ways in which service use can be analysed. The one used in this report i.e. service use for a finite amount of time per head of population accounts for both:

- ❖ Differences in service use between people from different ethnic backgrounds
- ❖ Overrepresentation in comparison to proportion of the population in the community.

Psychiatric intensive care provides a good example (Table 6).

Table 6: Analysis of PICU use by ethnicity

Ethnicity	People using PICU services		Total number of days	Average PICU days in year	PICU days per 100k adult population
	Number	Percentage			
Black	325	48.9%	15252	47	101
White	242	36.4%	9356	39	17
Other	67	10.1%	2669	40	19

The penultimate column in Table 6 shows that, among people using PICU services, there are only minor differences by ethnicity in lengths of stay, with the average Black user of these services staying about 20% longer than the average user in the White or Other groups. In contrast, the final column shows that, once allowance is also made for the over-representation of Black people among PICU users relative to their numbers in the general population, ethnic differences in PICU use become nearly sixfold.

In addition to data on service use, the financial implication of these differences can be expressed in monetary terms using unit costs that are available from finance departments in trusts. These would include costs per bed day for all inpatient facilities (e.g. acute, PICU etc) as well as the costs for running community teams (e.g. CMHTs, AO teams etc). Costs for community teams can be apportioned by service use based on the number of contacts with any particular ethnic group so as to detail the spend on that particular group. Though not wholly accurate, as contact with a team can vary from a few minutes (e.g. giving a depot injection) to an hour or more (e.g. reviewing a patient’s care programme), it will give a rough idea of how time is apportioned between people from different ethnic groups.

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