



## **Improving Pathways into Mental Health Care for Black and Ethnic Minority Groups: A Systematic Review of the Grey Literature**

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## Introduction

Previous reviews of specialist mental health services (1) and primary care (2) show ethnic variations in pathways to care. 'Adverse' and 'non-sought' routes to care (7) include referral from the criminal justice system and compulsory admission; both are significantly higher for people of African-Caribbean origin (3, 4). Other detrimental experiences reported by ethnic minorities include failure to receive appropriate care at the earliest possible stage of an illness. Delivering Race Equality (5) sets out an action plan to reduce inequalities in access to, experience of, and outcomes from NHS and local authority services. In order to achieve this, practitioners and policy makers need to recognise the cultural context within which illness is experienced (6) and then respond to public preference for specific services and more flexible modes of access. This approach embraces a broader definition of 'pathways to care' that includes help-seeking behaviours in the community before contact with statutory services. It expands existing pathways models (8) to include the voluntary sector, traditional healers and specialist services (9).

This paper synthesises existing knowledge from the grey literature on how to improve pathways to mental health care for ethnic minorities. A 'pathway' was defined as 'the *flow* of patients, service users or help seekers with mental distress *into* services or *between* services or professionals'. As previous reviews of care pathways for mental health have excluded non-statutory services (1, 7), this review aimed to include broader 'pathways' as a focus of intervention, including routes into, through and out of care across statutory and non-statutory sectors.

The grey literature is commonly overlooked in conventional literature reviews yet often contains innovations and insights of value to service developers as it includes perspectives from those actually delivering and receiving services.

## Method

### Data sources

Specialist libraries, databases containing grey literature, and subject specific databases were identified following advice from qualified librarians. Searches were applied to SIGLE (accessed at the British Library), Kings Fund (accessed on-site), Index to Theses ([www.theses.com](http://www.theses.com)), Dissertation Abstracts (via <http://erl-server.ucl.ac.uk>), the Warwick Centre for Research in Ethnic Relations (CRER) database ([www.warwick.ac.uk/CRER](http://www.warwick.ac.uk/CRER)), DH Data (via Dialogue Datastar), and Zetoc (<http://zetoc.mimas.ac.uk>).

A hand search of the following Kings Fund reading lists was conducted: *Mental Health: black and minority ethnic communities* (December 2005); *Care Pathways* (January 2006); *Ethnic Health: an introduction to ethnic health issues* (January 2006). As abstracts of grey literature were not provided, each list of titles was examined and potentially relevant documents retrieved for screening. This was supplemented by a hand search of relevant shelf marks of the Kings Fund library identified by a Kings Fund librarian and guided by previous search results (e.g. IJH:RLQ, IJHed:RLQ).

Specific websites were searched for relevant documents (see appendix for details). In addition, organisations and experts were identified from the *Kings Fund Ethnic Health and Social Care Organisations* list (Aug 2005), National Institute of Mental Health England's National Conference on Delivering Race Equality 2006, Social Science Information Gateway ([www.sosig.ac.uk](http://www.sosig.ac.uk)) and the national BME mental health researcher's database hosted by the Centre for Evidence in Ethnicity Health and Diversity at DeMontfort University and Warwick University. Where email contacts were provided for individuals and organisations, email requests

sought information on grey literature focused on improving pathways to mental health care for adult black and minority ethnic groups. In total 217 contacts were emailed. Bibliographies of retrieved documents were scrutinised to identify further documents and relevant experts or organisations.

### **Search strategy**

The search strategy was developed through an iterative process as classification systems within databases did not separate *care pathways* from *care destination*. Preliminary searches refined search terms. It was verified that terms included a broad range of services including, for example, Traditional Chinese Medicine and traditional healers. The final strategy combined one search on 'ethnic or minority groups' with a second search on 'mental health related service or mode of access'. The search terms were:

ethnic\* OR minority group\* OR minority ethnic group\* OR black OR African OR African Caribbean OR African American OR American Indian OR asian OR Chinese OR Indian OR arab\* OR eastern Europe\* OR irish OR Turkish OR muslim OR jewish OR migrant\* OR transient\* OR transient migrant\* OR immigra\*

AND

care path\* OR path\* to care OR acces\* to care OR acces\* care OR acces\* service\* OR acces\* help OR mental OR mental health OR psychiat\* OR health service\* OR help seek\* OR seek\* help OR distress\* OR psycholog\*OR outreach OR home care OR home treat\* OR specialist service\* OR crisis OR health promot\* OR community care OR community service\* OR refer\* OR consult\*

This framework was adapted according to the search engine structure of each database. Search strings, thesaurus mapping, truncation, stemming and synonym searches were applied when

available. Abstract and title searches were conducted in SIGLE, Kings Fund Database and DH Data. Full text searches were conducted in Dissertation Abstracts and Index to Theses. In databases where only simple searches were possible (e.g. keyword search in CRER), several searches were conducted and results were combined. The aim was to maximise yield while maintaining precision.

### **Inclusion criteria**

Statutory and voluntary sector interventions for adult services that improved initial access, referral between services and moving out of care were included. Documents were included if they contained evaluation data that demonstrated flows through existing or new pathways which lead to recovery, or a reduction in flows through adverse or unhelpful pathways. Evaluations of pathway interventions were considered sufficient if they reported changes in patient flow or pattern of service use, irrespective of whether a formal evaluation had been conducted. English language documents from the earliest date for each database to April 2006 were included.

### **Exclusion criteria**

Documents were excluded if they: presented descriptions of existing pathways with no interventions; contained no evaluation data; presented descriptions of pathway impacts without qualitative or quantitative empirical data; presented interventions for children and adolescents, dementia or learning disability services.

All titles, executive summaries and abstracts were assessed by JM & BS against inclusion and exclusion criteria. Those potentially matching the inclusion criteria were retrieved and screened. For potential documents without executive summaries, introductions, contents lists and relevant chapters or sections were scanned. A penultimate selection of documents were scrutinised and discussed in a consensus meeting of the research team to produce a final list.

### **Extraction of data**

JM extracted data according to emergent themes developed in pilot extractions. These were: reports by commissioners of service, overall description of service, pathway components that were evaluated, outcome measures; sample characteristics, data sources, geographic location, ethnicity and method of ethnicity classification; evaluation results and limitations. A second reviewer extracted data independently and discrepancies were resolved by consensus within the research team.

### **Assigning Quality Scores**

There is no single well established quality scoring instrument suited to grey literature. Consequently, the BMJ qualitative research checklist (10) was modified in accordance with Centre for Reviews and Dissemination guidelines (11). These criteria were reviewed to identify a schema appropriate to the documents. This allowed scoring of evaluation data regardless of whether the data were discussed in the document. From twelve original items, five were removed and one was replaced to produce a seven-item instrument specific to the included documents. The five removed criteria referred to theoretical framework, methodology and analysis items not relevant to the type of grey literature included. The BMJ item referring to generalisability of the sample was not congruent with aims to report on interventions for specific ethnic groups and was replaced with an item on ethnicity classification. The wording of the remaining six items was slightly modified (Table 1).

Two reviewers (JM & BS) scored documents applying a dichotomous scoring system.

Criteria 1 and 3 were double weighted as they relate to the description of the intervention and the clarity of the evaluation, and were therefore most relevant to the review. Inter-rater reliability for each document was determined by Kappa tests using STATA.

### **Analysis of data**

Descriptions of services were extracted and then analysed by JM to identify the pathway relevant characteristics. These were assigned to broad categories and analysed to generate higher order categories that captured their structures and functions. This was an iterative process using charted extraction data.

## **Results**

The combined searches yielded 1309 documents of which 365 appeared to meet inclusion criteria after screening titles. However, a more detailed review concluded that 8 documents fully met inclusion criteria. Twenty-eight experts recommended 32 documents but only 1 of them met inclusion criteria (14). The other 7 documents derived from handsearching the Kings Fund Library (15, 16, 17, 18), Kings Fund database (12, 13) and DH Data (19). The flow diagram in Figure 1 illustrates this process.

The services and type of evaluation data are presented in Table 2. There were 2 external evaluations of Antenna, an outreach service for young African and African Caribbean people (16, 17); 2 in-house project reports, one on an 'Access to mainstream mental health project' at Al-Hasaniya, a service for Arabic speaking women with mental health and social problems (15), and one on the role of the Mental Health Outreach Worker at Qalb Centre for South Asian people with mental health problems (18); one annual report on Vietnamese Mental Health Services (14); and book chapters on home treatment (19), Chinese Community Mental Health Nursing (12), and the role of a project worker at the Chinese Mental Health Association (CMHA)

(13). All services were based in the UK; 7 related to London-based services and 1 to a service in Birmingham (19).

Services were funded by the non-statutory sector (13, 18), Department of Health or National Health Service (12, 15) or a combination of the two (14, 16, 17). Two services received short term funding for one (15) or two years (18). One gained funding as a result of voluntary sector pressure (19) and one had lost funding (14). Duration of funding was unclear for the remaining services (12, 13, 16, 17).

### **Quality of documents**

A maximum quality score of 9 was possible. Quality scores ranged from 3 to 7 and were summarised into three categories: low quality (0-3); medium quality (4-6); high quality (7-9). There was one high quality document that presented a formal evaluation and provided a clear description of the intervention and data source (17). There were three medium quality documents that clearly described the intervention and method of data collection (15), clearly related outcome data to pathway impacts (19), or provided a clear description of the intervention (16). The remaining documents were low quality and presented limited evidence and poor descriptions of interventions (12, 13, 14, 18). Inter-rater reliability was good or excellent for each document. Quality scores and Kappa values are reported in Table 2.

### **Pathway relevant components of services**

Seven services are presented across the 8 documents. All services operate at multiple pathway levels (i.e. into, through and out of services) except one (19) which focused on changing pathways into care only. Seventeen pathway relevant service characteristics were identified across the seven services. Characteristics fall into *five broad categories*:

- specialist services for ethnic minority groups (S)

- collaboration between sectors (C)
- facilitating referral routes between services (R)
- outreach and facilitating access into care (I)
- supporting access to rehabilitation and moving out of care (O).

These are organised further into sub-categories and are presented in Table 3.

### **Evaluation data**

Data indicating pathway impacts were collected by case histories (12, 13), questionnaires (18), semi-structured interviews (16, 17) and referral rates and destinations (14, 15, 18, 19). Further synthesis of the evidence reveals 3 broad pathway improvement processes.

### **Collaboration between sectors and services**

Networking, partnership working, collaboration and integration of services featured in reports except one (19). Networking between statutory and voluntary sectors (18, 16, 17), networking between NHS and other statutory organisations (16, 17), and integration of specialist and mainstream services (12, 16, 17) are all described. Partnerships between NHS services and culturally specific community groups have led to the establishment of jointly managed or funded services (13, 14, 15). These services incorporate a two-way learning process and employ creative use of resources. However, pathway impacts arising from collaborative working are only demonstrated for Antenna (16, 17) and Chinese Community Mental Health Nursing (12).

#### *Collaborative working: NHS and other statutory services*

Evidence shows social inclusion and rehabilitation were supported through collaboration between Antenna and a variety of statutory health, social and community organisations (16, 17). Specifically, collaboration and partnerships with local employment and education services resulted in client completion of a work placement scheme and attendance at college. In addition,

group activities and awareness programmes to support rehabilitation were developed through joint working with local recreational services.

#### *Integration of services: specialist and mainstream*

Increased referrals to Antenna and joint assessments resulted from integration between Antenna and other mental health teams (16). Similarly, access to appropriate services was facilitated by integration of a specialist Chinese Community Mental Health Nursing service within a mainstream hospital (12).

#### **Facilitating referral routes between services**

Interventions to facilitate routes through care incorporate the different forms of collaboration between services and across sectors described above. Referral routes between services are further facilitated by a 'bridge' function and provision of culture-specific advocacy.

#### *Bridge between services*

A service can act as a 'bridge' between services and across sectors. Referrals are received from a range of sources, and clients are referred on to a variety of services. The opportunity for clients to remain in contact with the 'bridge' service may be available in the form of drop-in sessions, telephone advice line, or day-service facilities. A 'bridge' function can be provided by a service or by a specific role within the service, such as a mental health worker (15, 18). The 'bridge' function is facilitated if the service is culture specific, through networking with a variety of agencies, and campaigns to raise awareness about the service.

The 'bridge' function to access a diverse range of services is evident for the Qalb service which referred Asian clients to education, counselling, advice and culture specific organisations (18). In contrast, access to mainstream mental health services was facilitated by Al-Hasaniya, which

also prevented Arabic-speaking women from requiring 'high level' support (15). However, 44% clients refused referral to suggested services. This low success rate was attributed to clients' fear of statutory services, the institutionalised nature of services and cultural barriers. In addition to making referrals, all services acting as a 'bridge' provided information on other available services and how to access them. For example, advice from Antenna enabled clients to access private and supported housing.

### *Culture specific advocacy*

Evidence on culture specific advocacy to facilitate access exists for CMHA and VMHS. Data demonstrates that GPs, psychiatrists and social workers were assisted by advocates in reviewing clients' mental health state and medications (13, 14). Thereby, clients were assisted with accessing appropriate services, and prevented from referral to inappropriate services. The role of the Chinese Mental Health Association (CMHA) project worker extended beyond interpreting (13); befriending and accompanying clients to appointments, understanding cultural context, facilitating communication between clients and professionals, eliciting additional details of personal history, and identifying culturally appropriate services were all benefits provided in addition to a translation service. Furthermore, the role avoided unnecessary referral to a consultant psychiatrist and to potentially inappropriate counselling services. Rehabilitation was achieved through access to appropriate services.

### **Outreach and facilitating access into care**

A variety of alternatives to traditional services are described, including home treatment (19), home assessment (18), specialist clinics in hospitals, GP units or community settings (16, 17), and delivering health education campaigns or leaflets (13, 14, 16, 17, 18). All are ethnic group specific with the exception of home treatment provided in an area of high ethnic minority density (19). Evidence of pathway impacts exists only for home assessment and treatment.

### *Home assessment and treatment*

A culture specific home assessment service provided by a Chinese Community Mental Health Nurse was beneficial for ensuring accurate assessment and identifying appropriate services for Chinese clients (12). Client satisfaction measures also support home assessment as a viable alternative for Asian clients (18). Home treatment reduced admission to in-patient acute care by 50% (19), and indicated less than 20% of acute care episodes resulted in hospital admission, including less than 9% admitted under the Mental Health Act. Furthermore, 80% of clients with severe diagnoses were successfully treated at home and avoided hospitalisation.

## **Discussion**

### **Limitations of evaluations**

The evidence on impacts of pathway interventions is limited due to the quality of evaluations. Although evidence of social inclusion and moving out of care is reported as a result of collaborative working, longitudinal data is necessary to demonstrate rehabilitation more clearly, for example data on employment following work placements and information on completion of education courses would be compelling. Evidence on increased referrals resulting from joint assessments at Antenna is based on content analysis of semi-structured interviews and referral figures are not provided to substantiate the qualitative data. Evidence on integration of Chinese Community Mental Health Nursing is limited to two short case histories and does not compare outcomes with regular care packages. The data is not supplemented by client satisfaction with the service or referral success. Working alongside other health professionals and in the advocate role has positive pathway impacts that need to be demonstrated more clearly by further data.

Evidence on facilitating referral routes between services is incomplete. Questions about success of the 'bridge' function are raised as data on up-take of referrals is not always reported (18). The formation of a self-help group by Qalb clients in response to referrals suggests some referrals were not perceived as appropriate. Although explanations of refused referral are provided from Al-Hasaniya, they are based on client contact, focus groups and client consultation with no relating data or description of methods (15). Evidence is further compromised as comparison with baseline data is not possible and data presented do not always distinguish clients already accessing services from new and isolated service users. Specific connections between referral into and out of 'bridge' services cannot be deduced as referral sources and destinations were not matched. Therefore, while this intervention clearly provides a valuable function, it is not possible to compare specific resultant changes in care packages or conclude the level of effectiveness. Evidence on advocacy to review mental health state and medications is based on the number of sessions provided in outpatient clinics in which clients were accompanied (14). Although the number of clients who received the service is provided, resulting referral destinations are not reported. A descriptive statement is inadequate without comparison of baseline and follow-up data, therefore it is not possible to infer effectiveness. Although there is evidence that home treatment reduced admissions to in-patient acute care, figures for ethnic groups are not reported rendering effectiveness for specific groups unclear (19). Home assessment received client satisfaction (18) but data did not demonstrate how pathways were altered as a result.

## **Main Findings**

This is the first systematic review of the grey literature on interventions to improve pathways to mental health care for ethnic minority groups. The limited evidence indicates that routes into, through and out of care are achieved by integration of specialist and mainstream services, the 'bridge' function, culture specific advocacy, and home assessment. Routes out of care aiming for

social inclusion and rehabilitation are achieved through collaborative working between NHS and other statutory services. Hospital admissions, high level support and referral to inappropriate services were reduced by home treatment, the 'bridge' function and culture specific advocacy. Services provided in the voluntary sector facilitated access to culturally appropriate services to support treatment and rehabilitation. Integration, networking and partnerships between voluntary and statutory sectors support delivery of these interventions. Future pathway interventions should include these approaches.

### **Collaboration, Pathway Facilitation & Improving Access**

The three themes of collaboration, facilitation of referral between services, and improved access by outreach were not mutually exclusive functions (Table 3). For example, a 'bridge' service can be developed through partnership between statutory and non-statutory sectors (Al-Hasaniya; 15), or may incorporate culture specific assessment (Qalb; 18). Care pathways and care destinations are often intertwined and provided in the form of culture-specific services (12, 15, 18). Culture specific health workers have potential to elicit details contained within expressions of distress, and to combine cultural awareness with mental health knowledge.

### **Contribution of grey literature**

This review indicates that significant work remains unpublished and is consequently difficult to source. Hand searching libraries proved the most successful method of identifying relevant literature. Limitations prevented hand searching libraries outside the UK raising the possibility that additional documents exist. A larger proportion of work in London is expected due to higher density and broad cultural diversity. This may reflect the national distribution of funding opportunities and policy priorities that enable and drive service development, evaluation and research. Capacity to conduct this work is reliant on statutory or non-statutory commissioning. A tension exists between priorities to fund service provision and needs to complete service reports

with adequate evaluation data. Sources of funding is further complicated by the overlap between mental health and social services, and the holistic solutions required to adequately address the socio cultural and religious context of ethnic minority health.

### **Future Evaluations**

There are difficulties in assessing the quality of grey literature because it is mainly written by service providers who are not trained in research methods. Therefore most documents do not adopt a research framework or incorporate systematic collection of data. The grey literature quality scoring tool developed for this review addresses this by recognising valuable information in service reports and considering evaluation data inferred as a measure of successful intervention. A significant recommendation from this work is an evaluation framework for future studies of innovative services (see Table 4). Three overarching themes captured the type of activity at local service level, and future work should explicitly evaluate these functions.

Overall, the existing evidence on pathway interventions is not strong in evaluation terms, but provides knowledge from real services, clinicians and managers.

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## **Appendix**

### **Websites searched**

The Afiya Trust ([www.afiyatrust.org](http://www.afiyatrust.org)); Centre for Evidence Health and Diversity, University of Warwick ([www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth](http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth)); Centre for Research in Ethnic Relations, University of Warwick ([www.warwick.ac.uk/CRER](http://www.warwick.ac.uk/CRER)); Care Services Improvement Partnership ([www.csip.org.uk](http://www.csip.org.uk)); Diverse Minds ([www.mind.org.uk/About+Mind/Networks/Diverse+Minds](http://www.mind.org.uk/About+Mind/Networks/Diverse+Minds)); ESRC Society Today ([www.esrc.ac.uk/ESRCInfoCentre/research](http://www.esrc.ac.uk/ESRCInfoCentre/research)); Centre for Ethnicity and Health, University of Lancashire ([www.uclan.ac.uk/facs/health/ethnicity/index.htm](http://www.uclan.ac.uk/facs/health/ethnicity/index.htm)); Institute of Psychiatry ([www.iop.kcl.ac.uk](http://www.iop.kcl.ac.uk)); Mental Health Act Commission ([www.mhac.org.uk](http://www.mhac.org.uk)); Mental Health Foundation ([www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)); NIMHE ([nimhe.csip.org.uk](http://nimhe.csip.org.uk)); Rethink ([www.rethink.org](http://www.rethink.org)); The Royal Society of Medicine ([www.rsm.ac.uk](http://www.rsm.ac.uk)); Royal College of Psychiatrists ([www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)); Sainsbury Centre for Mental Health ([www.scmh.org.uk](http://www.scmh.org.uk)).

Figure 1

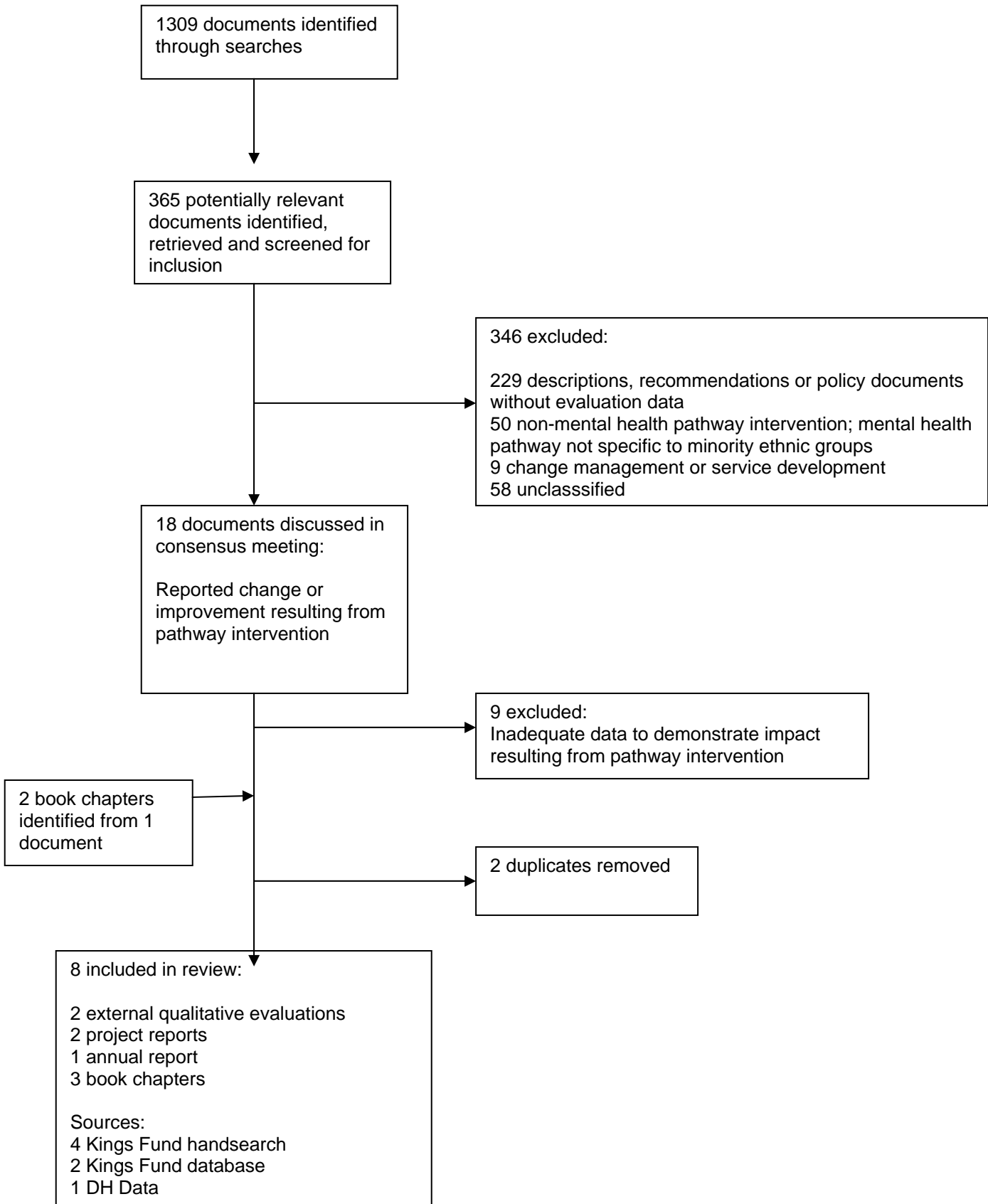


Table 1 Quality scoring system

1. Is the intervention and its context clearly described? (0 = no/incomplete; 2 = clear/complete)
2. Is ethnicity and method of classification clearly defined (0 = no; 1 = ethnic groups identified)
3. Evaluation method: is the type of data clearly described and justified e.g. source/method of collection? (0 = no/unclear; 2 = partial/complete)
4. Data: was the evidence (routine data, fieldwork notes, interview transcripts, documentary analysis etc) inspected independently by others? (0 = no; 1 = specifically stated)
5. Is sufficient of the original evidence presented systematically in the written account to satisfy the sceptical reader of the relation between the interpretation and the evidence, for example, were quotations numbered and sources given? (0 = no/incomplete; 1 = clear/complete)
6. Was qualitative and quantitative data combined to support evidence? (0 = no/incomplete; 1 = clear/complete)
7. Have observations that might have contradicted or modified the analysis been sought out and reported? (0 = no/unclear; 1 = partial/complete)

Table 2. Evaluated pathway interventions

Document	Service	Client group	Evaluated pathway intervention	Pathway categories	Type of evaluation data	Quality score	Kappa value
Byrne & Pillay (1998)	Al-Hasaniya Moroccan Women's Centre	Disadvantaged Arabic speaking women suffering from social and mental health problems	1 full time mental health advocate working on the 'Access to Mainstream NHS Project', providing assistance in accessing mainstream mental health services	R1	In-house project report  Referral sources and destinations  Personal account based on client contact, focus groups and user consultations	6	0.79
Lee et al (2002)  Greatley & Ford (2002)	Antenna Outreach Service	Difficult to engage African and African Caribbean people aged 16-25 in Haringey	Partnerships with community groups and statutory agencies e.g. education, recreation, employment, to facilitate social inclusion, early discharge and rehabilitation  Joint assessment between specialist and mainstream services	C2 C3	External evaluation  Scoping profiles  Service user semi-structured interviews	7	0.77
Li-Howard (1997)	Chinese Community Mental Health Nursing	Chinese clients in the East End of London	Culture specific home treatment and assessment, providing accurate assessment and facilitating appropriate access to services  Specialist service within mainstream Community Mental Health system	I1 C3	Book chapter  Case history	3	1
Yee & Au (1997)	Chinese Mental Health	Chinese clients	1 full time project worker	R2	Book chapter	3	0.53

	Association		providing culture and language specific advocacy		Case history		
Sashidharan (1999)	Ladywood	Clients living in Ladywood constituency, an underprivileged multi-ethnic inner city area of North Birmingham	Home treatment as a filter to prevent hospital admission to in-patient acute care	I1	Book chapter  Routine data: local hospital admission rates	6	0.52
The Qalb Centre (1998)	The Qalb Centre	Isolated Asian people who have had or are experiencing mental health problems	Mental health outreach worker providing support, befriending, information and advice on accessing specialist services  Networking with statutory and voluntary organisations to establish partnerships and referral systems	R1 I1	In-house project report  Referral sources and destinations  End of service feedback via questionnaire	3	0.53
Vietnamese Mental Health Services (2005)	Vietnamese Mental Health Service	Vietnamese people in and around London	Specialist service working in partnership with health and social care agencies	R2	Annual report  Service data: number of sessions	3	0.73

Table 3 Classification of service characteristics

Category	Component	Services
S	S1: Specialist service in community setting	Al-Hasaniya Qalb
S	S2: Specialist service funded/set up by NHS, not based on NHS hospital site	Antenna Al- Hasaniya
S	S3: Culturally specific/language appropriate treatment/counselling	Al-Hasaniya Qalb Vietnamese Mental Health Services Chinese CMHN
C	C1: Networking and collaboration: statutory and voluntary or community sector	Qalb

C	C2: Networking and collaboration: NHS and other statutory services	Antenna
C	C3: Integration: specialist and mainstream services	Antenna Qalb Chinese CMHN
C	C4: Formal partnership between NHS and voluntary sectors	Al-Hasaniya Vietnamese Mental Health Services Chinese CMHA
R	R1: 'Bridge' service providing referrals between agencies and across sectors ie taking and making referrals	Antenna Al-Hasaniya Qalb Chinese CMHN
R	R2: Culture specific advocacy: translator or mental health worker acting as advocate, or liaising with GPs or mental health professionals to assist correct assessment	Al-Hasaniya Vietnamese Mental Health Services Chinese CMHA Chinese CMHN
R	R3: Self referral possible	Antenna Al-Hasaniya Qalb Vietnamese Mental Health Services Chinese CMHA
I	I1: Outreach: home treatment/assessment	Antenna Qalb Chinese CMHN Ladywood
I	I2: Outreach: special clinics in hospitals, GP units, community settings	Antenna
I	I3: Outreach: health education or campaigns	Antenna Qalb Vietnamese Mental Health Services Chinese CMHA
I	I4: Outreach: mental health outreach worker/CWD/befriending	Qalb
O	O1: Rehabilitation: day centre	Antenna Al-Hasaniya Vietnamese Mental Health Services
O	O2: Rehabilitation: leisure/sports activities; community/social groups/ex-service user group	Antenna Qalb
O	O3: Rehabilitation: advice or support on benefits/housing/education/training/employment	Antenna Al-Hasaniya Qalb

**Table 4: Recommendations**

<p>Evaluations of pathway interventions should:</p> <ul style="list-style-type: none"><li>• Clearly identify context and aims of the pathway intervention</li><li>• Specify ethnic groups and classification method</li><li>• Provide a clear description of data source and methodology of collection, including questionnaires, interview schedules and method of analysis</li><li>• Include a balance of methodologies and data sources, including user perspectives and participant observation by mental health workers</li><li>• Involve a minimum of two people in data checking and/or analysis</li><li>• Present a balance of qualitative and quantitative data to support evidence</li><li>• Substantiate descriptions of pathway impacts with data</li><li>• Provide baseline data and match clearly with follow-up data</li><li>• Match referral source and destinations to illustrate route facilitated by service and to demonstrate changes in pathway patterns</li><li>• Identify limitations of intervention, analysis and evaluation data</li></ul>
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