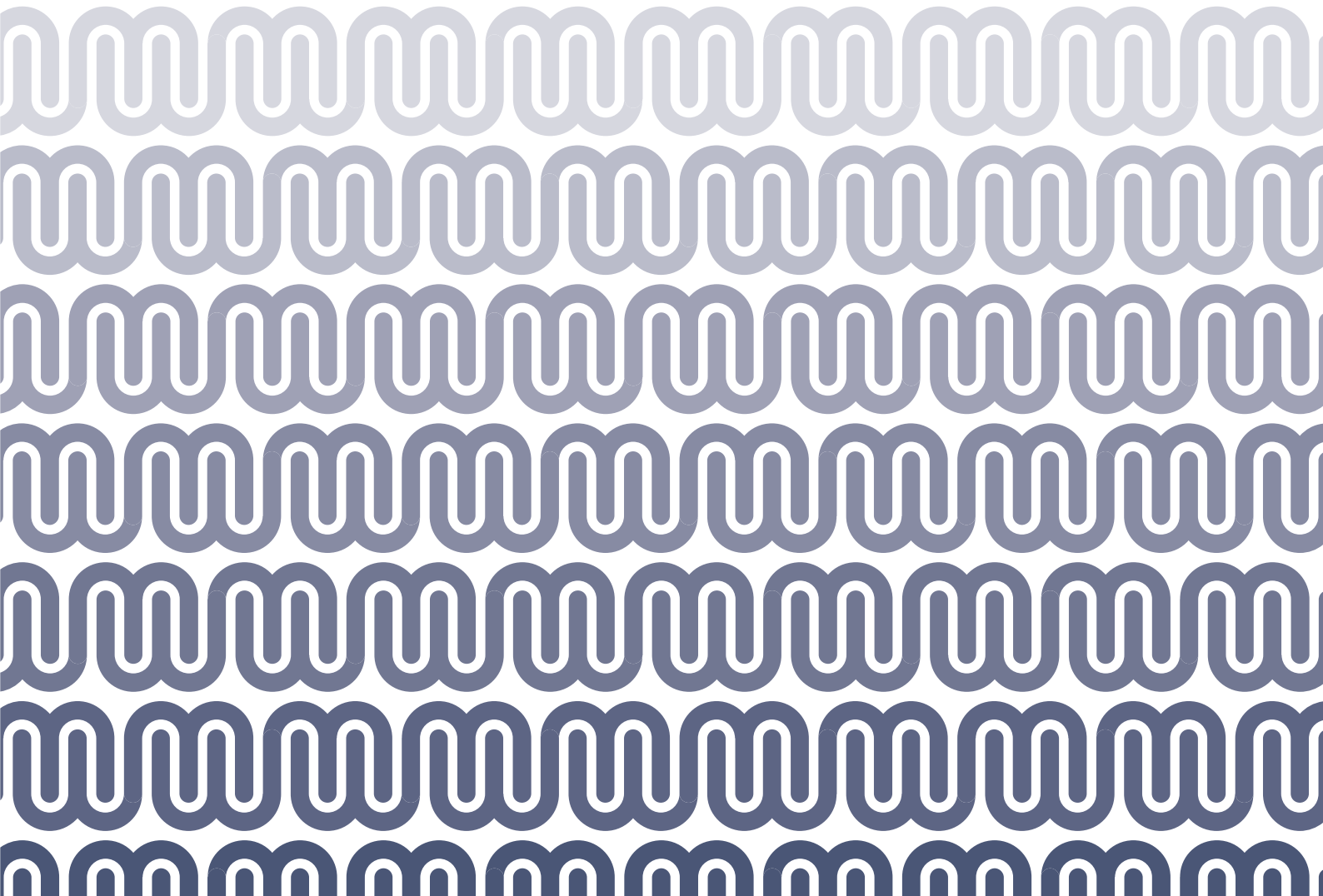# mental welfare
commission for scotland

Racial Inequality and Mental Health in Scotland

A call to action

September 2021

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Contents

Foreword – Sandy Riddell, Chairman of the Board

The murder of George Floyd in the United States in 2020 and the subsequent resurgence of the Black Lives Matter movement focused attention on how people from ethnic minority backgrounds continue to be discriminated against across the world. The Covid-19 pandemic has also focused attention on health inequalities and particularly on racial disparities in health outcomes.

With those two global events as drivers, we wanted to explore how well Scotland's mental health sector performs in relation to racial equality.

To address this we looked at six themes: ethnicity and detention under the Mental Health Act; the views of people with lived experience; the experience and training of Scotland's mental health services workforce; racial equality in that workforce; and recording and reporting of ethnicity across mental health services; including in the Commission's own work.

In each of these six themes we report areas that require improvement. These range from those areas that may appear to require minor changes, to the finding that almost a third of our survey respondents reported that they had seen or experienced racism directed at their NHS colleagues.

We found a real need and desire for training for staff on ethnicity and diversity, with over 70% of those we surveyed saying there were gaps in training available in Scotland's NHS.

Time and again we found that information on ethnicity had not been recorded and reported. This related to people being treated for mental illness and also to staff working across mental health services.

Poor quality data might seem simply a bureaucratic issue, but it is more than that – without gathering accurate information we cannot properly understand whether or not policies are being delivered for people or understand the extent of the disparities in health outcomes and interventions.

We spoke to people from diverse ethnic backgrounds including refugees in Scotland and heard that Scotland's mental health and social services must work much more closely with the third sector organisations that many people find instrumental in supporting them with access to mainstream services.

This report is detailed and wide ranging and we make recommendations to a wide range of organisations and to the Scottish Government for change. The span of the recommendations reflect that delivering a service that is truly fair for all will require a collective effort across civil society.

We are not there yet.

And we at the Commission will take this opportunity to review our own work in relation to ethnicity and equalities and to identify areas for improvement.

I hope this report leads to a series of actions within mental health services and is the start of a much wider discussion. We know that Scotland's mental health services are under enormous pressure but we need them to never lose sight of the importance of serving all of our communities.

September 2021

A note on terminology

We have summarised the ethnicity categories from the 2011 Census throughout this report as White Scottish, White Other British, White Other, Asian, Black, Mixed or multiple ethnicities, and Other.

We recognise that this approach erases the specific cultural heritages within these groups and there is a risk of disguising differences within groups. However, this allows us to use the Commission's data at a level that is at least better than referring to BAME groups (Black, Asian and Minority Ethnic) or BME groups (Black and Minority Ethnic). These terms further generalise different people and are now recognised as overused and often inappropriately used [1].

We try to avoid referring to minorities and instead use terms such as ethnically diverse groups or communities. However, there are instances when we use terms such as minorities and BME or BAME because it is the terminology used in the reports or policy documents that we reference.

We also note that the Scottish Census emphasises the 'visible minorities' that make up the four per cent of the non-white Scottish population referred to in the 2011 census [2]. However, we avoid using the term 'visible minorities' and for consistency, we use the terms Black, Asian, Mixed, Other when referring to the groups that make up the 'visible minorities', wherever possible.

In Scotland, an oft-repeated issue is that the numbers of people from diverse backgrounds are so few outwith the major urban centres that it makes diversity reporting and actions to address differential health outcomes difficult. We agree with a suggested approach to record the data, as disaggregated by each ethnic group as is possible, and over time this will allow a picture to build up that will allow for assessment of ethnic differences [3]. We have taken this approach in using data over a period of time to build the picture that we present here.

We have added a glossary of terms used in this report at Appendix 1.

Summary of findings

Trends in detention related to ethnicity

- We found that most of the detentions in Scotland over the last 10 years were of white Scottish people (83.9%), which is similar to the general population according to the last (2011) Census (82.5%). Compared to the general population, a slightly higher proportion of detentions were for 'white other' (4.9% compared to their 4% representation in the general population) or black people, 1.5% of whom were detained, compared to their 1% representation in the general population. These differences are greater for longer detentions (community compulsory treatment orders) for black people (2.1% compared to their 1% representation in the general population).

- We found differences in how the Mental Health Act is applied across communities in Scotland. Risk to oneself and/or to others is one of the criteria that must be met for authorising involuntary treatment. We found that more people who were black or of mixed or multiple ethnicity were perceived as a greater risk to themselves and others, whereas all categories of white people were more often perceived as a risk to themselves. Gender exerts a role on risk perception. The greatest difference was between black women, 48.4% of whom were perceived as of risk to themselves and others, and white Scottish women, of whom 33.8% were considered to be both a risk to themselves and to others.

- Independent mental health officers (MHOs) should give consent to all emergency detentions. We have raised concerns that overall this often does not happen, but when we examined this against ethnicity, we found that the independent MHO consent safeguard was lowest for black people, with 45% of detentions having this safeguard, compared to 53% of detentions in the white Scottish community having this safeguard.

- Emergency detentions are not the preferred route for detention from the community, a Short Term Detention should be used as they have greater safeguards. We found a higher proportion of emergency detentions starting in the community for black people (54%) compared to white Scottish people (41%).

- There is a relationship between areas of socio-economic deprivation and detentions with higher proportions of detained people from the more deprived Scottish Index of Multiple Deprivation (SIMD) categories, however this relationship was more distinct in the black group where 58% who were detained were from the most deprived areas of Scotland compared to white Scottish people of whom 36% were from the most deprived areas.

Lived experience perspectives

- We heard from 32 people with lived experience, either with their own mental health difficulties or as family/carers or volunteers. Around half of the people we heard from were refugees. They described difficulties in accessing treatment. When they did have contact with mental health services, some described how they did not feel that their stories were understood and at times, believed. They experienced difficulties in recounting narratives around the asylum process which they found traumatic.

- The people who we heard from described a constant drip of micro-aggressions (not overt racism but incidents that are discriminatory) that impacted on their mental health and their sense of belonging in Scotland. For example, one participant reflected on the effect it has on her mental health when she is followed by a security guard in a shop, another person spoke about being the only person singled out in a queue by a bus driver who asked whether she had the correct change, but did not ask anyone else.

- Those with lived experience said that the stigma of mental illness in their communities of ethnic identity can be very strong. One comment was also made that, in their experience, Scotland's national anti-stigma media campaigns on mental illness compounded the issues by only showing white people with mental illness.

- Clear difficulties reportedly emerged right at the start of the pathway for refugees at the primary care level. Some described a poor understanding of the asylum process by GPs and primary care-based community psychiatric nurses (CPNs). People told us that psychological therapies were not offered to them.

- They described how third sector community-based organisations build vital bridges between people and services, and engender trust.

Mental health staff – training and cultural competence

- One third of staff who provided details of experiences of racism, of whom almost all were white Scottish, reported that they had colleagues who had been racially abused. One survey respondent, a doctor, candidly reported that they left their job because of unaddressed racial abuse.

- Seventy per cent of staff acknowledged gaps in training. Staff reflected on the inadequacy of a 'one-off' diversity and equalities training module. Our survey suggests that there is an awareness that the most common training offered through the online platform NHS Learn Pro, is not fully addressing current equality, diversity and inclusion needs.

- The people who lead on equality and diversity (EDLs) in health boards confirmed that most training is via the online module, but that other training could and is made available. Only two of those with this responsibility from across all of Scotland's health boards were able to report on whether there is any impact assessment undertaken on whether the training works. The majority felt that their workforce was moderately culturally competent. They described a lack of awareness of issues, a lack of data, and a lack of senior representation as barriers to a culturally competent service. They also said that the equality and diversity lead role was not always being appropriately located within organisational structures to lead and deliver change.

- There was little sense or understanding from staff of how the data that they are asked to collect and record on ethnicity is used.

- Routine patient feedback is not stratified by ethnicity to allow services to know whether they are receiving feedback from all groups and to be able to improve on any access barriers or issues that people from diverse backgrounds might encounter.

- We found low awareness amongst staff of whether a Black and Minority Ethnic (BME) network exists within their health board and some comments demonstrated a lack of understanding of why it was needed.

- We learned that for mental health staff, cultural competence appears to be mostly understood in terms of tangible outputs such as accessing knowledge about another culture and availability of interpreters. Staff were keen for services to build relationships with third sector providers that might act as a bridge between communities and statutory services.

Diversity of the mental health workforce

- Differences in approaches taken by different health boards in providing data on ethnicity and the workforce made it difficult to build a national picture of the diversity of the mental health workforce in Scotland.

- Only three health boards – NHS Borders, NHS Greater Glasgow and Clyde and NHS Tayside – were able to provide us with data to work from to understand diversity, progression and differential attainment. From those three boards, for mental health nursing staff, the largest professional group in mental health services, we found differences in progression into the higher grades/bands for staff from ethnic minorities. The percent of white nursing staff who were Band 6 or higher was 35%, compared to 23% for non-white nursing staff, who were over-represented in the lower banded posts.

Recording and reporting of information within the Commission

- The Commission has a duty under the Mental Health Act to report on how the legislation is used and to ensure that the law is followed in a way that treats all people fairly. In relation to ethnicity, two key ways we do this are through analysing the information we receive on detentions, and on recording ethnicity information when we visit people to ensure that the Commission, as a safeguard, is meeting needs of all communities. In analysing detention forms (which must be sent to the Commission) we found that we had complete ethnicity information for 84% of all people detained under the Mental Health Act over the last decade. However, we only have 54% of complete ethnicity information for those detained under the Criminal Procedure Act.

- To follow through the above, we surveyed 110 psychiatrists and 18 hospital records staff to find out more about why detention data provided to us has gaps. We found a lack of clarity amongst staff as to who should complete ethnicity forms in relation to a detention. Psychiatrists told us that it can be difficult to ask a person who is acutely distressed about their ethnicity; 36% said they rarely ask and 27% say they never ask about a patient's ethnicity. The difficulties reported in this survey help to explain the difficulties in collecting this data and the need for a better way to capture this.

- In our last visiting year, pre pandemic, we averaged 36% of completed ethnicity information gathering on local visits. In our themed visits reports and guardianship visits reports from 2015 to 2020 we presented breakdown of the ethnicity of the people we visited in five of our 15 reports. The reasons for not gathering data are similar to those recorded by health board staff – often a reluctance to ask about this when

visiting people who are unwell. We acknowledge that we, at the Commission, have more work to do in order to ensure that our ethnicity recording is completed and reported in our work. One action we will be taking is to roll-out group based Equality, Diversity and Inclusion training across the Commission.

Recommendations

We make recommendations at the end of each chapter of this report. They are listed and numbered here under the organisations we are addressing them to, for ease and for clarity.

To health boards (with support from health and social care partnerships)

1. Consult with representatives from ethnic minority groups in their areas to explore barriers for individuals from minority backgrounds in accessing psychiatric care and treatment. Health boards should report on what steps they are taking to address the identified barriers to the Commission by September 2022.

2. Ensure that their wards and teams have accessible information on the local and national organisations that provide support and information to people from ethnically diverse backgrounds who access their services. Compile a list of organisations that provide input to diverse communities and/or share regional lists between neighbouring health board ethnic diversity lead officers (EDLs) by September 2022.

3. Mental health services in each health board should develop a bespoke programme of engagement meetings with those third sector organisations that meet their local requirements to develop trust and reduce barriers to service use by people from minority ethnic communities.

4. Consider adding demographic variables to patient/people who use services in the community and family/carer feedback forms so that they can collect feedback according to these to ensure and demonstrate that they are receiving feedback from all communities who use their services

5. Promote the availability of a black and minority ethnic forum (BME) (if one exists for the health board) and promote its purpose to all staff. Ensure staff have a clear understanding of the role and availability of the equality and human rights champion within their area, if applicable.

6. Review protocols for dealing with racially motivated incidents involving people who use services with the health board's black and minority ethnic (BME) network or in the absence of such a network with representativeness from people from diverse ethnic backgrounds. Ensure appropriate reporting and support for the victims of racism, and escalation processes by September 2022.

7. Address the incomplete returns on ethnicity for people who become subject to compulsory measures, ensuring that information for ethnicity recording can be collected at a time that is less likely to cause distress.

8. Explore any further reasons why their data return on ethnicity within mental health services remains incomplete. Report what steps they are taking to address the incomplete data to the Commission by September 2022.

To the Independent Review of Scottish Mental Health Law

9. Consider the findings on differential use of the law in its on-going review of Scots Law in mental health. Consult specifically with organisations that represent ethnically diverse communities. Publish the findings of these consultations as part of the Review.

10. Consider the findings noting how some safeguards appear to be less well used for ethnically diverse communities. Ensure that any recommendations for changes to mental health laws protect the civil and political rights for all of Scotland's ethnic communities equitably.

11. Consider the findings on socio-economic disadvantage and detention under the Mental Health Act, and how this is pronounced for people of colour. Ensure that mechanisms to promote the economic, social and cultural rights of people who are detained promotes these rights particularly for those that are most disadvantaged and who have been subject to greater restrictions on their liberty.

To the mental health officer training programmes

12. Ensure the information regarding differences in the use of the Mental Health Act from this report is part of the training curriculum for social workers who wish to become mental health officers (MHOs) from the next intake after the publication of this report.

To the Mental Health Tribunal for Scotland

13. Record and publish the ethnic breakdown of its membership by September 2022.

14. Take steps to address any gaps in representativeness and diversity of its membership to meet population norms.

To NHS National Education for Scotland

15. Include the findings on the differences in the use of the Mental Health Act on a section on inequalities in the Section 22 (s22) approved medical practitioner (AMP) course and appoint an equalities champion within the s22 approval scheme by September 2022.

16. Ensure that the Commission guidance[1] for professionals and interpreters in mental health settings is referenced at NES s22 AMP training course. The guidance should be evaluated by NES to see whether it might have wider applicability and usefulness beyond the mental health sector and if so, made available in training to other areas of health and social care.

17. Section 22 training should include discussion of the need to complete the form for ethnicity monitoring; and clearly state that the responsibility for this lies with the doctor assessing the patient from the next training session following the publication of this report.

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[1] Good Practice Guide: Working with an Interpreter. Mental Welfare Commission (2018) https://www.the Commissionscot.org.uk/sites/default/files/2019-06/interpreters_toolkit_feb2018.pdf

To Public Health Scotland

18.   Include in their analysis of access to psychological therapies, ethnicity as a variable to assess any inequalities in access to such therapies by March 2022.

To the Royal College of Psychiatrists in Scotland

19.   Consider why in the forms completed following detentions of people under the MHA why it is that people who are black are more likely to be recorded as a risk to 'self and others' than other racial groups; and why, of all the ethnic groups, a higher proportion of black and mixed race people were considered as greater risk to 'self and others' than to themselves.

20.   Explore the potential reasons behind the lower proportion of Fellows from psychiatrists from communities of colour in Scotland by September 2022.

To the Scottish Government

21.   Mandate an appropriate agency to record and publish national data on restraint, stratified by protected characteristics by September 2022.

22.   Consider further investment in minority ethnic organisations that support people from diverse communities with mental health difficulties, specifically to bridge the gap between them and access to mainstream services.

23.   Commission the appropriate body to develop an additional educational module for health and social care staff on asylum seekers' health needs including mental health. This module should be made available to all health and social care staff.

24.   Commission the development of a new module on diversity training for the public sector. Invite the Coalition for Race Equality and Rights who were commissioned by Scottish Government to publish standards for anti-racist training (published in April 2021) to review any new module on this.

25.   Mandate the appropriate health regulatory body or forum in Scotland to score progression on employee diversity and inclusion by September 2022.

26.   Provide NES the mandate to require and collate data from health boards by specific directorates as well as by grade and ethnicity to be able to support efforts to reduce systemic inequalities and racial inequity and to be able to identify more clearly in which directorates there may be diversity and inequality in progression issues and successes by March 2022.

27.   Consider including an ethnic identifier as part of the CHI index.

28.   Ensure that categories that are used in ethnicity monitoring forms in the public sector and other health related gathering of information on ethnicity are in line with the Census categories

To See Me, the national anti-stigma programme

29.   National anti-stigma campaigns should include the participation of more people from minority ethnic communities in the design of future campaigns

To the Scottish Social Services Council (SSSC)

30.   Take steps to improve the returns on self-reported ethnicity of the MHO workforce for the annual census reports. Describe within the next census report what steps are being taken to increase the diversity of the mental health officer workforce to match the diversity of the population it serves.

Chapter 1 – Introduction

Background to this report

The two drivers to the Commission undertaking this work were racism and the pandemic. The murder of George Floyd in the US in 2020 led to a global resurgence of the Black Lives Matter movement and a re-focusing on the systemic injustices that people of colour face in many parts of the developed world, including in Scotland.

The disproportionate impact of Covid-19 on people from non-white communities brought into sharp focus the racial disparities that exist across the UK. For example, data from England showed a 3.7 times higher rate of death for Black African males than White British males [4].

In Scotland, the pandemic has shone a fresh light on the continuing lack of completeness of data on ethnicity and health outcomes. In May 2020, Public Health Scotland (PHS) published an analysis that explored whether there was an association between ethnicity and outcome for confirmed Covid cases in Scotland however as ethnicity data for hospital cases was around 50% complete it was difficult to reach a clear view at that time [5]. In July 2020, using death records and census data, National Records for Scotland (NRS) published data on deaths due to Covid-19 by ethnicity. NRS found that the death rate for South Asians in Scotland, even after adjusting for age, sex, rural/urban classification and area level deprivation, was almost twice as high as for the White ethnic group [6]

Later reports from PHS on Covid-19 and ethnicity were more complete. In March 2021, they concluded that rates of hospitalisation and death were higher during the second wave across the population and those of South Asian ethnicity appear to have been at disproportionally greater risk compared to the White group during this period [7].

Policy context for racial equality in Scotland

The Scottish Government's Race Equality Framework (REF) is a 15-year framework (2016-30) that sets out the Government's approach to tackling racism and racial inequality in Scotland [8]. There are six themes that underpin the REF, which has a broad scope of public and community life. Three of these themes are relevant to our project (Box 1).

Box 1. REF themes relevant to the Commission

Theme 3
Participation and representation – Minority ethnic participation and representation is valued, effective, fair and proportionate at all levels in political, community and public life,

Theme 5
Employability, employment and Income – minority ethnic people have equal fair proportionate access to employment, and representation at all levels, grades and occupation types in Scotland's workforce and experience fewer labour market, workplace and income inequalities.

Theme 6
Health and Home- Minority ethnic communities in Scotland have equality in physical and mental health care as far as is achievable.

Source: Scottish Government (2016)

The Race Equality Action Plan is the mechanism to report on progress with REF [9]. The latest report from March 2021 suggests that the actions are now a twin track approach: taking forward measures in the short-term, including those identified by the Scottish Government's Expert Reference Group on Covid 19 and ethnic minority health (ERG) and developing actions that will lead to the realisation of the aims of the REF by 2030. The ministerial forward to the latest report highlights the Black Lives Matter protests in Scotland raising awareness of race and racism and how it is reflected in the legacies of our built environment and our education system.

A brief summary of the policy response

On health, theme six of REF identifies the aim of communities achieving equality in physical and mental health care. Over the last two decades there have been attempts to ensure that services meet the needs of all of Scotland's communities.

Fair for All: *Working towards Culturally Competent Services* was published by the Scottish Executive in 2002 as one of the responses to the murder of Stephen Lawrence and the subsequent Macpherson report. At that time, health boards were found to be at different stages in meeting the needs of diverse communities and some health boards had not prioritised this [10]. Fair for All aimed to develop a "culturally competent" Scotland [11]. Since then, there have been subsequent policy initiatives and agencies to deliver on this aim as summarised in Figure 1. A more detailed overview on these is presented in Appendix 2.

Figure 1. Overview of Scottish policy documents and agencies relevant to mental health
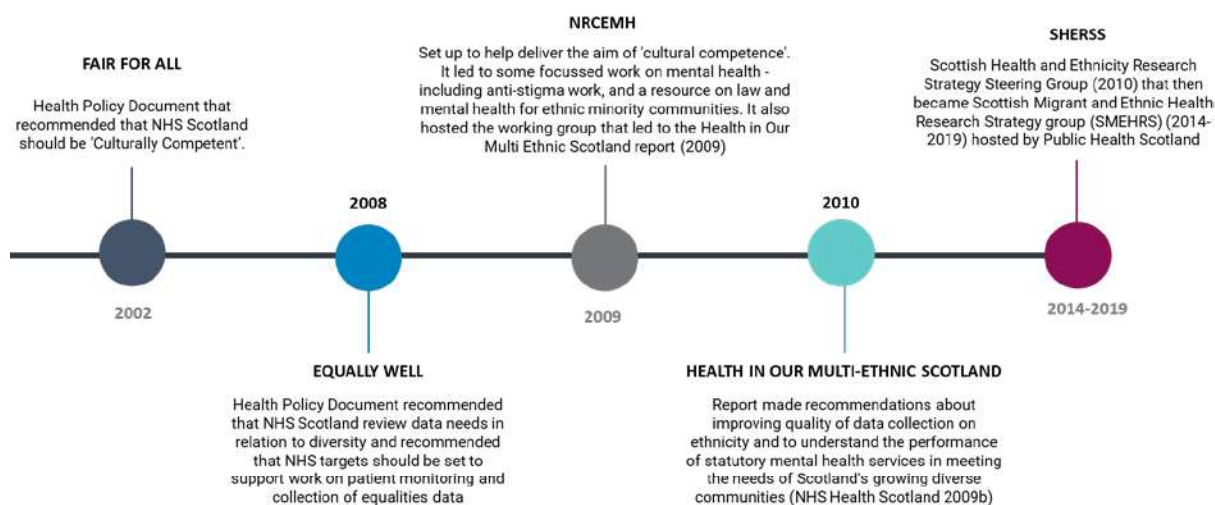
Despite the repeated calls for better data to understand the performance of statutory health, including mental health, services for minoritised groups, there has been limited progress. The pandemic spotlighted the ongoing issues on ethnicity and health outcomes, and data collection at health board level. This remains at a Scotland-wide average of 82% completion as reported for a 2019 Information Services Division (ISD) dataset. This report led to several

recommendations regarding data collection including revisiting the potential of an ethnic identifier in a person's community health index (CHI) number[2] [12].

Addressing race inequality in Scotland: the way forward [13] also highlights the incomplete recording of data as a key priority for the Scottish Government noting how without the data we cannot promote and protect health and without a good baseline it would be impossible to measure change. This report recommended that the "Scottish Government should, as part of its data strategy, create a system that ensures consistent ethnic coding within Scotland's health information systems" (Action 52, p.20). On mental health, this report recommended that Scottish Government "should commission research to identify the barriers, and a plan put in place to address, the unmet need and persistent ethnic inequalities in mental health care" (Action 55, p.21).

The Expert Reference Group (ERG) on Covid-19 and ethnicity made a similar recommendation that Scottish Government should "commission research to identify barriers and put in place a plan to address the unmet need and persistent ethnic inequalities in mental health care" [12].

We can see that this recommendation on understanding the barriers and addressing the unmet mental health need of minoritised ethnic communities has been made repeatedly in *Health in Our Multi Ethnic Scotland* [14], *Addressing Race Inequality in Scotland* [13] and *Improving Data And Evidence On Ethnic Inequalities In Health* [12].

A further example of the lack of progress on this issue is the Scottish Government's perinatal and infant mental healthcare Equality Impact Assessment (March 2021) which continues to report a lack of data on ethnicity and mental health [15].

Inequalities, ethnicity and health in Scotland

There has been a renewed focus on reducing health inequalities since the pandemic with an encouragement to build back fairer [16]. However even before the pandemic, research from the Glasgow Centre for Population Health has shown a rising mortality rate for Scotland's deprived communities [17]

Equally Well, a 2008 report from the Scottish Ministerial Task Force on Health Inequalities focused on a range of factors that contribute to unjust health inequalities such as income, age, disability, gender and race. The report recommended that NHS targets should be set to support work on patient monitoring and collection of equalities data. In mental health, it was reported that there was a 4.6 times higher rate of suicide in the most deprived areas of Scotland, compared to the least deprived areas [18].

The relationship between deprivation, socio-economic status, ethnicity and health outcomes is complex. In Scotland it has been argued that it is even more complex as some ethnic groups in Scotland have a socio-economically advantaged profile e.g., Indian and Chinese ethnic groups, however Black ethnic groups are much more likely to live in the most deprived areas of Scotland [19]. We must understand and address these complexities and take steps to reduce health inequalities by ethnicity, particularly as projections suggest that by 2031, in

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[2] CHI is a population register in Scotland, used for health care purposes. Each individual has a unique CHI number.

Glasgow, 20% of total population and 25% of the children will belong to a non-white ethnic group [19].

Terms of reference and structure of this report

Within the context of the policy initiatives in this area, and the powerful anti-racist drivers to this work, we set out to explore whether our mental health services are culturally competent as described as an aim in Fair for All, whether the aims of the REF are being met in terms of health outcomes (theme six) and whether our mental health services show participation at all levels (theme five), and to hear in 2021, what people with lived experience of mental illness and their carers and family from diverse ethnic groups feel about access to services; and finally to understand how well we at the Commission are doing in ensuring that the Commission acts as a safeguard for all communities.

The terms of reference for this work included:

- To identify areas we report on and to consider how we incorporate ethnic diversity reporting into this.

- To identify experiences, the barriers and problems that people from an ethnic minority with lived experience of mental health difficulties and illness and their carers experience in accessing and receiving support from mental health services and advocacy services.

- To identify training offered and accessed to professionals and the perceived challenges to services and the professionals working within these in ensuring access to services and support for people from ethnic minorities and how are these met.

- To identify and report on what health boards delivering mental health services have done to include diversity at different levels

- To consider how well the functions of the Commission in terms of visiting, the advice line, and investigations work are discharged for ethnic minority groups.

The following chapters follow these terms of reference.

Chapter 2 − Trends and characteristics of detentions by ethnicity

Key findings

- Ethnicity is recorded for 84.7% of Mental Health Act detentions, ranging between 82.1% and 86.8% over the past 10 years.

- Most of the detentions in Scotland over the last 10 years were recorded as White Scottish (83.9%), similar to the general population according to the 2011 Census (82.5%). Overall, 5% of detentions were individuals belonging to the four main ethnic groups.

- In the general population, according to the 2011 Census, 4.0% are from the four ethnic minority groups (Black, Asian, Mixed, or Other)

- Compared to the ethnic distribution of the general population, a higher proportion of detentions were recorded for White Other (4.9% vs 4.0%), Black (1.5% vs 1.0%), Mixed or multiple ethnicities (0.6% vs 0.4%), and other ethnic groups (0.4% vs 0.3%). There are higher proportions of community CTOs for Black, Asian and Other ethnicities compared to the general population ethnic distribution.

- There is a gradient in deprivation for detentions, with higher proportions in the more deprived SIMD categories. This gradient was more distinct in the Black group where 57.8% who were detained were from the most deprived parts of Scotland.

- EDCs are not the preferred order for admissions from the community, but 41% of EDCs for White Scottish people started in the community, while 54% of EDCs for the black community started in the community.

- Mental health officer (MHO) consent for an EDC was lowest amongst the Black community at 45%, compared to White Scottish (53%).

- People from Black, Mixed or Other ethnicities were deemed to be a higher risk to 'self and others', as compared to all three categories of White ethnicity.

- From the information we gathered in relation to detention decisions, more people from Black and mixed ethnicities are considered a risk to 'self and others' than to themselves. For all other ethnicities, more people are considered a 'risk to self' than to 'self and others'.

- There is an effect of gender. For women, we saw a big difference between the perception of risk towards 'self and others' for Black compared to White Scottish women (48.4% vs 33.8%) and for the category of Other ethnicities compared to White Scottish women (43.6 vs 33.8%).

Background

The Commission has a statutory duty to report on the use of the Mental Health Act and to promote best practice in its use. This relates to how well the principles of non-discrimination and respect for diversity are realised in practice.

Previous research has shown differences in the use of compulsory treatment for people of colour in many parts of the developed world. In 2019, a systematic review and meta-analysis (an integration of many different studies) concluded that there was a higher rate of detention for visible minorities in high-income countries across the world [20]. The analysis included 71 studies from 11 countries of which 49 were from the UK (including one study from Scotland). The authors found that Black Caribbean people were 2.5 times more likely, Black African 2.27 times more likely, and South Asian people were 1.3 times more likely to be detained to hospital than white ethnic groups. The most common explanations for the higher rate of detentions in these groups were prevalence of psychosis, increased perceived risk of violence, increased police contact, mistrust of general practitioners, and ethnic disadvantages [20].

The solitary Scottish study in the systematic review was from the Scottish Health and Ethnicity Linkage Study (SHELS) project that investigated ethnic variations in psychiatric admissions and compulsory treatment under the Mental Health Act (22). There was generally a lower risk of voluntary admissions for people from visible minority backgrounds. However, African, Chinese and any Mixed background groups were at higher risk of being detained under the Mental Health Act, compared to White Scottish people. This risk was greatest for longer term orders, such as Compulsory Treatment Orders where they found a 4.8 times greater likelihood of the use of compulsion. South Asians were also overrepresented in compulsory treatment.

The authors of SHELS suggested that the pattern of lower hospitalisation, but higher rates of compulsory treatment, supports the idea of lesser and later use of mental health services among ethnic minority groups [21]. This finding from SHELS study supports earlier work that showed that there was a high level of unreported psychological distress among certain Asian communities in Scotland [22].

From 2010 to 2017, the Information Service Division (ISD) of NHS Scotland published six-monthly data on health service use and ethnicity [23] . The latest data from 2017, shows what they describe as very high rates of psychiatric admission for males in the Black/Caribbean group, compared to females in this group and also compared to all other ethnic groups [24].

More recently, in 2021 data from the NHS Benchmarking Unit has indicated higher admissions and detentions among BAME groups compared to the proportion of people from these groups in the general population in Scotland (Box 2).

Box 2. Data from NHS benchmarking unit on mental health, ethnicity and Scotland

Adults
- 4% of the adult population (aged 16–64 years) are from BAME groups within Scotland
- 7% of adult mental health admissions were from BAME groups
- 8% of detentions to adult mental health were from BAME groups
- 12% of Intensive Psychiatric Care Units (IPCU) admissions were from BAME groups
- 11% of detentions in IPCU were from BAME groups

Older adults
- 1% of age 65+ in Scotland are from BAME groups
- 7% of admissions and detentions to older adult beds were BAME

Children and young people
- 6% of the children and young people in Scotland are from BAME groups
- 10% of the CAMHS caseloads were BAME

Source: NHS Benchmarking Unit (shared at Scottish Government Mental Health Benchmarking Conference, 2021)

Analysis of the detentions of young people in Western countries has suggested that the higher rate of detention in Black people with mental health difficulties starts at an early age, with a suggestion that this potentially sets up a cycle of inequality that persists into adulthood [25].

While there is evidence showing higher rates of detention for people from ethnically diverse communities, little is known about the characteristics of those detained and how aspects such as safeguards or criteria for detention differ in different ethnic groups. This chapter will look into detention data that the Commission holds over the last 10 years to get a deeper understanding of the way that the Mental Health Act is applied.

Our data

The Commission routinely gathers information about detentions under the Mental Health Act. When a person is detained, the doctor in charge of their care completes a form recording details of the person, the criteria for detention, and an ethnicity monitoring form. As will be discussed in chapter six, the completion rates of these forms is variable and leads to gaps in the data.

As all data is held centrally by the Commission, there is an opportunity to complete missing information for an individual record (e.g. if a person has been admitted before but the ethnicity form was not completed at a subsequent admission). This is done by matching individual identifier numbers across our dataset, so that if an individual had a recorded ethnicity at some point during the time period we could complete the ethnicity information across records that did not have any information entered.

For the 10 years included here (2010-11 to 2020-21), we were able to find a recorded ethnicity for 84.7% of detentions. This includes only orders under the Mental Health Act, as detentions under the Criminal Procedure (Scotland) Act 1995 had about 50% completeness of data. Figure 2.1 shows that this varied slightly from year to year. Where no information is available,

this is either because ethnicity has not been provided by the person (an active choice on the form), because the form was not returned to the Commission, or for other reasons the form was returned blank.

Figure 2.1. Percentage of detention with a recorded ethnicity
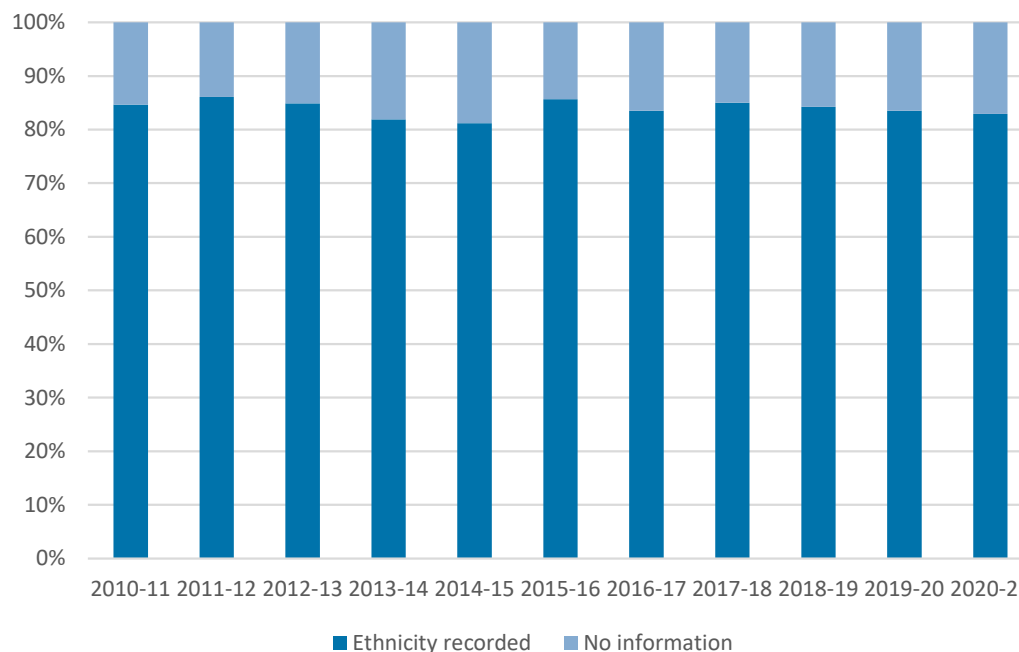
We look at level of deprivation of the home address of the person who was subject to compulsion, by matching the person's postcode with the Scottish Index of Multiple Deprivation (SIMD).This data is still not of the highest quality, but we are working to improve this. As we have routinely collected postcode data since 2016, we included the years from 2017-18 onwards. We manually checked all postcodes that had an invalid format, either because an incomplete postcode had been entered or errors happened in the scanning process, to improve the quality as much as possible.

There were a total of 31,861 detentions for the period where ethnicity was recorded and is the basis for the analysis presented in this chapter. We could match SIMD information to 83.1% (N=26,491) detentions. In cases where SIMD was not matched, this is because no postcode was given, the postcode was a hospital address, or the person was of no fixed abode. The analysis by SIMD, therefore, does not refer to the full dataset that the rest of the chapter relates to.

Trends

When looking at the entire time period across all detentions, we find that compared to the general population [26] there is a slightly higher representation of individuals of White Other, Black, Mixed, and Other ethnic groups among people who were detained (Figure 2.2). The combined percentage of the four non-white groups is 5.0%, compared to 4.0% in the general population.

Figure 2.2 Ethnic grouping of detentions compared to general population

Ethnic group	General population	Detentions
White: Scottish	83.9%	82.5%
White: Other British	7.9%	7.6%
White: Other	4.0%	4.9%
Other	0.3%	0.4%
Mixed	0.4%	0.6%
Asian	2.7%	2.5%
African, Caribbean or Black	1.0%	1.5%
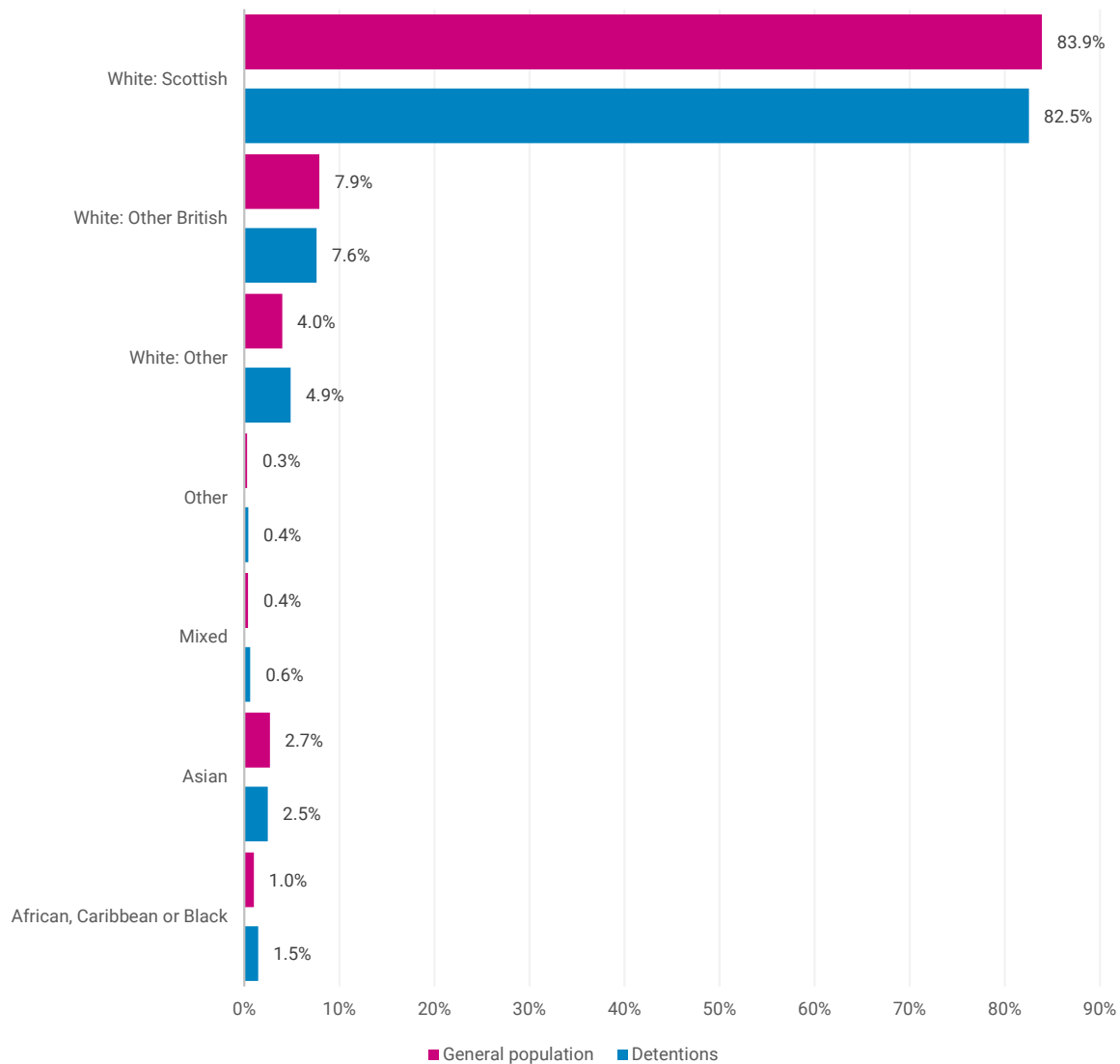
ᵃSource: Scotland's Census (2021) and the Commission's data

We looked at if there was any difference depending on the detention order. Figure 2.3 shows that there was a higher percentage of detentions in ethnic minority groups for Community Compulsory Treatment Orders (CCTOs) compared to the total for all orders for Black (2.1% vs 1.5%), Asian (4.0% vs 2.5%), and Mixed or multiple ethnicities (0.9% vs 0.6%). This was also the case for Interim CTOs for Black (1.9% vs 1.5%), Asian (3.1% vs 2.5%), Mixed or multiple ethnicities (0.8% vs 0.6%), and Other (0.5% vs 0.4%). For the other ethnicity group, there was a higher proportion detained under Nurses Holding Power compared to overall (0.6% vs 0.4%).

There was also a higher percentage of White Other for Interim CTO (5.8% vs 4.9%) and Nurses Holding Power (5.8% vs 4.9%), and the percentage of White Other British was much higher for Nurses Holding Power compared to overall (10.7% vs 7.6%).

Figure 2.3. Ethnicity by order
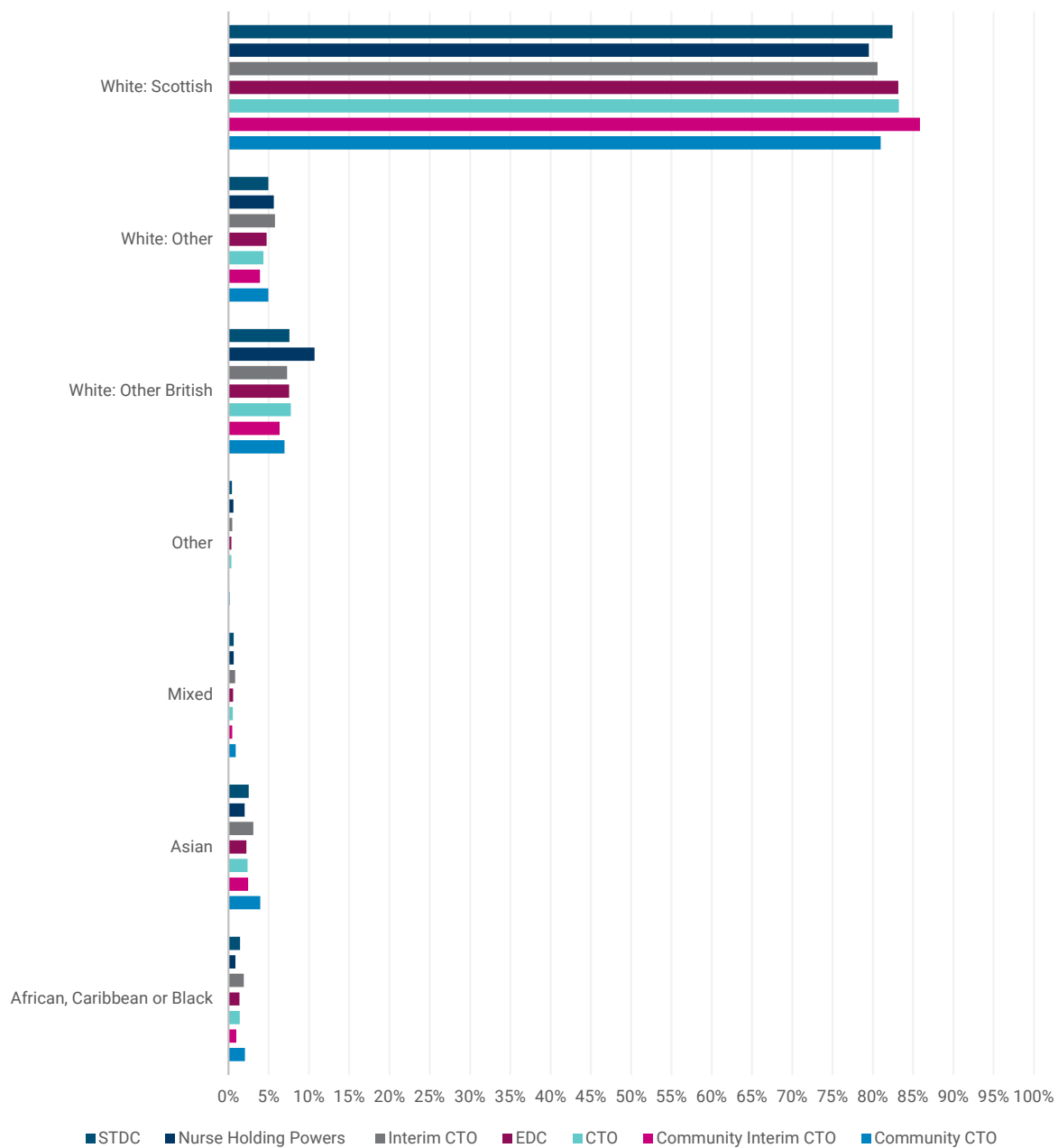
We also looked at whether the breakdown by ethnicity group changed over time. Figure 2.4 shows that in 2020-21, compared to 2010-11, the proportion of detentions that were White Scottish decreased by 4.7% while White Other increased by 2.3%, the highest increase in any ethnic group. There was also a decline in White Other British, while there was an increase in all other ethnic minority groups. This change does not appear to be a factor of missing information, as 14.6% of detentions in 2010-11 had no ethnicity recorded compared to 16.6% in 2020-21.

Figure 2.4. Changes in ethnic groupings between 2010-11 and 2020-21
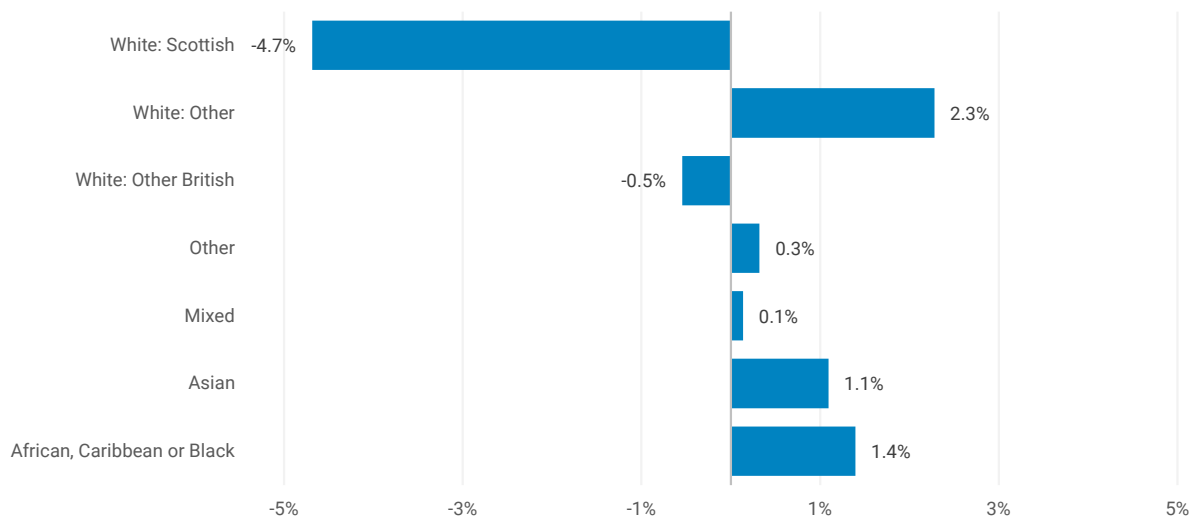
Geographical differences

We also looked at geographical differences for detentions where ethnicity was recorded. Figure 2.5 shows that detentions recorded in any of the minority groups was highest in Greater Glasgow and Clyde and in Lothian. Of note is that we did not identify any detentions in The State Hospital of any ethnic groups other than White Scottish and White Other. The State Hospital is a specialist hospital that meets the needs of people with mental illness who have committed serious offences.

Figure 2.5. Ethnic grouping of detentions by health board
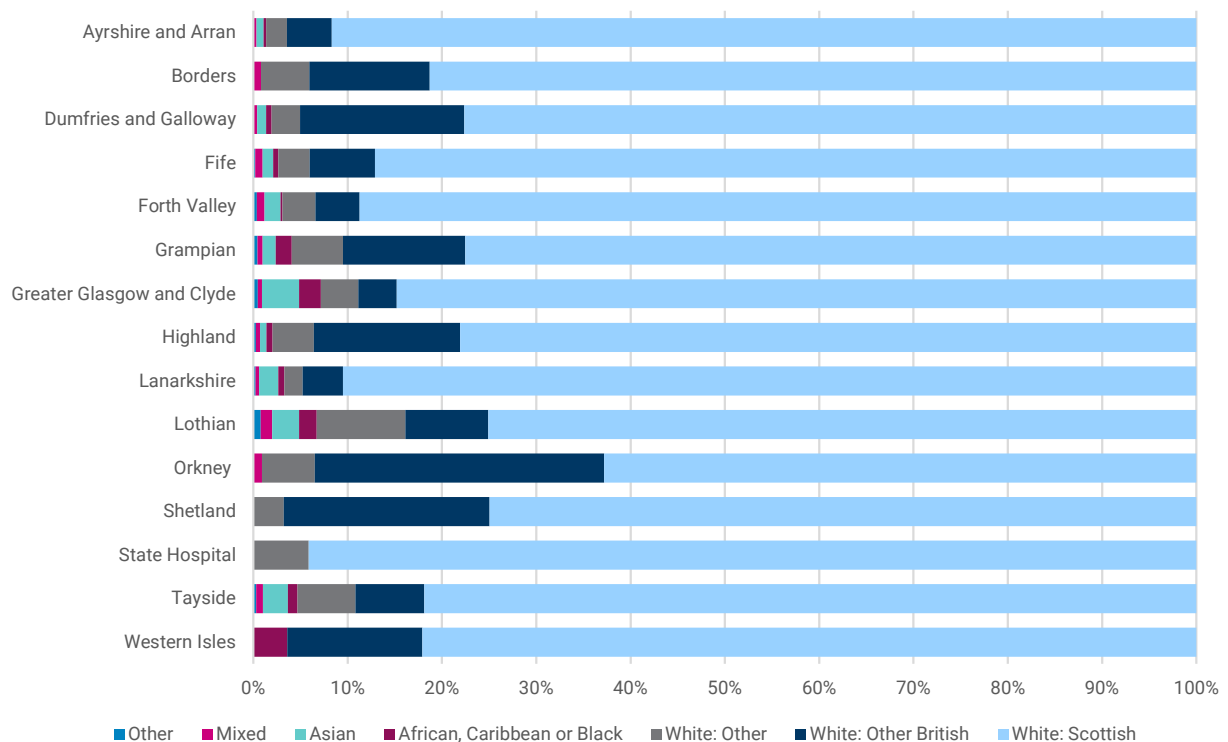
Individual characteristics

We compared individual characteristics, including age, gender, and level of deprivation for detentions by their ethnicity category.

Figure 2.6 shows that while the gender balance in detentions recorded as White Scottish, White Other and Asian the split was even, there was a higher proportion of males among African, Caribbean, or Black, Mixed or multiple ethnicities, and other ethnic groups but more females among White Other British. The male-to-female ratio was 1.2:1 for Black, 1.1:1 for Mixed, 1.3:1 for Other, whereas White Other British was 0.8:1. In comparison, the overall ratio was 1:1, which was also the male-to-female ratio for White Scottish and Asian.

Figure 2.6. Gender breakdown by ethnic grouping
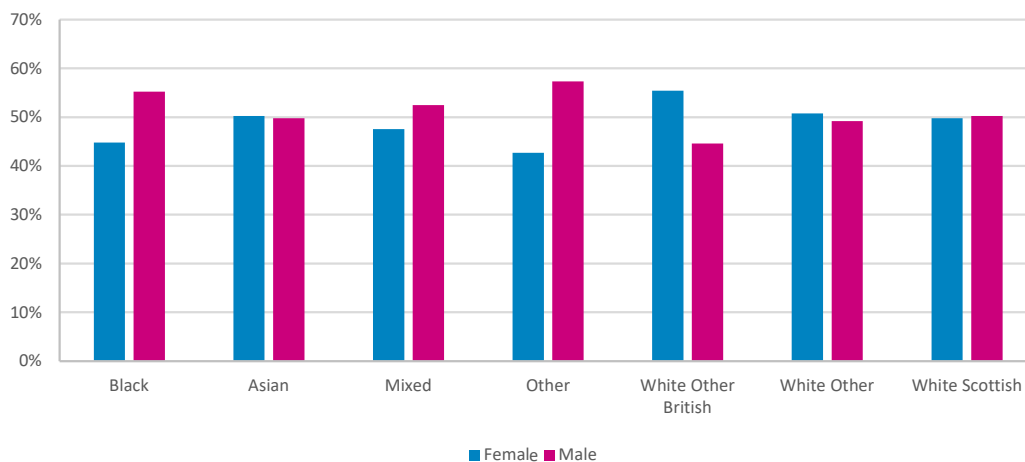
There is also a difference in age between detentions by ethnic group. For White Scottish and White Other British, about one third of detentions were aged 25–44 and another third 45–65, with about 25% in the oldest age category (65+ years). For all other groups, about half or over half were aged 25–44 years and apart from White Other, fewer than 10% of detentions were recorded for those aged 65 years or older. The skew towards higher percentage of detentions within minority ethnic groups in the younger age groups was true for both males and females (Figure 2.7a-b).

Figure 2.7a-b. Age categories by ethnic grouping for males

28
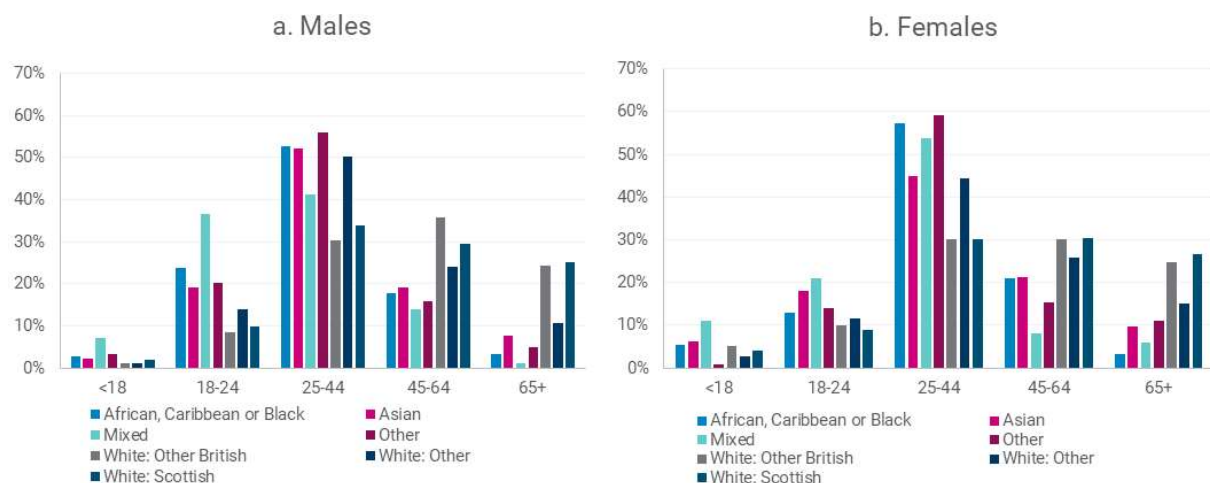
The average age at detention was higher among White Scottish and White Other British compared to other groups (Figure 2.8). Overall, the average age for the four ethnic minority groups combined was 36.4 years, which was younger compared to White Other (42.3 years), White Other British (49.4 years), and White Scottish (49.4 years). For all minority groups (including White Other), males tended to be younger than females.

Figure 2.8. Average age by ethnic grouping and gender
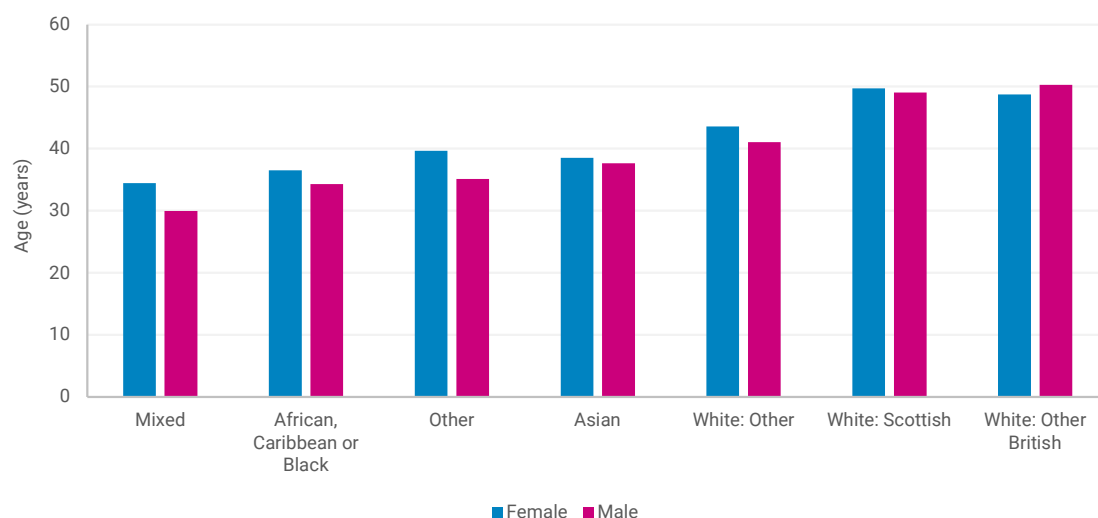
Overall, there is a gradient in detentions by level of deprivation, with more people living in the 20% most deprived areas of Scotland. Figure 2.9 shows that this gradient is greater in the Black and the Mixed or multiple ethic group. In the Black group, 57.8% were from the most deprived parts of Scotland, compared to 36.1% of White Scottish. Of note is that there is no gradient of detentions of White Other British, where 20.0% were from the most deprived areas.

Figure 2.9. SIMD category by ethnicity grouping
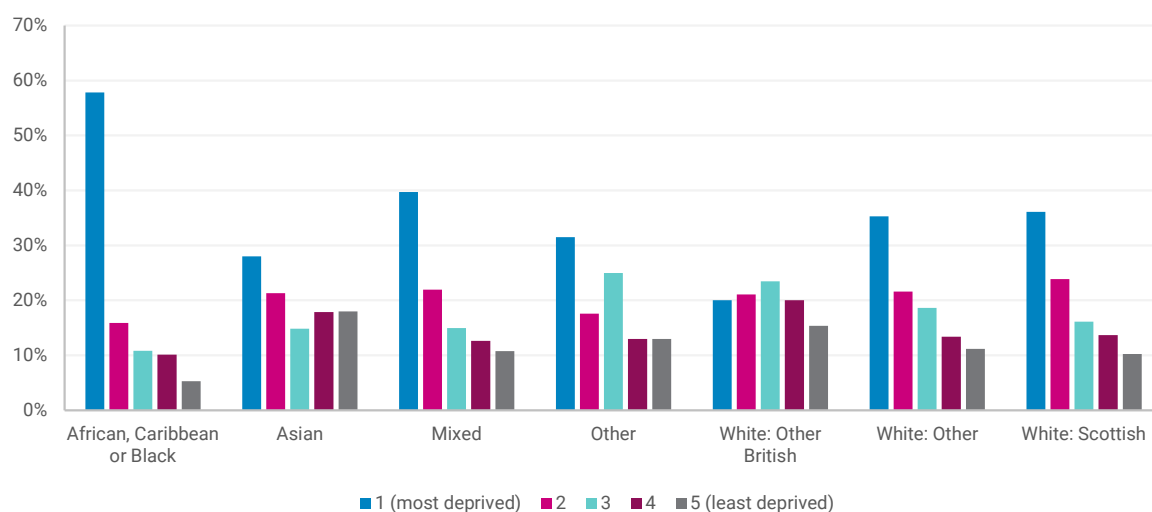
Note that this breakdown relates to detentions where an ethnicity was recorded and a postcode could be matched against SIMD. In 16.9% of all detentions between 2017-18 and 2020-21 we were unable to match a SIMD code so this relates to 83.1% of all detentions in that time period.

Where the detention starts

We looked at where people were detained, in the community or in hospital. The route into receiving care and treatment on a compulsory basis is meant to be following a STDC because there are more safeguards available. Overall, 42.5% of emergency detention certificates (EDCs) and 27.9% of short-term detention certificates (STDCs) started in the community. We found little difference in STDCs starting in the community between ethnic groupings (Figure 2.10). However, for EDCs 41% White Scottish detentions began in the community. The percentage of EDCs in the community was higher for all other groups with the largest difference for Black (54.2%) and Other (53.1%).

Figure 2.10. Percentage of detentions starting in the community
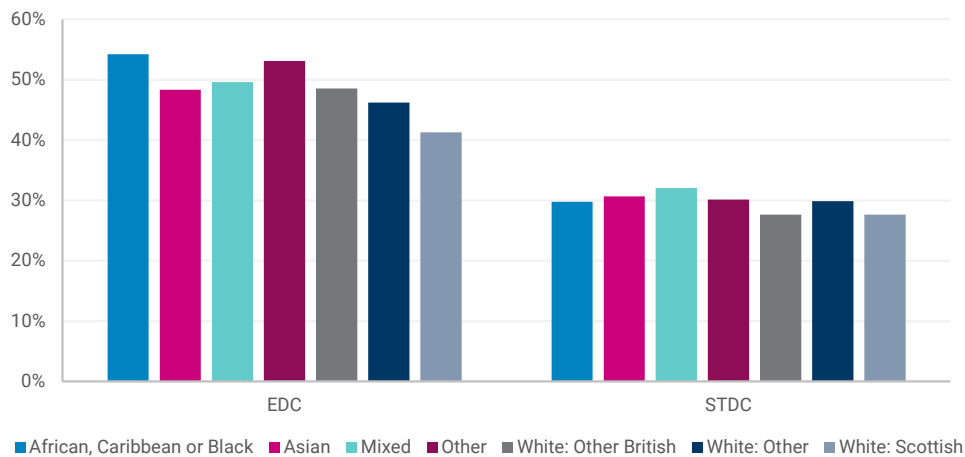
Significant risk perception

The Mental Health Act requires practitioners to certify that if the person was not detained that there would be a significant risk and determine whether they think this risk is to the patient, or to others, or to both patient and others. We wanted to explore whether there was any difference in whether the detention was justified due to i) risk to self, ii) risk to other people, or iii) risk to self and other people. The concern about safety of other people alone was similar across ethnic groups (1.1−2.0%).

The risk to 'self and others' safety', was higher among Black, Mixed or Other ethnicities compared to all three categories of White. Of note is that the perceived risk categories for Asian were very similar to that of White Scottish.

Figure 2.10a. Risk perception underpinning the detention
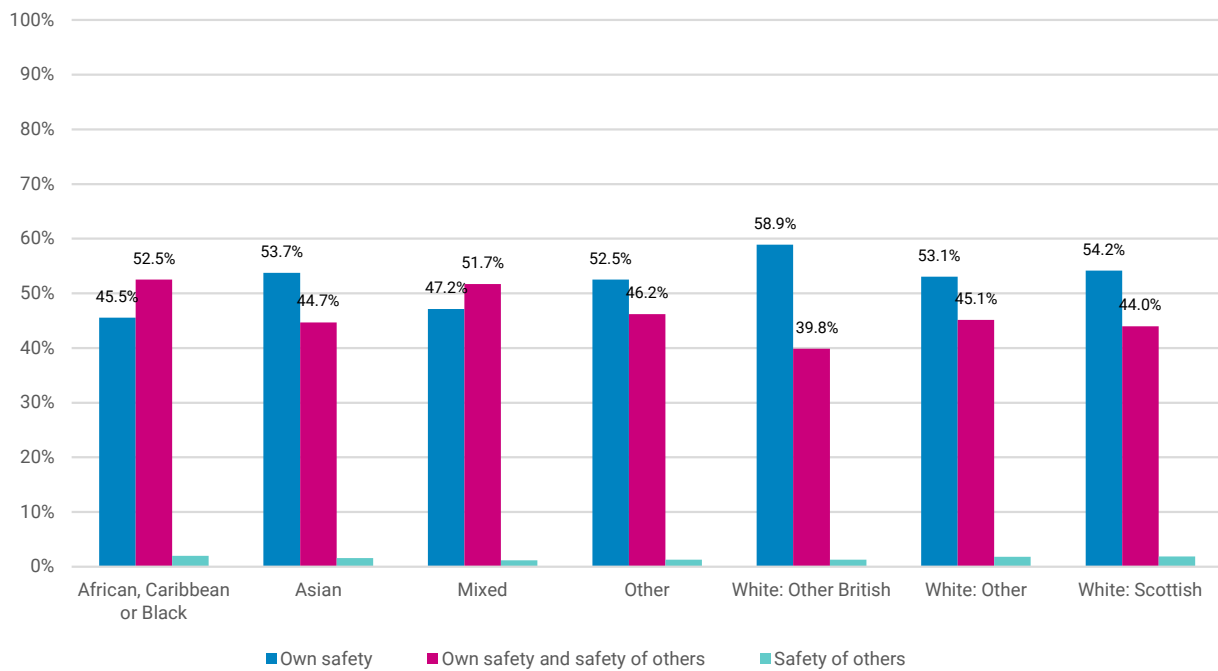
From the data we scrutinised, we found that black people and mixed race people are more likely to be seen as a greater risk to 'self and others' than to themselves, compared to all other ethnicities where people are more likely to be seen as a risk to self rather than to 'self and others'.

When we looked at this by gender we noted that there is an effect. For women, we saw a big difference between the perception of risk towards 'self and others' for Black ethnicity compared to White Scottish (48.4% vs 33.8%) and for Other ethnicity to White Scottish women (43.6 vs 33.8%).

The difference in 'own and others' safety in between Black and White Scottish groups was smaller in men (56.0% vs 54.1%) than overall (52.5% vs 44.0%). For Mixed or multiple ethnicities this difference was greater among men (62.6% vs 54.1%) compared to overall (51.7% vs 44.0%).

Currently the forms used to record gender only record male or female genders. We are working with stakeholders to correct this.

Figure 2.11. Perceived risk justifying detention by gender
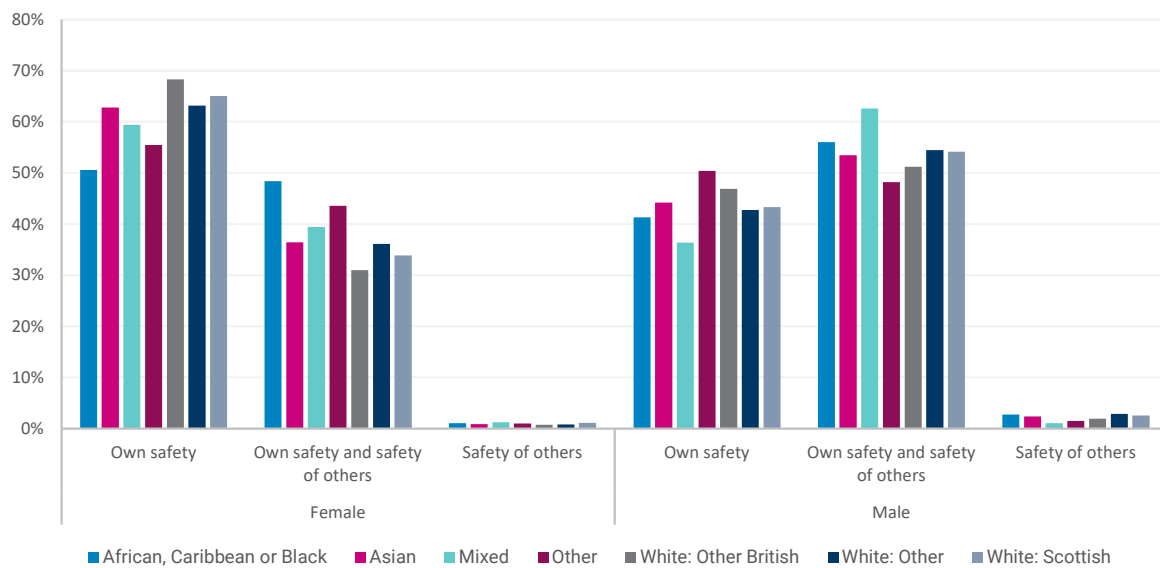
Safeguards

We also looked at the proportion of EDCs that had the consent of an independent MHO, which is an important safeguard for patients. The low proportion of EDCs that have MHO consent is something we have raised before [27] and we wanted to see whether there was any difference between ethnic groups around proportion of EDCs that had consent of a MHO.

The lowest percent of MHO consent was among Other (40.7%), Black (45.5%), and Asian (45.2%), compared to an overall average of 53.8%.

Figure 2.11. Percent of EDCs with MHO consent
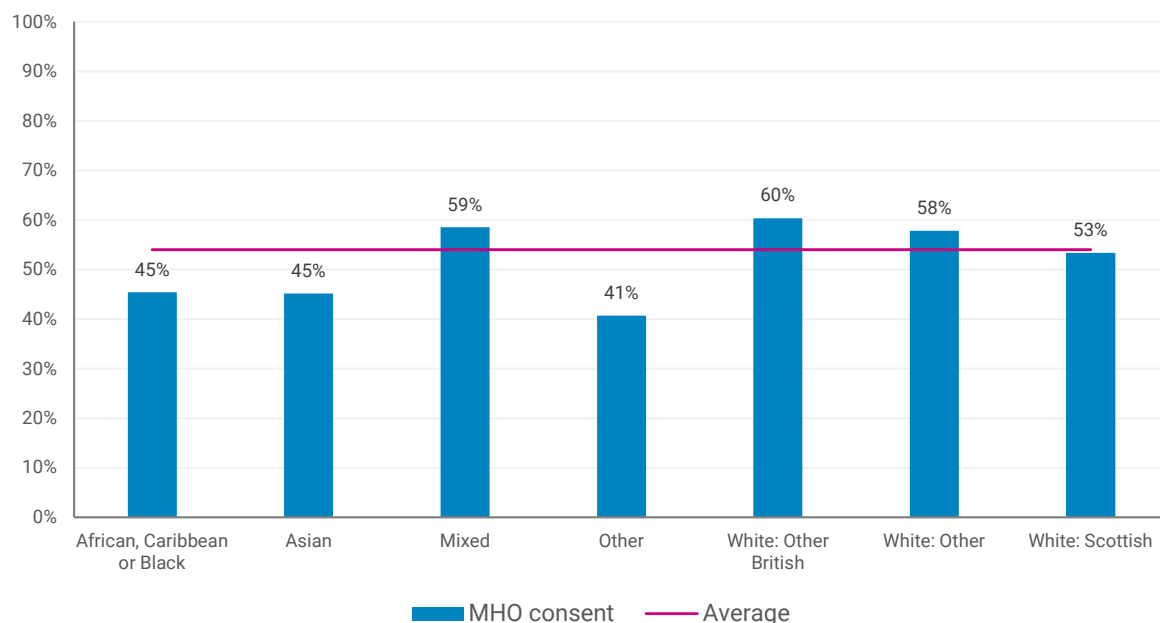
Figure 2.12 shows that there were some differences based on gender, with greater differences between males and females for Asian (39.7% vs 50.4%), Mixed (62.7% vs 54.7%) and Other ethnic groups (45.2% vs 35.9%).

Figure 2.12. Proportion of EDCs with MHO consent by gender
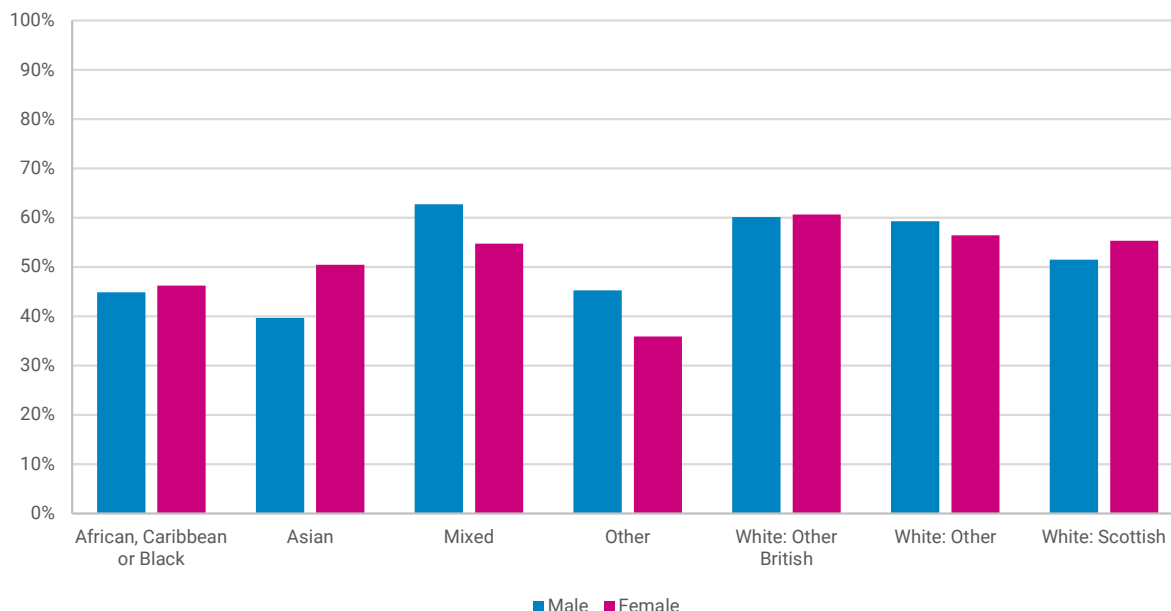
What this means

In this chapter we have described in more detail not only how many people from different ethnic backgrounds were detained but also the characteristics of those who were detained and how the law is applied to different groups. We highlight some differences in risk perception. We highlight how legal safeguards that should protect the political and civil liberties of all people seem to be differentially applied.

The preferred route of entry for involuntary care and treatment in hospital in Scotland for someone who appears to have a mental illness is a STDC. This is because there are more procedural requirements in the detention process (such as the requirement for an independent MHO consenting to the admission) and more safeguards like an appeal process. While EDCs are not the intended mechanism for admission to hospital, they can be used in this way. We found that the percentage of EDCs that started in the community for the four minority ethnic groups was higher than for White Scottish people (51.3% vs 41.3%). This shows that people of colour are more likely to be detained through a route which is less preferred.

We are also concerned that people from Black, Asian or Other ethnic groups had MHO consent for their EDC to a lesser extent compared to White Scottish people. We have already identified and called for action on the low rate of EDC consent from MHOs across all groups and we will continue to monitor this and the variations reported here. Through using a large data-set of detention records, we find evidence of people who are Black being considered to be a greater risk to themselves and others than other ethnic groups. Black and mixed race groups were the ethnic groups considered to be a greater risk to themselves and others than to themselves only. This finding requires further exploration. Whilst there may be other factors such as a

younger age (of the Black population), or the types of illnesses that they may be diagnosed with, socio-economic disadvantage etc. we cannot rule out biases in perception. The greater perception of risk extends particularly towards black women.

The impact of a perception bias of greater risk can be significant. The UK mental health charity Mind's briefing paper into racism and mental health from 2020 cited the higher rates of restraints for people who are black in England. They suggest that the racial stereotyping and related perceived risk of violence of black people is a potential cause for the higher rates of detention [28]. Unfortunately we do not have data on restraint by health board that can be explored by ethnicity in Scotland. There does not appear to be any national collection of this data.

A limitation of our work is that the findings we present here are descriptive and we are not controlling for variables that may also play a role e.g. socio-economic, geographical and clinical variables that might impact on any of the findings presented here.

Looking more broadly at detentions, for example, those that are undertaken by police and other authorities in the context of law enforcement, in written evidence to the UK Parliament in 2020, Inquest, the charity that provides expertise on state-related deaths and their investigations, describes how when racial stereotyping is woven into police and other detention settings, it can lead to a greater use of force [29]. Jordan et al. [30] describe how there is an "extraordinary risk at the nexus of mental illness, Black identity, and encounters with law enforcement" (p.8)

The concerns about racial biases are not remote or distant concerns that do not affect us. The terms of reference for the Public Inquiry into the death of Sheku Bayoh, a 31-year-old father of two who died following a police response to reports of a black male with a knife on the streets of Kirkcaldy, include the consideration of whether the events leading up to his death were affected by race or perceived race. This report, with its consideration of biases in risk perception, may be helpful to the Inquiry's work.

Could higher rates of mental illness explain what we see in the detention data?

Our data shows a relatively small over-representation of people from diverse communities in the detention data compared to the distribution of ethnic minority groups in the general population although there are issues with the completeness of the data collection. The issue of whether higher rate of mental illness might be the driver for higher rates of detention was raised in the mental health section of the report from the Commission on Race and Ethnic Disparities (CRED) [31] . This report was requested by the UK Prime Minister to address the question of whether structural racism exists in the UK and concluded, to the surprise and criticism from many organisations [32, 33], that it does not [31].

Although the CRED report mentioned the eight times higher rate of Community Treatment Orders for Black people in England and Wales, the report stated that this cannot be taken as evidence of discrimination *per se* as the rates of schizophrenia are higher for these communities. At the same time, the report noted that they were informed by experts that the higher rate isn't due to genetic predisposition but is due to adverse social conditions, which includes racism [31].

We would suggest that more work is needed to:

- Understand why the male-to-female ratio is higher in ethnic minority groups.

- Explore why there appears to be a significant age difference in detained individuals from minority backgrounds.

- Explore what might explain the difference in perception of risk based on ethnicity and gender and what the underlying reasons may be. We particularly note the effect of gender on reported risk for people who are detained.

- Further explore the specific issues facing individuals who are Black, as our findings suggest that this group may experience detentions differently to other groups and are also to a greater extent living in more deprived areas of Scotland. The overlap between inequalities in health related to ethnicity and deprivation needs to be a focus going forward.

Recommendations

To health boards (with support from health and social care partnerships)

- Consult with representatives from ethnic minority groups in their areas to explore barriers for individuals from minority backgrounds in accessing psychiatric care and treatment report on what steps they are taking to address the identified barriers to the Commission by September 2022.

To the Independent Review of Scottish Mental Health Law

- Consider the findings on differential use of the law in its on-going review of Scots Law in mental health. Consult specifically with organisations that represent ethnically diverse communities. Publish the findings of these consultations as part of the Review.

- Consider the findings noting how safeguards appear to be less well used for ethnically diverse communities. Ensure that any recommendations for changes to mental health laws protect the civil and political rights for all of Scotland's ethnic communities equitably.

- Consider the marked findings on socio-economic disadvantage and detention under the Mental Health Act, and how this is more pronounced for people of colour. Ensure that mechanisms to promote the economic, social and cultural rights of people who are detained promotes these rights particularly for those that are most disadvantaged and who have been subject to greater restrictions on their liberty.

To MHO training programmes

- Ensure the information regarding differences in the use of the Mental Health Act from this report is part of the training curriculum for social workers who wish to become MHOs from the next intake after the publication of this report.

To NES

- Include the findings on the differences in the use of the Mental Health Act on a section on inequalities in the Section 22 (s22) approved medical practitioner (AMP) course and appoint an equalities champion within s22 approval scheme by September 2022.

To the Royal College of Psychiatrists in Scotland

- Consider why in the forms completed following detentions of people under the MHA why it is that people who are black are more likely to be recorded as a risk to 'self and others' than other racial groups; and why, of all the ethnic groups, a higher proportion of black and mixed race people were considered as greater risk to 'self and others' than to themselves.

To the Scottish Government

- Mandate an appropriate agency to record and publish national data on restraint, stratified by protected characteristics by September 2022.

Chapter 3 – Lived experience perspective

Key findings

We heard from 32 people with lived experience of mental health difficulties, including family members, carers and volunteers. We spoke to them through a mixture of one to one meetings and focus groups, online surveys and written accounts. Sixteen of the people we spoke to were refugees.

- People with lived experience and their families and carers spoke about their difficulties in accessing treatment and their mixed experience on the cultural sensitivity of mental health services.

- On accessing care many faced difficult consultations where they felt dismissed and misunderstood. They did not feel heard or believed especially around issues with the asylum process. There were clear difficulties right at the start of the pathway at the primary care level as participants described a poor understanding of the asylum process in primary care.

- People with lived experience described micro-aggressions and racism that impacted on their mental health and their sense of belonging in Scotland.

- They commented on the stigma of illness in their communities of ethnic identity being strong but they also commented on how national anti-stigma campaigns on mental illness compounded the issues by only showing white people with mental illness.

- They reported that they were not offered psychological therapies.

- They described how third sector community-based organisations build vital bridges between people and services, and engender trust.

Who we heard from

We present here an analysis of the descriptions of the difficulties that were outlined to us by 32 people who we heard from about their experience of seeking help for their mental health difficulties in Scotland.

We recruited people through writing to relevant organisations to ask if people would speak to us or give us information in writing through an online questionnaire. We also asked people if they would prefer to speak to us in a group. We met with 16 people in a focus group. Three people submitted views through the questionnaire. The remainder were met through one to one meetings. All meetings were held online due to the pandemic.

We met with people who had moved to Scotland from many different countries, including Cameroon, Gambia, India, Iraq, Jamaica, Nigeria, the Philippines, Poland, South Africa and Zambia. The 16 participants in the focus group were all refugees.

In addition to people with lived experience we also spoke directly with three carers and a further three carers filled in our online questionnaire about the experience of being a carer from a minority ethnic community. We also spoke with two carer workers and two volunteers who support people from ethnically diverse groups in the community. The carers we spoke to came from different backgrounds and communities.

Themes

From the interviews with people we identified four themes in what they told us:

1. difficulties in accessing treatment and support;
2. mixed experience of services;
3. discrimination and being judged; and
4. helpful community and third sector support.

We describe each of these themes and sub-themes in the following sections. Our interviews with four volunteers and support workers in the third sector who provide support to people with lived experience of mental illness from diverse communities and their carers emphasised a fifth theme of the impact of trauma.

Difficulties in accessing treatment and support

People from minoritised ethnic communities living in Scotland who we spoke to described many challenges in accessing mental health treatment and support ranging from negotiating the asylum process, overcoming the stigma of a mental health difficulty, a primary care service that did not appear to understand their difficulties, and issues around language and interpreters.

The asylum process

This process was described as traumatic and contributed to further poor mental health.

Many of the participants on the focus group had experienced the asylum process which was described as the "worst time possible" (focus group participant). Another person described how:

> *"The first interview is bad enough and often brings on depression. This is then dismissed and ignored by the GP" (focus group participant)*

We heard how the substantial interview that follows requires the individual to build a statement and get a lawyer. We heard how the statement building often triggers past traumas and can leave people overwhelmed even if they are successful in their application.

> *"What do I do now? How do I fill the gaps and recover from the trauma of the asylum process?" (focus group participant)*

A woman spoke about the added stress due to the length of the asylum process and another participant spoke about the bureaucracy of form filling, repetitive questions and how the way that he was asked to complete these felt humiliating.

> *"I know the importance of documentation, but there's a way of asking for it, that isn't demoralizing." (individual interview)*

Stigma of mental health conditions and impact on carers

Many participants who we spoke to reported that the countries that they used to live in had deeply embedded belief systems that dismissed mental health as a "weakness", or a "disability" and that this meant that they could not share their feelings with people from within their ethnic community and without access to support or statutory services they were at risk of becoming more isolated. This creates another barrier to accessing services.

Carers also reported that the stigma around mental health problems made families reluctant to involve others around them. In some languages "mental health translates as mad" and people did not want to advertise their problems to others around them including in faith groups.

Some even avoided discussing with close family.

> *"My mum understands to a degree but the rest of the family do not understand the impact of poor mental health - it is still very taboo. They do not appreciate the harm it causes, which then has a knock on effect on the person experiencing it." (online carer survey response)*

One of the carers told us that the response to an addiction or mental health problem in their culture would be to "marry them off". They felt this was to pass on the responsibility, which they recognised was not an answer but carer support was lacking.

Only one of the carers who we spoke to had heard of and had an adult carer support plan done. Under the Carers (Scotland) Act (2016) carers are entitled to this. As well as information, barriers intersect, as for the carer who did have a support plan, although needs were identified they were left unmet due to a lack of counselling in her preferred language and a lack of appropriate community support for her relative. Two of the carers said they had not actually identified themselves as carers in order to access any support and this can be quite a lonely experience.

> *"My friends and my partner are very understanding and helpful, however I do feel like the burden lies with me and it can sometimes be quite overwhelming." (online carer survey response)*

Sometimes faith groups were helpful but at other times not. One man from a country in the Middle East described how an Imam had organized a teaching session on mental health. He was shocked at some of the comments and at that point realised that attendance for the Imams was compulsory rather based on interest. He also said that "there's no Arab or diverse charities promoting positive mental health – it is still very much hushed up."

One woman said that mental health is seen as "a white person's illness". Her impression is that "all the people on TV talking about it are white, even the pictures on the tablet boxes are white! She felt this emphasises the notion that if you are black, you are tough and must manage it" (focus group participant).

Experience of primary care

Participants who presented to primary care described a mixed experience. Some described how they felt that GPs dismissed their concerns, did not offer psychological therapies and reflected on how there was no route to support without a GP referral. On the other hand, GPs who were aware of wider landscape of community supports and were able to refer to these, even if they could not address underlying trauma were described as supportive and hugely influential.

Several female participants had negative experiences with their GPs in relation to the asylum process. They reported that they were accused of making up mental health problems in order to get a report for the Home Office. One participant in the focus group reported that they were told that their symptoms were imaginary, another survey respondent reported that unless they were suicidal they did not feel that they could get help, another individual interviewee reported that they now ask reception staff which GP is good on mental health. One respondent online felt that they were not even able to explain their difficulties:

> *"I was often dismissed or given one appointment and then deemed 'okay' because I was in a good mood that day. I feel like I have never been given the chance to properly explain the extent of my illness and how it affects my day-to-day life." (online survey response)*

The impact of having to retell one's story can also be traumatic. A participant in the focus group described narrating the depth of her depression to her GP who immediately sent her to another clinic where the professional there made her re-tell her whole story which reinforced traumatic experience. She was sent home weeping and felt much worse.

Another participant described a less than helpful encounter with a community psychiatric nurse (CPN). After sharing their story about experience of abuse with a private counsellor, the participant felt able to discuss this with their CPN. The reply was that "we don't do that – there is a charity in XXXXX you can go to." This shocked the participant. The CPN's body language was described as 'uncomfortable.' What followed was a discharge letter and a leaflet for the charity. Another interviewee supported the view that:

> *"Professionals do not want to open a Pandora's Box and [so] take the easy route. They can't really understand what the patient means so just leave it." (individual interview)*

Similarly, nearly all of the carers reported difficulties getting help from their GP. All of them were keen to be involved in the care of their relative but all felt their input was discouraged and some described language barriers, with no interpreters offered that meant relying on other family members which is not ideal.

Some people opted for counselling or were referred via primary care to this. Experiences were mixed. One participant who had access to private counselling described this as "amazing and affordable" (online survey response).However, another reported a wholly different experience that related to the counsellor's understanding of racial trauma:

> *"When I was in private counselling, my counsellor did not understand my family culture or religion and wanted to attribute parts of my condition to my parents' behaviour although I*

didn't feel particularly affected by those aspects. She also didn't have any sympathy or awareness about racial trauma and how micro aggressions work or how we experience everyday racism which has an impact on our wellbeing." (online survey response)

Language and interpreters

For some, language was a significant hurdle both in terms of accessing and using services, and also in the experience of isolation from the wider community. If an interpreter is used it is important to ensure that it is a person who is appropriately skilled, professional and that regional differences in dialect are also taken into account.

"Sometimes an interpreter is provided, yet they may not have the appropriate skills. In some countries, for example, there are very distinctive regional differences in dialect. So, the assumption that an interpreter is right for the job, based on a broad-brush understanding can be profoundly misleading." (individual interview)

In the absence of skilled interpreters, for someone who cannot speak English well, it becomes especially difficult. Participants described that even when they do get to see a GP or practitioner, they did not feel that they knew the jargon and felt unable to describe their situation, leading to a further sense of isolation.

Many who took part felt that there was a lack of clear signposting of the mental health system. One person suggested that it would be good to have a London Underground map equivalent of mental health services that shows where things are and what the paths are. The lack of clear descriptions of how services work makes understanding and navigating the system complex. This was not solely to do with language but also applies to participants with good language skills.

Mixed experiences of secondary care services

Carers reported that their cultural background was not acknowledged or considered when formulating mental health plans including around admission under the Act. Several commented on the lack of availability of interpreters and what they perceived as a reluctance of services to provide one which impacted on whether they had information to support their loved one. However they denied experiencing any racism.

One carer described her relative being detained and sent to a hospital out of area. She felt being away from cultural support from relatives had a significant effect on her recovery

"… the hospital was an over-the-top solution …had she been treated within her own health board close to her home she would have adjusted much better to the initial interventions. Instead she was socially isolated in an alien environment which made her recovery journey difficult." (online carer survey response)

Another carer highlighted that lack of contact with family can lead to many issues being overlooked or missed especially in the face of someone with a mental illness who has little insight. Four carers reported that they did not receive enough information about the person's mental health condition.

Discrimination and being judged

Racism and micro-aggressions

People told us about micro-aggressions and how this impacted on their health and wellbeing. People described how they felt that because of skin colour professionals would not immediately recognise an entitlement to services, of difficulties in obtaining employment leading to working at a lower skill level than their training and education and the impact that had on their sense of wellbeing and pride. Indeed, employment issues featured strongly in the individual interviews, both in terms of ethnicity as a barrier, and in terms of lack of appropriate employment leading to a loss of dignity and then becoming unwell when pride is hurt.

"This [ethnicity] was not an issue particularly in mental health services, but I am aware that my name on a CV was and is a barrier to employment." (individual interview)

"I came to Glasgow for family reasons and found it difficult to get a job in my specialist field of education. So, I took a contract customer service job to put food on the table. I wasn't happy doing it and maybe that's when I started to become unwell." (individual interview)

There were also reported examples of racism and micro-aggressions in the wider community. Several participants in the focus groups described the effect of repeated micro-aggressions. We heard how one woman was singled out in the bus queue from the other (white) people and asked whether she had the correct change, another reported being followed by the security guard in a shop, another being searched after shopping and when nothing irregular was found she was told to always keep her receipts. All of these instances, according to those who described these incidents, contributed to poor mental health.

"They look at you and judge you right away." (focus group participant).

"It is happening out there with the people we live with in society." (focus group participant)

Discrimination takes a toll on mental health, women in the focus group described the power imbalance as something they have had to fight with their whole lives. Living with the constant sense of being discriminated, of not being welcome, was expressed by multiple participants.

"Maybe it is better to die at the hands of your own people than to come to a new land and be discriminated against? It feels like a constant battle - always fighting and no time to find a solution. Makes you feel insignificant, lacking in confidence and has a negative effect on our mental health." (focus group participant)

> *"There was a recent news item about a building being sprayed with the words 'If you are not white get out.' In our community we can worry about this: do people really want us out? Do they dislike us? Do they speak about us like this behind closed doors?" (individual interview)*

Adjustment, guilt and alienation

Some people described both positive and negative emotions at making a new home, equating life here to coming out of jail, and being able to see doctors, access to clean air, but also feeling guilt for leaving people behind and a sense of not fully belonging anywhere.

> *"Coming here is so much better for my health. I do not worry about going to the doctors; my physical health is so much better because I live with clean air instead of the smog of my home country. It makes me feel incredibly guilty for friends and family who remain behind. It feels so unfair. I struggle with this every day." (individual interview)*
>
> *"I am not white, but I am not Asian anymore. I have no idea what the current news is at home. I would be seen as a stranger. There is a disconnect. I cannot reconcile there and here anymore." (individual interview)*
>
> *"Sometimes I feel I lose the part of me that is an African person; when I last went on holiday home; to be able to walk down the street and for no one to ask me where I come from was such a relief." (individual interview)*

Helpful community and third sector support

Many of the participants attested to the benefits of being in a safe, learning and social exchange setting talking about charities such as Freedom from Torture, Saheliya, and others that allow people to talk about their own experience but also to develop a sense of Scottish culture. One participant described how the third sector had been the stepping stone for them to enter into employment again which he felt saved his life. Again there was an emphasis on the need for primary care being aware of the third sector services and support being available in the community and for carers to be supported through local carers' centres which were also described as lifesavers.

> *"The last port of call should be the psychiatrist." (online carer survey response)*

Volunteers' views

We also spoke to a group of workers supporting carers in ethnically diverse communities. Two spoke to us individually as did two volunteers involved in carer support.

Trauma

The volunteers confirmed what we had heard that a lack of knowledge about mental health was one of the biggest problems faced and that stigma and cultural attitudes also played a significant part in the difficulties identified in accessing help. They felt it was important to acknowledge that some people in these communities live under terrible stress with financial difficulties, racism and ongoing worries about families left at home in dreadful circumstances.

Syrian refugees were particularly highlighted as having come from traumatic backgrounds. Many have physical disabilities and have post-traumatic stress disorder (PTSD) as a result of the trauma they have witnessed or experienced. Often they have ongoing anxieties around family still living through it. With no specific support they have nothing to help them with day to day life. The support workers expressed frustration in their own roles at the lack of printed information available in other languages. They felt having these available would help with increasing awareness and enable information to be left at mosques and in community settings where people could easily access them. They also described how although there are difficulties for people in speaking to statutory services, people are willing to talk in more informal spaces at coffee mornings, cultural centres and mainstream services need to reach out to those spaces.

> *"Organisations are not culturally sensitive and don't appreciate when they talk about "hard to reach communities" that they need to go to these communities as they will not come to services (carer worker)*
>
> *"The biggest barrier services put up is waiting for the communities to come to them. This is not going to happen and they must be proactive and go into the communities to form relationships, educate and inform" (carer worker)*

One of the volunteers who has been working with people in their communities for years highlighted the effects that the pandemic has had particularly in the Indian and other Asian groups she supports. She described a lot of the families she supports as "being in mourning. There has been a great deal of loss in the last year".

Suggestions for development

We spoke with 32 people. The following are suggestions they wished to make to mainstream services for improvements:

- Services should not expect the individuals to come to them. Develop appropriate community services including outreach workers who can go into communities, engage directly with people and provide education and awareness training.

- Attending coffee mornings, community events, religious services that will embed them in communities and allow trust to develop.

- Provide well trained and professional interpreters who can understand the nuances of mental health language and the different dialects that exist.

- Provide appropriate written information explaining mental wellbeing /mental illness/ access to treatment in all languages (suggestion was the refugee council would be able to direct which languages these should be)

- Make sure GPs are properly informed about cultural differences in their practices and have access to interpreters quickly when needed.

- Make sure mental health services have easy access to interpreters and actually use them.

What this means

Asylum process

The asylum process was described as a demoralising and tortuous process – people attested to a lack of proper psychological support. There is a need for education and training for staff in primary care and probably in secondary care (our sample was skewed towards people who had more experience of primary than secondary care) on the asylum process. Many people who seek asylum will have experienced past trauma. When the Commission visited the immigration centre at Dungeval in 2018 we made recommendations about avoiding re-traumatising people [34].

More broadly, a report of announced visits to custody suites run by Border Force in England and Scotland in 2017 recommended that staff in such settings should have skills in mental health in different cultural groups [35].

Similarly, staff who might be working with people who have interacted with the asylum or Border Force custody settings process ought to have, at least, a basic understanding of asylum processes. In this, we agree with the recommendations from a report from Strathclyde University that focused on the experience of asylum seekers in Scotland that suggested the need for the Home Office to accept the impact of the asylum process on health, and called for provision of training to NHS staff on the impact of asylum seeking on health, including specific training to GPs on dealing with trauma [36].

Primary care access

Our findings on the barriers to and implications of accessing primary care included distrust of mainstream services generally, stigma around mental health conditions, language barriers, perceived and real attitudes of GPs and risks of being re-traumatised. This supports the suggestion from the SHELS study that there may be delayed help seeking within minoritised communities that later translates into an overrepresentation in detention statistics [21]. This also fits with the work from the UK-wide Synergi Colloabarative Centre (2017) which showed lower access to primary care [37]. The barriers outlined above provide pointers to primary care services about what might be done, most tangibly for this sample of people (16 were refugees) this was understanding the impact of trauma and understanding the asylum process.

Access to psychological therapies

We noted the comments that participants did not feel that they were referred for psychological therapies. Although it is unclear to us how they had reached this view, studies from England have shown that compared to White peers, people from non-White communities are less likely to access Improving access to psychological therapies (IAPT), which is a talking therapy programme delivered in the NHS in England. If referred, non-White groups were less likely to be assessed and less likely to have treatments [38]. Similar data on access to psychological therapies is not available by ethnicity at a national level in Scotland.

Advice lines, language and interpreters

Advice lines are rarely accessible in other languages (this includes the Commission's advice line, at this time, however we intend to ensure that language support is available as an action arising from this work). Participants raised issues with the availability, appropriateness and the way that interpreters are used. The Commission has produced detailed guidance on using interpreters with sections for professionals and interpreters [39]. In a survey of psychiatrists in 2019 in Scotland, 53% of respondents had used an interpreter in the previous three months. 17% had training with working with an interpreter and 15% were aware of the MWC guidance [40][3].

Migrants Matters, a report by University of Highlands and Islands with members of the Highland User Group, looked at the experience of EU migrants in the Highlands and made recommendations about the need to understand the cultural meaning of mental illness in countries of origin, and the need to ensure adequate translation and interpreter services [40].

Stigma

Another theme that emerged was stigma towards mental illness within minoritised communities. A study which included focus groups with over 250 people from BAME communities in Scotland found that anti-stigma campaigns in Scotland on mental health had failed to impact on BAME communities because they were often culturally inappropriate, did not use the appropriate media channels, multi-racial and role models, and did not provide clear or translated materials. They concluded that community development workshops with dialogue and engagement might offer more than national anti-stigma campaigns alone [41].

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[3] Email communication, Dr Fiona Duncan, June 2021. Study details available on request to the Commission. With our thanks to Dr Duncan for providing this.

Our work supports both approaches – there was a clear call from carers to the workshop model of engagement but we also noted a participant called out what they perceived as a lack of diversity within the messaging from anti-stigma programmes.

We note that a motion in July 2020 at Holyrood also helpfully drew attention to the particular issues around mental health stigma in BAME communities [42].

Racism and micro-aggressions

The findings on racism and micro-aggressions and feeling like that they 'don't belong' are troubling and sad. There is an association between everyday discrimination that the interviews above show and distress, poor wellbeing, psychosis, and depression [43]. We also know from the 2018 Scottish Household Survey that minority communities in Scotland are less likely to feel that they belong [44]. The sense of alienation, of othering, of discrimination takes a toll on mental health. It is beyond the scope of an organisation or indeed a health system to correct this. That will take the work of all of us from the highest levels of Government to the everyday interactions between citizens that foster belonging, inclusivity and better mental health for all.

Community organisations

The only strengths to be drawn from these discussions are related to the role of community organisations. They were described as a 'lifesaver' by one participant. But some of these organisations, whilst well regarded, are on short-term funding cycles and are at risk of disappearing from the landscape.

Third sector groups appeared to act here as 'boundary spanners' that help to reach people who might not access mainstream services but will access a third sector organisation. Those we spoke with explained that they may feel more able to share stories with third sector organisations. In turn the third sector organisation might be able to 'plug in' to the statutory services that are able to offer the specialist help that people need.

As well as people with lived experience, services at the local level would also benefit from having a list of organisations that are able to support people coming from particular backgrounds to help facilitate cross-cultural care. Indeed this was a suggestion, echoed from the staff and equality and diversity leads who responded to our survey that we report in the next chapter.

Writing in the Lancet Psychiatry, Sashidharan and Gul [45] emphasised the need for statutory services to engage with BME communities and agencies rather than undertaking further inquiries and reviews.

Recommendations

To health bods (with support from health and social care partnerships)

- Ensure that their wards and teams have accessible information on the local and national organisations that provide support and information to people from ethnically diverse backgrounds who access their services. Compile a list of organisations that provide input to diverse communities and/or share regional lists between neighbouring health board ethnic diversity lead officers (EDLs) by September 2022.

- Mental health services in each health board should develop a bespoke programme of engagement meetings with those third sector organisations that meet their local needs to develop trust and reduce barriers to service use by people from minority ethnic communities.

To NHS NES

- The Commission guidance [46] for professionals and interpreters in mental health settings should be referenced at NES S22 AMP training course. The guidance should be evaluated by NES to see whether it might have wider applicability and usefulness beyond the mental health sector and if so, made available in training to other areas of health and social care.

To the Scottish Government

- Consider further investment in minority ethnic organisations that support people from diverse communities with mental health difficulties, specifically to bridge the gap between them and access to mainstream services.

- Commission the appropriate body to develop an additional educational module for health and social care staff on asylum seekers health needs including mental health. This module should be made available to all health and social care staff.

To See Me, the national anti-stigma campaign

- National anti-stigma campaigns should include more participation of people from minority ethnic communities in the design of future programmes.

Chapter 4 – The cultural competence of mental health services in Scotland

Key Findings

A culturally competent workforce has been a goal of NHS Scotland since 2002. This chapter presents findings from surveys conducted with all 15 equality and diversity leads from Health Boards and from 320 staff working within mental health services who responded to our survey that was disseminated by the Equality and Diversity Leads (EDLs). We asked a series of questions to understand the cultural competency of mental health services.

- The majority of EDLs for health boards feel that their workforce is moderately culturally competent.

- They describe the barriers to competence being a lack of awareness of issues, a lack of data, a lack of senior representation and EDLs not always being appropriately located within organisational structures to lead and deliver change.

- From the comments we received in response to our survey of mental health staff cultural competence appears to be broadly understood in terms of directly accessible resources, such as accessing knowledge about another culture and availability of interpreters; rather than any broader understanding around wider issues such as power dynamics within clinical settings and the impact of the history of colonialism and slavery and their legacies on trust, stereotyping and biases in clinical interactions.

- EDLs reported that most training is delivered by an online 'Learn Pro' module but that other training is or can be made available. They described barriers such as a lack of time and a lack of prioritisation to staff accessing further training. Only two leads reported that there were measures in place to evaluate the impact of the training.

- However it was clear that mental health staff grasped the inadequacy of current training on offer with 70% of mental health staff responding to our survey feeling - that the training on equalities had gaps. Many reflected on the inadequacy of a 'one-off' module sometimes with no requirement for any further or refresher training. There was a strong sense in the comments that the current training needs a full review.

- It was rare to see examples of any patient feedback being stratified by ethnicity to inform awareness of inequities in access that might inform service design and universalism. Where staff were collecting data on ethnicity they often had no sense of how or whether it was used. EDLs confirmed that patient feedback was not stratified by demographic variables.

- 38% of the survey respondents were aware of third sector organisations that were supporting people from diverse communities. There was a lack of awareness of health board BME networks, with only 16% of staff knowing whether their health board had one.

- 30% of staff (95% of whom were White Scottish) reported that they had experienced racism in their wards/teams. Comments showed that they were mostly referring to the experience, in their view, of witnessing their colleagues subject to racist abuse. The impact of unaddressed racism led one survey respondent to say that they left their job because of it.

Introduction

Developing a culturally competent workforce has been a stated aim of the Scottish Government's policy for the NHS since 2002 with the publication of *Fair for All* [11].

Cultural competence has been defined as an organisation-wide approach to enhancing effective cross-cultural communication which includes a number of interconnecting initiatives (e.g., staff diversity, staff training, interpreter services, improving staff attitudes to cross-cultural care) [47].

Another concept that has been influential in considering how services meet the needs of all people who access care is 'cultural humility'- this promotes openness and non-judgement while allowing the client to determine how their culture impacts their experiential reality and by extension, the clinical encounter. It recognises the role that culture, ethnicity, and race plays in shaping power dynamics, and being able to understand the role that culture might play in the experience of illness and healthcare systems.

We wanted to explore the extent to which cultural competence, in its broadest sense, is part of the landscape of mental health services. We disseminated a survey via equality and diversity leads (EDLs) that asked questions on various dimensions of cultural competence and included a question on the experience of racism, to staff working in mental health services across Scotland and another survey to the EDLs from each health board within NHS Scotland. In addition to the 15 returns (a full-set) from the EDLs, we received responses from 320 staff working within mental health services within NHS Scotland.

Staff survey on cultural competence

Background and demographics

Tables 4.1 and 4.2 details the health board, role, discipline, grade and demographics of the 320 respondents for the staff survey. We suppress data where the number of individuals in any category were fewer than five.

Table 4.1 Health board and role within the NHS

Category	Grouping	n	%
Health board	Ayrshire and Arran	71	22
	Borders	26	8
	Fife	26	8
	Greater Glasgow and Clyde	48	15
	Highland	9	3
	Lanarkshire	36	11
	Lothian	40	13
	Island boards	8	3
	Missing	*	*
	State Hospital	*	*
	Tayside	51	16
Role	Registered Mental Health/Learning Disability	88	28
	Nurse Team Leader/Senior Charge	51	15
	Allied Health Professional	40	12
	Psychiatrist	35	11
	Psychologist/Psychotherapist	31	10
	Service Manager/Lead Nurse/Clinical Nurse	14	4
	Pharmacist/Pharmacy	13	4
	MHO/Social Worker/Social Work Assistant	12	4
	Health care support worker/assistant/auxiliary	11	3
	Clinical Support Worker/Support Worker	8	3
	Administration assistant/officer	7	2
	Counsellor/Chaplain /Self Help Worker	*	*
	Community Care Assistant/Support Worker	*	*
Discipline	Nursing	165	51
	Psychiatry / Other Medical	43	13
	Allied Health Professionals	42	13
	Psychology / Psychotherapy	24	8
	Missing	20	6
	Other	11	3
	Social Work	9	3
	Pharmacy/Admin/Spiritual Care	6	3
Band/grade	Agenda For Change (AFC) Senior Management	*	*
	AFC Band 8A − 8C	37	11
	AFC Band 7	47	14
	AFC Band 6	93	29
	AFC Band 5	53	17
	AFC Band 4	7	2
	AFC Band 3	23	7
	AFC Band 2	7	2
	Consultant	19	6
	Speciality Doctor / Staff grade	*	*
	Higher Trainee / Trainee / Junior Doctor	5	2
	Missing	24	8

n<5 or secondary suppression

Table 4.2 Demographics of respondents

Category	Grouping	n	%
Age	<35	50	16
	35-44	69	22
	45-54	113	35
	>55	74	23
	Missing	14	4
Gender	Female	222	69
	Male	86	27
	Missing	11	3
	N/A	1	<1%
Ethnicity	White Scottish	250	78
	White Other British	31	10
	White Other	10	3
	Other Asian, Arab/Arab Scottish/British/Mixed/ Black/Black Scottish/British/Gypsy/Traveller community/Other	10	3
	Indian, Indian Scottish, Indian British	8	3
	Prefer not to say	*	*
	White Irish	*	*
	Missing	1	0

n<5 or secondary suppression

Cultural competence - staff training

Participants were asked whether or not they had completed various Equality and Diversity training over the past two years. Figure 4.1 details the completion rates and Figure 4.2 breaks completion of the Learn Pro Equality and Diversity module down by health board for these respondents.

Figure 4.1. Respondents who had undertaken various training in the last two years
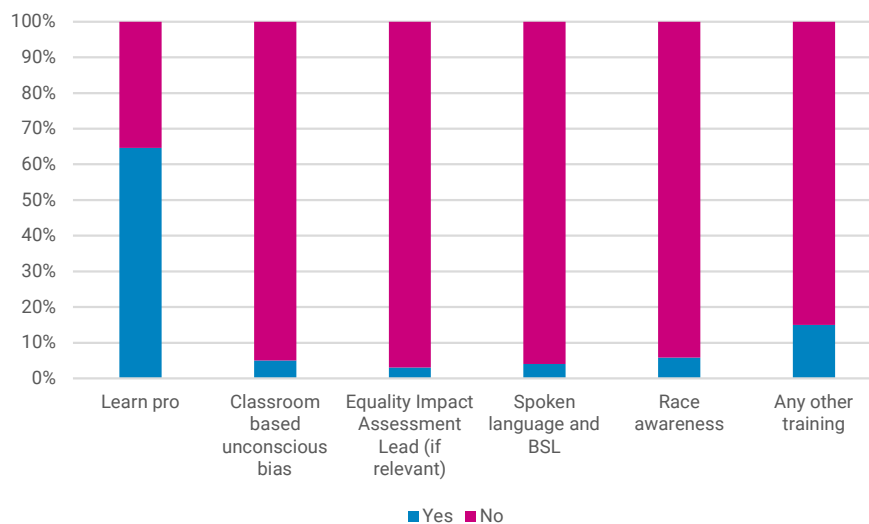
Note: The number of respondents for each of these questions were: 314, 295, 290, 296, 293 and 287

Figure 4.2. Learn Pro Equality and Diversity module completion, by health board[a]
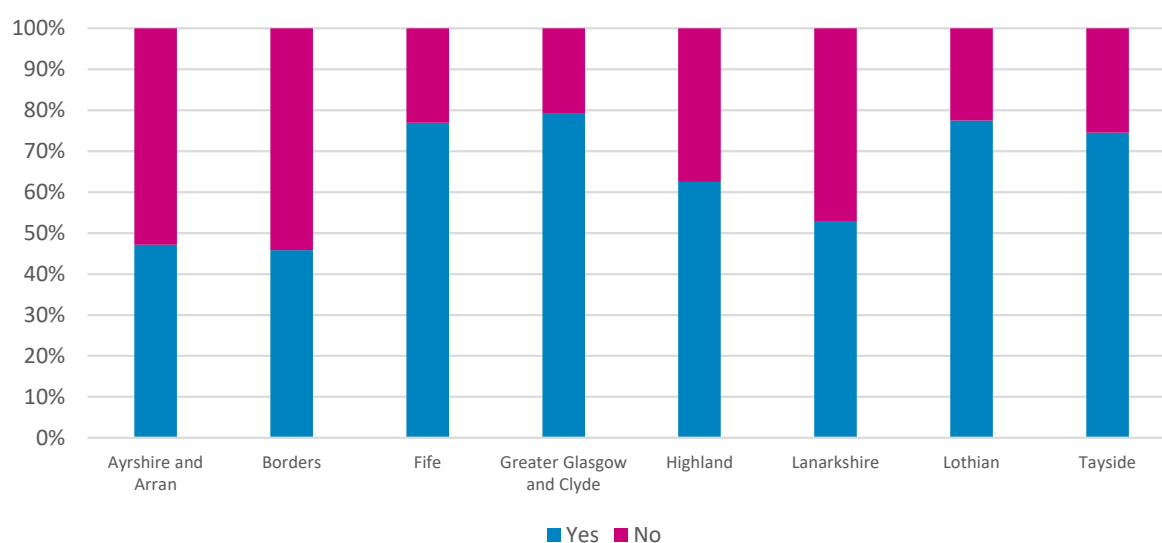
We asked the respondents about any other equality and diversity training they may have completed over the past two years to get a sense of what equality and diversity training staff are accessing. People reported they had accessed training on diversity through their professional organisations, through University online training courses and via the Turas platform (see next section). They accessed content on gender identity, gypsy and traveller communities, as well as race awareness and unconscious bias training. We noted comments from some people who had worked outwith Scotland on cultural practice training. Many participants described how they had not had formal training but had been reading up on these issues themselves or from the media.

Turas access

Turas[4] is NHS Education for Scotland's single, unified platform for health and social care professionals. It has an Equality and Diversity Zone developed by NHS Education for Scotland (NES), that provides resources to 'help NHS Scotland staff provide the best possible service to everyone in Scotland and support an inclusive workplace culture' (website accessed 28 June 2021). There are a number of resources on the platform.

We asked respondents if they had ever accessed the Turas Equality and Diversity Zone. Of the 319 staff who responded to this question 80% (n=256) had never accessed this.

Barriers to accessing training

We asked staff if they had experienced any barriers in accessing equalities training over the previous two years, which 86% (n=271) said they had. The most common barrier identified was lack of time to undertake the training. That was closely followed by a lack of opportunity and the fact that Equality and Diversity training is not promoted within the Health board, so staff were unaware that it was offered, what was on offer or how to book it. Some respondents

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[4] Turas is the Gaelic word for journey

felt this type of training was not relevant to their role and others simply said they had made no attempt to access it. The impact of the Covid-19 pandemic on services was mentioned, however given that the question pertained to the previous two year period, it would seem that these barriers predated the Covid pandemic.

Gaps in training

We asked staff if they felt there were any gaps in the Equality and Diversity training which is currently offered and 70% of the 300 respondents felt there were.

On further examination the main training gaps identified by staff were in relation to:

- hidden disabilities
- inequalities in mental health related to gender and ethnicity
- gender identity and transgender specific training, including awareness training around pronouns to avoid mis-gendering patients
- unconscious bias training
- asylum seekers and the specific difficulties they face
- travelling communities and the difficulties they face
- sign language and accessing interpreting services
- how to adjust and adapt psychological therapy services to make them more culturally responsive
- how to promote inclusivity in your service
- reflections from those with lived experience from an ethnically diverse background.

The lack of depth of training available

A common theme which emerged was that there was an over-reliance on training on Equalities and Diversity via an electronic module delivered on a platform called Learn Pro NHS which is widely used in the NHS in Scotland. The module was very often described as basic and too brief and therefore not able to provide enough depth in this complex area. With no opportunity to measure understanding or implementation, this potentially contributes to a gap between training and practical application.

There was a suggestion that a workshop format would create an opportunity for an open and safe place where staff feel comfortable asking sensitive questions without causing offence with the possibility for open discussion and challenge.

Some respondents commented that much of the equality and diversity training is 'one off' and optional, whereas mandatory training and refresher sessions would reinforce the importance of gaining cultural competence. Additionally they reflected that currently any further Equality and Diversity training is provided and promoted by those who have an interest and similarly taken up by those who have an interest, meaning that those who would benefit most from the

training, can easily avoid it. Others felt there was limited opportunity and availability and a clear lack of advertisement and promotion of what training is available.

There was a view that Equality and Diversity champions within health boards, could take a more prominent role as currently many staff do not know much about them or are unclear on their role.

One particular staff member felt that Equality and Diversity training is so poor, they had actually learned more about their own biases and areas for development in this area from social media, rather than any training course. There was also a feeling that there are huge gaps in training about how mental disorders present and are regarded in different cultures, and how these cultural factors impinge on care and treatment, risk misdiagnosis and perpetuate unequal access to care and treatment. There was recognition that universities need to review their training programmes to ensure graduates are equipped to meet the cultural needs of their patients on entry to employment within health services.

Cultural competence - Patient resources, information and feedback

We asked staff if they knew how to access various resources for patients and carers whose first language is not English, as well as if they seek feedback on the experience of patients/carers and whether there were any other services that are available.

Figure 4.3 shows that of those who answered the question, 76% knew where to access translated leaflets, 56% knew where to access human rights information for those who don't understand English, 33% reported that the service they worked for actively seek experiential feedback from patients/carers that can be stratified by ethnicity. Of 271 respondents who answered the fourth question, 26% reported that their health board have other types of patient/carer services catering for people from ethnically diverse communities.

Figure 4.3. Accessing resources and seeking patient/carer views
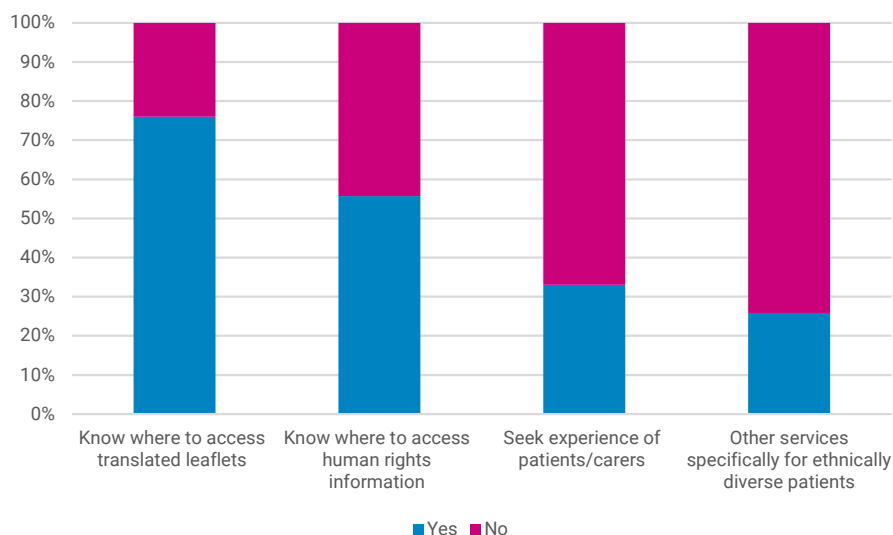
The number of respondents to these four questions were 317, 314, 312 and 271.

Figure 4.4 shows that the percentage of staff who knew where to access translated leaflets was similar across health boards, with the exception of Tayside where the proportion was higher than any other board. On the other three questions there were some variations between boards.

Figure 4.4. Accessing resources and seeking views, by health board[a]
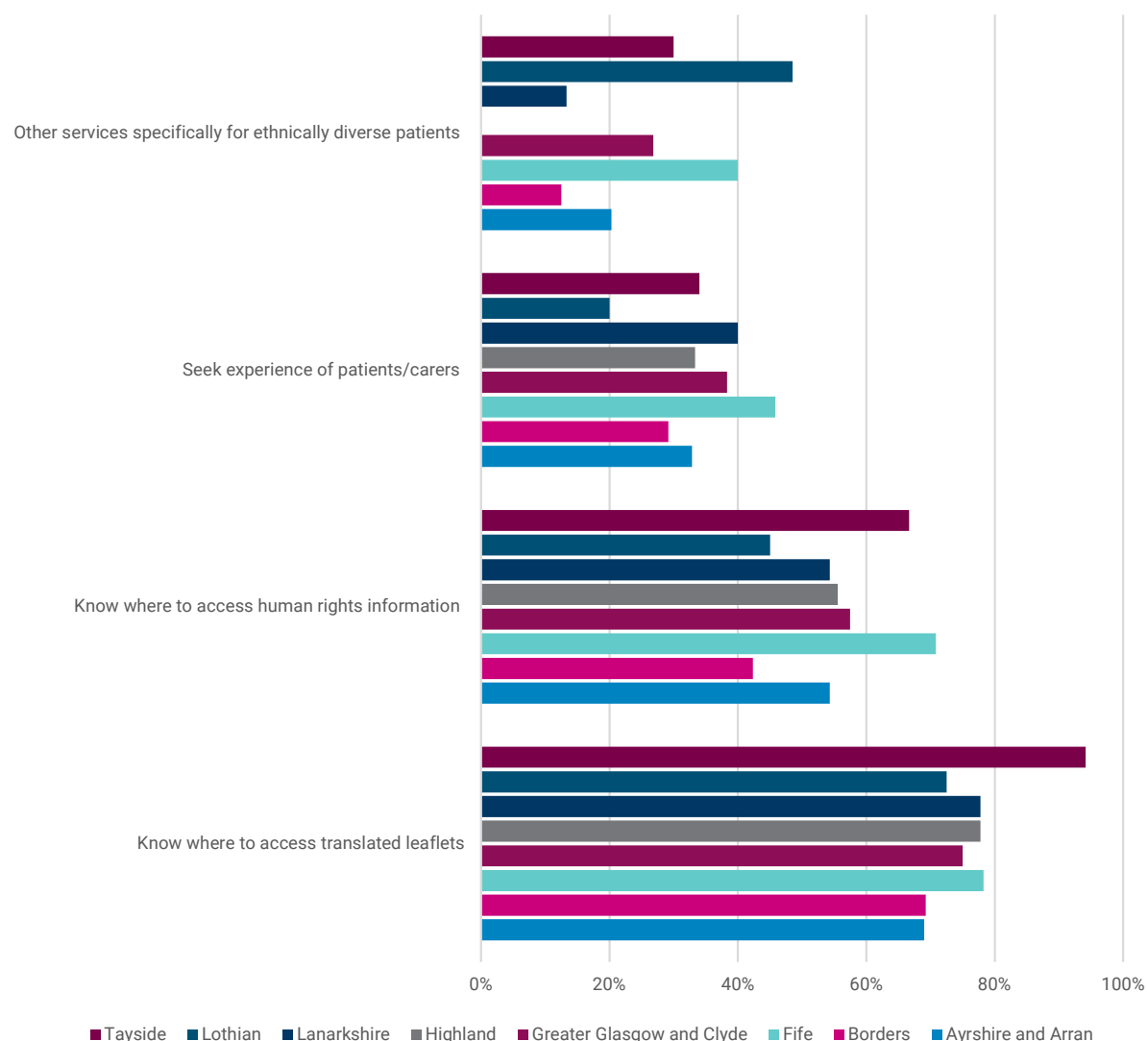
[a]Orkney, Shetland, State Hospital and Western Isles n<5 so not presented here (n=8). Note: The total number or respondents for these our questions were 304, 302, 299 and 259.

102 survey participants described in free text comments their experience of what was collected in terms of feedback from people using the service, stratified by ethnicity and what the barriers to doing this might be. Some of these responses were confirming that their service does not do this. We found that although in the survey 33% of staff reported that there was data collection on service feedback stratified by ethnicity in the free-text comments, respondents either reported that they collected feedback but did not say whether it was stratified, or reported that they did not know if it was possible to stratify feedback.

Meeting the needs of people from diverse communities

We asked whether staff felt that the team or ward in which they worked met the cultural needs of people from ethnically diverse backgrounds. 75% felt that they did. While the response to the question above suggests that overall the mental health workforce feels that their wards and teams would be able to meet the needs of people from diverse backgrounds, it is concerning that 25% of staff did not.

We asked survey respondents to tell us how equipped they felt in meeting the cultural needs of patients and carers from ethnically diverse backgrounds and what the barriers were to feeling equipped. There were over 300 comments in response to this question. The most common themes that emerged included:

- Low numbers of patients from ethnically diverse backgrounds and therefore lack of ability to develop competence.

- Language (where the first language is not English) as a barrier to engagement and an idea of meeting the needs that is limited to the ability to engage and obtain translation services or an interpreter. However, we heard that this can be especially difficult to do in rural and remote areas of Scotland.

- Sometimes people would approach colleagues from different backgrounds and discuss and learn from them in what seemed from the comments a genuine sense of respectfully wanting to learn.

A few comments referenced how staff had undertaken personal learning in this area as there was little in the way of learning from the boards as the Equality and Diversity module didn't appear helpful for this activity. There were also comments from staff who themselves came from BME backgrounds and felt more confident in ensuring delivery of culturally sensitive and competent services and comments from those who felt that it was unhelpful that even basic needs around diet are often not adequately met. And finally, there were comments from individuals who referenced that they felt competent but that this learning came from their work in other countries which they then applied in Scotland (England, Australia, New Zealand, South Africa and Botswana).

What would help to meet needs?

We then asked, what would help to overcome barriers and make you, the team or the ward more culturally competent. The responses generated were aggregated into common responses. The ideas generated were:

- Ethnicity and diversity workers embedded in every clinical team, who would be a contact or Equality and Diversity 'Champion'.

- Information about locally relevant services, for example a list or database of contacts, religious groups, community groups or local services who could be approached for advice, support or input.

- Provision of information about cultural, religious beliefs or practices that may prevent people from help-seeking via the NHS and advice on how services can become more culturally sensitive.

- Improved resources which provide a guide for cultural issues patients may face within mental health services, including better information on culturally sensitive end of life care.

- Culturally sensitive advocacy and perhaps organisations comprising of people who have lived experience of the barriers and cultural needs of different groups.

- Training delivered by people from ethnically diverse backgrounds and / or lived experience.

- More diversity in the mental health workforce.

- Improved access to competent interpreting services.

- Agreed national mandatory training standards with an increased focus on face to face training.

- Services being better equipped to meet cultural needs – safe place to pray, access to a range of spiritual support, better dietary provision, strategies for obtaining feedback.

Culturally competent advocacy services

We asked participants for their opinion on how culturally competent they feel mental health advocacy services are. We incorporated this question specifically in the light of the review of the English Mental Health Act in which one of the proposals that emerged was culturally specific advocacy services [48]. The respondents were mostly unable to comment on this question.

Activities aimed at improving the mental health of people from ethnically diverse backgrounds

We asked if respondents were aware of either activities within the health board or organised by third sector organisations to improve the mental health of people from ethnically diverse backgrounds. Nine percent were aware of activities within the health board and 38% were aware of specific activities organised by third sector organisations.

Figure 4.5. Awareness of specific activities to improve mental health (n=306)
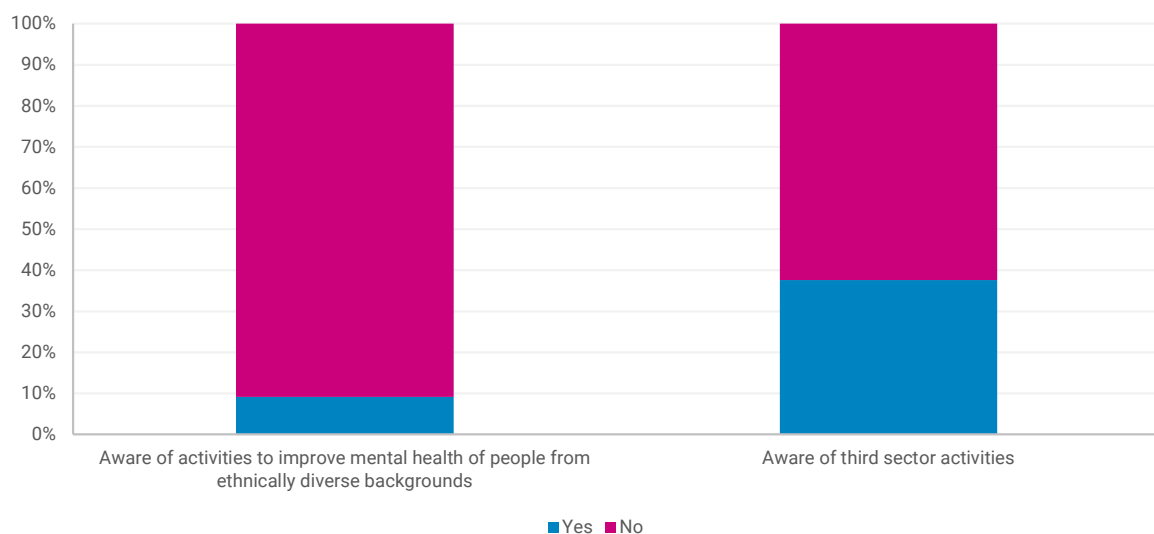
In terms of activities led by the respective health board, respondents did not report much knowledge of any specific activities that the health board was undertaking.

When asked if they were aware of any external third sector agencies which offer support to people from diverse communities, our survey respondents showed very little awareness of these third sector groups across all health boards. Where there was awareness, there had been little engagement and the occasional referral to the service. There was a sense of a lack of joint working or opportunities to engage. However, engagement through outreach sessions could lead to change e.g., a respondent from Greater Glasgow and Clyde described undertaking a teaching session in Urdu on Autism leading to translation of materials on the subject into Urdu.

Interpreters

We asked staff whether they knew how to access interpreter services for patients who need it. Of the individuals who answered the question 88% (n=310) knew how to access interpreter services for planned appointments while 60% knew how to access it for unplanned or crisis appointments. The comments suggest that practitioners were generally satisfied with interpretation services. There were comments that suggested that it can sometimes be difficult to organise meetings however there were no major concerns or suggestions for how services might improve interpretation services that are on offer. There was a suggestion that perhaps if interpreter services received some basic mental health illness and assessment training then it may make the process more meaningful and more accurately support staff to assess and treat those patients who for them, English is not their first language.

Collecting ethnicity data

We asked staff if data on ethnicity of individuals accessing services is collected routinely. Overall, 269 people responded to this question and 36% of them reported that data is collected routinely. This differed between health boards and a lower percentage than average of staff in Ayrshire and Arran and the Borders reported that data is collected routinely (29% and 17%, respectively). Figure 4.4 illustrates these responses however it should be borne in mind that only 84% of respondents answered this question, so it may well be that this information is routinely collected, however the respondents are not aware of these processes so the figures may not paint an accurate representation.

Figure 4.6. Routine collection of ethnicity data (n=269)[a]
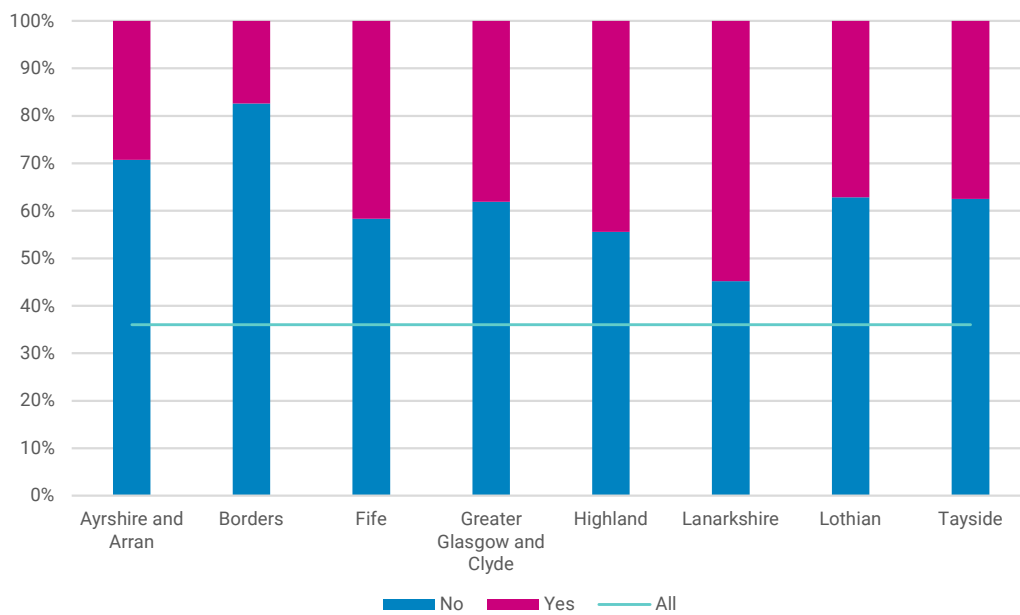
[a]*Island boards (n=8) not included*

We then asked if respondents answered yes to data being collected, could they tell us where this data can be accessed by staff and / or the public and how it is used to inform services. The free text responses to these questions showed that these respondents knew that the data was collected and was meant to be inputted onto records (electronic records like EMIS, TRAK, DAISY, etc) however there was a sense of confusion about whose responsibility it was to fill this, and how it was completed. There was a sense that government collected this data but it was unclear why. Ownership of this data was not clear with little understanding of how it was fed back to staff working in wards and teams.

Experience of/witness to racism in the mental health workforce

We asked respondents if they had ever experienced or witnessed any racial discrimination or hate crime in the course of their work, either involving patients, staff or themselves (Figure 4.7). Almost a third of respondents reported that they had seen racism or discrimination in the workplace. Ninety people provided further details of what they had experienced. Eighty five of these had indicated that they had seen and/or experienced racism at work. Of the 85 who had provided further details in free-text written comments, 78 were white Scottish (n= 61) or white British (n=14) and they came from all the larger health boards as shown below (in figure 4.8).

Figure 4.7. Experience of racism or discrimination (n=311)
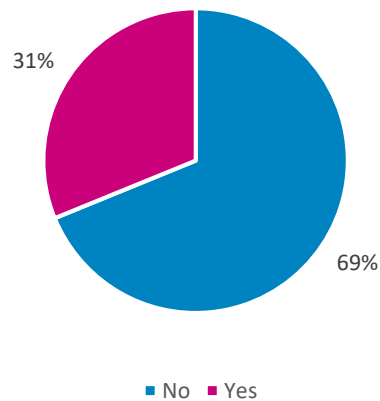
Figure 4.8 Experience of racism by health board (numbers of staff by Board)
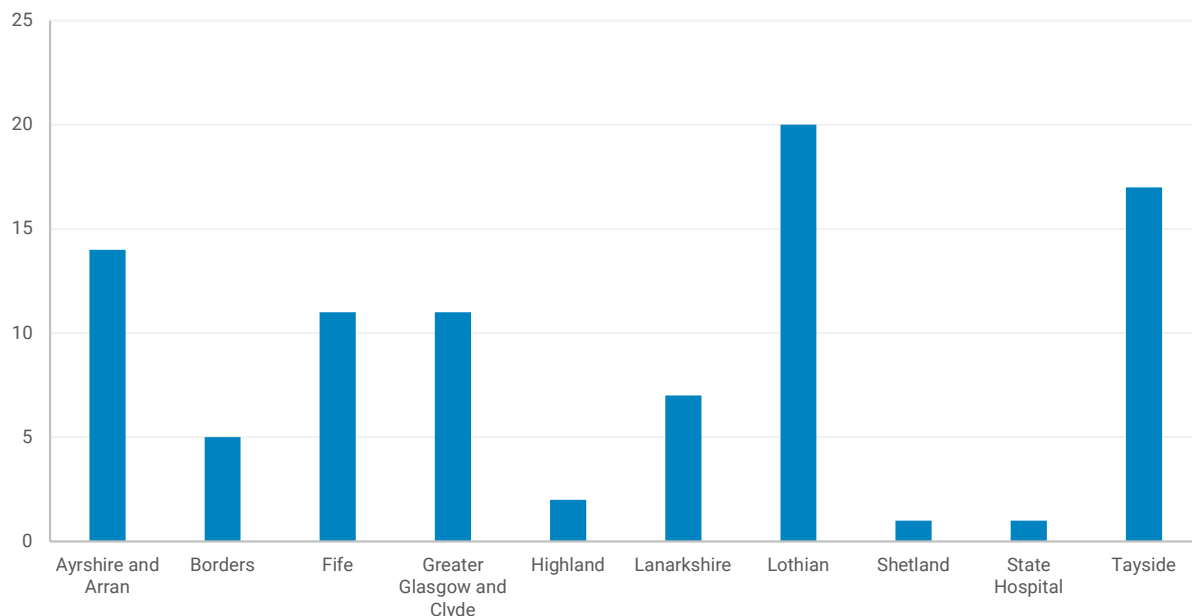
Most of the free text comments described patients being racist to staff members. 53 comments specifically mentioned that it was a patient being racist towards staff. 10 commented specifically that the incident was not dealt with. There were comments describing patients being sectarian or xenophobic towards other patients. There were five comments that described anti-English sentiment (4 of these came from white: other British respondents). There were isolated comments where people spoke about caste based racism between colleagues that they had observed and racist remarks towards patients. There were two instances of racist comments reported that were directed towards a patient who also had another protected characteristic (a disability, an older adult).

The narrative that emerged is that there is racism on our wards and in our teams. Much of this is from patients towards staff and that it often goes unreported by the staff, and when it is reported, there is often no action taken with one respondent lamenting – "no organisational support to challenge it and no police support to prosecute it."

In other cases, comments indicated that staff take a strong approach to tackling this issue and there is often support. However, the net effect of this inconsistency, that appears dependent on the team and the leadership in the health board, is that staff often don't know what to do to tackle this issue.

Staff who responded to the survey described how they felt unhappy to see racist comments directed at their colleagues but found that sometimes the doctors did not pursue this (this was also acknowledged by a doctor as illustrated in the quote below), at other times there was no response from the service, and if the police were involved, that did not proceed either, sometimes due to perceptions that the person lacked insight. The cost of this unaddressed racism is high. One doctor reported that they left their post because of it.

"Mostly from patients towards doctors, this is generally when the person is unwell and has no insight however at times this has been due to being unhappy with doctors' assessment/decisions. Patients have commented on the colour of their skin/ethnicity stating they do not know what they are doing and making reference to them originating from another country. I have also witnessed patients racially discriminate other patients again this had been due to being unwell and no insight. However staff will intervene and inform patients this will not be tolerated. If it was felt the person had insight police would be called." (senior charge nurse, health board B)

"I have witnessed frequent racial abuse directed towards Black/Asian/Irish and female staff with little/no reaction by police when reported. I have also witnessed service users being verbally and physically assaulted by other service users and visitors." (charge nurse, health board C)

"Racist comments from patients and prejudiced comments from colleagues. These are generally very brief encounters and it's hard to articulate why I didn't take action or seek support. The most common response if you even hint that what they said was inappropriate is the "I didn't mean that type comment." (consultant psychiatrist, health board A)

Staff forums and champions

Figure 4.9 reflects the responses to whether respondents were aware if their Health board had a BAME Staff Forum and an Equality and Human Rights Team/Champion.

Figure 4.9. BAME staff forum and Equalities and Human rights team/champion (n=287)
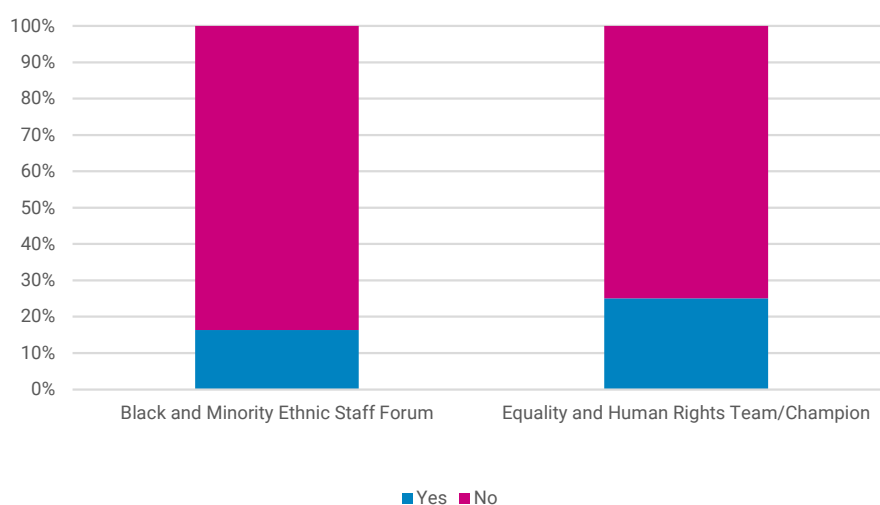
Other challenges

A common theme which emerged was an anxiety among staff that they may say the 'wrong thing', particular difficulties in rural and remote settings, a lack of diversity of senior staff in health boards, including at executive level, feeling helpless when working with asylum seekers. We also heard from some people about a sense of frustration regarding the extra time, resources, knowledge that fully assessing the cultural needs of patients, either with or without the use of an interpreter:

> *"Staff just have to add it to the endless ever growing list of things they have to do to deliver safe, effective and patient centred care."*
>
> *"It can be draining, stressful and resource intensive to work with interpreters, refugees and asylum seekers as Western concepts and sayings don't translate well."*

Seeing providing care to those from an ethnic minority background as an inconvenience is discriminatory. There was also a sense that some developments were viewed with skepticism and cynicism, such as a BAME forums and Equality and Diversity Champions only being tick box exercises and there were also comments in which the staff members said they did not believe that there was an issue and 'don't see what the fuss is about', declaring that they treat all patients the same, regardless of race or cultural background.

On a positive note, some staff commented that time is taken to discuss and explore a patient's cultural needs on admission to their service and others reported that there is usually good outcomes for care delivery. Others who belong to culturally diverse backgrounds spoke passionately about how this lived experience has helped them understand the cultural barriers which exist. One staff member commented warmly that they have gained a rich understanding of many cultures and religions and learned so much from patients they had worked with over the years. They identify, quite simply, that curiosity has been fundamental in developing a shared understanding of the individual, their cultural needs and how their ethnicity impacts on their illness, care and treatment.

Equality and Diversity Leads Survey

We sent a survey to all 15 EDLs within each health board and received a return from each of the 15 boards.

Training

We asked the 15 EDLs which of the following equality and diversity training specific to ethnicity and/or racism is offered across their health board. Figure 4.10 illustrates the responses.

Figure 4.10 Training available in responding health boards
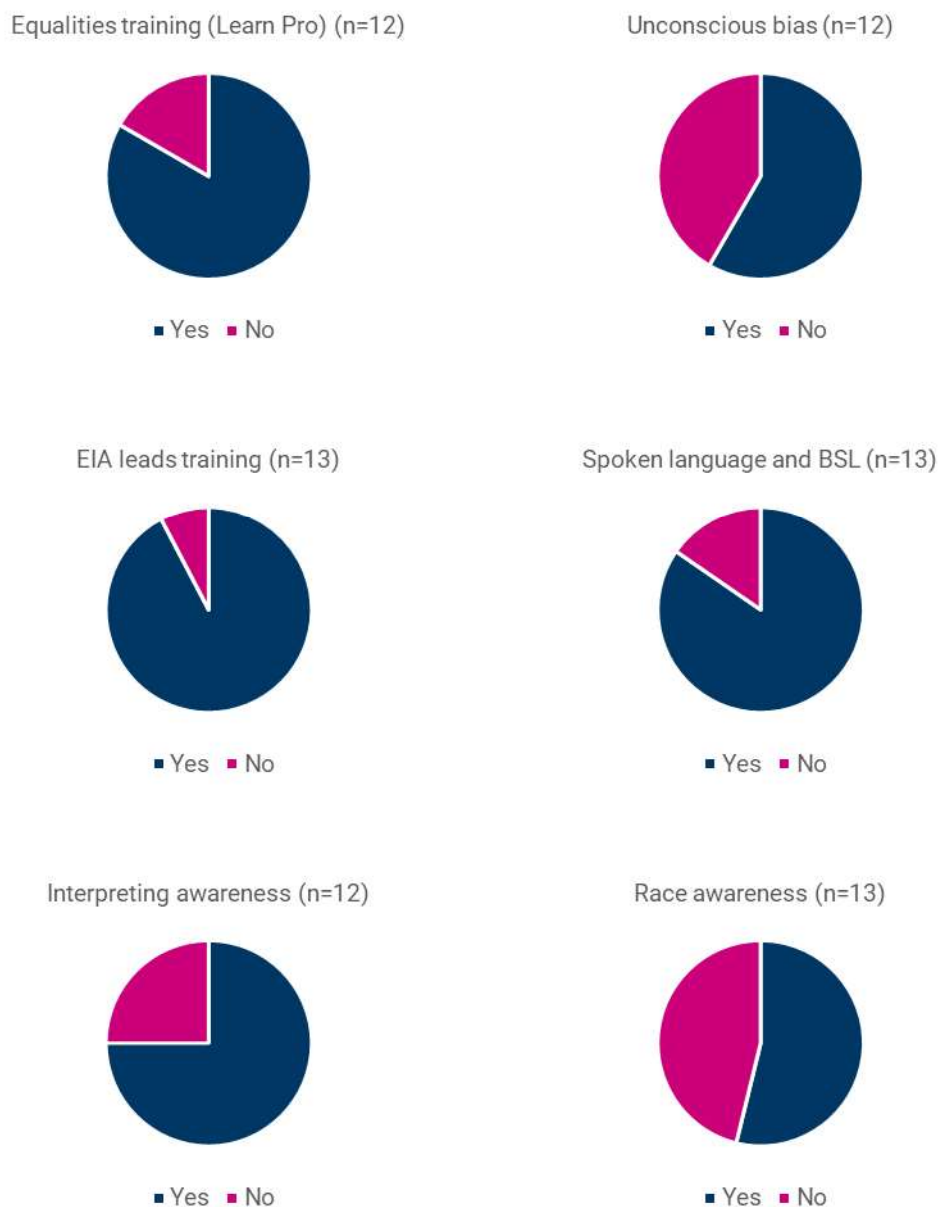
Other training available, aside from those in Figure 4.10, was reported by 14 health boards. We asked EDLs what percentage of their teams had received training. Most could not stratify

this to the level of mental health teams but were able to report this in terms of overall numbers for staff across their health board. These varied from 70% in one heath board to 96% in Greater Glasgow and Clyde that was also able to report this for mental health services specifically. (90.6%). Some reported that it should be 100% but did not provide the detail of what it actually is. Most health boards affirmed that this training is primarily based on what is contained within the Learn Pro module on Equalities and Diversity. There are some Health boards that offer classroom based unconscious bias training but the majority rely on the Learn-Pro module.

Mandatory training

We asked about following completion of the training (usually the learn-pro module), what was the approach to refresher training and are there any associated measures of this. Four leads were not sure at this time what the approach to refresher training was, three responded that between 83% and 90% complete refresher training, three responded that the training is completed once without refresher training, one said the training is valid for five years, one estimated refresher training to be completed by 25–30% and another lead estimated it to 64%. There is no shared policy or approach to refresher training.

Figure 4.11. Training that is mandatory within health boards
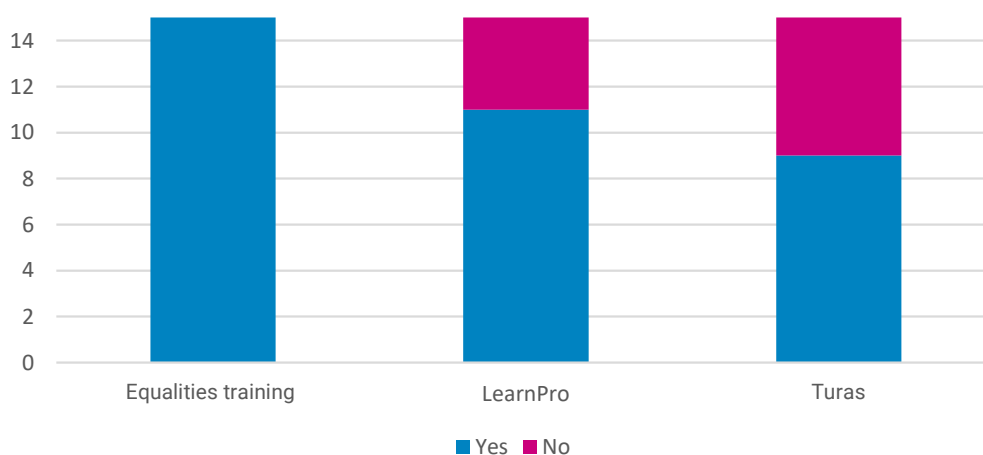
Barriers and measures of impact

Barriers

We asked EDLs what are the barriers to staff undertaking equality and diversity training and what measures are in place to know if any of this training is making a difference. Leads described barriers as a lack of time (n=8), a lack of prioritisation (n= 5) (once the mandatory module is completed further work is not prioritised by the staff member or the organisation); staff shortages (n=2). One Lead reported that the lack of diversity makes this less of a priority.

One Lead described a poor choice of courses available as a barrier. One also described a lack of understanding about the importance of this activity that led to staff and the organisation de-prioritising all but the essential mandatory module on equalities.

Impact

In terms of impact, only two health boards described an evaluation mechanism to note how well the training was working/what impact it was having. NHS Grampian had surveyed a sample of people who had attended Equality and Diversity and showed that 16% had been able to put what they had learned into practice and challenge inappropriate comments or behaviour from colleagues, patients and carers.

Greater Glasgow and Clyde suggested that they had built-in processing of the statutory/mandatory module to get monthly feedback to say if it has improved staff understanding, which is reviewed on a regular basis to see if the module is delivering what it is designed to. Three health boards said they had no formal mechanisms to know if the training made a difference.

One health board described how broadly speaking most staff equalities networks, including the BME network, had described dissatisfaction with the training that is currently provided.

One health board suggested the generic mechanism iMatter, would pick up concerns if the training was not working. iMatter is the NHS Scotland staff experience continuous improvement tool, developed nationally, and used within all NHS Scotland Boards and is designed to help individuals, teams, Directorates/HSCPs and Boards, understand and improve staff experience. By interrogating iMatter responses, in tandem with collecting patient feedback, and monitoring for whistleblowing, there was a suggestion that concerns would be sufficiently picked up this way. We were surprised by this suggestion that patient feedback forms would highlight the success or otherwise of the training, as we had not found, as part of this piece of work, any health board collecting routine patient feedback data stratified by ethnicity.

One health board reported feedback was 'anecdotal' but cited that they do not get many complaints related to equalities and diversity.

Information and feedback

We asked about what sort of information health boards collect in relation to patients' experience of services. We were assured to see that all health boards were able to source information (patient and carer leaflets) in other languages (Figure 4.12).

We asked the question if services in their health board seek experiential feedback (such as patient satisfaction surveys) from patients and carers stratified for those from an ethnically diverse background. All health boards reported that they collected patient feedback however none of the health boards had an ethnic identifier so that they might be able to stratify and understand better if there were particular issues from any of the diverse communities that they might serve. One health board said adding such a layer of stratification might be a barrier to engagement. One health board said although they do not collect information stratified by ethnicity they do liaise with external third sector organisations who work with diverse groups to gather feedback through this mechanism.

Figure 4.12. Information and experiences
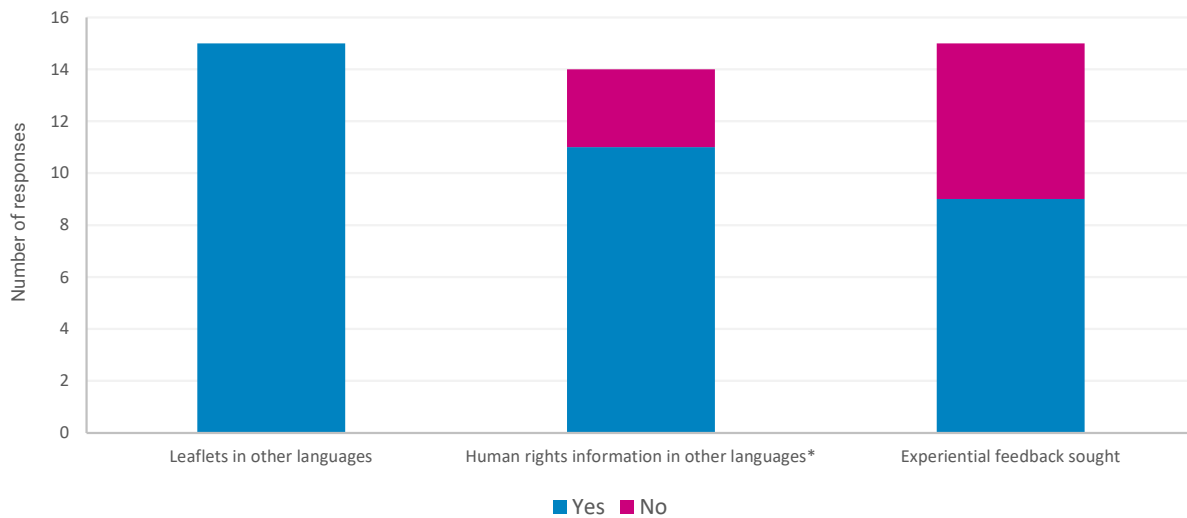
* No response from Borders

Specific services

We asked whether the health board has any patient and carer services that cater specifically to people from ethnically diverse communities. Nine suggested that the health board had specific services and six said they did not. Eleven of the 15 respondents provided free-text comments to provide more detail about the specific services that they have for people from diverse communities or why they did not.

Three leads reported that the specific services they offered were spiritual care and/or a multi-faith room.

One health board, Lothian, described a Minority Ethnic Health Inclusion Service (MEHIS) that works in partnership with BME communities to tackle BME health inequalities, facilitate health promotion and screening to improve the health status of BME communities.

Greater Glasgow and Clyde mentioned that the Equality Act requires that services should not be segregated on the grounds of race so unless there was a specific reason to work with a group to understand their needs more, before embedding into mainstream services, they would ensure mainstreaming of services.

We were told that in Ayrshire there is a coordinator for the resettlement programmes who supports those who have come to Scotland and resettled in Ayrshire. Ayrshire also made reference to their interpreter services. Two further boards mentioned their translation and interpretation services. Two boards specifically referenced organisations that they are partners with that do work with BME communities.

Perception of cultural competence

Most leads felt that their mental health services were moderately culturally competent (Figure 4.13). They saw advocacy and interpreter services as more competent than the mental health services within their health board.

Figure 4.13. Perception of cultural competency within services
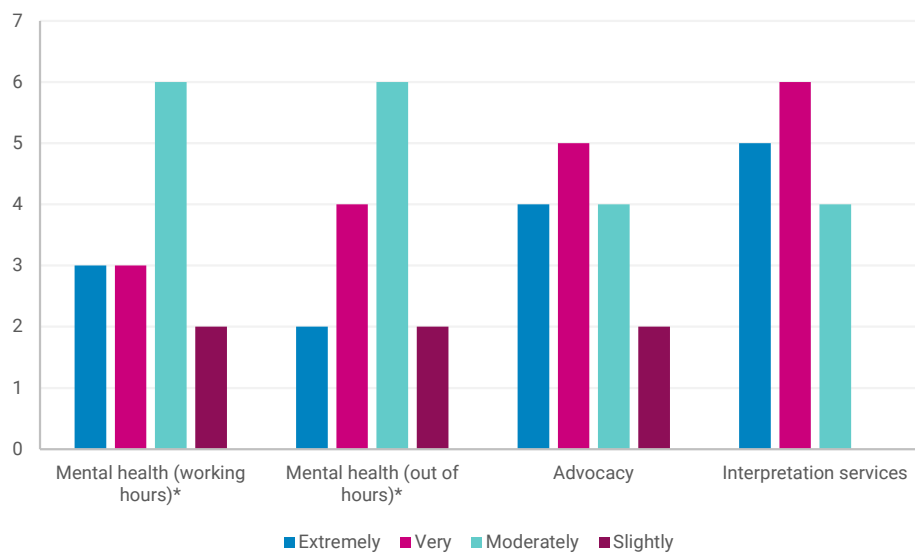
Missing responses from Fife

We asked the leads what the barriers are, if any, in delivering culturally competent services. Six leads did not comment. Of those who responded, two said there were no barriers at all. Others reported a lack of awareness, a lack of appropriate training and a lack of data.

One lead wrote in rich detail on what they saw as a multiplicity of interacting barriers and sometimes poor experience from those from diverse backgrounds using the service leading to or reinforcing a lack of trust in Euro-centric models of care. One lead wrote of the lack of representation from all communities in the health board they are the lead for and the lack of diversity at the senior most levels.

Activities to improve mental health of diverse communities

Ten EDLs reported that they were undertaking specific activities to improve mental health for people from diverse backgrounds. However one board said activities to improve health are not for any one group. Others did not provide any detail (n=4) and one said that as there were not enough people from diverse communities this was not a current focus. Three health boards provided detail on specific activities that are being undertaken. In Lothian, a corporate level objective is hoped to lead to change:

"A Corporate Objective on addressing racism and other forms of discrimination (to be approved by Board April 2021) - based on promoting conversations between senior leaders and Staff Network members, pairs and groups, leading to reverse mentoring and paired learning. A support for this approach within Royal Edinburgh and Associated Services, and our HSCP partners. This work is intended to bring change for our staff, our patients, and our role in civic society."

In Greater Glasgow and Clyde the experience was that:

> *"Our Lead Associate Medical Director for Mental Health set up a group, called the Ethnicity Expert Panel, at the end of 2020 to review and create an action plan for improving BME communities' experience and use of NHS Greater Glasgow and Clyde MH services. This group made up of mental health staff, third sector experts, a non-exec Board member, the Board's Equality and Human Rights Team and the Chief Officer for Glasgow City HSCP is driving an action plan to implement change."*

Like Lothian, Greater Glasgow and Clyde also described Reverse Mentoring:

> *"The Organisational Development Department are also looking to develop a reverse mentoring scheme for BME staff to support them in their posts as ethnic monitory staff".*

Ayrshire and Arran also provided details of a plan with HSCPs to fund specific training for 2-3 practitioners working in primary care aimed at increasing cultural needs and care provision. Funding is being sought for this from the Asylum, Migration and Integration Fund.

Engagement with third sector organisations

The degree of engagement and when expertise might be sought and how varied significantly between health boards. Many health boards actually described named organisations that they are working with. One health board EDL suggested that they access third sector for what they described as "Faith related input - Muslim patients", whereas another described a more structured approach and mentioned a regional equality council that had been agreed as a partner agency for race. Lothian mentioned how the pandemic and the need to ensure vaccination access to all communities had led to stronger engagement with multiple third sector organisations working with diverse communities. Other health boards described a reasonably similar model of commissioning or working with the third sector through regional equality councils. We were interested in the approach that Greater Glasgow and Clyde health board are considering in understanding and listing the third sector organisations who might support people they work with regardless of whether they are commissioned by them or not.

> *"Our Expert Panel on BME issues in MH has suggested an audit of all third sector organisation who provide such support – these are external to the NHS and not procured by us."*

Collecting and monitoring of information

We asked if mental health services within the health boards routinely collect and monitor race and ethnicity in relation to local population demographics and those accessing mental health services. Eleven out of the 15 EDLs told us they do and four reported that they do not.

We then asked those that do, how this is analysed, reported and used to inform services. We received 11 responses and one other response providing additional information. Although most of the responses described the process whereby all demographic information which is

collected, is collated, held and published by ISD for NHS Scotland and can be accessed at any time via a Freedom of Information request, we have already established earlier in this report that health services are poor at collecting feedback data that can be stratified.

BME staff networks

Eleven health boards confirmed they have a BAME staff forum, with the other four advising that they do not. Nine out of the 15 reported that they have an Equality and Human Rights Champion, with six reporting they do not.

Comparing this information to the responses we received from the staff working within mental health services it was evident that a relatively few number of staff have awareness of any BAME staff forum within their health board. Table 4.3 illustrates the number and percentage of staff who responded to our survey who had this awareness.

Table 4.3. Awareness of BAME staff forum

Health board with a BAME forum	Staff responses (n)	Number of staff aware of a forum	% of staff
NHS Greater Glasgow and Clyde	48	5	10%
NHS Lothian	40	16	40%
NHS Lanarkshire	36	8	22%
NHS Tayside	51	9	18%
NHS Ayrshire and Arran	71	3	4%
NHS Fife	26	2	1%
NHS Borders	26	2	1%
NHS Grampian	0	0	
NHS Orkney	1	0	0%

The amount of staff who had knowledge of the Equality and Human Rights Champion was equally poor. Only 13% (n=18) of respondents from the four health boards (NHS Greater Glasgow and Clyde, Lothian, Tayside and Orkney) that have an Equality and Human Rights Champions knew this to be the case. Conversely, 44 staff from the other health boards who did not have an Equality and Human Rights Champion erroneously told us that they did.

Challenges and other comments

We asked the EDLs if they could identify any other barriers or perceived challenges in delivering safe, effective and patient centred care to patients from an ethnically diverse background. Four mentioned the small size of their boards and lack of diversity within the patients they serve. Conversely two leads from larger health boards identified the extreme diversity in their areas with one commenting that over 100 languages are spoken within schools in their health board and that service staff profile does not match the population, meaning that so much about diverse cultures and the impact this has on family life and mental health is misunderstood.

One lead spoke about societal attitudes leading to an increase in xenophobia and racism, which has been even more evident post Brexit vote. One lead mentioned the recent increase in migrant workers and asylum seekers in their area and the importance of ensuring they and their families registered with a GP and linked into NHS Healthcare services and were not 'lost' to the system.

There was a widely held view between leads that it is fundamental that the EDL is appropriately graded to ensure they have the necessary budget and have access to the Board of Directors and other senior level committees. In some health boards it seems that the Equality and Diversity Lead can have little budget and can be powerless to affect change and improvements.

EDLs suggested that a mandatory generic one off equalities courses is meaningless if staff cannot relate them to their jobs. They suggested perhaps a specific suite of training that addresses mental health and ethnicity could be created and completed every two years. Staff should be asked to evidence their ongoing understanding of equalities. The training could cover the basics but also focus on attitudes, barriers and reluctance to use services and challenge staff with regards to their own attitudes and practices. By doing so the aspiration should be to *"build a reservoir of knowledge, rather than a single very deep pool."*

One lead suggested that this area requires to be explored at different levels. They go on to say that we talk about 'institutionalised racism' in organisations, but we must recognise that staff are trained and accredited by universities and professional bodies, so cultural/social competence has to be embedded at the beginning, not just an add on post qualification and by the health board.

At organisational level, the role of equality impact assessment is key. Ethnically diverse communities are often 'unseen' as they are perceived to 'not access services.' If services are not reflective of their needs, then reluctance to engage with them is completely understandable. Care plans could also be audited to assess if they are culturally competent.

Lastly there was a commonly held view that there needs to be better links, liaison and engagement with ethnically diverse communities and religious groups when producing mental health strategies, service design and delivery to ensure we seek to understand the needs of people and that the voices of those from an ethnically diverse community are heard.

What this means

Among mental health staff, 70% felt that the training currently on offer (largely the Learn Pro module) has gaps. Most EDLs feel that staff are moderately competent. This does not reflect the excellence in cultural competence that Scottish Government has aspired for our NHS. The Scottish Government commissioned CRER to develop a resource on race equality training. This key resource was set to be sent to all public sector bodies in April 2021 [49].

Most training on equalities is through short online modules. However CRER have reported that this modality of training particularly fails to change behaviours in white men [49].

There is no uniform approach to refresher training. Given that staff may remain with a board for many years, society is changing, and that e-modules do not have a great evidence on changing attitudes we find that the current situation needs remedied, with clear refresher dates being signposted as part of a new suite of training offer.

Our survey respondents demonstrated, through their comments, that the majority evaluate cultural competence in the more direct, tangible way as evidenced by their sense of the need to acquire knowledge of cultures and have interpreters readily available. This view of cultural competence is in keeping with what is seen in other parts of the developed world and in other services [47]. This is a much narrower formulation than the concept of cultural humility.

Having said that, engagement with the third sector (commissioned and non-commissioned organisations) is high on the list of what staff and leads think will help to build cultural competency. This sense of a need to build bridges and competence through an increased use of the third sector organisations that work with people from diverse ethnic backgrounds also came through from our chapter on the lived experience of people who have mental illness and identify as being from a minority ethnic community.

We note the high level of racism reported within the mental health sector towards staff. Our finding is not an isolated one. A Royal College of Psychiatrists survey from September 2020 showed that nearly 60% of psychiatrists from BAME backgrounds report being the victim of overt or covert racist incidents and only 29% said that the incident was reported. [50].

Similarly our survey respondents indicated that incidents are often unreported and if reported there appears to be a lack of clarity on how to respond, particularly with reference to police involvement

We also note the high-cost these instances can extract with one person saying that they left their job because of unaddressed racism.

We noted the comments that some staff had made that they do not see why there is a need for any of this as they treat all people the same. Whilst we presume these statements are well meant, they again do not appear to appreciate that inequalities in healthcare related to ethnicity *do* exist and if staff and services do not first realise this, then it will be almost impossible for these inequalities to be addressed and remedied. Another response was critical of their health board for creating a BAME forum stating "why would we be interested in segregating blacks by setting up forums for blacks? This is not a route I feel to be healthy." This particular quote was blunt and perfectly captured the amount of work required in this particular area.

It is important to note that in Scotland's mental health service framework, there are some instances of exemplary practice into cross-cultural care that both recognises that we are on a journey towards anti-discriminatory practice and yet aims at the highest possible standards and recognises that we are all at different skills levels. The NES Perinatal Mental Health curricular framework [15] might serve as a model that other areas of mental health might wish to emulate and consider as part of their curriculum development- spread across competencies aimed at reducing stigma, preventing discrimination and promoting anti-discriminatory practices, the framework sets out skills at different stages of development from 'informed' at the most basic level to 'specialist'. We did not evaluate how this has been used in practice.

Whilst we advocate the improvements that are needed to the training and retraining that is on offer, we agree with the comments made by one of the leads that this is not simply the duty of health boards, but professional bodies have a role here too to ensure their members are culturally competent. We would extend this to wider society and say that it is the responsibility of our educational and cultural leaders to promote the sort of values that we want in Scotland.

We also agree with and endorse the recommendations of the Covid-19 Expert Reference Group on Ethnicity on the need for 'change in the cultural landscape' that includes change to the 'curriculum for excellence' to include slavery, empire and colonialism and to consider how

to address the built environment in a way that demonstrates a commitment to an anti-racist Scotland.

Recommendations

To health boards (with support from health and social care partnerships)

- Ensure that their wards and teams have accessible information on the local and national organisations that provide support and information to people from ethnically diverse backgrounds who access their services. Compile a list of organisations that provide input to diverse communities and/or share regional lists between neighbouring health board ethnic diversity lead officers (EDLs) by September 2022.

- Mental health services in each health board should develop a bespoke programme of engagement meetings with those third sector organisations that meet their local needs to develop trust and reduce barriers to service use by people from minority ethnic communities.

- Consider adding demographic variables to patient/people who use services in the community and family/carer feedback forms so that they can collect feedback according to these to ensure and demonstrate that they are receiving feedback from all communities who use their services

- Promote the availability of a black and minority ethnic forum (BME) (if one exists for the health board) and promote its purpose to all staff. Ensure staff have a clear understanding of the role and availability of the equality and human rights champion within their area, if applicable.

- Review protocols for dealing with racially motivated incidents involving people who use services with the health board's black and minority ethnic (BME) network or in the absence of such a network with representativeness from people from diverse ethnic backgrounds. Ensure appropriate reporting and support for the victims of racism, and escalation processes by September 2022.

To Scottish Government

- Mandate the appropriate health regulatory body or forum in Scotland to score progression on employee diversity and inclusion by September 2022

- Commission the development of a new module on diversity training for the public sector. Invite the Coalition for Race Equality and Rights who were commissioned by Scottish Government to publish standards for anti-racist training (published in April 2021) to review any new module on this.

Chapter 5 − Race Equality in the Mental Health Workforce

Key findings

- Staff representation and progression is not only important to deliver on the fair society we would like to live in, but it is also vital to transform cultures, reduce inertia in tackling racial inequalities, and ensure that actions and culture changes takes place at the highest level. The Public Sector Equalities Duties include duties to report on workforce ethnicity and staff grades by ethnicity. However our project came across challenges when we sought to use this data to build a picture of workforce progression and representation within mental health services specifically.

- Asking for the data at health board level may not lead to any ownership of any problems at the service/ward/team levels where patient interaction occurs. Data stratification by visible minorities and by mental health service to build a national picture was not possible for many health boards due to either an inability to stratify, or due to the small numbers of staff at each grade that would make them identifiable. NES did not hold this data at this level. Three health boards did provide data and we are grateful to NHS Greater Glasgow and Clyde, Tayside and Borders for recognising the importance of developing a national picture for mental health services and providing information.

- There is differential attainment in nursing staff grade attainment. Using an approach from earlier work in NHS Lothian we found that for white nursing staff, 35% progressed to band 6 and above, but for black nursing staff this was 23%.

- Data from the Royal College of Psychiatrists in 2020 showed 16% of the Membership in Scotland is from a visible minority however only 5% of their Fellows (an award to mark significant contribution to Psychiatry) are from a minority background compared to White colleagues who make up 75% of the membership and 89% of the Fellows.

- Scottish Social Services Council data from 2019 shows that 25% of MHOs do not report their ethnicity. From the returns that it has, the SSSC report that 1.4% of MHOs are from ethnic minority backgrounds.

- The Ethnicity of the membership of the MHTS was not formally recorded at its inception in 2005.

Background

We recognise that race equality is an issue that requires the support of everyone in every sector of society in Scotland, a view expressed in the Ministerial foreword to the recent Race Equality Action Plan [9] along with a call to unpick the systemic discrimination which perpetuates racial inequality.

As the public sector body with the duty to uphold and promote the principles of the Mental Health Act we are particularly concerned to ensure that any systemic discrimination and racial inequality within mental health services is addressed.

The Race Equality Framework (REF) 2016-2030 makes clear that people from all communities should have participation and representation at all levels in keeping with population norms. Participation and representation are vital if we are to build a fair society.

We wanted to ascertain whether mental health services and professions that work in mental health services (in health boards) were representative of the populations that they served and whether staff from different races were represented proportionally at all levels.

In recognition of the role that the Mental Health Tribunal for Scotland plays in ensuring justice in the care and treatment of people with mental illness who may require compulsory care we also wanted to understand how representative the MHTS was as part of its approach to issues around Equality, Diversity and Inclusion.

Under the Public Sector Equalities Duties (PSED), listed authorities with more than 20 staff, must gather information on the composition of its employees for reporting on staff- as well as their recruitment, development and retention, all broken down by relevant characteristic and then publish this every second year. Every four years they should report on the ethnicity pay gap. At the same time, authorities must publish information on any occupational segregation among employees including the concentration in particular grades, and particular occupations of staff.

We considered that data on representation should be easily available. To understand progression we were keen to replicate a study [51] that described the lack of progression in the work place for nurses from minority ethnic backgrounds in NHS Lothian. In 2013, NHS Lothian became concerned that BAME nurses seemed under-represented at senior grades. They surveyed their staff and found that of 500 BAME nurses only 12 had progressed beyond the lower grades whereas if their attainment had been the same as their non-BAME counterparts 150 should have progressed. Dr. Ima Jackson writes that this reflects an experience familiar to migrant nurses that they might be 'hyper-visible' in their physical presence but 'invisible' in the organisational structure [51].

We considered that data from the PSED exercise ought to make it possible to easily replicate this study across mental health services in Scotland to determine whether there was a race-related attainment gap.

This work

We asked all heath boards to provide us with the extent to which the diversity of the organisation was representative of the population it served, the diversity of the Executive Board, the data stratified by grade and occupation (so that we could see evidence of workforce progression) and we asked that this was stratified for the mental health workforce and its senior leadership team in each health board.

We started with this broad request and narrowed it to the mental health sector to demonstrate how the Commission was trying to use existing data-sets to further the area that it had locus to ask for detail and report on.

We received a full response from all health boards to the request for data, as it was in line with the PSED reporting, but the different approaches taken by health boards to providing the data made it very difficult to build a national picture. Some of the smallest island health boards were unable to stratify for mental health services as staff members would become identifiable

and one mainland health board said that they did not 'single-out' mental health staff which is where we wished to focus.

It was clear that the data from PSED that we thought would make this easy to address would not meet our question.

We confirmed with NES that the level of stratification we were asking for is not available to NES as the Boards are not required to provide this level of detail to them. We had anticipated that the national body responsible for workforce data would hold this information.

We revised our plan and decided to focus on the professionals who make up the largest numbers of front-facing staff from mental health services: nursing staff and medical staff and sought to replicate research carried out in Lothian in 2013 [51].

We therefore asked health boards to provide us just the details of nursing and medical staff stratified by grade and ethnicity in a prescribed format in order to build a national picture of the extent of the differential attainment gap in the front-facing aspects of the mental health workforce (if any). This format is reproduced below with the data from health boards that supplied us this. We were clear that we would not report numbers less than five and in order to protect identities and to provide confidence of this we undertook to share the findings of the report and the analysis prior to publication. However, most health boards declined to participate on the basis of protecting staff anonymity or non-availability of the data at the level of mental health services.

With this limited data set, exploring representativeness in the mental health services in Scotland was not meaningful.

In order to explore progression, we adopted a similar methodology to Lothian and report the percentage of nursing staff at band 5 and below and band 6 and above by ethnicity. Only three health boards were able to provide the data required to do this. We are grateful to NHS Borders, Greater Glasgow and Clyde and Tayside for working with us to report this.

Table 5.1 shows the distribution of nursing and medical staff across grades by group. Table 5.2 shows the distribution of nursing staff by grades (band 5 and below; band 6 and above) by ethnicity.

For medics, of White medics (n=265), 62% were consultants, 20% were non consultant non training grades, and 17% were trainee psychiatrists. Of non-White medics (n=65), 46% were consultants, 30% were non consultant non training grades, and 24% were trainee psychiatrists. A smaller proportion of people from communities of colour were in consultant grades and more were in non-consultant-non-training grades.

Table 5.1 Number of mental health staff by professional grade and ethnicity in NHS Borders, Greater Glasgow and Clyde, Tayside

	White	Non-white				Prefer not to say/ unknown
		Total non-white	Asian	Black	Other	
Nursing						
Band 2	33	0	-	-	-	5
Band 3	987	22	*	10	9	319
Band 4	29	0	-	-	-	7
Band 5	1182	47	10	29	8	303
Band 6	817	15	*	5	5	122
Band 7	283	6	-	*	*	47
Band 8+	74	0	-	-	-	15
Other	-	0	-	-	-	-
Medical						
Consultant	159 (62%)	30 (46%)	26	*	*	44
Training Grade	45 (17%)	16 (24%)	9	*	*	39
Other	52 (20%)	19 (30%)	15	*	*	26

White includes: White Scottish, White Other British, White Other, Polish, Irish, Gypsy/Traveller; Asian includes: /Scottish Asian/Asian British; Black includes: Black/Caribbean/Scottish Black/Black-African/Black British

Table 5.2. Ethnicity of staff nurses (as percentages) by grade in NHS Borders, Greater Glasgow and Clyde, and Tayside

	Ethnicity				
	White	Non-white			
AfC grade		Total non-white	Black	Asian	Other
<Band 5	65%	77%	80%	75%	70%
>Band 6	35%	23%	20%	25%	30%

What this means

In Chapter 4, we described how staff and EDLs mentioned the lack of diversity in senior leadership. In this chapter we use health board data to demonstrate an attainment gap. The work also indicated to us that the data is not presented in this way to staff in services, i.e. a way that intuitively demonstrates this attainment gap.

The data remains abstract and therefore makes it less likely for representation and progression to be visible. Health boards were unable or felt it was not appropriate or potentially breached confidentiality to provide us the data we requested.

Carol Young of the Coalition for Race Equality and Rights (CRER), a strategic anti-racist organisation in Scotland, describes how the PSED approach has the potential to deliver transformative change however they find that although the information is collected, the extent to which it is used is poor. This can lead to a sense of despair for those working in the equalities sector. She writes:

> *The essential truth is that in most cases, current 'good practice' activities in Scotland's public sector are mostly procedural and focus on outputs rather than outcomes. The refusal to properly evaluate and monitor work intended to tackle racial inequality is part of a pattern of institutional racism which deliberately swerves the hard tasks by focusing on celebrating diversity and 'building capacity' in communities which already have plenty* [52].

As the approach we took did not allow us to comment on workforce progression in the way we had anticipated we approached professional bodies and organisations to understand whether they held data on representation and progression within their membership data.

Data from the Royal College of Psychiatrists in Scotland in November 2020 suggests that its membership of 1387 psychiatrists has 16% members who are people of colour. However only 5% of the Fellows of the Scottish College (an honorary title awarded by the UK College to reflect a significant contribution to psychiatry) are people of colour compared to White colleagues who make up 75% of the membership but 89% of the Fellows. However, we were informed by the College that the Fellowship process requires a member to have been so, for over ten years. It was explained that it is for the members to put themselves forward to seek the role of Fellow and that, as this is likelier to be the older segment of the membership, this group represents the diversity of the College 10-20 years previously.

Unlike psychiatrists, where the proportion of doctors from an ethnic minority is greater than the population level diversity, for MHOs, the proportion of those identifying as an ethnic minority is lower. Data from SSSC on the MHO workforce shows that in 2019 only 1.4% of the MHO workforce was from a minority ethnic background. Further stratification is not available. It is important to note that 25% of MHOs did not provide information on their ethnicity [53].

Another key institution in the mental health sector in Scotland is the Mental Health Tribunal for Scotland (MHTS) that exists to provide judicial determination of applications made to it in relation to compulsory care and treatment. The MHTS advised us that ethnicity of membership (general members, conveners, and medical members) was not formally recorded at its inception in 2005 however steps have been taken to ensure diversity data is now recorded and that it is considered in further recruitment initiatives.

We note that in 2020, the mental health charity Mind recommended that it be obligatory, where appropriate, for membership of the Mental Health Review Tribunal (the equivalent body that operates in England) to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.[28].

Recommendations

To the Scottish Government

- Provide NES the mandate to require and collate data from health boards by specific directorates as well as by grade and ethnicity to be able to support efforts to reduce systemic inequalities and racial inequity and to be able to identify more clearly in which directorates there may be diversity and inequality in progression issues and successes by March 2022.

To the Royal College of Psychiatrists in Scotland

- Explore the potential reasons behind the lower proportion of Fellows from psychiatrists from communities of colour in Scotland by September 2022.

To the Mental Health Tribunal for Scotland

- Record and publish the ethnic breakdown of its membership by September 2022.

- Take steps to address any gaps in representativeness and diversity of its membership to meet population norms.

To the SSSC

- Take steps to improve the returns on self-reported ethnicity of the MHO workforce for the annual census reports. Describe within the next census report what steps are being taken to increase the diversity of the mental health officer workforce to match the diversity of the population it serves.

Chapter 6 − Incorporating and Improving Routine Reporting of Ethnicity

Key findings

- Collecting information about individuals' ethnicity is challenging and our various sources of data are incomplete and there are gaps we need to fill to improve upon our recording of ethnicity in our work and outputs.

- Within detentions made under the Mental Health Act over the last 10 years we have ethnicity recorded for 84%.

- Missing information for detentions vary by the type of detention. On average 9% of detentions have completely missing information (form blank, not returned, or error within system) and for 8% ethnicity is 'not provided'.

- In a survey of psychiatrists and hospital record staff we found that there was a lack of clarity as to who should complete ethnicity forms in relation to a detention.

- Psychiatrists also told us that it can be difficult to ask a person who is acutely distressed about their ethnicity and they highlighted that this can be a barrier to get the information recorded

- Within our own visiting activities ethnicity was not recorded for an average of 7.8% of visits. After a change of the system our most recent visiting year unfortunately had 64% where no ethnicity was recorded. We will learn from this change and we will ensure improvement for our next visiting year.

Background

Collection of information related to people's ethnicity, and other protected characteristics, is key to address inequalities within areas such as health, care and treatment. Research by the Scottish Government has shown that while a priority for public sector organisations, the collection and use of equalities data varies between organisations in Scotland [54]. Along with other public sector organisations, the Commission strives to fulfil its responsibilities under the Equalities Act 2010 and a way to do that is to collect information about ethnicity in the many areas of our work.

Ethnicity data is however not always complete in other jurisdictions too. For the 2019-20 data reported for England, ethnicity was recorded for 85% of the detentions that occurred that year [55].[5]

Our work

The Commission has set out in the equality outcomes and mainstreaming progress report [56] to carry out visits that take equalities issues into account. One of the mental health action points of the equalities report was to improve completion rates of equalities monitoring forms.

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[5] The report included detentions under section 2 and 3 of the Mental Health Act 1983, short-term detention orders, and community treatment orders.

We reported on this in 2021 with updates on protected characteristics of individuals we visited [57]. As part of our updated equalities report we noted difficulties with getting complete data on ethnicity. In this chapter we:

- look at how complete the recording of ethnicity is in the Commission's data, how and where we collect information on ethnicity;

- explore difficulties in ensuring completeness of data completed externally;

- explore how we have reported on ethnicity over time;

- identify gaps in collection of ethnicity data; and

- suggest solutions and identify improvements to be made to the collection of ethnicity data both internally and externally.

Ethnicity recording and reporting

Detentions under the Mental Health Act

The Commission has a duty under the Mental Health Act to report on how the legislation is used and to ensure that the law is followed in a way that treats all people fairly.

In Chapter 1 we noted the process for obtaining information about ethnicity when a person is detained. As we also noted in that chapter, over a 10-year-period we were able to find complete ethnicity information for 84% of people. For the Criminal Procedure Act we could only find complete information for 54%.

Data on ethnicity for detentions has issues with two types of missing information: i) the information is missing altogether, and ii) information not provided. When information is missing completely, this is because no ethnicity form was filled out, that the form has not been returned, or an error has occurred within our own system. When information is 'not provided', this is actively indicated on the form as the person either did not or could not provide their ethnicity, or it was not possible to complete the information.

Figure 6.1 shows that there is variation on percentage of detentions where information is missing or not provided depending on the order.[6] The orders with the most missing were S200 Committal (60%), S57(2)(a) Compulsion Order (Community) (50%), S57(2)(a) Compulsion Order (44%), and S59 CORO (44%). It is worth noting that the total number of S200 and S57(2)(a) was less than 10 for the entire time period. The difference in 'not provided' was smaller, with an overall of 8% across the 10 years and all orders.

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[6] This data relates to an analysis of detentions under the Mental Health Act between 2010-11 and 2020-21. This is described in more detail in Chapter 1.

Figure 6.1. Ethnicity missing and not provided, by order type (2010-11 to 2020-21)
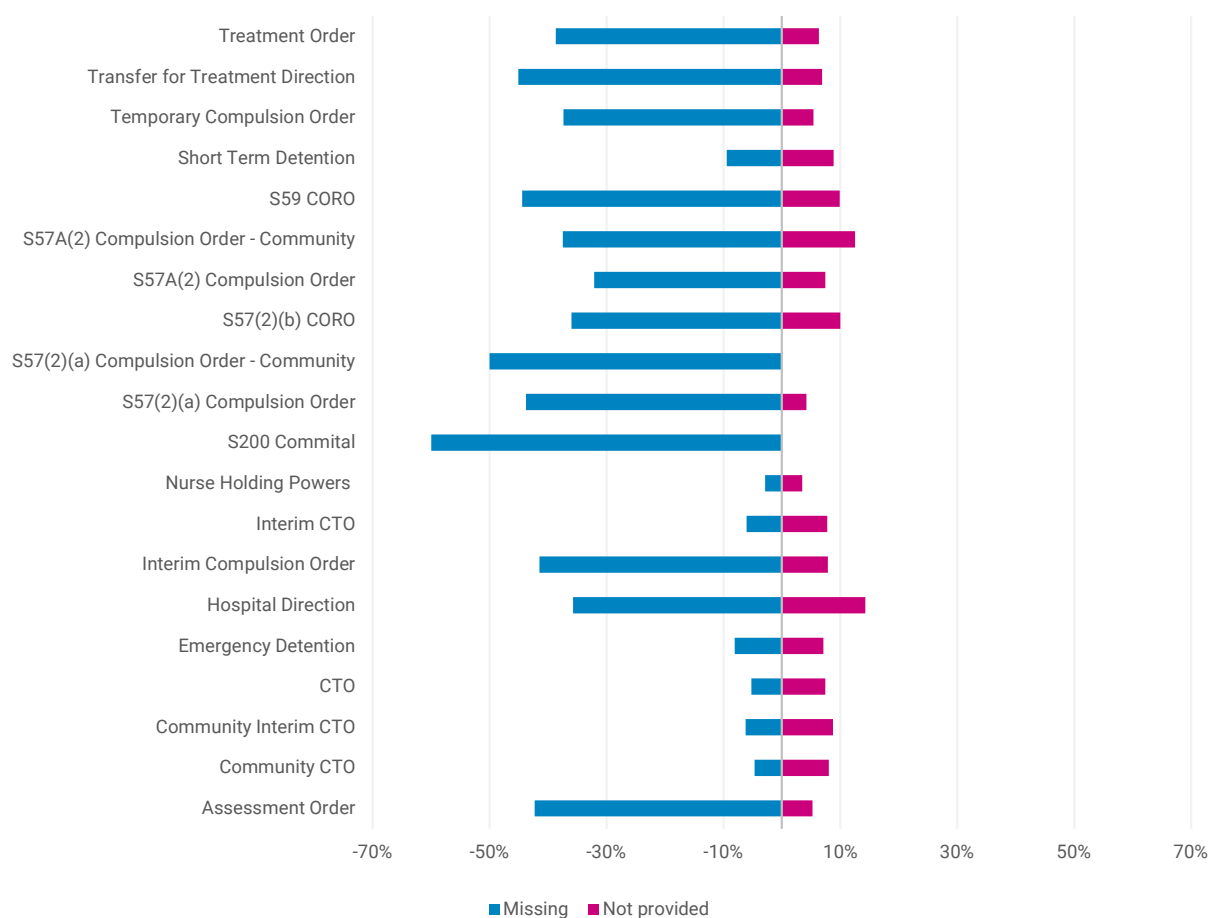
Collecting information in practice

The Commission's visiting activities

The completion of ethnicity recording has been set out as a clear objective in the *Equality outcomes and mainstreaming progress report* and is reliant on the Commission's practitioners completing equalities monitoring forms when undertaking local or themed visits.

In the most recent visiting year (pre-Covid-19), 2019-20, we did a total of 1,363 visits, for which we had some information entered onto our system for 497 visits. Of these, 4% were from an ethnic minority background. Seven of these forms were "Ethnicity not provided", which was 0.5% of all visits. Overall, however ethnicity was not recorded on 64% of the visits that took place in this year, a lot higher than previous years. We have reported on our completion of ethnicity in our visiting activities in our *Equalities Mainstreaming Report* [57].

In our Equalities report we describe how we have changed the way we record ethnicity, which led to a greater gap in recorded information. Looking at our published themed visits reports and guardianship visits reports from 2015 to 2020 we presented a breakdown of the ethnicity of the people we visited in five of our 15 reports. The Commission has more work to do in order to ensure that our staff complete ethnicity recording and ensuring that we report it in our work.

Completing information for people who are subject to compulsory powers

While the collection of ethnicity information is related to the Commission's own work visiting people subject to welfare guardianships or as part of its themed visit work, for detention data external stakeholders play a large part in collecting this information. We therefore wanted to get a better understanding of what the barriers or gaps to collecting information about an individual's ethnicity are when they are being detained.

To get an understanding of this we created two online surveys. One was sent to psychiatrists, who fill out the detention forms when an individual is being detained, and one to hospital administrators, who process the forms psychiatrists fill out. Drafts of the survey were shared with a small number of practicing psychiatrists and hospital record staff to ensure the included questions were relevant and did not miss any important information.

The survey was shared via email list server for hospital records staff and through the Royal College of Psychiatrists' newsletter for psychiatrists. We received a total of 128 responses (110 psychiatrists and 18 hospital medical records staff). A summary of respondents is provided in Appendix A.

Perceived difficulty and importance of asking about people's ethnicity

About one in five psychiatrists (108 responses to the question) felt that asking patients about their ethnicity in relation to a detention was easy or very easy. Many felt that it was neither easy nor difficult (44%), while 25% felt it was difficult and 12% that it was very difficult.

We asked respondents to rate how important they feel it is to fill out the ethnicity form. Almost half (48%) felt that it is important or very important to fill out the information, 13% felt that it is somewhat important, and 39% that it is fairly important or not important

Frequency of detentions and filling out the form

Most of the respondents reported detaining patients monthly (46%) or quarterly (19%), with only 17% detaining patients weekly. Twelve respondents (11%) detained patients every six months and six (5%) yearly. One respondent left this question blank.

Figure 6.2 shows that about one in five respondents reported always or often asking patients about their ethnicity, while 53% asked the patient rarely or sometimes, and 27% reported never asking the patient. On the contrary, 56% reported always filling out the ethnicity form and 14% 'often' filled it out. Sixteen percent reported filling it out sometimes or rarely and 15% reported never filling it out.

Figure 6.2. Frequency of asking patient and filling out the ethnicity form
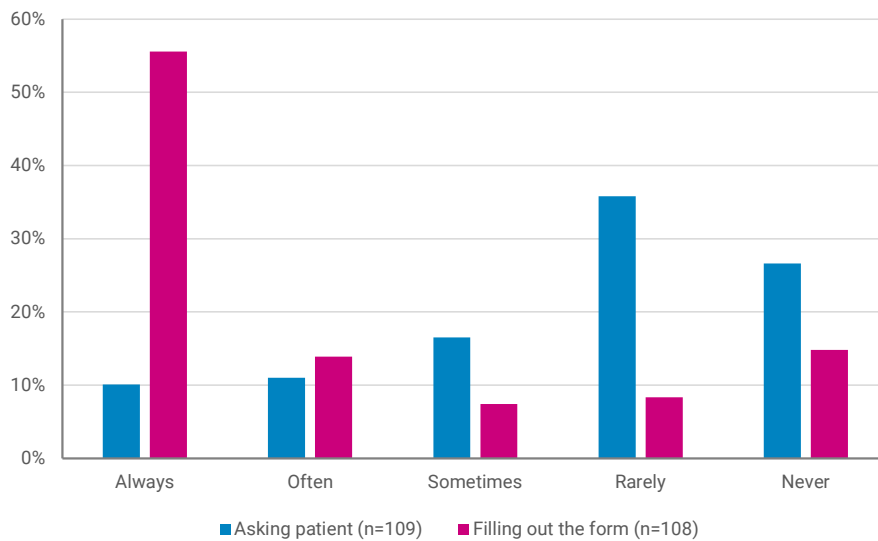
Hospital records staff reported that they process forms daily (72%) or weekly (17%), with one respondent reporting processing forms monthly and one less frequently than monthly. Only 17% responded that the ethnicity forms are always or very often returned to medical records. When returned, 39% reported that the information returned was incomplete always or very often.

Barriers or issues

We asked psychiatrists to tell us about what they perceive as barriers to get information about patients' ethnicity when they are being detained. Eighty one (74%) psychiatrists gave us details about this and all responses in this section relate to these. There were three main themes of responses: relationship and mental state, situational barriers, and related systems (Figure 6.3).

The most common theme was around relationship with the patient and the patient's mental state (81%). High levels of distress when being detained was a main reason why it is difficult to also ask about ethnicity. Psychiatrists told us that this did not always feel appropriate, specifically as it might make the patient more agitated (five responses).

> *"When people are being detained they are mentally unwell and often acutely distressed, upset or unable to think clearly. Asking about ethnicity seems a low priority at the time of detention. If I have not asked the patient directly, I mark 'info not available' as I do not want to make assumptions." (psychiatrist)*

Figure 6.3. Themes and topics related to barriers

Relationship and mental state	Systems	Situational barriers
Confusion/cognitive impairment/patients with learning difficulties	Did not know it was part of form/thought medical records or other staff completes it	No need as most patients are White/use other information to determine
Hostility of patient/lack of engagement	Doesn't feel relevant/serves no purpose	Forget in the moment/focusing on immediate issues
May affect rapport	No history available/"can't tell" what ethnicity patient is	Don't want to imply ethnicity is reason for detention
Some find question offensive/too contentious	Already know as part of patient history/gather from patient history/find information elsewhere	Adds to already busy workload/lack of time
Not appropriate – distress/mental state		Difficulty in defining ethnicity/acquire information

Twelve psychiatrists (15%) mentioned that sometimes they are already aware of the patient's ethnicity as part of their medical history. Only four explicitly said that no available history or not being able to "tell" what ethnicity a patient is was a barrier to recording this.

"I find the questions in this survey about asking about ethnicity at time of detention rather artificial. Regarding patients I detain, I will usually be aware of their ethnicity from information gathered previously or more occasionally in patients not known at the time of the assessment. Gaining a personal history is part of good psychiatric practice and this includes details of their birth and upbringing - so I have no need to specifically enquire about their ethnicity. I appreciate some patients' self-identified ethnicity may be complex or not clearly evident but for the vast majority of patients I see their ethnicity is obvious. The majority are White Scottish but also may be equally obvious from information known they may belong to another ethnic group e.g. Indian, Chinese, African." (psychiatrist)

A few psychiatrists (9%) noted that they did not know the ethnicity form was part of the detention paper work or they thought it was the responsibility of someone else to fill it out.

"I had always assumed it was role of MHO to complete demographic details in Mental Health Act detention documentation. There's not a clear division of roles sometimes, Mental Health Act paperwork is not intuitive." (Psychiatrist)

Another 9% told us that most of their patients are White (Scottish) and it is therefore not needed to ask specific questions about the patient's ethnicity. One psychiatrist told us this, but also that they would make sure to ask the patient in most situations so that the information was clear and accurate:

> *"If the patient's ethnicity is fairly obvious then I have on occasion not asked (e.g. White British). However, I do try to ensure that I have asked the patient, especially if there is any ambiguity in my mind." (Psychiatrist)*

As part of this question, one psychiatrist reflected on that despite being of a protected characteristic themselves they had not thought about these questions previously:

> *"I think it's incredibly important now it's being highlighted. I hadn't given much thought to it, interestingly as I have protected characteristics under the equality act myself." (psychiatrist)*

Practices around processing forms

We asked hospital records staff to tell us how they normally go about handling forms and what they do if information is missing. Responses varied, with some saying they do not do anything if ethnicity information is missing, some reported checking on the system, if information is available there and if not indicate 'information not provided' or leave it blank. Other responses included:

> *"Not a priority currently and do not chase up for information." (hospital records staff)*
>
> *"I don't do anything. I assume if the ethnicity is not completed it is because the patient is unable to give us the information." (hospital records staff)*
>
> *"I do nothing as it is ward responsibility." (hospital records staff)*

Views on completing ethnicity information

We asked psychiatrists for their views on the recording of ethnicity information. About half of respondents either agreed or strongly agreed that doctors need to get better at filling out the ethnicity information and 44% either agreed or strongly agreed that, doctors do not think this information is important (Figure 6.4). However, 76% agreed or strongly agreed that it is important to ensure information is returned to the Commission.

As already noted, some felt that completing the information is not part of their job – in total 17 psychiatrists agreed or strongly agreed that it was not their job to complete the information. In addition, 29 (27%) neither agreed nor disagreed with the statement, indicating that there might be some lack of clarity of roles in filling the forms out. A majority (73%) of psychiatrists told us that it is easy to forget to ask about ethnicity in the context of detention.

Figure 6.4. Psychiatrists' views on ethnicity recording
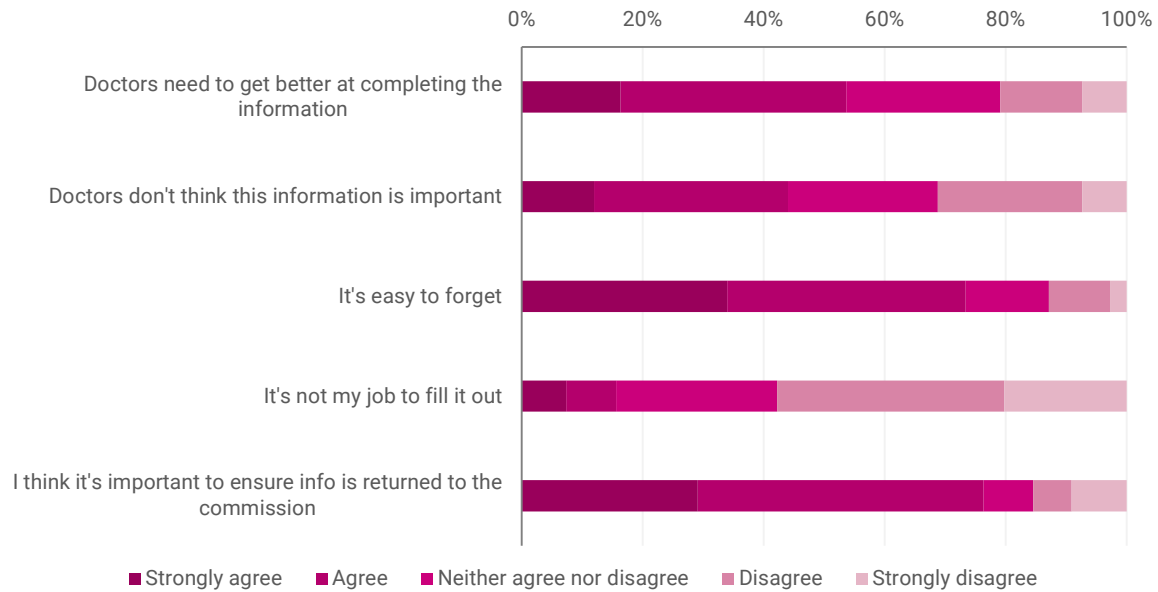
Most hospital records staff (82%) agreed or strongly agreed that doctors need to get better at completing the ethnicity information and 53% thought doctors might not think the information is important, which is why it is sometimes missing (Figure 6.5). The majority (76%) agreed or strongly agreed that it is not their job to complete missing ethnicity information. About one third (29%) disagreed or strongly disagreed that high workload prevents them from completing missing information, while 42% agreed and 29% neither agreed nor disagreed. About two thirds (65%) agreed or strongly agreed that they need to look up other information that is missing so looking up missing ethnicity information, if available, is not additional work while 12% disagreed with the statement.

Figure 6.5. Hospital record staff's views on ethnicity recording
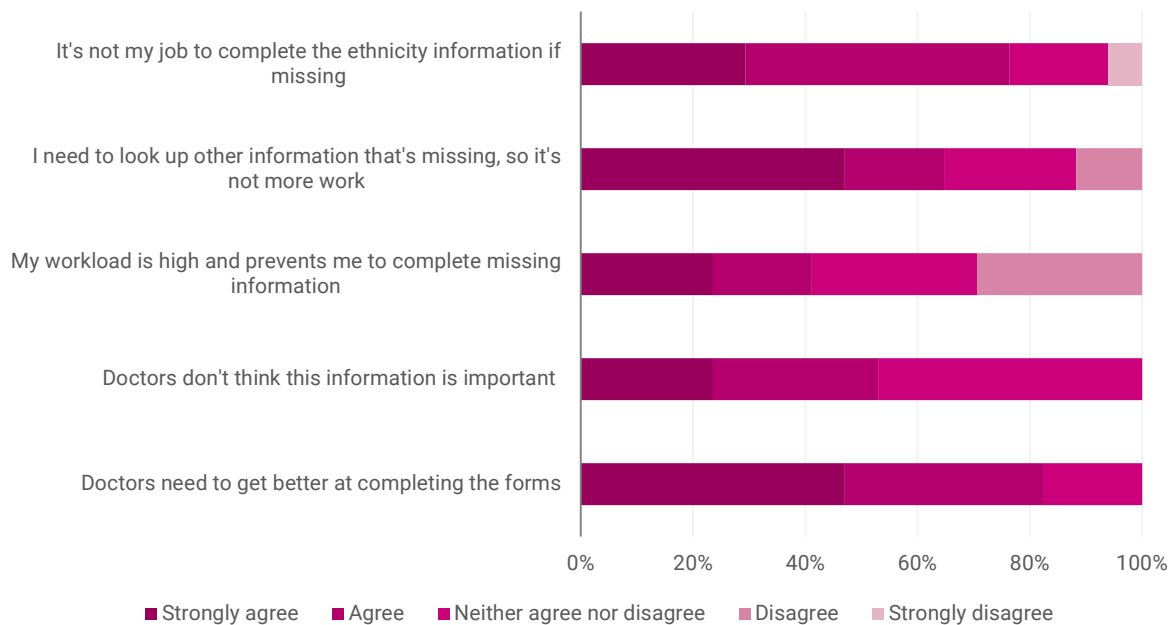
Other comments

We asked all respondents for any other information or views they had on the topic. Thirty eight psychiatrists gave us more information and some reiterated their comments from earlier in the questionnaire.

From the psychiatrist responses there were some common themes. Firstly, respondents told us that there is a need to look at the overall system and use information available elsewhere (e.g. TrakCare) to complete ethnicity information. Secondly, some felt that since the ethnicity form is at the back of the detention form it suggests it might not be important, while if it was at the very front it might get completed better. Thirdly, the information, if collected from the patient, is better collected at a later time when the patient is no longer acutely unwell and/or distressed. Finally, psychiatrists highlighted a need for awareness raising of the importance of collecting the information and the purpose and use of the information collected.

"I think we need to publicise to colleagues the reason for collecting this data is to check that we are meeting the needs of all ethnic groups, not to classify or play identity politics or chastise clinicians. Maybe also helpful to explain exactly where/how this information is recorded." (psychiatrist)

"I should add that I am from a minority ethnic group myself and I think this emphasises to me the importance of monitoring these issues. I would like my colleagues to appreciate the continued relevance of this." (psychiatrist)

One psychiatrist told us they did not believe that it is the role of statutory organisations to collect the information. Another told us that the issues with non-completion of ethnicity forms goes beyond the questions asked in the survey as defining ethnicity is complicated and self-definition by patients may not be accurate and may present issues if patient self-defines as something they are not.

Other comments from individual psychiatrists included that "During training the forms have always been described as optional and there has never been a push to complete them" and comments about the categories on the ethnicity form. One psychiatrist questioned why Scottish, Irish and Gypsy are part of the form but English and Welsh is not. Another told us that there "are subcontinents and discrete areas and then broad continents like Africa", which they felt is not representative of the patients in their practice.

From medical records there were a few comments on how things currently work and how things can improve. One suggestion was refresher training and reminders to doctors and nurses to get information completed before returning to medical records. One medical records staff told us "I find it frustrating when not completed". There was a suggestion to confirm or clarify that administrative staff can fill out information if it is missing on the returned form. Medical records staff, just like some psychiatrists, told us that moving the ethnicity form to a location in the overall detention form that brings attention to it might improve completion. It was also suggested to have a more simple form, which could "be completed with information readily available".

One respondent reported not being aware of the forms or where to get them. Other comments from respondents included:

"I don't see it as a clinician role primarily but it is more practical/streamlined for it to be done by the detaining doctor. I assume these details are collected for epidemiological/equality purposes and for that reason could be done by anyone involved in the process." (hospital records staff)

"I wasn't aware that I could complete the ethnicity section as there is no heading above to indicate who should complete it. Perhaps if it was headed to be completed by the approved medical practitioner (AMP) then more doctors would fill it in." (hospital records staff)

What this means

In our review of our own data and activities we have identified gaps in collection, recording and reporting of ethnicity. Through this project, however, we have worked with new methods to improve our completion of ethnicity data in our detention data. The work has also given us an opportunity to re-visit our commitments and work on our visits to ensure that we record ethnicity as well as other protected characteristics, which is part of our responsibilities under the Equality Act.

Through looking at our own work and practices we have identified gaps and areas of improvements to ensure that we report on and visit people from diverse backgrounds. While we have work to do to improve our own practice to ensure greater completion of ethnicity information, set out in our *Equality and Outcomes Mainstreaming Report* as a minimum target of 95%, this also requires collaboration with other stakeholders [57]. We acknowledge that some organisations may not be collecting information that would inform our work and aim to explore avenues for collaborating with them to improve this.

For the people we visited in the last reporting year, 4% were from an ethnic minority group. Considering our analysis in Chapter 1, which shows us that there is a slightly higher proportion of ethnic minority groups subject to the Act compared to the general population. We will need to do further work to ensure that we visit people from diverse backgrounds and that the proportion we visit from diverse backgrounds reflect the representation within these groups.

There are also gaps in our collection of data on policing and mental health that this work has spotlighted. For example, every health board in Scotland is required to maintain and update a psychiatric emergency plan (PEP) and under S297 of the mental health act, police have powers to remove someone they suspect may have a mental health difficulty and in need of immediate care to a place of safety. To date, there has been no exploration of whether there are differences in the way these powers are used across different ethnic groups in Scotland, and whether PEPs cater to the needs of all Scotland's communities. We note the recommendation from Dame Elish Angiolini in her policing review that HMICS, along with the appropriate health inspection or audit body, should conduct a review of the efficiency and effectiveness of the whole-system approach to mental health [58] and consider that data on the use of s297 powers and a review of how well PEPs meet the need of all communities informs this review that Scottish Government is progressing [59]

 While we, in this report, are focusing on ethnicity, there are other protected characteristics that we need to integrate and ensure we address in our work. This project has allowed us to also take a look at other information that we need to get better at recording and reporting.

This includes gender, but also social inequalities like homelessness which we have not been routinely recording. We are taking this opportunity that the Ethnically Diverse Project has presented to continue the work we set out in our regular monitoring of our commitments to equality.

Recommendations

To health boards (with support from health and social care partnerships)

- Address the incomplete returns on ethnicity for people who become subject to compulsory measures, ensuring that information for ethnicity recording can be collected at a time that is less likely to cause distress.

To NES

- Section 22 training should include discussion of the need to complete the form for ethnicity monitoring; and clearly state that the responsibility for this lies with the doctor assessing the patient from the next training session following the publication of this report.

To Scottish Government

- Ensure that categories that are used in ethnicity monitoring forms in the public sector and other health related gathering of information on ethnicity are in line with the Census categories.

- Consider including an ethnic identifier as part of the CHI index.

Chapter 7 – Conclusions

Our work shows racial inequalities in the mental health sector in Scotland.

We describe differences in the way that the Mental Health (Care and Treatment) Scotland Act (2003) and its safeguards are applied for different ethnic groups. We describe differences in how risk is perceived and reported for those who are detained and we consider what the implications of this might be. We make recommendations so that we can ascertain how people might be affected by this. For example, we make a recommendation for the establishment of a national register on the use of restraint and a recommendation to ensure that ethnicity is captured in data-sets that report access to psychological therapies. These are areas where data is lacking altogether currently.

In other areas, we are hampered by incomplete data and so we recommend that there is consideration of whether the CHI index should include an ethnic identifier to allow a complete collection of data and identify areas where we require to make progress.

We establish a baseline of data in many areas related to the operation of the Act that will be useful in the future to assess progress. We acknowledge the limitations of our work and suggest ideas for further work and research.

There are some areas where the data is collected but is difficult to use to measure progress. This was the case in the work that we conducted to understand whether our NHS mental health workforce shows evidence of differential attainment. Although we were unable to build a national picture, from the information from three health boards, we found that nursing staff from minoritised backgrounds were more likely to be overrepresented in lower grades. Although we make recommendations on how workforce data might be better collected, we also suggest that a specific mandate be provided to an appropriate organisation to score progression on diversity and representation at all levels- work that will aid one of the aims of Scotland's Race Equality Framework (2016-30).

Through meeting people with lived experience and understanding their perspectives, we appreciated the work that the third sector does in building bridges between diverse ethnic communities and statutory services. No community is hard to reach, sometimes we need to reach differently. We were moved by the resilience of those who spoke to us, the generosity with which they gave of their time and experience and the suggestions for change that they made – including the need for a better understanding of the asylum system and the needs of refugees- comments that attract greater salience given the events in Afghanistan in August 2021- and the impact this will have on those who will make Scotland their new home.

Both the medical journal the *Lancet* and the American Medical Association have described racism as a public health emergency [60, 61]. People from diverse ethnic backgrounds who spoke to us describe everyday micro-aggressions. As we describe in the chapter on lived experience, racism and microaggressions are linked to worsening mental health, perpetuating a cycle of disadvantage.

In meeting the needs of diverse and minoritised communities, the ambitions set out in the Scottish Government's *Fair for All* [11] nearly two decades ago to develop a culturally competent service and the themes of REF (2016-2030) have not yet been achieved within mental health services.

Around the same time, the Commission made recommendations to the Scottish Executive and to health boards on cultural competence following our investigation into deficiencies of care and treatment of Mr J, an older man from an ethnic minority who was misdiagnosed, spent far longer in hospital than was needed, and whose basic cultural, language and family needs were not met. Our recommendations at the time related to the provision of interpreters, befriending services, and developing protocols to ensure the needs of people from minority ethnic communities are met [62].

Whilst our evidence from this work shows that there are improvements in the obtaining of interpreters, our work does not show full and embedded training on or understanding of the influence of culture and race on the interactions that shape healthcare outcomes. Indeed, 70% of staff in our survey acknowledged the gaps in training. Equality and Diversity Leads report that health board staff are moderately culturally competent. We identified a lack of awareness and understanding of the role of the BME networks and make recommendations to address this.

We note that some of the recommendations that we make are not new. It is fair to ask why it is proving challenging to develop or sustain actions in Scotland's mental health services on even the basic issues such as data collection on ethnicity, understanding barriers to accessing services or tackling some of the racial issues that this work has identified and that have been identified in successive reports as outlined in the introduction and in more detail in Appendix 2. An argument put forward by the Runnymede Trust is that racial literacy and awareness in Scotland, from those in leadership positions, to those delivering services, is rudimentary at best. The impact of this is that there is a lack of knowledge and a lack of confidence on dealing with these issues and as a consequence the issue is often downplayed. "It does not happen here" becomes a more comfortable narrative to work within Scotland [52].

Yet, findings from the Runnymede Trust suggest that a third of people of Black, Asian and ME groups (non-white) had experienced racial discrimination and more than a third considered racial discrimination as being widespread in Scotland [52]. Against that perhaps our finding that 30% of staff had experience of, or had witnessed racist comments directed towards their colleagues is not surprising but it remains unacceptable. We make recommendations on involving the BME networks in reviewing the protocols around how such incidents are reported, and how those who experience racism are supported. This ultimately impacts on patient care as well as our sense of fairness and desire for equity.

We also note the work that we at the Commission have to do. As mentioned, we are implementing training on equality, diversity and inclusion for all staff, we are committed to improving our own practices both in the recording of data but also in ensuring that the Commission's functions that act as safeguards for the rights of people with mental illness and associated conditions are accessible to all communities in Scotland.

The principles of non-discrimination and respect for diversity that underpin the Mental Health Act are not yet fully realised.

The Commission hopes that this work and the call to action from this will contribute to changes that will lead to a society and services that are genuinely fair for all.

Acknowledgements

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Appendix 1: Glossary

AMP
An Approved Medical Practitioner (AMP) is a medical practitioner who has been approved under section 22 of the Act by an NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder

Anti-racism
Anti-racism has been defined as the active and deliberate process of identifying and dismantling racism in all its manifestations so that power may be redistributed and shared equitably in society [61].

CHI
The Community Health Index (CHI) is a population register, which is used in Scotland for health care purposes. The CHI number uniquely identifies a person on the index

CTO
A compulsory treatment order (CTO) allows for a person to be treated for their mental illness involuntarily. In this report we refer to Community CTOs (CCTO) and hospital-based CTOs (CTO)

Cultural competence
Cultural competence is an organisational-wide approach to enhancing effective cross-cultural communication which includes a number of interconnecting initiatives (e.g., staff diversity, staff training, interpreter services, improving staff attitudes to cross-cultural care) [47].

Cultural humility
Cultural humility promotes openness and non-judgement while allowing the person to determine how their culture impacts their experiential reality and by extension, the clinical encounter. It recognises the role that culture, ethnicity, and race plays in shaping power dynamics, and being able to understand the role that culture might play in the experience of illness and healthcare systems [47].

EDC
An emergency detention certificate (EDC) allows a person to be detained in hospital for up to 72 hours while their condition is assessed

Ethnicity
Ethnicity has usually been used to refer to long shared cultural experiences, religious practices, traditions, ancestry, language, dialect or national origins (for example African-Caribbean, Indian, Irish). Ethnicity can be seen as a more positive identity than one forged from the shared negative experiences of racism. It's more commonly used and asked about within diversity questionnaires in the UK [1].

HSCP
Health and Social Care Partnership. Whenever the term Health and Social Care Partnership or HSCP is referenced in the report, this refers to the joint operational arrangements that exist in a council area between the council social work services and the health care services of the local health board. All clinical, professional and support staff who work within a HSCP are employed by the health board or the council in the specific geographical area.

iCTO	Interim CTO (iCTO)– in the case where a CTO has been applied for, the Mental Health Tribunal can grant an interim order whilst considering the need for a CTO. A patient cannot be subject to an interim order for a period of more than 56 days.
Micro-aggressions	A term coined by African American psychiatrist Dr Chester Pierce to describe the commonplace daily verbal, behavioural or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or harmful racial slights and insults toward people of colour.
MHO	A mental health officer (MHO) is a social worker who has undertaken specialist mental health training that includes the relevant legislation.
MHO consent	Following a medical examination of a patient in the process to grant an EDC or STDC, the practitioner should seek the consent of a mental health officer (MHO). An EDC can be issued without MHO consent, in circumstances where waiting for the assessment would be considered impracticable and result in undesirable delay. An STDC cannot be issued without MHO consent
MHTS	The Mental Health Tribunal for Scotland (MHTS) considers and determines applications for compulsory treatment orders (CTOs) under the 2003 Act and operates in an appellate role to consider appeals against compulsory measures made under the 2003 Act
NES	NHS Education for Scotland (NES) is an education and training body and a national health board within NHS Scotland. It is responsible for developing and delivering healthcare education and training for the NHS, health and social care sector and other public bodies. They have a Scotland-wide role in undergraduate, postgraduate and continuing professional development
NRS	National Records of Scotland (NRS) is a non-ministerial department of the Scottish Government. Its purpose is to collect, preserve and produce information about Scotland's people and history and make it available to inform current and future generations
PHS	Public Health Scotland (PHS) is Scotland's lead national agency for improving and protecting the health and wellbeing of all of Scotland's people. It brought together functions from the Information Services Division (ISD), Health Protection Scotland and NHS Health Scotland in April 2020

Race   Race is a categorisation that is based mainly on physical attributes or traits, assigning people to a specific race simply by having similar appearances or skin colour (for example, Black or White). The categorisation is rooted in White supremacy and efforts to prove biological superiority and maintain dominance over others. It's now widely accepted that race is a social construct. However, having been racialised and shared common experiences of racism, racial identity is important to many and can be a basis for collective organising and support for racially minoritised individuals [1].

STDC   A short-term detention certificate (STDC) should be the preferred route for compulsory care and treatment over an EDC, as there are more safeguards for the individual. A short-term detention can last up to 28 days

SSSC   Scottish Social Services Council is the regulator for the social work, social care and early years workforce in Scotland

Unconscious bias Also known as 'implicit bias'; refers to the underlying attitudes, prejudices, and stereotypes we hold towards people that evade our conscious awareness, but which will still influence the behaviour and treatment of these groups

Appendix 2: A further history of policy response to ethnicity and health

The National Resource Centre for Ethnic Minority Health (NRCEMH) was set up in 2002 as one of the *Fair for All* initiatives to help develop a culturally competent service. A specific programme within the NRCEMH on mental health led to some clear outputs: the establishment of three regional networks on ethnic mental health; an anti-stigma resource designed for minority ethnic communities; a resource on mental health and the law; and support for an NHS Scotland research project to define wellbeing with minority ethnic communities.

In 2007, the NCREMH hosted a conference where the cabinet secretary for health spoke of the need for ensuring faster progress on monitoring and data collection. That conference called for a working group to lead on the development of a key document defining the priorities and recommendations for achieving equity: health in our multi-ethnic Scotland.

The NCREMH closed in 2009, as an Equalities and Planning Directorate was created within NHS Scotland however there were concerns expressed that without the focus of the NCREMH there would be a loss of focus on race equality.

In 2009 the *Health in our Multi-Ethnic Scotland* (HIOMES) report was published by NHS Health Scotland. In the report, the then Chief Medical Officer, Sir Harry Burns, wrote that he:

> *"…strongly supported the Working Group's conclusion that our top priority must be to improve the quality of our data collection. Without this, our ability to make those important links between ethnicity and health will be severely limited." (p.4) [14]*

The report also included a specific recommendation on understanding issues related to mental illness and ethnicity and the performance of statutory mental health services in meeting the needs of Scotland's growing diverse ethnic communities [14].

The Scottish Health and Ethnicity Research Strategy Steering Group (SHERSS) was formed in 2010 in response to recommendations in the HIOMES report. The SHERSS, which later changed its name to Scottish Migrant and Ethnic Health Research Strategy group (SMEHRS), laid out its progress report against the HIOMES recommendations and its strategy for 2014-19 in 2014 [63]. The SMEHRS report suggests that the HIOMES identified gap on statutory mental health services meeting the needs of ethnic minorities was closed through this being a focus in the Mental Health Strategy 2012-15 [64]. The SMEHRS report concluded that:

> *"Ethnicity and mental health is growing in importance as a research area in Scotland, and for Scottish researchers. The Mental Health Strategy for Scotland: 2012-2015 states that the government will work with health boards & partners to monitor access to services (including information about ethnicity) so that this can inform decisions about service design and remove barriers. Also, the SRC Refugee Integration strategy 'New Scots' identified mental health and Gender-based violence as areas of unmet health need for asylum seekers and refugees" (p.10) [63]*

There is little clear information about whether we are monitoring access to mental health service by ethnicity and how this informs decisions about service design and removes barriers in 2021. We are also not aware of what steps were taken to meet the unmet mental health needs of asylum seekers and refugees.

The SMEHRS report also makes clear that it intended to focus less on measures to drive up data collection as this has plateaued. It was acknowledged data collection remained incomplete but that ethnicity could not be linked with Community Health Index (CHI) number due to technological constraints and that the best way forward was to work on ensuring ethnicity data was recorded as per census categories in relevant databases. In their conclusion SMEHRS state that they will increase its efforts to persuade the Scottish Government and Information Services Division of the feasibility and value of including an ethnic identifier in the successor to the CHI index

The Scottish Migrant and Ethnic Health Research Strategy Unit website suggests that there are significant inequalities between ethnic groups when it comes to health and needs and outcomes, but also that:

> *"The main effort to improve health should be focused on the unhealthiest group, which is the indigenous white Scottish population, with effort targeted at people within the group who are income and employment deprived. However there is also scope for ethnically targeted obesity and diabetes prevention strategies, and for better treatment in Scotland for genetically influenced conditions experienced by certain ethnic groups, for example sickle cell disease in African origin groups."*

We must tackle the challenges of health inequalities for all our communities together. The Scottish Public Health Observatory reports that data sources on the health of minority groups are much more extensive in England and Wales and may be useful as a general guide to the likely issues in Scotland [65] although there are differences in migration trends to Scotland (see book reference [51]).

Appendix 3: Who we surveyed

A total of 110 psychiatrists responded to the survey, which was 21% of all members who opened the newsletter where the survey link was distributed. Just over half of respondents were female (54%), with 43% male and 4% missing or responding that they preferred not to say. The average age of respondents was 43 years (range 25–68) and over 70% of the sample worked in Lanarkshire, Greater Glasgow and Clyde, or Lothian (see Table A1). Eleven health boards and the State Hospital were represented.

Table 1. Health board and specialty

Characteristic	Category	n (%)
Health board (n=108)	Lanarkshire	29 (26)
	Greater Glasgow and Clyde	26 (24)
	Lothian	24 (22)
	Grampian	8 (7)
	Borders	6 (5)
	Fife	*
	Tayside	*
	Highland	*
	Dumfries and Galloway	*
	Forth Valley	*
	Ayrshire and Arran	*
	State Hospital	*
Specialty (n=107)	General adult	44 (42)
	Old age	17 (16)
	Other[a]	14 (13)
	Intellectual Disability	10 (9)
	CAMHS	8 (7)
	Liaison	7 (7)
	Forensic	6 (6)

* n<5, [a]Other includes Addictions, Rehab, Eating disorders, Perinatal, Core training, Psychotherapy, Specialty Doctor, and multiple specialties.

In total, 18 hospital records staff responded to the survey (51% of all staff on the Commission email list). The majority (83%) of respondents were female, with the remaining reported being male or choosing not to answer the question. Respondents were on average 49 years (range=26–61 years) and had on average worked in the role for 12 years (range=1–41 years). Eleven out of the 12 Health boards contacted[7] were represented (all but Tayside). Due to the small number of individuals responding for each health board, these are not broken down here.

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[7] The island boards were not included due to the very low number of detentions, as patients are often transferred and subsequently detained in a mainland health board.

national
preventive
mechanism

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