

Ethnic variations in the experiences of mental health service users in England

Results of a national patient survey programme

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Background Minority ethnic groups in the UK are reported to have a poor experience of mental health services, but comparative information is scarce.

Aims To examine ethnic differences in patients' experience of community mental health services.

Method Trusts providing mental health services in England conducted surveys in 2004 and 2005 of users of community mental health services. Multiple regression was used to examine ethnic differences in responses.

Results About 27 000 patients responded to each of the surveys, of whom 10% were of minority ethnic origin. In the 2004 survey, age, living alone, detention and hospital admissions were stronger predictors of patient experience than ethnicity. Self-reported mental health status had the strongest explanatory effect. In the 2005 survey, the main negative differences relative to the White British were for Asians.

Conclusions Ethnicity had a smaller effect on patient experience than other variables. Relative to the White British, the Black group did not report negative experiences whereas the Asian group were most likely to respond negatively. However, there is a need for improvements in services for minority ethnic groups, including access to talking therapies and better recording of ethnicity.

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Patients from Black and minority ethnic groups in the UK are generally perceived to have a poor experience of mental health services. However, robust comparative information in this area is scarce. *Inside Outside* highlighted the need for a national strategy to address the mental health needs of Black and minority ethnic groups (Department of Health, 2003). *Delivering Race Equality in Mental Health Care* outlined an action plan for tackling ethnic inequalities, one of its goals being increased satisfaction with services among patients from Black and minority ethnic groups (Department of Health, 2005). The Department of Health's standards require equity in access to services for minority groups and include a national target for improvements in patient experience as measured by national, validated surveys (Department of Health, 2004).

The Healthcare Commission coordinates a national programme of patient experience surveys on behalf of the Department of Health. This paper analyses ethnic variations in patient experience as reported in the 2004 and 2005 surveys of 26 625 and 25 143 users of community mental health services respectively across all National Health Service (NHS) mental health and primary care trusts providing mental health services in England. Surveys of mental health service users on this scale are unprecedented and offer a unique opportunity for analysing ethnic differences. This paper builds on previous analyses of ethnic variations in patients' experience of NHS services (Commission for Health Improvement, 2004; Healthcare Commission, 2005a, 2006).

METHOD

The 2004 and 2005 postal questionnaire surveys of users of community mental health services included all 81 NHS mental health trusts and primary care trusts providing mental health services in England.

The surveys were approved by the Multi-Centre Research Ethics Committee for Scotland.

The questionnaire was developed following a review of the published literature on surveys of mental health service users (although there had been very few community-based surveys) and of the survey tools currently in use by NHS mental health trusts. Telephone and face-to-face interviews were carried out with mental health professionals and voluntary sector organisations to identify the issues they thought important to include. The information was used to construct a topic guide for use in focus groups with mental health service users, including those from Black and minority ethnic groups, in different parts of England. The results were used to construct a draft questionnaire, which was tested in cognitive interviews for face validity, comprehensibility and salience with people with mental health problems. Following consultations with an advisory group, including members of the Department of Health's Mental Health Task Force and service user group leads, the questionnaire was piloted before the surveys were launched.

Trusts were given detailed written guidance on sampling methods and advice on sampling was available from the NHS Surveys Advice Centre. To construct the sampling frame, trusts were asked to compile a list of service users aged 16–64 years on care programme approach (CPA; standard or enhanced) who had been seen within the 3 months prior to each of the surveys. They were asked to ensure that all separate CPA lists were combined and that any lists not held electronically were included. Trusts were asked to exclude service users that had been seen only once overall, current in-patients, those who had had no contact with NHS mental health services in the past 3 months and those that did not have a known UK address. Furthermore, prior to the survey a number of reviews of the quality of CPA lists were carried out; one of these is included in the Mental Health Survey Development report (Osborn *et al*, 2004). Full details of the sampling instructions can be found at http://www.nhssurveys.org/docs/MH2005_Guidance_v1.pdf

For each of the surveys, trusts were asked to take a simple random sample of 850 service users from their population lists. Detailed instructions on doing this using the Rand function in Excel were

provided. The sample was not stratified by CPA level or by any other variable, because it was considered more important to minimise the risk of trusts making sampling errors by keeping the sampling instructions simple. Non-responders were sent up to two reminders.

The analysis is based on the national data-set for each of the two surveys. Although the sample was designed to be restricted to service users aged 16–64 years, some trusts included those over 64 years; these records were excluded from the analysis. The questionnaire used the 16 ethnic categories in the 2001 population census in England and Wales conducted by the Office for National Statistics (ONS). For the analysis, the ONS census ethnic categories were grouped as: White British; White Irish; White Other; Mixed (White–Black Caribbean, White–Black African, White Asian, Mixed Other); Asian or Asian British (Indian, Pakistani, Bangladeshi, Asian Other); Black or Black British (Black Caribbean, Black African, Black Other); Other (Chinese, Other).

For the 2004 survey, we analysed ethnic differences in experience of using services. The questions were grouped into domains of experience, developed jointly by the Department of Health and the Healthcare Commission with advice from the Picker Institute Europe, as follows: access and waiting (access); safe, high-quality, coordinated care (coordination); better information, more choice (information); building relationships (relationships).

Details of which questions were used to construct each of the patient experience domain scores are given in the Appendix. Domain scores from these surveys are used in the Healthcare Commission's performance assessments of trusts providing mental health services. They are also used at national level by the Department of Health to monitor progress against its Public Services Agreement target with the Treasury regarding annual improvements in patient experience.

Patients' responses to questions were scored between 0 and 100, reflecting the gradient of negative–positive experience of services. Higher scores reflect a more positive experience than lower scores. Mean scores for each domain and an overall mean were derived for each ethnic group by aggregating scores for users' responses to individual questions.

Multiple regression analysis was used to examine ethnic differences in responses

after controlling for age, gender, employment status, living alone, self-reported mental health status, admission to hospital in the previous year for mental health reasons, detention under the Mental Health Act 1983 in the previous year and trust of treatment. Mean domain scores by ethnic group were estimated for a baseline group of respondents using the model coefficients, to illustrate the differences between different ethnic groups. Care programme approach status (i.e. standard or enhanced) was not known for 20% of respondents, hence it was not included in the model.

For the 2005 survey, we analysed ethnic differences in patients' access to services and treatments, based on binary responses to individual questions. The White British group was used for comparison. Logistic regression was used to examine ethnic differences after controlling for selected independent variables. Adjustment was made for the same variables as in the 2004 survey, with two exceptions: the question on living alone was not included in the 2005 questionnaire and information on CPA status was more complete in the 2005 survey and hence was included in the analysis.

Results by ethnicity are presented after forcing all covariates into the model. Conclusions from models reduced using a stepwise approach to contain only significant covariates were highly similar. Statistical analysis was conducted using STATA version 8.0 for Windows. Details of the surveys, questionnaire, domain score methodology and trust-level results are available (Healthcare Commission, 2004, 2005*b*).

RESULTS

A total of 27 398 and 26 555 service users responded to the 2004 and 2005 surveys respectively, with overall response rates of 41 and 40% respectively. It was not possible to calculate response rates for ethnic groups with any degree of accuracy because, although self-reported ethnicity was available for 97% of respondents to both surveys, ethnicity was grossly under-coded in the sample records. In the 2004 survey, 50% of the 67 179 sample records did not have an ethnic code and in a further 2% self-reported ethnicity of survey respondents did not match ethnicity in the trust record; in the 2005 survey, 37% of the 66 948 sample records did not have an

ethnic code and in a further 1% self-reported ethnicity in survey respondents did not match ethnicity in the trust record. Moreover, it is not known whether there were any ethnic-specific biases between where ethnicity was or was not recorded in trust records. Finally, in trust records ethnicity was often coded with a general term such as White/Black/Asian rather than one of the 16 ONS categories used in the survey questionnaires. For these reasons, any comment on response rates by ethnicity has to be very tentative. Based on the partial information available, the indications were that response rates were lower among minority ethnic groups: in the 2004 survey they were 33, 32 and 45% in the Asian, Black and White groups respectively, and in the 2005 survey the corresponding figures were 30, 30 and 41%.

In both the 2004 and 2005 surveys, 10% of respondents were of Black and minority ethnic origin (i.e. excluding White British; 2745 and 2559 respectively; Table 1). The ethnic composition of respondents was similar across the two surveys.

The characteristics of respondents were also similar across the two surveys (Table 2). In both surveys, respondents from minority ethnic groups, other than the White Irish group, were younger than the White British group. Female respondents outnumbered male respondents except in the Asian group in the 2004 survey and in the Black group in the 2005 survey. The proportion living alone (only available for the 2004 survey) was highest in the Black group, being almost three times greater than in the Asian group. In both surveys, the proportions in paid work were lowest among the Asian, Mixed, Black and

Table 1 Ethnic group of respondents to the 2004 and 2005 surveys of users of community mental health services in England

Ethnic group	2004 survey	2005 survey
	(<i>n</i> =26 625) <i>n</i> (%)	(<i>n</i> =25 143) <i>n</i> (%)
White British	23 880 (89.7)	22 584 (89.8)
White Irish	369 (1.4)	368 (1.5)
White Other	610 (2.3)	530 (2.1)
Mixed	329 (1.2)	336 (1.3)
Asian	702 (2.6)	688 (2.7)
Black	622 (2.3)	514 (2.0)
Other	113 (0.4)	123 (0.5)

Table 2 Characteristics of survey respondents by ethnic group for 2004 and 2005 surveys

Variable	White British		White Irish		White Other		Mixed		Asian		Black		Other	
	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005	2004	2005
Age, years: mean	44.8	44.5	48.3***	48.6***	42.6***	42.0***	38.7***	39.3***	42.0***	40.8***	41.5***	40.9***	39.8***	40.3***
Male gender, %	42.1	41.6	44.8	48.4*	40.8	40.0	47.4	42.6	52.3***	46.8*	44.0	50.0**	37.2	38.2
Living alone, %	31.8		44.2***		32.1		40.4**		16.8***		47.9***		26.5	
Paid work, %	22.6	22.2	15.6**	14.5	23.4	27.8	13.3***	15.4	12.4***	19.3	15.7***	13.6	23.4	19.1
Poor/very poor self-reported mental health status, %	25.0	21.7	27.5	23.5	28.0	22.8	21.7	21.7	26.1	22.6	15.2***	12.1***	19.1	19.3
Admitted at least once in past year for mental health reasons, %	22.5	16.9	26.0	18.9	25.7	19.3	25.5	20.0	26.9**	21.3*	32.8***	22.9*	26.5	19.3
Detained at least once in past year, %	7.0	6.2	10.1*	7.1	11.3***	8.9	11.3**	12.8***	12.7***	11.4***	17.6***	16.5***	10.7	13.8*
On enhanced CPA	37.4	33.5	42.1	33.7	32.5*	30.6	48.7***	42.9*	44.6***	35.7*	50.4***	49.7***	37.0	44.6

CPA, care programme approach.
*P < 0.05, **P < 0.01, ***P < 0.001 v. White British group.

White Irish groups. Self-reported mental health status was poor/very poor in about one-quarter of respondents in most ethnic groups in 2004 and in about one-fifth in 2005; in both surveys, the proportion was significantly lower in respondents from the Black group (15.2 and 12.1% respectively). The proportion of respondents with at least one hospital admission for mental health reasons, or detention under the Mental Health Act 1983, in the past year was higher among minority ethnic groups than in the White British group, the proportions detained in the Black group being more than double those in the White British group in both years. Minority ethnic groups, the Black group in particular, were also more likely to be on enhanced CPA.

For the 2004 survey, we analysed ethnic differences in patients' overall experience of using services (classified by domains of patient experience) after controlling for the independent variables (Table 3). Compared with the White British group, patient experience scores were lower for the White Other group for the access and information domains, and overall. For the Asian group, scores for the information domain were lower than for the White British group, and scores for the coordination domain were higher. Scores for respondents from the Black group were higher than for the White British group for the coordination and relationships domains.

The regression analysis (Table 4) showed the extent to which the independent variables predicted patient experience scores. Although ethnicity was a significant predictor of patient experience for some ethnic groups for some domains, overall some other independent variables had stronger effects. Self-reported mental health status had the strongest explanatory effects across all domains and overall, with respondents in poor health responding more negatively. Increasing age was a significant, positive predictor of domain scores. Living alone, detention and hospital admissions in the past year were negatively associated with patient experience.

For the 2005 survey, we analysed ethnic differences in patients' access to services

and treatments, based on responses to individual questions and with the White British group as the baseline for comparison. Odds ratios from the regression analysis are given in Table 5. Overall, 84% of respondents had been in contact with mental health services for over a year and about half for over 5 years. After adjusting for the independent variables, the White Other, Asian and Other groups were more likely to have had a shorter duration of contact with mental health services (i.e. under 1 year) than the White British. Overall, 83.6% of respondents said they had seen a psychiatrist in the past 12 months. Except for the Other group, there were no ethnic differences from the White British group for being seen by a psychiatrist in the past

Table 3 Mean patient experience scores from 2004 survey according to ethnic group

Ethnicity	Overall mean	Access	Coordination	Information	Relationships
White British	73.4	70.6	75.1	70.3	82.0
White Irish	74.3	71.6	75.5	71.2	83.2
White Other	71.7*	67.8**	74.7	66.9**	81.6
Mixed	72.8	68.7	75.3	70.1	82.8
Asian	72.8	69.4	77.9*	67.1**	82.5
Black	74.4	72.0	77.8*	68.3	84.6**
Other	71.8	63.8**	76.1	68.3	82.6

*P < 0.05; **P < 0.01 v. the White British group.
I. Scores were predicted using the regression models for the baseline group (any age in years, male, excellent mental health, not living alone, not detained in past year, not admitted to hospital in past year, in paid work).

Table 4 Beta coefficients¹ from multiple regression analysis of 2004 survey data

Variable	Overall	Access	Coordination	Information	Relationships
Age ²	0.17***	0.15***	0.22***	0.09***	0.25***
Female gender	-0.02	-0.73*	-0.18	1.16**	-0.24
Ethnicity					
White Irish	0.90	1.01	0.41	0.90	1.18
White Other	-1.73*	-2.79**	-0.40	-3.38***	-0.32
Mixed	-0.55	-1.85	0.18	-0.26	0.80
Asian	-0.62	-1.14	2.81**	-3.19***	0.57
Black	1.05	1.44	2.76**	-1.98	2.62**
Other	-1.59	-6.80**	1.00	-1.99	0.64
Self-reported mental health					
Very good	-0.87	-1.76*	-0.71	-0.77	0.12
Good	-3.96***	-4.66***	-2.78***	-4.65***	-2.77***
Fair	-8.79***	-8.53***	-6.78***	-10.47***	-6.99***
Poor	-14.49***	-13.11***	-11.98***	-17.42***	-12.79***
Very poor	-20.30***	-18.07***	-16.59***	-24.00***	-19.14***
Living alone	-2.01***	-0.56	-1.85***	-2.62***	-2.74***
Detained at least once in past year	-2.54***	-0.45	-2.73***	-3.88***	-3.27***
Hospital admissions in past year					
1	-0.37	2.37***	-3.13***	-1.62***	-2.06***
2-3	-1.59**	1.47	-4.72***	-2.47**	-4.32***
>3	-1.92	-1.53	-1.61	-1.30	-5.46**
Employment					
Not currently in paid work	-0.08	2.63***	-2.57***	-1.72***	-1.00**
Working casual or voluntary basis	-0.35	0.40	-3.12***	0.31	-1.73*
Full-time student	-1.25	-0.50	-2.63	-1.83	-1.40
Constant (unadjusted mean score)	73.39***	70.57***	75.08***	70.32***	81.97***

* $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$.

1. Coefficients using the regression models relative to the baseline group (male, White British, excellent mental health, not living alone, not detained in past year, not admitted to hospital in past year, in paid work).

2. For individual year of age.

12 months or for being seen by the same psychiatrist at the last two appointments. Overall 57.9% of respondents said they had seen a community psychiatric nurse (CPN) in the previous 12 months. Compared with the White British group, a greater proportion of respondents from the Black group said they had seen a CPN. Just over half (55.3%) of respondents said they had also seen a health professional other than a psychiatrist or CPN in the past 12 months; the proportion was significantly lower in the Asian group than the White British group.

Overall, 92.6% of respondents said they had taken a medication for mental health problems in the past 12 months; no ethnic differences were observed after controlling for the independent variables. Overall, 40.6% of respondents said they had had some form of talking therapy (e.g. counselling or psychotherapy) in the past 12 months. Compared with the White

British group, significantly lower proportions of respondents from the Asian and Black groups said they had received any form of talking therapy in the past 12 months. However, overall, 42.6% of respondents said they did not want a talking therapy. Among those who said they did want a talking therapy, overall 65.7% said they had received it. The odds ratios for those receiving talking therapy among those who wanted it were below 1 for all minority ethnic groups except for the Other group. The results did not reach statistical significance but this could reflect sample sizes as most of the confidence intervals for the individual ethnic groups only just straddled 1.

Almost two-thirds (62.5%) of respondents said they had been told their care coordinator; significant proportions said they had not (27.6%) or they did not know (9.9%). Compared with White British respondents, the proportions that said they

had been told their care coordinator were significantly lower among White Other and Asian respondents, and significantly higher among Black respondents. Over two-thirds (69.6%) of respondents said that it was less than 1 month since they had last seen their care coordinator, 19.0% said it was 1-3 months, with the remainder stating it was over 3 months. A higher proportion of the Asian and Other groups compared with the White British said they had last seen their care coordinator over 1 month ago.

When asked whether they had been given or offered a written or printed copy of their care plan, overall under half (44.9%) answered affirmatively, a similar proportion answered negatively (44.4%) and 10.7% said they did not know. Compared with the White British group, a significantly lower proportion of Asian respondents said they had a copy of their care plan. Overall, 47.1% of respondents

Table 5 Fixed-effects logistic regression analysis of results from 2005 survey adjusting for confounding variables¹

Outcome	Odds ratio (95% CI) ²					
	White Irish	White Other	Mixed	Asian	Black	Other
In contact with services > 1 year	1.10 (0.76–1.6)	0.63 (0.49–0.81)	0.92 (0.65–1.32)	0.64 (0.50–0.80)	0.84 (0.62–1.14)	0.44 (0.27–0.72)
Seen a psychiatrist in past 12 months	1.44 (0.97–2.15)	0.99 (0.76–1.3)	0.97 (0.68–1.39)	0.81 (0.63–1.03)	0.98 (0.71–1.36)	2.73 (1.17–6.37)
Seen by same psychiatrist past 2 times	0.86 (0.65–1.16)	0.95 (0.74–1.23)	0.88 (0.64–1.20)	1.02 (0.83–1.26)	1.02 (0.80–1.30)	0.92 (0.57–1.48)
Seen CPN in past 12 months	1.06 (0.83–1.36)	0.85 (0.69–1.05)	1.14 (0.88–1.49)	1.04 (0.86–1.25)	1.60 (1.28–2.01)	0.99 (0.65–1.53)
Seen someone else in mental health services in past 12 months	0.93 (0.73–1.18)	1.02 (0.83–1.25)	1.06 (0.82–1.37)	0.82 (0.68–0.98)	0.91 (0.74–1.12)	0.96 (0.64–1.45)
Taken medication for mental health problems in past 12 months	0.95 (0.58–1.54)	0.97 (0.69–1.36)	0.76 (0.50–1.17)	1.03 (0.72–1.45)	1.00 (0.66–1.51)	0.77 (0.39–1.53)
Any talking therapy sessions from NHS in past 12 months?						
All respondents	0.87 (0.68–1.11)	1.15 (0.94–1.39)	0.96 (0.75–1.23)	0.69 (0.57–0.83)	0.73 (0.59–0.91)	1.25 (0.84–1.88)
Those requesting therapy	0.75 (0.54–1.02)	0.86 (0.67–1.11)	0.75 (0.55–1.03)	0.80 (0.62–1.03)	0.74 (0.55–1.00)	1.54 (0.83–2.86)
Told care coordinator	0.91 (0.69–1.2)	0.67 (0.53–0.84)	1.05 (0.78–1.43)	0.79 (0.64–0.96)	1.35 (1.04–1.74)	1.01 (0.62–1.62)
More than 1 month since last saw care coordinator	1.10 (0.79–1.52)	1.25 (0.94–1.68)	1.09 (0.77–1.53)	1.41 (1.10–1.80)	1.04 (0.79–1.37)	1.68 (1.01–2.82)
Offered copy of care plan	0.97 (0.75–1.25)	0.80 (0.64–1.00)	0.79 (0.6–1.04)	0.76 (0.62–0.92)	1.08 (0.86–1.36)	0.89 (0.56–1.40)
Care review in past 12 months	1.05 (0.82–1.36)	0.92 (0.75–1.14)	0.83 (0.64–1.08)	0.82 (0.68–0.99)	1.53 (1.22–1.91)	1.18 (0.77–1.82)
Have the number of local NHS mental health service to phone out of office hours	1.10 (0.86–1.42)	0.81 (0.66–1.01)	0.58 (0.44–0.76)	0.75 (0.62–0.91)	0.82 (0.67–1.02)	0.68 (0.44–1.06)

Results in bold are significant.

CPN, community psychiatric nurse; NHS, National Health Service.

1. Adjustment was made for age, gender, paid work status, self-reported health status, admission to hospital as a mental health patient, detention under the Mental Health Act 1983, care programme approach level and trust of treatment.

2. Minority ethnic groups compared with the White British group.

said they had had a care review in the past 12 months; compared with the White British group, this proportion was lower among Asian respondents and higher among Black respondents.

When asked whether they had an out-of-hours number for the local NHS mental health service, 44.4% of respondents said yes, 46.5% said no and 9.1% said they were not sure or did not know. The proportions responding affirmatively were lower among Mixed and Asian respondents compared with White British respondents.

In summary, relative to the White British group, the main ethnic differences were for the Asian group, who responded negatively to several questions about access to community mental health services. No negative differences were apparent for the White Irish and Black groups. Respondents from the Black group were more likely than White British to say they had seen a CPN, had a care review in the preceding year and had been told their care coordinator. Overall, minority ethnic groups were less likely to have said they had received talking therapies in the past year.

Age, employment status, hospital admission, detention under the Mental Health Act 1983 and CPA status were stronger and more consistent predictors of responses than ethnicity. The strongest predictor was self-reported health status.

DISCUSSION

Ethnic differences in rates of mental illness, and access to and experience of mental health services, have been a focus of widespread and long-standing debate and concern in the UK. It is widely reported that Black and minority ethnic groups in England, especially African-Caribbeans, have adverse experiences of mental health services (Sainsbury Centre for Mental Health, 2002; Department of Health, 2003, 2005). Patient experience is increasingly recognised as being critical to service development and the provision of patient-centred care. However, there is a paucity of robust comparative research on the experiences of mental health service users, including those from Black and minority

ethnic groups, as there have been few systematic, comparative studies with robust sample sizes.

Strengths

The Healthcare Commission has a national programme of patient experience surveys across NHS primary care, acute, mental health and ambulance trusts in England. The surveys provide direct feedback on patients' experiences of NHS services, and are intended to inform improvements in the services provided by healthcare organisations. These are among the largest such surveys conducted internationally. They are designed to measure patients' factual experience of health services rather than levels of satisfaction. Patient satisfaction can be influenced by predetermined expectations, gratitude bias and other factors (Sitzia & Wood, 1997; Crow *et al*, 2002), hence it is considered a less reliable marker of patient feedback and inter-group differences. However, questions about specific aspects of the healthcare actually experienced by patients provide more objective

and comparable measures of service quality. This approach is now used across the NHS.

The results presented here are based on surveys of all NHS providers of mental health services in England. Almost 27 400 users of community mental health services participated in the 2004 survey and 26 500 in the 2005 survey. About 10% (2750 and 2560 respectively) of the respondents were of Black and minority ethnic origin. These are uniquely large samples for analysing ethnic variations in the experiences of those using community mental health services.

These surveys have several strengths for analysing ethnic differences in the views of service users with long-term mental health needs. Postal surveys such as these are a cost-effective way of obtaining feedback from large numbers of service users, hence they offer the statistical power for measuring ethnic differences that smaller, qualitative or interview-based studies do not. The surveys focused on priorities for service users and were developed with user involvement. The data were collected directly from service users and are independent of potential external bias. Hence the surveys are considered to be reliable markers of patient experience, and are used in the Healthcare Commission's assessments of NHS trusts and by the Department of Health for monitoring national progress on the Public Service Agreement target relating to patient experience.

Poor experience of mental health services among patients from Black and minority ethnic groups is widely reported, and undoubtedly this reflects the views expressed. However, systematic comparative research into ethnic variations in patient experience is scarce, based on small samples and shows mixed results. Bhugra *et al* (2004) reported that Black mental health patients tended to be more dissatisfied with general practitioner (GP) services than White patients. Parkman *et al* (1997) noted that African-Caribbeans were less satisfied with secure services than White service users. Other studies have found small or no ethnic differences in satisfaction with care (McGovern & Hemmings, 1994; Leavey *et al*, 1997; Callan & Littlewood, 1998; Commander *et al*, 1999). Although there is a dearth of research on ethnic differences in experience of mental health services, a study of disengagement and engagement with services among assertive outreach patients showed no differences between African-Caribbean

and White patients (Priebe *et al*, 2005). The surveys analysed here had significantly larger samples and examined patient experience rather than satisfaction.

Limitations

There are some caveats to the findings. Although the analyses controlled for mental health status, hospital admissions and detention status as proxies for case mix, these variables may not fully control for diagnostic differences (e.g. depression, psychotic illness), which can affect the way patients respond (Fakhoury *et al*, 2002). This might be reflected in the significantly lower rates of self-reported poor/very poor mental health status among the Black group compared with other ethnic groups in both surveys. It is also not possible to say whether or not the level of functioning affected patient responses.

The overall response rates to the surveys of about 40% are lower than those for the other Healthcare Commission surveys. However, we are not aware of other surveys published in the UK that have achieved a higher response rate from mental health service users sampled from CPA registers, or similar sampling frames of people with relatively serious mental illness. A comparative study in Switzerland of surveys of mental health patients discharged from hospital had response rates that were only moderately higher, in the range of 43–50% (Peytremann-Bridevaux *et al*, 2006). It was not possible to derive accurate response rates by ethnic group, as ethnicity coding in the trusts' samples was significantly incomplete. The partial information available indicated that response rates were lower in respondents from minority ethnic groups than the White British group. This would be significant only if there is an additional systematic non-response bias. However, it is not possible to say whether there is such a bias, or in which direction it might operate. Moreover, similar ethnic differences in response rates are indicated in the Healthcare Commission's surveys of patients in other sectors (e.g. in-patients and out-patients in acute trusts, accident and emergency, ambulance service users, primary care), where we have reported more marked ethnic differences in patient experience than those observed here for mental health service users (Commission for Health Improvement, 2004; Healthcare Commission, 2005a, 2006). Response rates among Black

and minority ethnic groups tend to be lower than among the White British population across most national surveys (McManus *et al*, 2006). However, in the absence of alternatives, this does not stop survey findings being used widely. Lower response rates among minority ethnic groups are in part attributable to the fact that response rates to surveys are generally lower among younger people, deprived groups, and those living in London and other inner-city areas, characteristics that apply particularly to minority ethnic groups. So, the apparent lower response rates from Black and minority ethnic groups will in part be due to artefactual demographic reasons. For instance, in the 2005 survey, overall response rates at ages 16–25, 26–35, 36–50, 51–64 years were 30, 33, 40 and 48% respectively.

Furthermore, indications that the sample is broadly representative are that the proportion of respondents from minority ethnic groups (10%) broadly reflects the proportion in the general population, and that ethnic differences in patient characteristics reflect other research evidence (Morgan *et al*, 2005a,b) such as the proportions in employment, living alone or having had a hospital admission or detention under the Mental Health Act 1983. For these reasons, we consider response bias is unlikely to affect the results significantly.

Differences in therapy

Patients from minority ethnic groups are frequently cited as being more likely than White patients to be prescribed drugs and electroconvulsive therapy rather than talking treatments such as psychotherapy and counselling. One study showed that people of Caribbean origin with psychosis were less likely to receive psychotherapy and be treated for depression (McKenzie *et al*, 2001). However, there is limited evidence on these issues. Effective community care could reduce the need for acute secondary care, but research on the use of community mental health services and therapies by ethnicity is particularly sparse.

Our analysis of the 2005 survey showed few or no differences relative to White British patients in terms of the proportions of patients from minority ethnic groups who saw a mental health professional in the past 12 months or those on medication. Although this study is limited to users of community mental health services, this is an important finding, since minority ethnic groups are widely reported as being more

likely to receive medication (Sainsbury Centre for Mental Health, 2002; Department of Health, 2003, 2005). Our results relating to access to talking therapies (among respondents who said they wanted such therapies) narrowly failed to reach statistical significance for the individual minority ethnic groups; however, the odds ratios for most groups were low, indicating that ethnicity may be associated with a lower likelihood of receiving talking therapies.

Differences among groups

Where negative experiences were apparent, they applied in the main to the Asian group, who were more likely than the White British to say they had not received some services (2005 survey). Asian (and White Other) respondents also showed some negative differences from the White British group in the analysis of domains of patient experience, although not consistently (2004 survey). Whereas much of the published literature focuses on issues relating to African-Caribbean patients with mental illness, these findings clearly indicate the need for improvements in the care provided for Asian service users. Asian groups also report less favourably than White British patients in a range of other patient experience surveys (Commission for Health Improvement, 2004; Healthcare Commission, 2005a, 2006).

In contrast, patient experience scores for the Black group showed few differences from the White group, and in some cases were higher. No differences in access to mental health professionals or medication were observed for the Black group, other than a higher rate of CPN contact. Compared with White British counterparts, they were also more likely to say they knew their care coordinator and to have had an annual care review. These findings suggest that where Black groups of patients are in contact with community services, their self-reported experience is not very different from (and in some cases better than) that of White British patients. Based on a community sample, our findings are not dissimilar to some other studies and do not support the widely held view of adverse experiences of mental health services among Black groups.

These findings in relation to Black groups are encouraging and could reflect growing awareness and institutional changes towards more culturally sensitive

services (McLean *et al*, 2003). There may also be other explanations. McGovern & Hemmings (1994) suggest other factors might be responsible for a lack of Black-White difference in satisfaction with services; for example, that, for Black patients, White patients may not be the reference group for comparing quality of care. Diagnostic differences could play a role (Fakhoury *et al*, 2002); for example, patients with depression might respond differently to those with psychotic illness. Compared with patients with major depression and anxiety disorders, self-rated health and life satisfaction are better in patients with schizophrenia (Koivumaa-Honkanen *et al*, 1999). This may explain why Black groups, who are reported to have a higher prevalence of psychotic illness, had a lower proportion reporting poor/very poor mental health status in these surveys.

Research findings to date almost consistently show higher rates of diagnosed psychotic illness, hospital admission and detention among African-Caribbean patients, although the reasons are not fully understood (Sharpley *et al*, 2001; Bhui & Bhugra, 2002; Bhui *et al*, 2003; Morgan *et al*, 2004, 2005a,b; Fearon *et al*, 2006). This was most recently reflected in the 2005 and 2006 censuses of mental health in-patients in England and Wales, which highlighted the need for preventive action to reduce hospital admissions and detentions among these groups where appropriate (Healthcare Commission *et al*, 2005, 2007). It is possible that the excess of African-Caribbean patients detained and admitted to hospital reflects in some measure patients who are not in contact with community services, or those who have dropped out of contact. The literature provides some support for this view, as it indicates crisis modes of entry into secondary mental healthcare for African-Caribbean patients, with low GP referral rates, and high rates of detention and hospital admission via the criminal justice system (Bhui & Bhugra, 2002; Bhui *et al*, 2003, Morgan *et al*, 2004, 2005a,b; Healthcare Commission *et al*, 2005, 2007).

Our findings reiterate the need for earlier access to and full engagement with primary care and community mental health services by African-Caribbeans at risk of mental illness. This requires a coordinated response on the part of mental health service commissioners (primary care trusts and others), service providers, local authorities and other statutory agencies, in

conjunction with African-Caribbean communities and voluntary groups. A key feature of the government's reform of mental health services is the implementation of community psychiatric services, including early intervention, assertive outreach and crisis resolution teams. These services have the potential for improving outcomes for people with severe mental illness, including those from minority ethnic groups (Department of Health, 2003; Chisholm & Ford, 2004, Johnson *et al*, 2005).

Other factors

We found that age, living alone, detention under the Mental Health Act 1983, CPA status and hospital admission were stronger and more consistent predictors of patient experience than ethnicity. Of all the independent variables examined, self-reported mental health status had the strongest explanatory effect, consistent with the findings of other studies (Hargreaves *et al*, 2001; Ren *et al*, 2001). Reviews of patient satisfaction surveys have similarly shown a positive association of patient satisfaction with increasing age and better health status (Sitzia & Wood, 1997; Crow *et al*, 2002). These findings suggest that factors associated with ethnicity, rather than ethnicity *per se*, are stronger determinants of patient experience. However, ethnicity does have an independent residual effect, and our findings show that improvements are needed in mental health services provided to minority ethnic groups, including better access to talking therapies.

Ethnicity coding

One of the aims of the 'Count Me In' censuses of 2005 and 2006 was to improve organisational recording of self-reported ethnic status and to provide a baseline for ethnic monitoring (Healthcare Commission *et al*, 2005, 2007). Our study shows that ethnicity recording in trust records is significantly incomplete and needs to be improved to support ongoing and effective ethnic monitoring, and adherence to the Race Relations Amendment Act 2000.

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APPENDIX A

2004 survey of users of community mental health services: questions used to construct patient experience domain scores

Access and waiting

D1. In the last 12 months have you had any talking therapy (e.g. counselling) from NHS mental health services?

E10. Can you contact your care coordinator if you have a problem?

F9. In the last 12 months, have any appointments been cancelled or changed by mental health services?

G1. Do you have the number of someone in mental health services that you can call out of office hours?

Safe, high-quality, coordinated care

B3. Did you have trust and confidence in the psychiatrist you saw?

B6. The last 2 times you had an appointment with a psychiatrist was it with the same psychiatrist both times or with two different psychiatrists?

B9. Did you have trust and confidence in the CPN?

E7. Did you find the care review helpful?

Better information, more choice

C2. Do you have a say in decisions about the medication you take?

E5. Were you told that you could bring a friend or relative to your care review meetings?

E6. Were you given a chance to express your views at the care review meeting?

F7. In the last 12 months have you received any information about local support groups for mental health service users?

J2. Do you have enough say in decisions about your care and treatment?

J3. Has your diagnosis been discussed with you?

Building relationships

B2. Did the psychiatrist listen carefully to you?

B4. Did the psychiatrist treat you with respect and dignity?

B5. When you last saw a psychiatrist, were you given enough time to discuss your condition and treatment?

B8. Did the CPN listen carefully to you?

B10. Did the CPN treat you with respect and dignity?

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