

# Dual Heritage Study – Camden and Islington

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A Review of Mental Health Act Assessments  
2007-2010

**Diarmuid Magee, Camden and Islington NHS Foundation Trust**

**March 2011**

A review of the extent to which ethnic identity was taken into account with people of dual heritage backgrounds subject to an assessment under the Mental Health Act 1983 (Revised in 2007)



# Dual Heritage Study – Camden and Islington

## Acknowledgements

This report was written by Diarmuid Magee, Camden and Islington NHS Foundation Trust. The author of this study expresses thanks to the National Steering Group looking at issues affecting people of mixed heritage backgrounds in mental health, hosted by Mind. Particular thanks to Mind and the National Mental Health Development Unit for providing the funding to allow this study to take place. Thanks to Camden and Islington NHS Foundation Trust for being the study site, and therefore willing to share learning with others.

## Executive Summary

### Purpose

The purpose of this project was to identify learning from a small study into the access and experience that people of dual heritage have in a mental health service. The findings of the study identify a need for a fuller scale study and help make a case for further funding. The study looked at people of dual heritage backgrounds who were subject to Mental Health Act assessments in the three years 2007-2010 in Camden and Islington. Despite the small numbers involved, the findings are important for all providers, (Note: the larger cohort of people from mixed heritage backgrounds was narrowed for the purposes of this study to people of black/white dual heritage.)

### Methodology

Data on the number of people from mixed heritage backgrounds subject to a Mental Health Act Assessment in the years 2007-2010 were obtained. The credibility of ethnic coding for the study group was tested against evidence in other sets of records. Once a verified cohort was identified the service response to ethnicity and identity was analysed by reviewing service user records.

### Findings / conclusions

A total of 17 people were included in the study group (specifically of dual heritage), over the three years 2007-2010.

Though the numbers in this study were small it was evident that recording of ethnicity was more often than not inaccurate.

There was evidence of some good attempts to incorporate needs relating to ethnicity into work with service users.

The study highlighted that inaccuracies in identifying ethnic background impeded the ability of workers to provide a specific response. Where ethnicity emerged in work with service users, the rationale for actions was not always clear.

## **Recommendations**

### **Camden and Islington NHS Foundation trust**

- Further support, guidance and training on ethnic recording, including the need and use, is required for all staff;
- An exercise should be undertaken to further investigate whether work with service users covered ethnicity and identity to a greater extent than shown in the files. This would take the form of follow up discussions with frontline staff;
- Clinical governance audits on the recording and use of ethnicity data should be undertaken each year with staff to identify omissions in their recording. The exercise could potentially include verification with service users;
- A specific briefing / training on meeting the needs of people from Black/White dual heritage backgrounds should be available for staff.

### **Recommendations for all Mental Health Trusts**

- Audits of ethnic recording should be undertaken annually;
- Action to reduce inequalities for people of BME backgrounds should include reviews of the steps taken by frontline staff to deal specifically with the risks associated with failure to take account of ethnic identity, including being from a Black/White mixed background.

### **Recommendations for National Policy**

- A larger scale multi-site study of the experience of dual heritage people in mental health services should be commissioned, including interviews with workers about their decision making on recording and care planning.
- Support should be made available for mental health NHS Trusts in implementing the Equality Delivery System (EDS), the new national strategic framework for implementation of equality plans in the NHS. Support should include guidance on the relationship between poor recording of ethnicity and the appropriateness of response.

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## **Main report – Study of Access and Experience of People of Dual Heritage Backgrounds subject to Assessment under the Mental Health Act 1983 between 2007-2010**

### **Background**

Ethnic monitoring of health and social care services in mental health, following the 1991 national census, benefited from improved (though still imperfect) data on proportions of different ethnic groups in the population. Having access to ethnic monitoring data enabled various inequalities in service utilisation to become more apparent. The ethnic and cultural mix of societies do not remain static. Increasing inter-ethnic relationships have brought a growth in the number of people identifying themselves as being of mixed heritage backgrounds. Since 2005 the annual national Count Me In Censuses of psychiatric inpatients in England and Wales have identified that there are specific variations in utilisation and experience of services by people of mixed heritage backgrounds (See censuses at: [www.cqc.org.uk/db\\_documents/Count\\_me\\_in\\_Census](http://www.cqc.org.uk/db_documents/Count_me_in_Census)). Despite the increasing numbers in the population and in mental health services, the needs of people from mixed heritage backgrounds have not received much specific attention.

In 2010 a group of professionals with research, service and personal experience formed a national steering group with the intention of undertaking a national review of available data on people of mixed heritage backgrounds in mental health services. Mind agreed to host this steering group. Membership of the steering group is attached as Appendix 1. A proposal was developed for action research to look at risks, both positive and negative, faced by of people from mixed backgrounds inside and outside of formal mental health services.

Prior to receiving any substantive funds to undertake a large study, Mind and the Equalities Programme in the National Mental Health Development Unit (NMHDU) funded this small study.

The steering group developed a brief proposal and used existing relationships to identify a test site.

The project operated to tight timescales. This was due to the fact that NMHDU would cease its work on 31 March 2011. This need for pace dictated the process by which the site and resources were mobilised. The proposal was to test the hypothesis below.

## Hypotheses

Based on their research and service management experience the steering group hypothesised that:

- the numbers of people from dual heritage backgrounds in mental health services are increasing at a disproportionately fast rate compared to numbers in the baseline population;
- the ethnic coding of people from mixed heritage backgrounds in mental health services was often incorrect;
- as a consequence any service response to ethnicity would be erroneous; and
- ethnicity was often not fully taken into account and appropriately responded to in work with service users. This view emerged from research and the personal experience of steering group members in reviewing service user records in other projects (e.g. see the follow up interviews to the Count Me In census 2005 (MHAC 2006). The steering group noted that the numbers of people from dual heritage backgrounds were increasing.

The study was restricted to people of Black / White mixed heritage as the project steering group considered that the category 'mixed heritage' included an infinite range of permutations. There were two steps in the decision-making process. Firstly, given the restrictions on time and cost, the principle was established that not all mixed ethnicities could be studied if meaningful information was to be produced as an outcome. Secondly, a decision was required on the mixed group or groups that would be studied and the rationale for the choice made. These two points are now developed further.

The principle that the study sample needed to be restricted was informed by the following:-

- the tight timescale and budget meant that only a small cohort could be reviewed. If a wide range of ethnicities were being studied it would be difficult to identify patterns and themes;
- as cohorts across three years were being reviewed it would have been possible for ethnicities to appear in only one or two years being studied. As part of the hypothesis was in relation to staff responses it was important to have consistency of the study cohort;
- Experiences vary significantly between different ethnic groups. For example, see the study - *Use of new mental health services by ethnic minorities in England* (Glover & Evison 2009). If too wide a range of mixed ethnicities were included the key messages about experience will have been diluted.

The rationale for choosing Black / White mixed as the study group consisted of:-

- Evidence from the population census is that the Black/ White mixed group is the largest mixed ethnic group, accounting for 47.8% of all mixed groups (<http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=14433&Pos=&ColRank=1&Rank=272>).
- The inequalities in relation to this group – high numbers of admissions, more experience of detentions under the Mental Health Act 1983 (revised in 2007) and forensic services – are similar to those affecting Black African and Caribbean groups. These types of variations have tended to be considered more contentious. This is seen for example in the series of opposing articles and letters in the press setting out challenges to evidence and views about the causes of variations. (Guardian 2010).

### **The Study Area – Camden and Islington**

Camden is a London Borough that, according to the 2001, census has a population of just over 200,000 people. Measuring eight square miles it is located in North London. It includes the affluent Hampstead on its northern borders, and the more working class areas of Bloomsbury and Holborn to the south. The Eurostar terminus is located in the King's Cross ward. This is an area which is undergoing major regeneration. Camden's ethnic make up includes White British (52.4%). White and Black Caribbean make up 0.8% of the population and White and Black African make up 0.6% (GLA 2008).

To the east of Camden is the borough of Islington. It measures 5.7 square miles. The 2001 census reported that just over 175,000 people live there. Nearly 60% of the residents are White British, 1.2% are from White and Black Caribbean backgrounds whilst 0.7% are from a White and Black African background (GLA 2008).

### **Methodology**

Camden and Islington NHS Foundation Trust agreed to be a test site for the study. The trust identified a member of staff to audit its service data as part of clinical governance processes.

The aim of the study was to identify the cohort of people with black/white dual ethnicities (from the larger cohort of people from mixed heritage backgrounds) who have received an assessment under the Mental Health Act (MHA) 1983 in the years 2007-2010 in Camden and Islington. The quantitative demographic data collected by both boroughs were reviewed. It was decided that for the purposes of this study that only the people recorded as having a combination of a White European and a Black African or Black Caribbean ethnic background would be included in the study. The rationale was that the group 'mixed heritage' contains a diverse mix of people. Reviewing the issues relating to such a diverse group in this small study would dilute the specificity of any potential learning.

## **Exclusion criteria**

Those who were not from a White and Black Caribbean or Black African background or were not assessed under the Mental Health Act 1983 between 2007 and 2010 were excluded. The rationale for this was that the category 'mixed heritage' includes a wide-ranging mix of ethnicities. The rationale for focusing this study on Black African or Caribbean / White mix was set out in the 'Background' section of this report.

## **Process**

Electronic and paper service user records were then reviewed to confirm that the correct ethnicity had been recorded by the Mental Health Act assessor. These records were then used to investigate whether race, identity or discrimination were identified at three points in time:

- “pre-morbid” (i.e. prior to a mental health problem becoming evident or diagnosed)
- at the Mental Health Act assessment
- at admission or other treatment or care

The internal auditor obtained the statistics held by Camden and Islington, which record details on Mental Health Act assessments (MHAA). These are assessments under the Mental Health Act 1983 that could lead to detention. They are undertaken by Approved Mental Health Professionals (AMHPs). Service users who were possibly from both a White and Black Caribbean or Black African background were identified. Other records (such as those made by ward or community teams) were checked to ensure that the ethnicities documented at the assessment stage were accurate.

The managers of the Community Mental Health Teams (CMHTs) which provided a service for the identified people were contacted to request access to the paper notes.

## **Intended randomisation**

The intention was to randomise the group down to five people from each borough for each of the three years of the study. This was not necessary due to the low number of people meeting the set criteria once data had been validated.



## Findings

### Data on Mental Health Act Assessments and population statistics

#### Camden

In 2007/08 Camden carried out 582 assessments under the MHA. This study had access to the spreadsheet which served as the database of information on 333 of those assessments. Of these, one person was recorded as White/black. A second person was recorded as both White/black and White/black. A third was recorded as White/Black but was from a Chinese background. Following verification by review of electronic and paper files, only two people were identified for the year 2007-08 as meeting the criteria for this study. (The author checked the category 'Black Other' but no one in that group met the criteria.)

In 2008/09 Camden assessed 649 people under the MHA. Of these one was recorded as Black/White; 16 assessments were recorded using 'Mixed' as ethnicity; one was recorded as White/Black and another as White Caribbean. The electronic and paper files suggest that of these 19 people five met the research criteria of being from both a White European and a Black African or Caribbean background.

In 2009/10 Camden carried out 601 assessments under the MHA. Three were recorded as Mixed Race, one as Mixed Race British, one as Mixed White British and one as Mixed/African/British. Two people met the criteria to be included in the research.

#### Islington

In 2007/2008 Islington undertook 434 Mental Health Act assessments. Twelve assessments were carried out on nine different people where the ethnicity was recorded as mixed parentage. Three assessments recorded the ethnicity as White and Black Caribbean. Three were carried out on two different people where the ethnicity was recorded as White and Black African; and nine were carried out on six different people where the ethnicity was recorded as Other Mixed Background.

During 2008/2009 416 people were assessed under the Mental Health Act in Islington. There were seven people with the ethnicity White and Black European assessed and two people recorded as Other Mixed Background were assessed. Six were recorded as mixed parentage, one of which met the criteria for the study.

In 2009/2010 409 people were assessed under the Mental Health Act. Only one person was recorded as having a dual ethnicity, recorded as White and Black Caribbean.

Of the total numbers for Islington, five people who were recorded as being from a White and Black Caribbean background did not fall into this group once data was verified in case notes and/or other reports. One person was recorded as White and the rest were either Black African or Black Caribbean.

Table 1 below shows the incremental reduction from the total number of people of people assessed in Camden and Islington between 2007-2010 to those included in the final cohort for this study. It shows that ill formed conclusions would be drawn if data on mixed heritage (the broad category usually used) was to be assumed to include primarily Black/White dual heritage people. Further, the table summarises the outcome of verification of data. Seventy nine *assessments* over the three years were thought to be for people of Black/White dual heritage, however fifteen individuals were included in this category following verification of coding and identification of multiple assessments on the same person.

**Table 1: Summary of the process to refining data to arrive at the number included in the final cohort**

	<b>Total no of assessments</b>	<b>Total no of mixed heritage</b>	<b>No of Black/white or 'mixed' from assessment data</b>	<b>No of Black/White mix after verification</b>
<b>Camden 2007/08</b>	582	3	3	2
<b>2008/09</b>	649	22	19	5
<b>2009/10</b>	601	19	15	2
<b>Islington 2007/08</b>	434	30	27	4
<b>2008/09</b>	416	16	14	4
<b>2009/10</b>	409	1	1	0

N.B. The last column refers to individuals whereas other columns refer to 'total number of assessments' and therefore include multiple assessments on the same person.

### **Review of case notes**

Paper records are difficult to review with 100% accuracy. Despite the constraints on time the records were scrutinised with significant care so that rather than just expecting to see work on ethnicity and culture set out in care plans entire files were reviewed. The process required reading through (for example) pages of contact records, reports, assessments, risk assessments and correspondence, potentially over several years. This work is time consuming and relied on the reviewer picking out key words.

## **Camden**

There appeared initially to be only one case in Camden where issues related to identity and ethnicity were recorded. However, more detailed scrutiny identified that in three of the cases there had been work on identity. One related to work on 'cultural formulation', which is an approach in work with service users where they are asked to talk about their life story and mental health problems from the perspective of their ethnic and cultural identity. The second and third cases were referred to the Bridge Project (a service specifically targeting people from BME backgrounds). The intended outcomes of referrals to specific services were stated in broad terms such as 'to have *'cultural needs met'* or *'to see how culture informs their thinking'*.

## **Islington**

Five of the eight sets of records in Islington included some reference to cultural and/or identity issues, indicating that the worker considered these aspects. However it appears that only three of them took any specific action with the service user in relation to these aspects of their identity. For example, one file contained information about the service user's experience of being alienated by Black people for not being Black and the role that identity confusion played in the crises that led to an admission. There was however no evidence that ethnic identity was explored in the work with the service user, with an aim of providing specific support on this.

## **Themes in service user records**

As stated, some work was undertaken with the service user with regard to ethnicity, race and culture for three of the nine people in Camden and three of the eight in Islington. This was against a backdrop of race, culture and ethnic identity emerging in various ways in the records for fifteen of the total of seventeen dual ethnicity people across both Camden and Islington over the three years. The themes and issues that emerged for the fifteen individuals indicate that ethnic identity and culture were important in influencing the experiences of service users.

Types of issues included:-

- Racial abuse in wider society
- Racial abuse from the white parent
- Stigma and poor self esteem
- Feelings of not fitting in (in wider society)
- Expressions of greater contentment in associating with other people of dual ethnic backgrounds

- Use of drugs to block out negative feelings about being ethnically different to peers
- Development of negative views about black people (by service user of dual heritage)
- Articulation of belief systems considered to be delusion, which have race as a central theme.

It was not clear from the records why matters to do with ethnicity race and culture were explored and taken into account in care planning in only six of the fifteen cases where these issues were clearly highlighted as concerns. It was not within the scope of this study to undertake follow up interviews with either the service users or the workers involved. It is possible for example that the omission was not in the work but in the recording. Either cause would represent a failing, but the required response would be different. For example, if staff have awareness and competence to work with ethnicity and do so well, but fail to record appropriately, the challenge would be different than if there were competence gaps. This study highlights that there are gaps either in practice, recording or both and that further investigation is required to determine the precise nature of challenge.

### **Review of Mental Health Act Assessment Reports**

The statutory duty to undertake an assessment under the Mental Health Act 1983 (revised in 2007) rests with local authorities and a discrete system of recording and storing of reports is in place. The records of these assessments provide insight into the considerations taken into account at a crisis point for the service user. Mental Health Act Assessments are typically stressful times for service users and workers and are triggered by some concern about risk to the individual or other person or persons. The Approved Mental Health Professional who writes the report tries to provide a record of the circumstances leading up to and surrounding the assessment and the consideration of alternatives to hospital admission. MHAA reports can be a source of ideas and strategies for ongoing work with service users. For example, if a report highlights racism or alienation due to ethnicity as causal factors in someone's breakdown it would be expected that these matters would be picked up in ongoing work as part, at least as part of the strategy to try to prevent further crises.

### **Camden**

Eight of the nine Camden AMHP reports were available for review and four mentioned race or identity in them. The first mentions dual ethnicity and that racism was suffered in early youth. A second states Black/ Black British in the ethnicity section of the AMHP report of 2010, but later refers to 'mixed heritage.' Two reports merely refer to parental ethnic identity but nothing else.

## **Islington**

One Islington MHAA report mentions the person's ethnicity whilst another notes the wrong ethnicity, reporting the person as white.

Given the fact that fifteen of the seventeen cases included some concern around experiences relating to ethnicity, it may be that the MHAA reports were a lost opportunity to raise the profile of these matters in the work with service users.

## **Testing the Hypotheses**

The responses to the hypotheses that were the subject of this study are set out below. The *conclusions* section of this report develops the analysis and implications.

***Are the numbers of people from dual heritage backgrounds in mental health services increasing at a disproportionately fast rate compared to numbers in the baseline population?***

There appeared to be no particular trends with regard to the number of assessments undertaken on people of dual heritage backgrounds. Table 1 identifies that in Camden assessments were undertaken with three people of dual heritage backgrounds in 2007/08; nineteen in 2008/09 and fifteen in 2009/10. In Islington twenty seven assessments were undertaken on this group in 2007/08; fourteen in 2008/09 and just one in 2009/10. Without a larger scale study it is not possible to draw conclusions about trends. A larger future study will be able to plot the growth (or decline) in the numbers subjected to a MHAA as trend lines against patterns in the baseline population.

***Was ethnicity identified accurately?***

In Camden, eight of the people in the final cohort of nine had errors in the recording of ethnicity. In Islington, four of the eight people in the final cohort had similar errors.

Examples of recording errors were:-

- Ethnic categories that changed from one report or document to another with no reason given. Ethnic group should be self-defined and may be changed subjectively. If this were the case it is likely that there will have been some record in the notes that an individual wishes to identify themselves differently.

- Inaccurate ethnic recording remains on record and is repeatedly reported inaccurately, for example dual heritage people were recorded as being Black or Black African or even Afro-Caribbean. One person was recorded as being White.

***Was any response made in relation to ethnicity?***

Not surprisingly the errors in identifying ethnicity undermined the ability of services to make an appropriate response. There were however some examples of workers responding to identity such as the referral for work on cultural formulation and to the specialist service targeting BME people, called the Bridge Project. In total, six of the seventeen service users had a response to their ethnic identity. Again it is not possible without follow up interviews to identify what led some workers to determine that ethnic identity and related issues should be incorporated into care planning. Considering that fifteen of the seventeen cases in the cohort had some mention of ethnicity, race and culture it is not clear whether lack of competence, confidence or knowledge about resources available were the causes of a lack of response.

***Was the response appropriate?***

An appropriate response to ethnicity and identity is one where the service user is supported to identify how these aspects affect their lives and their mental health and for an agreement about a useful response to emerge in care planning. Person-led planning and personalised approaches demand that the individual determines the matters that are important. This does not entirely supplant a worker's expertise or obligation to try to promote equality. For example, if a service user was the subject of racist abuse in shared accommodation but wanted to ignore it for a quiet life the worker would still have a moral obligation to seek to tackle this discrimination. How this obligation is fulfilled cannot be prescribed, but would take place within the context of the relationship with the service user. The measure for appropriateness would be:-

- Was the matter raised?
- Was there a clear analysis as to what constituted the problem?
- Was the responsibility for the problem ascribed to the right person or persons?
- Was the intended outcome of any intervention clear?
- Was the approach driven by the service user?

The examples of a response to ethnicity and identity in this study indicate that there is some understanding of an appropriate response. For example, the referral for support with cultural formulations was in response to the service user's own view about the prominence of ethnic identity

to them. The purpose and intended outcome was also clear (*'to see how culture informs their thinking'*). By definition, as cultural formulation would be based on the ethnic identity defined by the service user, so the response would be in relation to the person's dual ethnic identity as opposed to being based on an erroneous ethnic identity. However in a separate case a referral was made *'to have their cultural needs met'*. In this latter example it was not clear regarding the intended outcome. It was not clear either if or how the service user informed such a strategy.

Table 2 summarises the findings in relation to the second and third hypotheses that informed the study (*'was a response made'* and *'was the response appropriate'*). The ideal scenario would be that every service user in the study cohort had some response to their ethnic identity. As a minimum the fifteen cases where ethnicity was identified should have an evidence of a service response. The table shows a different picture.

**Table 2: Numbers of people for whom an appropriate service response was made.**

<b>Total number in final cohort (i.e. Black/White mixed)</b>	<b>Number where ethnicity / identity were identified in any way</b>	<b>Number where ethnicity /identity were dealt with in work with service user</b>	<b>Number where ethnicity /identity were dealt with showing a clear rational in relation to the 'issue' and why the response</b>
17	15	7	5

### **Analysis and Conclusions**

There was mixed evidence of attempts to incorporate needs relating to ethnicity into work with service users. This was hampered by problems with the accuracy of ethnic recording. It is not possible to provide a personalised service where there is confusion about the identity of the service user. In eleven of the fifteen cases where some issue relating ethnic identity was highlighted there was no evidence of a service response. These points are developed below.

The limited cohort of this study inhibits generalised conclusions. However despite the small numbers the study points clearly to areas where further and larger investigation is required. A question at the start of the study was whether the local data in Camden and Islington showed an increase in numbers of people of dual heritage who were subject to a Mental Health Act assessment over the study period. It appears that there was not the expected increase but this finding is not consistent with the trends in the national Count Me In Census of admitted patients in psychiatric wards both in the NHS and independent sectors

[www.cqc.org.uk/db\\_documents/Count\\_me\\_in\\_Census](http://www.cqc.org.uk/db_documents/Count_me_in_Census). This is an area that may valuably be studied in a number of sites to establish trends more accurately.

One of the most significant findings from this study was the extent to which there were errors in the coding of ethnicity. **Twelve of the seventeen people in the final cohort had one or more errors in the recording of their ethnicity.** This may be due to busy staff using available information uncritically; or guessing about a person's ethnicity.

There are clear policies in the NHS which are aimed at identifying clients' and patients' ethnicities. Training also exists to enable staff to gather this information. Considering the evidence, even in this small study, it will be important to establish the causes of the repeated inaccuracies in the collection of data.

The correct understanding of a person's ethnic identity is a fundamental requirement in offering a personalised service. The errors that this study have identified in relation to ethnicity recording raise important issues of the need to address inequality in relation to the delivery of modern mental health services. For example, current mental health and public health policy identify the need for commissioners to carry out joint strategic needs assessments (JSNAs) to gather good information on population groups. This requires robust data collection.

It is not clear from this study the extent to which inaccuracies in identifying ethnic identity have led to poor experiences and outcomes. Owusu-Bempah (2005) referred to the historical racist practice, of treating anyone as Black who had so-called 'Black blood' (meaning they were from some form of Black mixed heritage). This may be non-controversial for some people of dual heritage backgrounds, but for others it may be problematic and a compounding of previous concerns. This point emphasises the fact that what is referred to as a coding error may have ramifications for the relationship with the service user and the quality of care provided.

This study also showed that accurate recording does not always translate to an appropriate service response to issues of identity and ethnicity. It is likely that not all discussion, planning or action in relation to this area is recorded. However, data incompleteness (quantitative and qualitative) can lead to poorer outcomes and experiences associated with being from a dual heritage background. The risks (of providing inappropriate care and treatment as a result) should be highlighted in the same way that people who are discharged on a Section 3 of the Mental Health Act are considered to be at a greater risk of suicide. At the very least, it should be worthy of some note and follow-up action.

If the absence in records of action on ethnic identity reflects poor data recording rather than poor care planning and action, one implication from this study is the need for continuing and systemic



training for staff to enable a better understanding of the need to collect accurate information on people from dual heritage and other ethnic backgrounds. Good information is a key to meeting the needs of diverse client groups in mental health care.

Camden and Islington NHS Foundation Trust has in place a robust system of clinical governance, which includes audits of recording and also the extent to which care addresses the needs of people from BME backgrounds. The type of study undertaken within this project was time intensive and required painstaking cross checking of information. As such it outstrips the resource requirement of an ongoing audit programme that covers all responsibilities of a mental health trust. It is likely that the types of errors that have emerged in this study are typical of those in any busy mental health trust. The findings should trigger similar investigations in other trusts.

## **Recommendations**

### **Camden and Islington NHS Foundation Trust**

- Further support, guidance and training on ethnic recording, including the need and use, is required for all staff;
- An exercise should be undertaken to further investigate whether work with service users covered ethnicity and identity to a greater extent than shown in files. This would take the form of follow up discussions frontline staff;
- Clinical governance audits on the recording and use of ethnicity data should be undertaken each year with staff to identify omissions in their recording. The exercise could potentially include verification with service users;
- A specific briefing / training on meeting the needs of people from Black/White dual heritage backgrounds should be available for staff.

### **Recommendations for all Mental Health Trusts**

- Audits of ethnic recording should be undertaken annually;
- Action to reduce inequalities for people of BME backgrounds should include reviews of the steps taken by frontline staff to deal specifically with the risks associated with failure to take account of ethnic identity, including being from a Black/White mixed background.

## Recommendations for National Policy

- A larger scale multi-site study of the experience of dual heritage people in mental health services should be commissioned, including interviews with workers about their decision making on recording and care planning.
- Support should be made available for mental health NHS Trusts in implementing the Equality Delivery System (EDS), the new national strategic framework for implementation of equality plans in the NHS. Support should include guidance on the relationship between poor recording of ethnicity and the appropriateness of response.

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## Glossary

### AMHP

Approved Mental Health Professional. (A mental health worker such as a social worker, nurse or occupational therapist trained to assess people under the Mental Health Act 1983 (as amended by the Mental Health Act 2007)

### ASW

Approved Social Worker. The name of AMHPs before the amendment to the Mental Health Act in 2007.

### **Dual Heritage**

An ethnic identity arising from a partnership of parents from two distinct racial backgrounds. The term 'dual heritage' is usually preceded by an explanation of the mix, e.g. Black/white Dual Heritage or Caribbean/White Dual Heritage

### **MHAA**

Mental Health Act assessment. An assessment to determine whether a person needs to be admitted to a psychiatric hospital. This could be an informal admission or against someone's will where they meet the criteria set out in the Mental Health Act 1983. Commonly known as 'sectioning.'

### **Mixed Heritage**

Any identity arising from partnership of any configuration of ethnic or racial background. For example a person who is Chinese / White mixed may have a child with someone from a Caribbean background.

30 March 2011

# Appendix 1

## Membership of the Mixed Heritage Steering Group

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