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ETHNIC MENTAL HEALTH INEQUALITIES AND MENTAL HEALTH POLICIES IN ENGLAND 1999-2020

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Abstract

Background: Despite many policy initiatives in the last two decades, ethnic mental health inequalities have persisted in England.

Aim & method: This paper presents a thematic synthesis of mental health policies published in England from 1999 to 2020. We specifically focus on *ethnicity-related mental health issues* highlighted in policies, *policy recommendations* and *performance measurements of policy implementation.*

Findings: Findings from this synthesis demonstrate that ethnic mental health inequalities remain comparable over the last two decades. Ongoing issues include a lack of data on the ethnicity of mental health services users. Where data is available, these highlight ethnic inequalities in access to, experiences of, and outcomes of mental health services, as well as a lack of cultural capability in healthcare professionals. Policy recommendations have also remained the same during this time, and include: collecting data on the ethnicity of service users, raising awareness of the cultural needs of Black and Minority Ethnic (BME) populations amongst healthcare professionals, recruiting BME staff into mental healthcare services and improving community engagement. The synthesis identified poor indicators of performance measurement on policy implementation and weak monitoring regimes.

Policy/practice implications: The synthesis discusses the challenges of policy implementation using literature from the field of organizational behaviour.

Keywords: Mental health policy, Mental health inequalities, minority ethnicity, National Health Service (NHS), Policy implementation, Organizational behaviour.

Introduction

Mental health inequalities in England have been persistent and pervasive (HM Government, 2020). This is despite the ethnically 'superdiverse' population of England, typical of many former colonising nations. In some English cities, ethnic 'minorities' are in fact the majority. Reports have

frequently highlighted the disproportionate overrepresentation of Black and Minority ethnic (BME) people within mental health services, combined with poorer experiences of care, treatment and outcomes (Cabinet Office, 2017; HM Governement, 2018; Wessely *et al.*, 2018). Following the first National Mental Health Service Framework (NMHSF) (1999) significant national efforts have been made to address ethnic mental health inequalities. However, the multiple challenges that remain are reminiscent of those highlighted by Busfield over 20 years ago (Busfield, 1999). Busfield was critical of mental health policies in England as being for majority populations without explicit attention to ethnicity and specific ethnic needs. Without due attention to the needs of people from BME backgrounds, policies embed bias, discrimination and further division (Hui *et al.*, 2020). Busfield identified a need for policy makers and politicians to have greater awareness of, and sensitivity to, ethnicity and social identity in discussions of mental health policy (Busfield, 1999). This paper presents a thematic synthesis of mental health policies, published in England between 1999 and 2020, with a focus on ethnicity. In doing so, this paper highlights current prevailing ethnic mental health inequalities, with recommendations for improving policies and practice.

Methods and analysis

The UK government website (gov.uk) and NHS online databases (nhs.uk) were searched using the search terms: mental health policy in England, NHS mental health policy, Black and Minority Ethnic (BME) and mental health policy. These are the main databases where policy documents are indexed. Policies were included based on a specific focus on BME mental health, and snowballing approaches were used to check the reference lists of policies found, to ensure relevant policies were included. Documents were excluded if they were guidelines, standard operating procedures, primary studies, and implementation frameworks. We excluded implementation frameworks as these are the documents that just focus on how a policy should be implemented. However, our focus in this paper was to review and appraise documents that state what a policy is and what policy makers say need to be done to improve mental health services. The included and excluded documents are provided on table (I). The documents were imported into the qualitative data analysis software NVivo 12 and coded individually. A Framework Analysis approach was used to systematically review the data, enabling the researchers to identify themes whilst reducing bias (Ritchie and Spencer, 1994). Framework

Analysis is an appropriate method to analyse policy documents and conducting secondary data analysis (Ritchie and Spencer, 1994). We deductively coded specific areas of interest, namely: ethnicity-related mental health *issues highlighted* in the policies, *policy recommendations* to address the highlighted issues and *performance measurements* on policy implementation.

Findings

In total twenty documents published between 1999-2020 were found. Eleven documents were included and synthesised for analysis, whereas nine documents are excluded because they are guidelines, standard operating procedures, and implementation frameworks. Included and excluded documents are given in the Table (I). These policy documents are applicable for England, which means Scotland, Wales and Northern Ireland are not covered

Table. I : Policy documents included in the analysis

Document No.	Title of the Document
1	National Service Framework for Mental Health: Modern Standards and Service Models (1999) - (Apply to England)
2	Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services and the Government's Response to the Independent Inquiry into the Death of David Bennett (2005) – (Apply to England)
3	Mental Health Act (1983) Amended (2007) – (Apply to England and Wales)
4	New Horizons: A Shared Vision for Mental Health (2009) – (Apply to England)
5	Delivering Race Equality in Mental Health Care: A Review (2009) – (Apply to England)
6	No Health Without Mental Health: A Cross-government Mental Health Outcome Strategy for People of All Ages (2011) – (Apply to England)
7	The Five Year Forward View of Mental Health (2016) – (Apply to England)
8	Modernising the Mental Health Act Increasing Choice, Reducing Compulsion: Final Report of the Independent Review of the Mental Health Act 1983 (2018) – (Apply to England)
9	NHS Long Term Plan (2019) – (Apply to England)
10	NHS Mental Health Implementation Plan 2019/2020- 2023/2024 (2019) – (Apply to England)
11	Advancing Mental Health Equalities Strategy (2020) – (Apply to England)

Documents excluded from the synthesis	
1	Reducing the Need for Restraint and Restrictive Intervention Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings (June 2019)
2	The Government's revised mandate to NHS England for 2018-19 (May 2019)
3	Cross-Government Suicide Prevention Workplan (January 2019)
4	The independent review of the Mental Health Act - Interim report (May 2018)
5	Race Disparity Audit Summary Findings from the Ethnicity Facts and Figures website (March 2018)
6	Mental Health Act 1983: Code of Practice (2015)
7	Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing (2015)
8	Positive and Proactive Care: reducing the need for restrictive interventions (2014)
9	No health without mental health: implementation framework (2012)

After analysis and synthesis of the findings from the included documents, three themes are identified: i). ethnic inequalities in mental health, ii) policy recommendations and iii) performance measurements suggested by the policies to monitor implementation.

Theme 1 Ethnic inequalities in mental health

The challenges around inequalities that BME communities experience are complex, multifaceted and pervasive (NIMHE, 2003). These include measurable differences, such as the use of coercive measures. They also include more subtle forms of discrimination, such as unconscious racial bias, all of which impact upon experiences and outcomes of mental health (HM Governement, 2018).

1.1. Differential access

The policies reviewed highlight differential access to mental health services based on ethnicity, gender and education (HM Government, 1999). Those individuals having multiple protected characteristics, such as ethnicity, disability, gender, sexual orientation and religious beliefs. They

are most likely to experience differential access to mental health services and to be most disadvantaged (HM Governement, 2018).

During the 1990s, a lack of awareness of available services was documented as contributing towards differential access (NIMHE, 2003). Policies have since highlighted fear, stigma, discrimination and language barriers as contributing towards accessing mental health support, particularly amongst Black and Afro-Caribbean populations (NIMHE, 2003; HM Government, 2009). Language barriers create additional stressors for BME populations (HM Government, 1999; NIMHE, 2003; HM Government, 2005, 2009, 2011). Language barriers were found to be particularly challenging for those attempting to access therapy (HM Government, 2009). They are also problematic in forming therapeutic relationships (HM Government, 2011), leading to further deterioration, prolonged suffering and longer recovery times (HM Governement, 2018).

1.2 Differential treatment

Discrimination experienced by BME people begins at the point of assessment (NIMHE, 2003). Depression and serious mental health problems amongst BME populations were often misdiagnosed or left undiagnosed (NIMHE, 2003). Treatment options were also dependent upon ethnicity with BME people being less likely to be referred for therapy and more likely to be prescribed medication compared with white populations(HM Government, 1999, 2005). BME patients and relatives are also more likely to be excluded from decision-making surrounding the care and treatment options (HM Governement, 2018).

1.3 Differential Experience and outcome

The mental health experiences and outcomes of BME populations are consistently poorer than white majority populations (NIMHE, 2003), including reports of discriminatory treatment by healthcare professionals (HM Government, 2009). Factors such as racism, stigmatization and stereotyping have each been attributed to differential experiences (HM Governement, 2018). BME populations frequently reported lack of satisfaction and mistrust of mental health services(HM Government, 2020) . Fear and mistrust of mental health services are reported to prevail from poor past experiences, including negative treatment experiences, forced medication,

and disproportionate rates of detention under the Mental Health Act (HM Government, 1999, 2016; HM Governement, 2018; HM Government, 2020) .

1.4 Coercive Treatment

The Mental Health Act highlighted coercive measures as being used 'against' BME people rather than 'for' them, with those detained expressing helplessness with no one to hear their concerns (HM Government, 2016). BME populations are disproportionately more likely to experience coercive treatment within mental health services, with females from BME backgrounds are most likely to be restrained (HM Governement, 2018). Of the multiple pathways leading to hospital admission, African-Caribbean people are most likely to be referred via the criminal justice system, and to be compulsorily detained under the Mental Health Act (HM Government, 1999, 2005, 2007). BME populations were also heavily over-represented in the use of Community Treatment Orders (CTO) (HM Governement, 2018). BME populations accommodated within inpatient wards reported both physical and sexual abuse (HM Governement, 2018). This review did not found any evidence suggesting whether individuals from BME groups have more serious abuse compare to other groups.

1.5 Lack of culturally competent services

The importance of culturally competent services has been acknowledged in almost all of the policy documents, including a need for practitioners to be trained in working with diverse groups of people (HM Government, 1999). It was observed that knowledge and competence to address mental health problems presented by minority groups is limited (NIMHE, 2003). Where the presentation of symptoms of BME people could not be completely understood by mental health professionals, this led to more cases of poor diagnosis, wrong treatment and negative outcomes (HM Government, 1999; NIMHE, 2003). An underrepresentation of staff from BME backgrounds, particularly in senior roles, is reported to contribute towards a lack of cultural diversity and competence in the workforce. Service users from BME backgrounds repeatedly report not feeling understood by healthcare professionals leading to further forms of exclusion and disparity . Whilst there is agreement that cultural competence is required between the policies reviewed, there has been no specific guidance as to how this might be achieved (NIMHE, 2003).

1.6 Lack of Implementation

A lack of action and implementation of recommendations towards addressing the needs of BME populations has been a recurrent theme throughout the policy documents reviewed (NIMHE, 2003; HM Government, 2005; HM Governement, 2018). The Inside Outside Report highlighted that the actions advised in the MHNSF (HM Government,1999) were insufficient and that issues "may be getting worse" (NIMHE, 2003). Despite strong evidence of discrimination, the development of services has been slow (HM Government, 2005). The focus on solutions, such as cultural competence training, has been insufficient to address BME populations' needs (HM Governement, 2018). Policies have highlighted a need for advocacy services specifically to address the needs of BME populations (NIMHE, 2003), however, advocacy services have not been effective in engaging BME people who perhaps need this service most (HM Governement, 2018).

1.7 Lack of data and research

Policies have highlighted a lack of BME population data resulting in inadequate action. The MHNSF(1999) highlighted that there was insufficient ethnicity data within the NHS, including a lack of data on suicide rates amongst BME populations and experiences of BME populations in mental health services (HM Government, 1999; NIMHE, 2003). Comparisons of data across BME populations has been difficult due to inconsistencies in how ethnicity is categorised, including when individuals identify with more than one category (HM Governement, 2018).

Policies have highlighted that local information on ethnicity has not been readily available and when it was available, it was not used for planning (HM Government, 2005). The Independent Review of the Mental Health Act highlighted many areas where, due to a lack of data, adequate strategies could not be developed. This included a lack of ethnicity data on the use of restraint, detention under the Mental Health Act and applications for discharge. This lack of data was reported to have impaired the development of effective policy and to have made it difficult to measure the efficiency of policies developed to tackle inequalities (HM Governement, 2018). Though steps have been taken to fill this gap, there are still many challenges in improving the

flow and quality of data especially regarding 'protected characteristics' (HM Government, 2020).

Theme 2 Policy Recommendations

2.1 Developing cultural competence

One of the recommended solutions to tackling ethnic mental health inequalities has been cultural competence, whereby awareness of cultural norms was advocated (HM Government, 1999). Compulsory cultural awareness training was recommended for all healthcare professionals working in mental health services (NIMHE, 2003). This was recommended for all stages of treatment, and particularly during assessment, to take into account the importance of identity and protected characteristics. However, the complexities of having a culturally competent workforce was highlighted in the review of the Delivering Race Equality Action Plan, which recognised that there are different needs between so-called 'BME populations' (HM Government, 2009). The policies identified two major initiatives for providing culturally appropriate services, i) linguistic competence, relating to the use of interpreters, translators or advocates, particularly for individuals whose first language is not English; and ii) workforce development, relating to knowledge, skills and attitudes for working respectfully with people from BME backgrounds, whilst also creating a more diverse workforce(NIMHE, 2003; HM Government, 2005; HM Governement, 2018).

2.2 Reducing restrictive practices

There has been major concern regarding the rates, frequencies and durations of restrictive practices experienced by BME patients in mental health services (Hui, 2017). A strong emphasis has been placed on reducing restrictive interventions, such as physical restraint, seclusion, segregation and involuntary medication, and practicing in least restrictive ways. Other recommendations include changes to organisational culture, attitudes and practices, including reducing compulsory detention. Evidence demonstrates that Black people are more than four times as likely as White people to be detained under the Mental Health Act, and that Black Caribbean people experience the highest rates of detention of all ethnic groups (HM Government, 2021) It has been suggested that crisis teams or residential alternatives to hospital

admissions be accessible for all services, with crisis plans to be developed in advance (NIMHE, 2003).

Policies recommended that specific plans be put in place to reduce the disproportionately high numbers of BME people detained under the Mental Health Act and to work in the least restrictive ways possible (HM Government, 2016). Once in mental health services it was recommended that BME people should have access to a second opinion, if desired (HM Government, 2005). It was recommended that the NHS, in collaboration with the BME voluntary organizations and the criminal justice system would develop schemes for early identification and movement of patients from the criminal justice system, to mental health services. The recommendations also included increasing training for police to better support people with mental health problems, and particularly those from BME backgrounds (HM Governement, 2018).

2.3 Improving inclusion

Including service users, especially those from BME backgrounds, in service development and implementation was recognized as important for all future policies (HM Government, 1999). The need for inclusion was not limited to policies and services but extended to treatment and outcomes as well (HM Government, 2005). An emphasis was placed on the involvement of carers, family members and advocates in treatment decisions (HM Government, 1999). This included patient choice in choosing his/her nearest relative or to nominate a person who possesses special rights in taking decisions regarding their treatment (HM Governement, 2018). Closer collaborations between service users, their carers and the local community was recommended to overcome inequalities and discrimination.

2.4 Enhancing Research and Data

Highlighted in almost all policy documents reviewed was the lack of data on ethnic minority populations within mental health services. This lack of data was reported to have affected the planning of adequate policies, and also the evaluation of those policies, to improve services for BME populations. It was recommended that patient records must contain information about ethnicity and preferred spoken language (NIMHE, 2003), that categories of ethnicity should be

standardised to allow meaningful comparisons (HM Governement, 2018) and that data should be collected annually over the longer term to allow monitoring of trends over time (HM Government, 2005). Action plans included enhanced information and ethnicity monitoring to specifically include information on admission rates, diagnoses, use of seclusion, physical interventions and Mental Health Act orders. Action should be taken if variation was found in any of these, where there was no clinical justification for that variation (HM Government, 2005).

Policy recommendations also emphasised the need to conduct culturally appropriate research that has a cultural or ethnic component; includes BME populations, takes into consideration implications and considerations for BME populations and that uses methods appropriate to engage with BME populations (NIMHE, 2003). Research was also recommended to study the interactions of mentally ill people of different ethnic backgrounds with the police, and the importance of advocacy for ethnic minorities during their entire interaction with mental health services, and ways to make it more efficient.

2.5 Community Capacity Building

The first MHNSF (Department of Health 1999) recommended that community mental health teams should be empowered to improve engagement with service users from BME backgrounds, and that specialist services, such as early intervention, home treatment and assertive outreach, be available (HM Government, 1999). Capacity building for community involvement was proposed as a crucial strategy to combat inequalities and the role of community development workers (CDWs) was emphasised to focus on socio-cultural challenges experienced by BME people (NIMHE, 2003). Policies highlighted the need for local mental health services to develop multi-agency community engagement schemes, with the role of CDWs being to create a bridge between service developers and users (HM Government, 2005). The roles of CDWs were to assess and report on the needs of the communities, particularly those from BME backgrounds, and to support communications between statutory and non-statutory sectors (HM Government, 2005). Further recommendations were to enhance training and education for CDWs, improve inter-agency communication, enhance and sustain the roles of CDWs within organisations and raise public awareness of CDWs' roles (HM Government, 2009). However, disparities in pay,

clarity of role descriptions and availability of training were criticised as varying greatly between different services and sectors (Allcock and Hollingsworth, 2009).

2.6 Increase monitoring and accountability

Policies highlighted the importance of monitoring and accountability to reduce ethnic and racial inequalities in mental health services (NIMHE, 2003). The Delivering Race Equality Framework (2005) emphasised the need for top-down approaches, suggesting that action plans be led by senior management. Chief executives should be held responsible for progress in this area. It was also recommended that all mental health services formulate written policies on racist abuse, with these being made publicly available. Any violation of these policies, found as a result of monitoring, was to be documented so that action could be taken against the perpetrators (HM Government, 2005).

'Equality champions' were recommended whose responsibilities were to lead initiatives to curb discrimination within mental health services (HM Government, 2016). The review of the Mental Health Act further recommended that the Care Quality Commission modified their frameworks to prioritize ethnic minorities. It was also recommended that where the rights of advocacy services were being denied or not made available to people (especially those from ethnic minorities) managers be held accountable through the organization competence framework (OCF). The OCF could also be utilized to monitor the interaction of police and people with ethnic minorities under the Mental Health Act (HM Governement, 2018).

2.7 Synergy

Policies persistently highlighted social exclusion, discrimination and stereotyping as contributing towards mental health problems amongst BME people, as well as affecting access, experiences and outcomes of mental health services (HM Government, 1999; NIMHE, 2003). In doing so, policies emphasised that efforts in mental health services alone were insufficient and that combined efforts were required in tackling different sources of discrimination, including schools, neighbourhoods, statutory and non-statutory sectors (HM Government, 1999). It was recommended that the voluntary groups and local initiatives must be engaged and supported at every level to ensure equality of services. Prisons were highlighted as a service requiring improvements, specifically mental health training for prison officers and addressing the mental

health needs of prisoners, and BME prisoners in particular (NIMHE, 2003). In line with the MHNSF, the Delivering Race Equality action plan highlighted that health agencies should form sustainable partnerships with communities of diverse faiths so that discussions about mental health can be generated to improve mental health services for people with different faiths (HM Government, 2005).

Theme 3 Performance Measurement

Performance measurement has been patchy regarding ethnicity monitoring or evaluation of mental health policies. The standards that were recommended could not necessarily bring significant improvements as outcomes for ethnic minorities were not being measured (NIMHE, 2003). There has been a lack of evidence of good practice as the effectiveness of services for BME populations cannot be established through evidence (HM Government, 2005).The review of the Delivering Race Equality highlighted that the twelve characteristics of the action plan were not calculable indicators (HM Government, 2009). With the backdrop of these issues recommendations were made to improve performance measurement. The MHNSF recommended that local authorities collate information so that services could be made more equitable for BME populations, including evidence of adequate access and care provided to the patients from African-Caribbean and other ethnic minorities (HM Government, 1999). Feedback from local communities, especially inclusion of BME voices, was recommended to be incorporated in the assessment of performance (NIMHE, 2003).

Existing performance indicators and inspection models were recommended to include indicators of equality and discrimination (HM Government, 2005). Detailed performance indicators were recommended to ensure adequate, unbiased and non-discriminatory mental health services. These should include suicide rates, monitoring of prescription antidepressants, hospital admissions and readmissions, with particular attention to protected characteristics, including ethnicity and gender (HM Government, 2011). Further indicators included reducing variations by ethnicity relating to detention under the Mental Health Act, satisfaction, experiences and outcomes; and a workforce that is representative of its community (NIMHE, 2003). Transparent definitions of risk were also advocated to prevent unnecessary, and longer than necessary, detention of BME people (HM Governement, 2018).

Discussion

This paper has reviewed government mental health policies on the mental health needs of BME people, published between 1999-2020. The findings highlight that Black and Afro-Caribbean people have continued to be disproportionately over-represented in mental health services and that mental health services are not meeting their needs (HM Governement, 2018). BME people are likely to experience multiple forms of disadvantage relating to mental health, educational attainment and socio-economic status (Hui *et al.*, 2021). Furthermore, BME people have been experiencing higher rates and frequencies of being sectioned, secluded, and restrained, and have been more likely to access mental health services via the Criminal Justice System (Wessely *et al.*, 2018). These each indicate differences in how BME people have been assessed, treated and served, with negative implications for their mental health, experiences and outcomes.

Busfield (1999) identified that people from BME backgrounds, particularly men, were more likely to be considered dangerous, to be diagnosed with experiencing severe mental health problems and to be accommodated within secure mental health services. She stated that "on the one hand, mental health services and mental health policies themselves reflect the gendered and ethnic organisation of society, and on the other hand, they contribute to that organisation" (p.58). Given that little has changed in the disproportionate representation of BME populations within mental health services in England; Busfield's statement has grave implications for the continued institutional injustices, biased practices and policies that have done little towards social change. Moreover, such lack of progression in the treatment of people from BME backgrounds within mental health services, suggests wider inequalities, discrimination and injustice for BME populations in society as a whole.

Despite two decades of policies focusing on improving the quality of mental healthcare for BME populations, stark inequalities remain, indicating that policies have been unsuccessful in achieving their stated objectives. There is acknowledgement, at policy level, that the challenge of reducing mental health inequalities for BME groups is complex and multi-faceted. Despite this acknowledgement, the implementation of recommended actions is not matching the

requirements of the task (Grey *et al.*, 2013) There also appears to be lack of understanding and guidance on how to embed equity in commissioning of NHS mental health services (Wenzl, McCuskee and Mossialos, 2015).

It is increasingly recognised that implementation itself is difficult, to the extent that a new academic discipline of implementation science (Bauer *et al.*, 2015), which studies problems of implementation, and possible solutions, has developed in the 20 years since Busfield's paper. A key consideration in policy implementation is that it is carried out by organizations composed of members who play many roles in this process. The actual process of implementation (the 'how') remains understudied, particularly in the field of mental health. How these organizational members 'make sense' of the policies and in what ways they try (or not) to achieve policy objectives are important factors in effective policy implementation (Siciliano *et al.*, 2017). It is argued that individual policy beliefs, which shape implementation decisions and behaviours, are socially constructed and legitimized (Siciliano *et al.*, 2017). If there is racism in society, it is going to be reflected in the workplace as well (Opie and Roberts, 2017). A policy which is not based on an understanding of the sense-making and interpretation process of its actors is likely to achieve poor outcomes (Coleman *et al.*, 2010). There is also a need to understand how a policy is filtered and practised in various levels of the organization and within professional categories.

The policy documents reviewed in this paper lack focus on the implementation of the policies they propose. Like most policy, they are not based on the findings of research on how policy is implemented (or not) in organisations (Harris *et al.*, 2015). The policies stated what changes were required but placed very little focus on how these changed 'behaviours' or 'practices' can be achieved by the main policy actors, i.e. the organizational members of NHS. For example, service providers have not been offering talking therapies due to lack of language competency and the cost involved (Loewenthal *et al.*, 2012). Breugel and Scholten (2017) conducted a comparative study on ethnic diversity and mainstreaming in public service provision in the UK, France and the Netherlands. They defined 'mainstreaming' as the effort to embed ethnic diversity in a generic approach across policy areas as well as policy levels, to establish a whole-society approach to diversity rather than an approach to specific ethnic minority groups. Breugel

and Scholten (2017) concluded that ethnic mainstreaming agenda in public service provision is driven by political and economic motives rather than considerations of superdiversity itself. They observed that on a pragmatic level, a 'mainstreaming' agenda is applied as an instrumental strategy for circumventing or avoiding dilemmas of recognition in superdiversity in the population.

Finally, making a comprehensive policy is one thing, but ensuring that an enabling structure and culture is in place to implement them is a different task. This task requires appropriate strategy, adequate financial resources and a greater understanding of the organizational behaviour of the staff. The task of making a young white female nurse able to deliver 'equal' and 'culturally relevant' care to an elderly black male patient rests with the leadership and management of the NHS and relevant training bodies. What strategy would be appropriate (incentive/penalty/training) to get the task done is a critical question for NHS leaders and managers. In general, the evidence suggests that the UK NHS responds well to financial incentives driven by targets, though this has concomitant dangers of gaming the system (Maynard and Bloor, 2010). Research (Hussain *et al.*, 2020) has found that a strategy based on diversity training and workforce diversity was not helpful in developing the capabilities of an NHS organization in delivering high quality and equal care for BME population groups. Atkin et al. (2014) found that among healthcare professionals, despite a commitment to policy expectation of offering sensitive care, professionals struggle to engage with cultural diversity and reconciling individual behaviour with what they think they know about South Asian cultures. This creates misunderstandings, leading to poor practice. To address this, research (Hussain *et al.*, 2021) has emphasized recognising service users' diversity in mental health service planning and its delivery.

Conclusion and Policy recommendations

Despite the 20 years since Busfield's paper, the picture of policy for mental health services for BME people remains depressingly familiar. Policies have not been implemented fully, or even at all. This is compounded by a lack of meaningful targets (which appear to be a major driver of performance in the NHS) and a lack of data against which performance could be monitored. Many of the policy aims specified are not straightforward to accomplish (due to shortages of

resources, both human and financial) so in the absence of a robust system for policy implementation and monitoring, issues are compounded. We propose action-orientated policies that mandate specific clear goals, and deliverable objectives would be beneficial. These should specifically address the discriminatory cultures, actions and processes of mental healthcare organisations and the individuals working within these organisations. This also means developing the ability to challenge systemic bias and enable positive institutional change.

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PAPER TITLE: ETHNIC MENTAL HEALTH INEQUALITIES AND MENTAL HEALTH POLICIES IN ENGLAND 1999-2020	
Associate Editor's Comments	**Authors' Reply**
There may be some confusion where the title refers only to England but some of the documents analysed apply to either England & Wales, or the whole UK (with amendments as appropriate). This will need clarification; maybe on the table.	We have clarified this point in the table and highlighted in 'yellow' colour.
I think (a) (b) etc are not needed; also some DOIs. Add date accessed for other URLs	We have removed (a) (b) etc. Also DOIs are also removed from the references. We have added accessed date for URLs
References present in reference list but not cited in main text.	We have identified these references in text citations and highlighted in 'yellow' colour.