**Wandsworth BME Mental Health Forum**

**Thursday 23rd July 2020 3.00pm-4.30pm – ZOOM**

**Present**

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| Alexandra Mladenovic (AM) | Sunshine Recovery Cafe |
| Antonia Buamah (AB) | Hope for Wellbeing Project |
| Becca Walker (BW) | Richmond and Wandsworth Council |
| Carlis Douglas (CD) | Hope Atrium |
| Corey Hemmings (CH) | South West London and Maudsley NHS Foundation Trust |
| Dayo Balogun (DB) | One Support Housing Group |
| Delrita Tester (DT) | Caius House |
| Glenroy Browne (GB) | Ransom AME Zion Church |
| Geetha Maheshwaran (GM) | Shree Ghanapathy Temple |
| Joan Robinson (JR) | Seventh Day Adventist Church |
| John Morrill (JM) | Voicing Views |
| June Pilgrim-Ndure (JPN) | WCEN |
| Kirt Hunte (KH) | Primary Care Plus |
| Lystra Charles (LC) | The Hope Atrium |
| Martin Haddon (MH) | Health Watch Wandsworth |
| Michael Areola (MA) | Deeper Life Christian Church |
| Nathaniel Pamah (NP) | Unity Centre |
| Owen Mukotekwa (OM) | WCEN |
| Sarah Phillips (SP) | AMHPS |
| Sarika Sharma (SS) | NHS |
| Ukaku Kalu (UK) | Former Service User |
| Razia Karim (RK) | WCEN |
| Malik Gul (MG) | WCEN |
| Amina Smith Gul (ASG) | WCEN |
| Nathalie Gibson-Wilson (NGW) | Lynwood Christian Fellowship |
| Sherene Briscoe (SB) | Caius House |
| Kofi-William Osafo (KWO) | CNFC Pastor’s Network |
| Ruth McKinney (RMc) | WCEN |
| Jerry Hall (JH) | Christians Against Poverty |
| Prof Sashi Sashidharan (SS) | EMHIP |
| Kalu Obuka (KO) | NHS SWL CCG |
| Mia Morris (MM) | Soundminds |
| Amrinder Sehgal (AS) | NHS SWL CCG |
| Greta Headley (GH) | Carer Rep Wandsworth Carers |
| Sybil Qasir (SQ) | South West London and Maudsley NHS Foundation Trust |
| Dorrett Boswell (DB) | Independent |
| Anna DAgostino (AD) | WCEN |
| Jacob Adams (JA) | WCEN |
| Thomas Herweijer (TH) | NHS SWL CCG |
| Ranjeet Kaile (RK) | South West London and St George’s NHS Mental Health Trust |
| Wirhney | Care Agency |

**Apologies**

Mark Robertson, Ken Phillips, Sahar Beg, Miranda Taggart, Becca Neaves

**Abbreviations**

SWLSTG - South West London and St Georges Mental Health Trust

UCL - University College London

BME - Black Minority Ethnic

SLAM - South London and Maudsley NHS Foundation Trust

IAPT - Increasing Access to Psychological Therapies

WCEN - Wandsworth Community Empowerment Network

## LGBT - lesbian, gay, bisexual, and transgender

**Agenda**

1. Welcome and Introduction
2. Covid-19: Preventing a Mental Health Crisis Summit - Action Plan
3. Update on the Ethnicity and Mental Health Improvement Project (EMHIP)
4. Feedback and Discussion
5. AOB
6. **Welcome and introduction**

1.1 MG, introduced the forum and talked about the current situation with COVID-19 and discussed the viral social media post of George Floyd, and how COVID exposed existing inequalities.

1.2 He noted how our local public agencies have begun to see the importance of early intervention and prevention work with BME communities; and an increasing recognition that this must be invested in so that these communities are much more able to withstand further crisis and hardships.

1.3 MG welcomed Ranjeet Kaile, Director of Communication at SWLSTG

1. **Covid-19: Preventing a Mental Health Crisis Summit - Action Plan**

2.1 RK introduces himself and the recent SWLSTG Summit.

2.2 The Summit came about to look at how we can come together during these unprecedented times. Mental health services that NHS provide are only for those with acute need. Emergency services calls have gone up by 30% related to mental health. Our communities have a role to play in thinking about how we can support each other.

The actions agreed from the summit -

a) Create a mental health prevention task force

b) Develop a program for mental health capacity building across South London that will work with schools, faith and community groups and build upon the work that EMHIP is doing, by addressing inequalities within BME communities.

c) Develop a free COVID-19 digital wellbeing training course for people via the recovery college and ensure its culturally adapted.

d) Work together in tracking the level of psychological distress and the impact on the community from COVID-19.

e) Host a mental health summit in autumn to feedback on the progress.

2.3 MG, the pandemic has had many mutual aid groups starting to emerge and a lot of self-help in communities. The current narrative is talking about what institutions and the council have done, but communities and their relationship has been the most powerful during this time. How do you see the trust co-producing with organisations in and around Wandsworth?

2.4 RK, we cannot do this alone, the heart of this work is working with community groups and we can reach out to people through those who already have networks. We want to give people the tools to manage mental health in their own communities and networks. We will do this through listening, from conversations we will know how people are feeling. What do people really need? Do people need just the tools?

2.5 MG, this cannot be done from a top-down basis. I understand we must do listening, but there is a danger that all we are doing is listening and no actions? There are certain things we can do, and we know that we should be co-producing with community groups, investing in these communities, and redesigning pathways. I do not want us to be led into a cul-de-sac but move towards action and implementation.

2.6 RK, I could not agree with you more. Our community transformation program is about reshaping the work we are doing in communities. We know there are problems, and we need to escalate things rather than carrying out another survey etc. an element of what we need to look at is how is loneliness affecting mental health? What is the state of Public Health England funding for mental health looking like? Also, we know faith plays a huge role in people’s lives and we need to work with communities and see we how we can reach people. We have no idea how deep mental health issues have gone or will go, this is a 12-month programme of work, but it will take 2-3 years, COVID will have a lasting impact. Prevention is something that we need to enable as a day to day language.

2.7 MG, we are more than enough to deliver real action and change, we already hold the capacity and capability amongst ourselves and each other to make a difference. Keen to see as the plan develops and, in our network, where we can support and work collaboratively. Would be great if the action plans are shared with the Forum.

2.8 RK, would be a gift to have you all involved, as we are the glue that will bind this work together. This programme is owned by all of us. It will not succeed if left in institutions.

2.9 BW, noted the importance of co-production and working together. One of our projects ‘Clear the Streets’ which is getting homeless people into accommodation. In this project, we have managed to get many people involved such as the trust, social services, housing, voluntary sector and everyone is working together. We need to continue with this momentum and continue to collaborate in these ways and make progress.

2.10 MG, thank you that was very useful.

2.11 ASG, shared with the Forum the research project which Black Minds Matter is developing with UCL on the effects that COVID has had on young BME people.

2.12 MG, thank you Amina, women and young people are impacted by COVID which is not spoken about enough. The project with UCL asks BME young people about their experiences with COVID and how they are coping. One of the things that has come up is that the amount of people whose families live in extreme financial hardship, food poverty and fuel poverty. There are families that still must decide to buy food or top up their electricity or gas. It is important that these of poverty and hardship continue to be highlighted and addressed.

**3, Update on the Ethnicity and Mental Health Improvement Project (EMHIP)**

3.1 MG, introduces Professor Sashidharan and the EMHIP project.

3.2 SS, the five key interventions that have been identified will be applied across the mental health system within primary care, community, and adult mental health care. We have devised specific interventions and have adapted it to Wandsworth. There has never been a detailed plan to change our services, previous projects have been trying to make communities aware of services rather than actual plans that can be applied to the mental health system. This has attracted a lot of attention nationally; we are proposing simple things. The mental health system will change, BME communities will benefit more as they have more inequalities. We will be introducing mental health and well-being centres in Wandsworth; we have identified 9 so far and 6 of the 9 centres will be around faith groups and places of worship, which is how we will receive our referrals rather than waiting for them. The referral process from primary to secondary is outdated and does not work well, so the hubs will be the first point of contact with anyone with a mental health problem. We are going to have nurses and psychiatrists embedded in hubs. We are also looking to train people within the community with lived experience. We will also be providing alternative residential care services, so 24/7 crisis houses for communities, targeting people from BME communities who have been admitted to mental health acute wards. We will also be developing a team to work with young black men who are repeatedly sectioned and lost in the system, giving them opportunities to nurture and develop themselves in local businesses and encouraging them to take part in training. A crucial part of treating mental health is to help individuals to gain autonomy, not just diagnosing the problem. People in the community such as faith leaders will be trained and involved in the decision making for inpatients and family members will be involved in the care planning process. We will introduce a process of cultural mediation and train people to come in, when there is conflict between service users and nurses. The call for EMHIP has never been more needed, 60% of the people who use services from SWLSTG are from ethnic minority backgrounds.

3.3 MG, thank you Professor Sashi. Everything that we are proposing has already been recommended in previous reports and inquires, yet 80% of these recommendations have never been fully implemented. The EMHIP project is NHS led, as it should be, as addressing inequalities must be mainstream business as usual. The ‘community hubs’, are at the core of EMHIP, are not envisaged to be single buildings; but part of a network of local groups, businesses, schools and youth centres facilitating access into services and support through multiple venues. to different services.

3.4 CD, it is always exciting to talk about this, and I believe things will happen in the right time. There are a number of things this project can harness. We know quite often people who are experiencing high levels of stress and early stages of mental health may not recognise it and may not want to go to a therapist or their GP. They may be more comfortable sharing things with friends rather than their GP and it’s important to have spaces where people can go when they are in crises. When people have the right support at the right time, they may be able to recover where they do not have to be admitted. Also, I am pleased to hear about the intervention with young men and rehabilitating them because a man who is lost can cause stress to his family and the consequences become much greater.

3.5 MG, Thank you Dr Carlis. We have placed the EMHIP intervention in the chat box and you can also access through our website document for you to view. Can I invite Becca to come in now?

3.6 BW, I am Becca, the commissioning manager for Richmond and Wandsworth council around drugs and alcohol, mental health and in relation to housing. We are responsible for redesigned the drug and alcohol services. We made sure that we had staff based in hubs around the borough, we have been doing mapping exercises looking at where we would be best placed. It would be great if we could link and offer staff to come into some of your community hubs. We are also running a dual diagnosis workshop; we are trying to get the SWLSTG trust and the drug and alcohol services to be clear about how they will work together. One of the key things in our contract with SLAM is reviewing and working with more BME clients. There is a real concern around mental health issues, bereavement issues, suicidal ideation, and toxic mixture of drugs. SLAM are really keen to come to this meeting in the future. The presentation from Professor Sashi was fantastic. I get really excited, but I also get concerned because when large amounts of money are asked for, they may have to cutting it out of the current system and money is going to be so tight, so it is important to show commissioners what we are going to do and how cost savings are going to be made.

3.7 MG, thank you Becca. You are right, the commissioners have said that in our business plan, we must show where our savings are. When the Trust sends people to outer borough placements, the cost for that place is very high. Keeping people in hostels is also a very high cost. Our model is based around taking care of people in their family, pastoral and community networks, which is will provide costs savings to the system. For example, IAPT made the argument that they will take people off benefits and unemployment by providing talking therapies in communities and make cost savings by investing in IAPT staff as opposed to long term welfare spending. That is the case that we are making.

MG introduced Kalu (Kaz) Obuka. He is a new member of our community and borough. He has reached out and is keen to work with us. He has an important role as Public Involvement and Diversity and Equality Lead with the CCG.

3.8 KO, It has been great to listen to everyone on this call. My role started 5 months ago now, as Head of Public Involvement and Equality in Wandsworth. Communities are the place where health and wellbeing are produced. Several incidents have happened during the early stage of lockdown in terms of inequality. How might I be of service in the EMHIP project? And my second question is if there is a second wave, who are the people in the community where people seek advice?

3.9 MG, thanked KO and welcomed his support and participation. His role is writ large through all the work we are doing so we will be looking to work collaboratively. JM has mentioned something very important in the chat, regarding the LGBT community. BME communities are marginalised and within this community, LGBT is further stigmatised, and the mental health impact is huge with disproportionate rates of suicide and trauma. We really need to start working in our communities to make sure that the work we do here is prominent. John you are a real champion of that work and I am very keen to keep that voice inside the work that we do. As long as we are running the Forum, we will make sure that equality is not just about race. Does anyone want to make any final contributions?

3.10 DB, good afternoon everybody, it is very interesting, and it captivated me when Professor Sashi spoke. The only comment I have is, this approach does work and there are various examples across the country that are tried and tested. There will be challenges, but this approach will change things. Service users who are discharged from us and end up coming back to us after a year, but if these approaches are put in place, it will transform delivery of services. I have been looking into places where approaches like this have been put in place.

3.11 MG, thank you Dayo.

3.12 SS, so I am an approved mental health professional, I go out and do mental health act assessments. With the current situation, there have been a number of new people but also the number of people who have been stable for a number of years and because of COVID, it has had such a negative impact on their mental state. I am feeling positive about having alternatives to admissions; crisis houses will make such a difference to people’s lives. Thank you, you have really cheered me up on a Thursday afternoon.

3.13 MG, thank you Sarah, our better days are yet to come!

3.14 JR, I agree with Dayo but the government needs to be convinced and we are here because we have already been convinced, so we at WCEN are not going to give up even through COVID 19 but we certainly want the paradigm shift to become the paradigm effect.

3.15 MG, thank you Joan.

3.16 NGW, the young people will do it. We will see the end of it, but we won’t do it. The youngsters will do it, they have youth and courage in the hearts, and we must be prepared to support them.

3.17 MG, thank you Natalie, Natalie was a nurse at St Georges hospital in the 60s and some of the stories about how black nurses were treated by the NHS, always getting the late shifts and jobs that no one else wanted to do are a reminder of generational inequality. Fifty years later, our youngsters are facing the same such discrimination when it comes to jobs and stop and search. The work we are doing is to create a better society, to tackle racism and social injustice. The programs that we are supporting will enable us to get to a better place. In this respect we are not running projects; we are building better societies. It took me 10 years to figure out that it is the necessary the Council or The Health Services that will bring about change, but people using their own capabilities and resources within their own communities and networks, We need to reach out to our local leaders and ask, how are you supporting BME communities, what are the issues and barriers, what help and support can we give to help unlock these?

Thank you all for coming, the next meeting we have will be in October and hopefully it will be a real-life meeting. We look forward to seeing you all there.

**Meeting Closed 4.45pm**