



# Key Interventions

September 2020

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# Contents

In	<b>Introduction</b>	<b>3</b>
Ex	<b>Executive Summary</b>	<b>5</b>
1	<b>SECTION 1: Background and Process</b>	<b>6</b>
2	<b>SECTION 2: Key Interventions</b>	<b>11</b>
	Key Intervention 1: Mental Health & Wellbeing Hubs	12
	Key Intervention 2: Increasing Choice and Service Options	21
	Key Intervention 3: Reducing Coercion	33
	Key Intervention 4: Enhancing Inpatient Care	43
	Key Intervention 5: Culturally Capable Workforce	48
3	<b>SECTION 3: Recommendations and Way Forward</b>	<b>52</b>
Ap	<b>Appendices</b>	<b>53</b>
	Appendix 1: Evidence Review	53
	Appendix 2: Focus Groups & Interviews	57
	Appendix 3: Mental Health Assets – Wandsworth	72
	Appendix 4: BME Mental Health Expert Panel	78
R	<b>References</b>	<b>79</b>



# In Introduction

Significant ethnic inequalities persist in most aspects of mental health care in the UK. Compared to the majority population, Black and Minority Ethnic (BME) communities have poorer access, more negative experiences and worse outcomes in mental health care.

In 2005, Delivering Race Equality (DRE) in Mental Health Care, a major Government initiative, invested in a new change programme. The Wandsworth Community Empowerment Network (WCEN) was commissioned to facilitate a BME Mental Health Forum to bring together local stakeholders to help inform the programme.

Although there was some progress with the DRE programme, it became evident that a much more systemic response was required to reduce BME inequalities. In the meantime, the WCEN continued the work of the Forum, supported by South West London and St George's NHS Mental Health Trust (SWLSTG). In 2009, in partnership with the New Testament Assembly Church Tooting, the largest Black Majority Church in Wandsworth, WCEN hosted a Conference 'Healing our Broken Village' to highlight the ethnic disparities in mental health and work towards change and improvement.

In May 2015, the SWLSTG Trust Board commissioned an internal Report 'Equality in the Trust's service delivery and use of the Mental Health Act'. This detailed the range and scale of present inequalities and recommended the development of a stakeholder group and action plan to work towards reducing them. NHS Wandsworth also established a Clinical Reference Group on BME Mental Health inequalities to invest in initiatives to help improve service user experience across the care pathway.

At the 8th edition of the Conference in October 2016, the CEO of SWLSTG began a process to commission an improvement programme. This arose from demands by the local communities for change and improvement and the recognition that there was little change in the care experience of BME communities. The plan was to build a coalition of stakeholders, both inside and outside the Trust, to design and deliver a programme of improvement consistent with the objectives of the Trust and demands from the BME communities.



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# Introduction Continued

An Expert Panel was convened which included senior decision makers from NHS Wandsworth and SWLSTG, Service Users and Community Representatives as well as independent experts. They commissioned the Ethnicity & Mental Health Improvement Project (EMHIP) which was formally launched at the 11th edition of Healing the Broken Village Conference by WCEN in October 2019.

EMHIP has identified a set of Key Interventions to reduce ethnic inequalities in mental health care in Wandsworth. The outcomes of these interventions and the process of change will be monitored and evaluated through a series of ethnicity audits. EMHIP intervention programme and recommendations are presented in the following pages.

**S P Sashidharan & Malik Gul**

10 March 2020



# Executive Summary

- The Ethnicity and Mental Health Improvement Project (EMHIP) was commissioned as an 18-month project. Phase 1 of the project (October 2019 – April 2020) comprised: (i) a knowledge synthesis process, to collate the available knowledge and evidence relating to ethnic inequalities in mental health care in the UK and strategies to reduce them (ii) engagement and consultation with key stakeholders in Wandsworth, South West London, to identify and understand key areas of change and priorities for improvement (iii) the development of specific interventions to reduce ethnic inequalities in service access, experience and outcomes in South West London and (iv) agree a process for evaluating change.

- We have now developed a set of Key Interventions.

These consist of specific actions to bring about the following:

- Establishing Mental Health and Wellbeing Hubs (MH&WB Hubs) in the community with Community Embedded Workers
- Increasing service options by providing: (i) crisis residential alternatives (ii) enhanced support for people with longer term mental health needs and (iii) specialist support for those subject to multiple MHA admissions
- Reducing restrictive/coercive practices through (i) inclusive and shared decision making and (ii) eliminating the use of Restraint & Control
- Enhancing inpatient care experience through (i) community involvement in inpatient care and (ii) cultural mediation
- Ensuring a culturally capable workforce.

- The details of the Key Interventions are set out in this document. These involve system-wide changes in the community along care pathways and across service lines in South West London and St George's Mental Health NHS Trust in Wandsworth.
- The next stage involves (i) approval of the Key Interventions (ii) securing sustainable funding and (iii) developing an implementation plan / change programme. Phase 2 of EMHIP can only start after this.
- In Phase 2, the programme of change will be implemented across Wandsworth, underpinned by measuring and monitoring the change and outcomes achieved.

Your comments and suggestions are welcome and will assist us in improving and implementing EMHIP.  
Please send your comments to: [feedback@emhip.co.uk](mailto:feedback@emhip.co.uk)



# 1 Section 1: Background and Process

## *Introduction/background*

In this document, we set out specific changes to the current mental health system in Wandsworth as part of the Ethnicity and Mental Health Improvement Project (EMHIP).<sup>1</sup>

The proposed changes are limited to the general adult mental health services (age 18 - 64) in the borough of Wandsworth. They do not apply to specialist services such as forensic, older adults or CAMHS.

## *Aim*

The aims, background and methodology of the project are explained elsewhere.<sup>2</sup>

The specific aim of EMHIP is to reduce ethnic inequalities in mental health care and this intervention programme is designed to achieve this.

## *Policy context*

The changes we are proposing are consistent with the NHS Long Term Plan<sup>3</sup> to redesign health services to meet the challenges and needs of the 21st century.

The intention is to make the NHS

- more joined up and coordinated in its care
- more proactive in the services it provides
- more differentiated in its support offer to individuals

Five major changes to the NHS service model are outlined over the next five years in order to bring this about.<sup>4</sup> These are:

- boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services
- redesign and reduce pressure on emergency hospital services
- give people more control over their own health and provide more personalised care when they need it
- Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services through new Integrated Care Systems (ICS)
- digitally enabled primary and outpatient care will go mainstream across the NHS.

The EMHIP Intervention Plan is consistent with the first four of these five aims.

The Five-Year Forward View for Mental Health<sup>5</sup> recognises the importance of a shift towards prevention and the parity of mental health with physical health and wellbeing. It identifies the following priorities for action by the NHS:

- A 7-day NHS: right care, right time, right quality
- An integrated mental and physical health approach
- Promoting good mental health and preventing poor mental health - helping people lead better lives as equal citizens.



Reducing inequalities is one of the four key strategic objectives of South West London and St George's Mental Health NHS Trust (SWLSTG) over the next five years (2018 - 2023)<sup>6</sup>. The Trust has identified a core set of programmes (including quality, co-production and service user and carer involvement, collaboration and partnership working, transformation etc.) to enable the delivery of the strategic objectives. Both the aims and methodology of EMHIP are entirely consistent with this.

The EMHIP Intervention Plan reflects all the policy/strategic priorities outlined above. In addition, our proposals are based on what are considered good and effective models of mental health care and service options that promote human rights and recovery by the World Health Organization.<sup>7</sup>

Mental health services are poised for major changes under the Sustainability and Transformation Plans, which bring significant new funding<sup>8</sup>. All local areas are required to develop plans<sup>9</sup> to bring together all parts of the health economy to demonstrate how they plan to implement the NHS Five Year Forward View, including the Five-Year Forward View for Mental Health. The EMHIP Intervention Plan is entirely consistent with this and the substantial additional funding that will become available should make it possible to implement and sustain this programme.

### Process

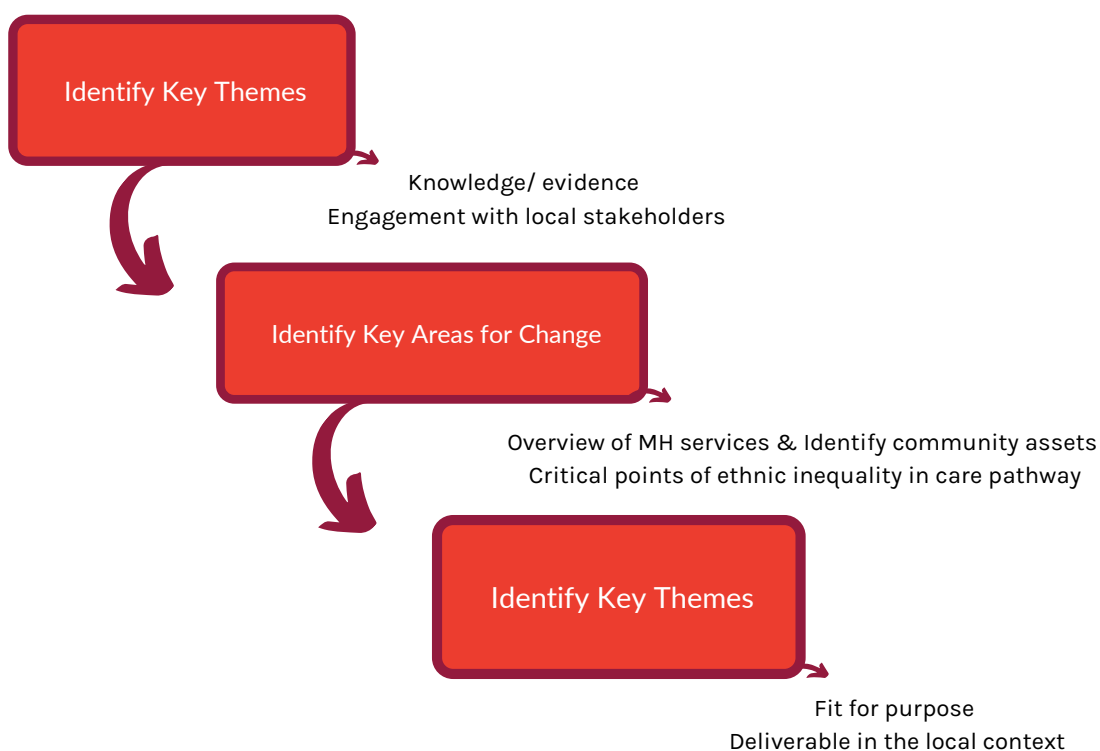
We have developed the EMHIP Intervention Plan by adopting a systematic approach. This involved a process of evidence review in relation to ethnic inequalities in mental health care in the UK, specifically focused on strategies and initiatives to make mental health services more appropriate to the needs of minority ethnic communities (Appendix I). There is a considerable body of knowledge in relation to ethnicity and mental health, including epidemiology of mental health problems in BME communities, variations in service use and ethnic disparities in mental health care. There is also a wealth of evidence in relation to service experience by BME communities and ethnic disparities in mental health care. A number of national inquiries and independent reports have reviewed the relevant evidence and made recommendations for improving BME mental health care. Apart from the published (and, therefore, easily accessible) evidence in this area, there is a significant grey literature related to the work and experience of BME voluntary sector over the last five decades outside the conventional, academic publication and distribution channels.

Together, this body of knowledge constitutes a significant evidence base. We have marshalled and reviewed this as part of our evidence review.



The thematic review of evidence also relied on BME service user experience as reported in the literature. This is linked to the wider service user experience of mental health care as reported over the years; in particular, the failings and shortcomings in the current mental health system in relation to person-centred, rights-based services that promote recovery. Allied to this is evidence of the key ingredients of what constitutes “good practice” in mental health and the underpinning values and principles. We drew on this extensive knowledge base to develop our intervention plans.

**Figure 1: EMHIP process of identifying the Interventions**







Key Themes

We identified nine key themes in relation to ethnic disparities in mental health (Figure 2).

**Figure 2: Key Themes - Improving mental health care for BME communities**



These are consistent with the findings and recommendations of previous research, inquiries, reports and service user priorities.<sup>10,11</sup> They are the critical drivers of ethnic inequality in mental health care and any change should target these areas.<sup>12,13,14</sup>



### Key Areas for Change

Based on the Key Themes and priorities for change, as identified during stakeholder engagement events, we believe that significant changes/reforms are required in the following specific service areas in Wandsworth.

**Table 1: Areas of Change**

1. Care Pathways: improve and enhance pathways to mental health care

2. Assessment: introduce a broad-based and inclusive assessment process that is person-centred

3. Patient safety and rights: actions to reduce coercion, including detentions under the Mental Health Act

4. Therapeutic benefit: prioritise patient benefit from intervention/treatment

5. Autonomy, choice and plurality: ensure alternatives to current models of 'one size fits all'

6. Cultural capability: make specialist mental health care culturally appropriate to BME needs and the providers are culturally competent in delivering it

7. Advocacy: enhance and extend support/advocacy of BME service users and families.

8. Involvement and ownership: increase the involvement of BME service users in key decisions about them, ensure greater accountability and invest in BME user-led services.

9. Public Mental Health: reduce stigma, increase awareness and engagement, initiate specific actions to address social determinants of mental health, including racism.

We set out below a number of Key Interventions that are designed to achieve this. Our recommendations are based on triangulated evidence from literature search, focus groups and interviews with a broad cross-section of local stakeholders, including people with the actual experience and knowledge of local mental health system and communities.



## 2 Section 2: Key Interventions

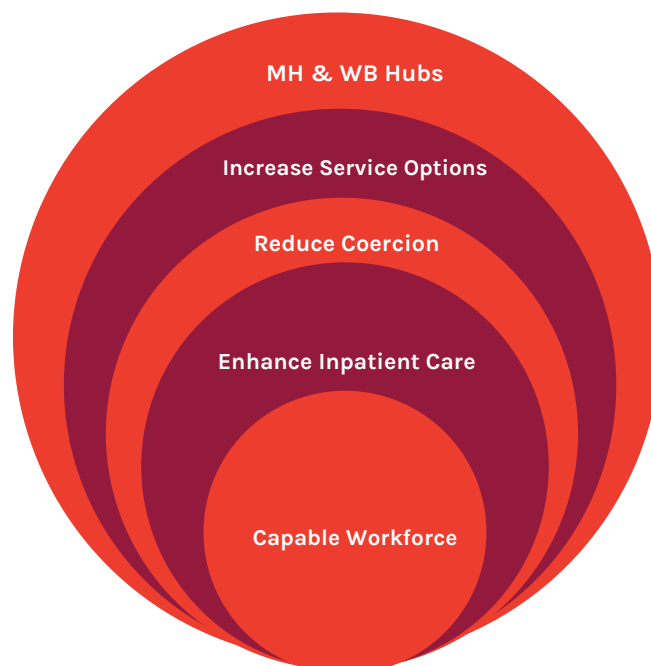
### Key Interventions

We propose five key interventions to reduce ethnic inequalities in mental health care access, experience and outcomes in Wandsworth (Figure 3).

These will require (i) additional investment (ii) changes in clinical practice and (iii) organisational changes, in particular, recruitment and inclusion of BME Service Users/Community Advocates/Peer Support Workers in mental health care delivery.

The Key Interventions target areas where urgent changes are necessary. The integrity of current work streams and the overall structure of mental health services in Wandsworth will not be affected. The major impact will be how care and treatment are provided and the overall culture of mental health care in Wandsworth.

**Figure 3: EMHIP – Five Key Interventions**



Each Key Intervention comprises a number of changes and innovations:

1. Set up Mental Health and Wellbeing Hubs (MH&WB Hubs) in the community with Community Embedded Workers
2. Increase service options by providing: (i) crisis residential alternatives (ii) enhanced support for people with longer term mental health needs and (iii) specialist support for those subject to multiple MHA admissions
3. Reduce restrictive/coercive practices through (i) inclusive and shared decision making and (ii) eliminating the use of Restraint & Control
4. Enhance inpatient care experience by (i) community involvement in inpatient care and (ii) cultural mediation
5. Culturally capable workforce: provide capability training



## Intervention 1

### Mental Health & Wellbeing Hubs

#### *Background and context*

There is strong, consistent evidence that BME communities, in comparison to white communities, experience more aversive care pathways in and out of specialist mental health care.<sup>15,16</sup> Recognition of mental health problems and help seeking are more likely to be delayed in minority communities. There are significant barriers to BME communities receiving help at both primary and secondary care levels. This is one of the biggest challenges in improving mental health care for BME communities. Black and ethnic minorities take different pathways to care services and different routes out of care. For example, some minority ethnic groups are less likely than other minority groups to seek help and/or are recognised as needing help at primary care level while other groups (particularly, Black African and Black Caribbean) more likely to circumvent the conventional referral route (community/primary care/community mental health service/acute and intensive care settings) and follow a non-conventional referral route (usually involving non-health sector agencies) and be admitted to hospital (usually under the Mental Health Act) as their first point of contact. Over the years, there have been many initiatives in the BME mental health voluntary sector to address this problem by improving access to services as well as step down facilities from specialist care.

According to a systematic review of the relevant literature, “the key components of effective pathway interventions include specialist services for ethnic minority groups, collaboration between sectors, facilitating referral routes between services, outreach and facilitating access into care, and supporting access to rehabilitation and moving out of care”<sup>17</sup>. It is likely that the current service configuration of most secondary care services (specialist community mental health teams and gradual weakening of whole system care) reduces the potential for such collaborative arrangements and a specific focus on any specific group, such as BME communities. A BME-focused Mental Health Hub in the community will go a long way towards improving access into and out of specialist care and thus reduce the ethnic differentials in this area.

Problems in relation to mental health awareness and stigma in the BME communities are also recognised as contributing to delayed access and appropriate and early intervention.<sup>18</sup> The Mental Health & Wellbeing Hubs outlined here will have the capacity and reach to improve this. More generally, this innovation is consistent with the overall vision for mental health care as indicated in the Five-Year Forward View for Mental Health: a decisive step “to break down barriers in the way services are provided”<sup>19</sup>. The Hubs are envisaged as places where an integrated approach to mental and physical health is possible and will promote good mental health and wellbeing and prevent poor mental health in BME communities. By unlocking the social capital and capabilities in local communities (through the various linkages and joint working), the Hubs will contribute to attempts to help people lead better lives as equal citizens. The potential for early recognition and intervention in mental health problems will be enhanced by the interconnectivity and community engagement through the Hubs.



### *Intervention*

Addressing these problems is central to EMHIP. This will be achieved, primarily, by creating Mental Health & Wellbeing Hubs in the community which will act as a gateway to specialist mental health services. The Hubs will also be linked to the diverse community resources/assets in the local area. In this way, the Hubs will function as an informal mental health resource providing easy access with capacity to engage, support and provide onward referral to specialist mental health services.

The Hubs are designed as community safe spaces and will be set up within existing community resources that are popular and, traditionally, used by people needing help.

Mental Health & Wellbeing Hubs are consistent with one of the central themes in the Five-Year Forward View of Mental Health. The traditional divide between primary care, community services and hospitals and the rigid demarcation of social and mental health care are seen as barriers to personalised and coordinated health care.

Therefore, it is argued that “over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries”<sup>20</sup>. Given the problems that minority ethnic groups experience in accessing mental health care and negotiating the existing care pathway (community to primary care and then to specialist care), easing the traditional boundaries would allow for easier and earlier access to mental health resources. Mental Health & Wellbeing Hubs should be effective in achieving this through their location (in the community and as part of the community), function (mental health as part of overall needs), connectivity (with all relevant community assets and other services) as well as their reach and easy accessibility.

### *Activities / functions*

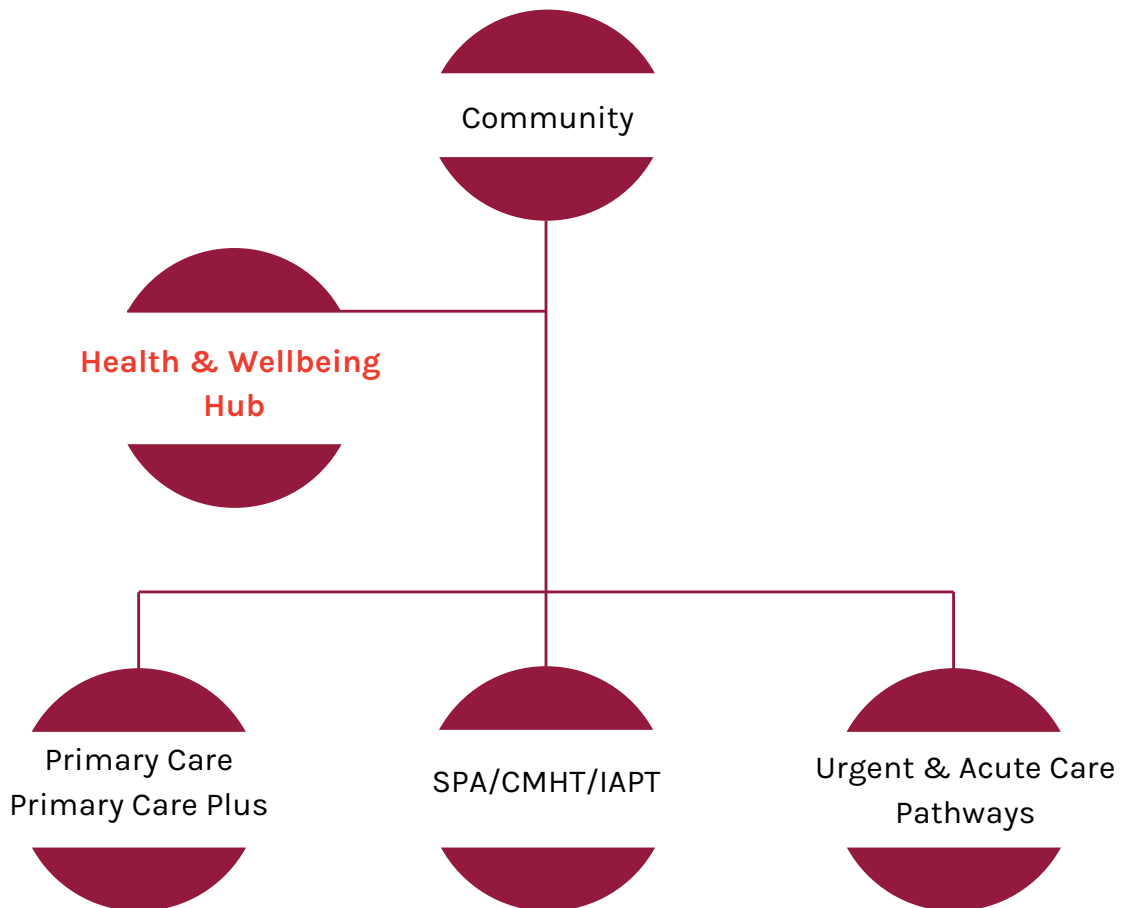
The MH&WB Hubs will function as a hub of all mental health related activities in the community. They will be closely aligned to formal mental health networks such as GPs, primary care and secondary care mental health services at SWLSTG as well as informal mental health systems and other community assets. These assets will be mobilised and streamlined with the Hub. This means that the Hubs should facilitate early and unmediated access of help and support for mental health and related problems as well as onward referral to specialist services, if required. Specialist teams like the Community Mental Health Teams (CMHT), Home Treatment and Early Intervention teams will work collaboratively<sup>21</sup> with the Hubs, including in CPA planning and delivering care and treatment. The Hubs will also provide step-down options from specialist care.

While the Hubs will operate as community-based initiatives they will, in effect, function as extensions of the local community mental health services i.e. CMHTs. They are positioned across primary and secondary care which should allow a more permeable barrier between the community and specialist mental health care, in both directions. The expectation is that the Hubs will not be just an “add on” to the mental health system but will become an integral part of it.



The Hubs are positioned within the existing care pathway of specialist mental health care (Figure 4).

**Figure 4: Mental Health & Wellbeing Hubs as part of the Care Pathway**

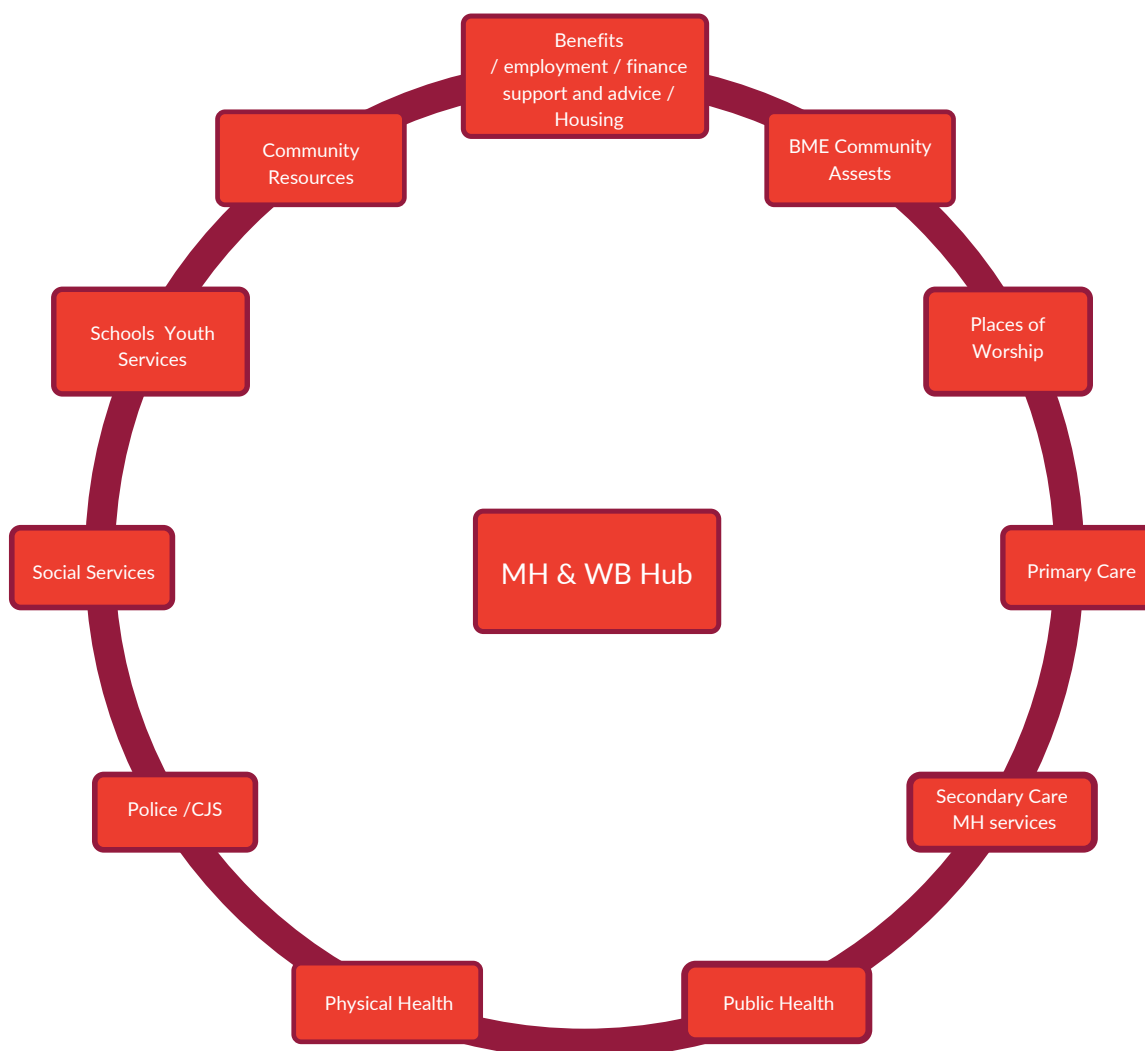


The Hubs will be aligned with the nine Primary Care Networks in Wandsworth. Similarly, the three Community Mental Health Teams (CMHTs), Single Point of Access (SPA) Team and the primary care step-down service, Primary Care Plus (PCP) in Wandsworth as well as the Improving Access to Psychological Therapy (IAPT) service will be connected/aligned to the relevant Hubs in their locality. Thus, the Hubs will be embedded in the local mental health system, straddling the statutory and non-statutory sectors and closely connected with a variety of community assets. In functional terms, the Hubs will be positioned in the community/primary care/secondary care pathway as well as the exit/discharge pathway from the CMHTs/hospitals into primary care and the community.

The embedded nature of the Hubs and connectivity with all the network of mental health resources and community assets is shown in Figure 5.



**Figure 5: MH & WB Hubs - connections**



**The Hubs will serve the following functions:**

- Provide a safe space in the community for people with mental health problems
- Serve as an access point (including walk-in, self-referral) for mental health difficulties including crisis access
- Offer assessment, support, triage and signposting
- Provide support to links in the local community
- Offer support and encourage people with psychosocial difficulties/mental health problems to access voluntary work, vocational and pre-vocational training, return to employment
- Unlock and mobilise social capital and local capabilities to support and enhance mental health
- Provide help with accessing services, such as benefits, housing and debt services through partnerships with CAB, Advice First Aid.
- Offer advice and support in relation to a broad range of life/social difficulties
- Offer self-help, peer support groups and activities



- Provide liaison with Primary Care and Primary Care Plus
- Provide direct referral to secondary care services
- Engage in joint working with secondary care/specialist mental health teams
- Facilitate Wellbeing Workshops (Talk Wandsworth)
- Integrate with local initiatives to improve physical health, such as early health screening and advice programmes - “stroke-busters” - and Expert Patient Programme of self-management of long-term health conditions<sup>22</sup>
- Offer mentoring and support for young people ‘at risk’ of mental health problems

#### *Resources and Staffing*

Hubs will function as part of the community organisations where they are located e.g. churches, mosques, youth club etc. They will be integrated within the overall structure and functioning of the host organisation; for example, they will provide access to and overlap with its facilities (space, activities etc) and involve people who are connected with these centres in common purpose. Most of these centres/organisations have ‘hidden’ capabilities in their membership/affiliates, such as people with health/mental health expertise or experience. The Hubs will mobilise and utilise this expertise with activities around mental health.

*To deliver the specific mental health and wellbeing activities, the following additional resources will be required.*

#### **1. Community Embedded Worker from the CMHT/SPA/PCP (Community Psychiatric Nurse).**

Community Mental Health Teams are expected to work in their local communities, including engaging with and mobilising local community assets to deliver appropriate mental health care. However, their actual practice (as we have heard consistently) falls far short of this. CMHTs are based in hospitals and patient reviews and visits are carried out during clinic- based appointments. The very high case load of Community Psychiatric Nurses (CPN) makes it difficult for them to extend their work beyond medication management and supervision in the community. There is also little liaison between specialist teams, such as CMHT and community resources like churches and mosques, which are the first point of contact for many people with mental health problems and families from BME communities. There is no direct access for the community agencies to specialist mental health care (apart from crisis referrals) other than through the conventional care pathway. In this context, embedding a dedicated mental health professional from each of the CMHTs in the local Hubs will help address many of these problems.

Embedding specialist mental health workers in agencies and resources outside specialist mental health care is not unusual and such approaches have been successfully implemented in relation to crisis care, policing etc.<sup>23,24</sup>

This facilitates early detection and intervention for people with mental health problems, direct and easy access to specialist care, and ongoing support and engagement in the community for people with longer term mental health needs.





*The Community Embedded CPN role:*

- Act as the main liaison/link between the Hub and secondary mental health care
- Triaging and signposting people who are considered as requiring specialist assessment
- Act as a pathway coordinator/mental health access facilitator
- Contribute to mental health training/increasing awareness
- Provide clinical input into assessment and supervision
- Supervision of Community Support Workers

## 2. Community Support Workers

Engaging local communities in mental health care and provision of community-based support are critical to facilitating early detection, engagement and sustained care and treatment for those with recognised mental health problems.<sup>25</sup> Many of the key tasks in community mental health, including delivery of psychosocial interventions, can be ‘task shifted’ effectively to community workers or peer workers with training and support. Given the current dynamics of disengagement and distrust of mental health services by BME communities, we believe this will be a preferred option for delivering many aspects of community mental health care to these communities (for example, support, engagement, psychosocial rehabilitation (PSR) recovery-focused work). Including such workers in specialist mental health services will ensure that their work will be properly coordinated, supervised and supported. We heard during our consultation/engagement events that the existing specialist services (CMHT, EIS for example) in Wandsworth are currently struggling to deliver some of the core interventions in community mental health. There are various reasons for this, including high caseloads of the teams, inadequate staffing and increasing demands. These service pressures are unlikely to be alleviated in the short-term. The recruitment of a new cadre of staff, Community Support Workers, to work alongside specialist mental health teams would go some way towards addressing these problems and ensuring effective and comprehensive care.

We are proposing the recruitment of 1 Community Support Worker to work alongside the Embedded Mental Health Worker in each of the Mental Health & Wellbeing Hubs. The Community Support Worker will be recruited from the minority ethnic communities around which the Hubs will be configured (see Table 3). No professional background or specific mental health training will be a pre-requisite for this job but a commitment and interest in BME mental health and ability to work as part of a team will be necessary. People with significant life experience or lived experience of mental health problems will be particularly suitable for this position.

### **Community Support Worker role:**

- Community engagement. Working with local BME communities and, thus, facilitating early access to mental health care and support through the Hubs, awareness raising, addressing stigma.
- Support and engage people with long-term mental health problems and their families/carers in collaboration with Key Workers and as part of Care Programme Approach (CPA)



- With bespoke training and support, there is the potential for delivering (i) cognitive training (ii) social skills training (iii) PSRs, including vocational and pre-vocational skills (v) family support and (vi) psychoeducation
- Ensure social inclusion and active citizenship for people with Serious/Severe Mental Illness (SMI)
- Identify individuals, especially young people, at high risk of mental health problems (prodromes, social adversity, social withdrawal, risky health behaviour, such as onset substance misuse, antisocial acts, suicidal thoughts etc) in the community
- Provide help to ensure treatment adherence and detect early relapse
- Mental health advocacy

### 3. Community Family Practitioners

An important community asset in Wandsworth is the Network of Lay Family Practitioners.<sup>26</sup> These are people from local BME communities who have completed a 2-year programme of training in systemic family therapy. There are 30 people who have completed this training and another 10 people are in training. Currently, they are not aligned to the formal mental health system. We hope to mobilise this important community asset and align them with the MH&WB Hubs to provide family-based interventions, support and counselling.

Community Family Practitioners will be matched with the Hubs (based on ethnicity, language skills and locality). They will work with individuals and families who are identified as experiencing mental health problems and/or significant stresses or life difficulties. There is external, professional supervision in place to oversee this work and the practitioners' professional development. Each Hub will have 3 Community Family Practitioners attached to it.

#### The Community Family Practitioner role:

- Provide counselling, support and other family-based interventions
- Link with [Talk Wandsworth \(IAPT\)](#) and collaborative working
- Joint working with other mental health assets at the Hub
- Act as point of community contact/access for those experiencing mental health problems and their families in the local community.

### 4. BME Mental Health Champions

Like Lay Family Practitioners, BME Mental Health Champions<sup>27</sup> are another important community asset that is currently not utilised or aligned with the formal mental health care system. BME MH Champions are lay people from the local African and African Caribbean community who have undergone a training programme (18 months) to provide help and support for people experiencing mental health difficulties. They primarily work as 'facilitators', helping and guiding people with mental health problems to access appropriate help.<sup>28</sup>



Three Mental Health Champions will be aligned and work with each of the Hubs.

The BME MH Champion role:

- Provide support and advocacy
- Act as ‘facilitators’ helping and guiding people with mental health problems to get appropriate help and support
- Provide early support and intervention for people experiencing mental health difficulties
- Act as point of community contact/access for those experiencing mental health problems and their families in the local community

*Potential Hubs*

We have identified nine potential MH&WB Hubs across Wandsworth (Table 2). Five of the nine hubs are aligned to/located at places of worship used by BME communities in Wandsworth (two mosques, two churches and one temple). One Hub will be developed at a local youth centre that is popular with BME young people and connected with a variety of youth services.

**Table 2: Potential MH&WB Hubs – Wandsworth**

MH & WB	Location	Main BME Groups	Lead
Gatton Road Mosque	Gatton Road, Tooting SW17	Pakistani Muslims	Imam Zahir Karim
Battersea Mosque	Battersea SW8	Pakistani/Somali Muslims	Imam Safwaan Hussain
Elays Network	Battersea SW9	Somalian/North African Muslims	Mohammed Ali
Eritrean Muslim Community Association (EMCA)	Wandsworth Rd, SW11	Eritrean/Somali/ North African Muslims	Imam Abdul Saad
New Testament Assembly (NTA)	Beechcroft Road, Wandsworth SW17	African Caribbean	Bishop Delroy Powell
Deeper Life Ministry (DCLM)	Clapham Junction, SW11	West African African Caribbean	Pastor Frank Oyibo
Mushkil Aasaan Centre	Tooting, SW17	South Asian Women	Naseem Aboobaker
Shree Ghanapathy Temple	Effra Rd, London SW19	Sri Lankan Tamils/Hindu	Geetha Maheshwaran
Caius House Youth Centre	Battersea SW11	All BME Youths	Delrita Tester



## Outcomes

- Improve access to mental health services
- Early recognition and identification of mental health problems
- Early referral to specialist mental health services, substance misuse services and thus
- reduce treatment delay
- Early recognition of individuals ‘at risk’, especially young people
- Less aversive pathways into specialist mental health care
- Easier availability and access to help (including specialist intervention) in crisis
- Greater engagement with mental health services, treatment adherence and improved continuity of care
- Enhance community mental health care and follow-up options for CMHTs, HT and EI services
- Improve focus on social outcomes and facilitate a ‘whole system’ approach to treatment and support for people with severe mental health problems as part of the CPA
- Increase community awareness and acceptability of mental health problems and the importance of mental wellbeing
- Greater uptake of physical health screening/monitoring/checks for people with SMI
- Greater ownership and involvement in mental health services by the local BME communities.



## Intervention 2

### Increasing choice and service options

#### *Background and context*

Unless there is demonstrable and sustained positive service experience for people from BME communities, attempts to facilitate their entry into mental health services are bound to fail. That is why EMHIP prioritises the need to improve the treatment and care experience of black people within mental health care. Nowhere is this need more obvious than in the acute and urgent care pathway within specialist mental health care in Wandsworth.

One of the key findings in relation to ethnic inequalities in mental health in the UK is the lack of choice and plurality in service provision for BME communities.<sup>29</sup> Current services are experienced by many people as inflexible and as providing a ‘one size fits all’ model. In areas where ethnic inequalities are most pronounced (in acute and crisis care, involuntary treatment), the lack of alternatives to traditional, hospital-based care is an impediment to providing person-centred and consensual treatment. One of the greatest areas of need for BME communities is long term treatment and support for people with severe and enduring mental health problems and those with a complex history of institutional care. Current care provisions available to these groups are predominantly coercive, with an emphasis on control over care, such as secure facilities, repeated involuntary admissions under the Mental Health Act and highly disproportionate use of Community Treatment Orders (CTO). The lack of choice available to BME service users, especially in relation to acute and complex care, emerged as a common theme during our consultation with local stakeholders. Current services are experienced as severely limited with little choice and, more often than not, failing to deliver optimum care and support.

#### *Intervention*

To provide increased choice and ensure plurality of care and treatment options, we have identified three priority areas for new service provision for BME communities in Wandsworth: (i) crisis care (ii) support for people with long-term mental health needs and (iii) a bespoke, specialist service for those experiencing repeated admissions to hospital. The new services we propose target people with complex and severe mental health problems, high risk of hospital admission and involuntary/coercive treatment. These are (i) crisis residential alternatives to hospital admissions (ii) increased options for early discharge, follow up and psychosocial rehabilitation in partnership with BME organisations and (iii) a bespoke, community-based service for those with a history of repeated hospital admissions under the Mental Health Act, poor treatment adherence and who are, traditionally, seen as “hard to engage” or “refractory” to treatment.

#### Intervention 2.1: Crisis residential alternatives

There is extensive literature on the benefits of crisis residential options as an alternative to hospital admission.<sup>30</sup> Such provisions increase the choice available to service users and their families in mental health crisis and allow greater flexibility around clinical care and risk management for clinicians and mental health teams.



Home Treatment (HT) is the most widely used alternative to hospital admission. For HT to work most effectively, options other than hospital admission should be available to the HT team when home-based treatment is not clinically appropriate or feasible. Community alternatives to hospital admission are associated with greater service user satisfaction and less negative experiences.<sup>31</sup> Currently, in SWLSTG, the HT team and service users going through mental health crisis have no access to any crisis residential options other than hospital admission. The s136 suite and the Lotus suite at SWLSTG, which act as assessment facilities prior to admission, are hospital-based services with limited functions. We also heard from staff working in the inpatient units (including consultants) that there is “tremendous pressure” on inpatient beds to the extent that this is “compromising” patient safety and quality of care.<sup>32</sup>

We propose two types of crisis residential alternatives in Wandsworth, Crisis Houses and Adult Placement or Shared Lives service.

#### *Crisis House*

Mental health crisis houses have operated as part of mental health services for a long time. They were established in response to service user demands for alternatives to acute psychiatric inpatient hospital admissions.<sup>33,34</sup> The Crisis House is now very much part of acute and crisis care pathways and provides a residential alternative to hospital admissions in diverse mental health settings.<sup>35</sup> Mostly, these are houses set up specifically for people in mental health crisis who would otherwise be admitted to hospital.<sup>36</sup> The houses are managed by voluntary sector providers or jointly with statutory providers. Crisis Houses operate closely with the local Crisis and Home Treatment Teams. Support staff are usually available at the crisis house but the clinical management and treatment of people admitted to the crisis house can be provided by the Home Treatment Team, as part of an individual care plan. These are 24/7 services (like HT) and are closely aligned to the HT team. Evidence over the last 30 years in the UK shows that Crisis Houses are safe and effective alternatives to hospital admission, provide increased choice to service users and foster rights and recovery. Previous experience in many urban settings in England suggests that they are valued as an alternative to hospital admission by people from BME communities.<sup>37</sup>

#### *Activities/Functions*

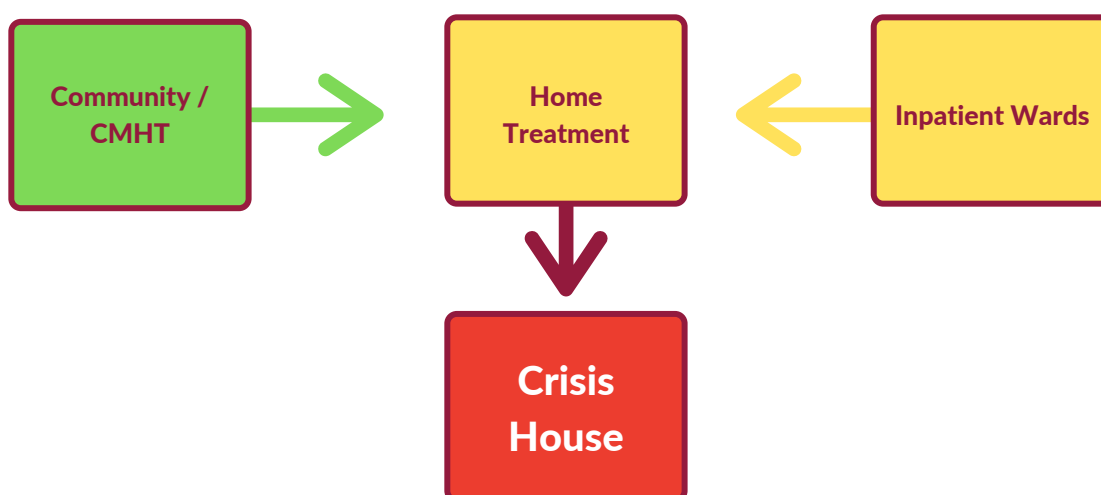
We propose 2 Crisis Houses in Wandsworth, one primarily for Asian (Muslim) women and the second for Black African/African Caribbean men. These communities are prioritised as they tend to have more adverse experiences in acute admission settings, as currently configured and utilised. Inpatient stay is a particularly alienating experience for Muslim women. They feel unsafe in acute inpatient wards (even in women only wards) and are concerned about the loss of family support and involvement following hospital admission.



Fear of being admitted to hospital is often reported as a reason for avoiding mental health care. Black men are significantly over-represented in acute inpatient admissions and, generally, are more likely than others to experience coercive and restrictive care as inpatients. The disproportionately high numbers of black men being admitted to hospital under the Mental Health Act also indicates a general unwillingness to engage with such care.

The Crisis House model followed here is one where the facility is closely linked to the NHS Crisis and Home Treatment Service. In this model, the Crisis House will become part of the acute and urgent care pathway of SWLSTG and access to the service will be through the Home Treatment Team. This means that all those referred to crisis house placement will remain under 24/7 care of the HT team. HT will act as the gateway to this service as well as being clinically responsible for clients' care and treatment. Crisis House placement may also be considered as a post-discharge option as a way of shortening inpatient stay. In this instance, the 24/7 supervision and support provided by the inpatient ward will be replaced by HT support and supervision while the client remains at the Crisis House.

**Figure 6: Crisis House - care pathway**



Our proposal is that Crisis Houses in Wandsworth will be set up jointly by SWLSTG and BME community agencies in Wandsworth. Community organisations, such as local faith groups, are already actively involved in providing mental health care and support. Most of them have well-established support systems for members of the local community, including personal support and pastoral care.

- The Crisis House will serve the following specific functions:
- Act as a crisis placement for people who are assessed as requiring hospital admission
- Placement will be part of the crisis care plan
- Placement for up to 6 – 8 people at any one time
- Length of stay limited to 8 weeks
- Provide independent living options
- Prioritise hospitality, relational security and support in crisis
- Provide Crisis Support





- Provide Crisis Support
- Workers to offer help and support, non-judgemental empathy and a safe space for the residents.
- Ensure family visits, support and joint working with families.
- Treatment and care as well as supervision provided as part of the individual care plan for residents by the HT team.
- HT will provide support 24/7, including crisis access to HT

#### *Resources/staffing*

It is expected that each Crisis House will employ up to 6 staff (part-time) as crisis support workers. They will be given training in mental health first aid and crisis support work and their input will be supervised by the HT team in conjunction with the NGO. Each House will have a designated Manager.

#### **Service Model: Crisis House**

There are two mixed gender crisis houses in Camden & Islington Trust, providing 24-hour intensive support in a residential setting for people going through mental health crisis. Individuals can self-refer or be referred by their community team, GP or via the Crisis Team. The Crisis House also acts as a 'step down' from an inpatient ward (i.e. the individual is ready to leave the acute inpatient ward but continues to require a level of support). Each Crisis House is supported by a multi-disciplinary team including psychiatrists, psychologists, mental health nurses and Crisis House Manager.

Interventions at the Crisis House are based on the recovery model and aim to help individuals build their skills, confidence and self-esteem. All service users have a care plan and psychological and medical treatments are available. There are no restrictions on leave and service users are encouraged to continue engaging with their day-to-day life. Discharge from the Crisis House is on the basis of multi-disciplinary planning. Follow up and aftercare, if required, are provided through the Trust community mental health teams.

An evaluation of the North Camden Crisis House found high user satisfaction. Most of the service users were single, living alone, unemployed and known to mental health services.

[Link](#)

#### *Crisis Family Placement or Shared Lives Services*

The second proposal in relation to crisis care is the development of an adult placement programme (sometimes referred to as adult fostering) using a Shared Lives model, to support and treat people going through mental health crisis.<sup>38</sup> Carers/families are chosen from the local community and are given sufficient training to provide community-based support for people with mental health problems or psychosocial disability.





Specialist mental health teams, such as Home Treatment, will work closely with the host family and ensure ongoing support and supervision. Service users who are considered suitable for this option can move in or regularly visit the home of the approved carer family. The host family or carer is chosen through a process that ensures compatibility and that they have the necessary commitment and personal qualities to provide support and informal care. The host family/carers receive comprehensive training (including Mental Health First Aid) as part of the assessment process devised by the Crisis Team and mental health trust. This is delivered to the families prior to them being approved for placement of a person experiencing mental health crisis.

We are proposing commissioning such a service in Wandsworth aligned to the local Home Treatment service. This means that the HT team will place the individual who needs crisis residential support with the host family, usually for a short period, as an alternative to hospital admission. Placements at the host family follow a crisis assessment by HT or on discharge from hospital. Placements will be part of HT and HT team will ensure 24/7 support for the service user and host family throughout the placement. According to the Shared Lives model, a Personal Plan is co-produced with the service user and host family. The Personal Plan sets out the actions required to meet the individual's well-being, care and support needs, and how the individual wishes to be supported to achieve their personal outcomes. It includes all the information that the carer needs to ensure that the support they offer is compatible with the needs and preferences of the individual. This plan is reviewed regularly by the HT team with the individual to ensure it remains relevant to meet their day-to-day needs and chosen outcomes. This plan will be consistent with and integrated into their Home Treatment care plan. Both the host family and service user have the option of terminating the placement at any time.

This is a well-tested model in providing support for people with psychosocial disability, including in mental health crisis.<sup>39</sup> Shared Lives, who have pioneered this service have over 150 such schemes in England and Wales regulated by the Care Quality Commission. Shared Lives is consistently rated as the safest and highest quality form of care and is highly valued by service users.<sup>40</sup>

#### *Activities and functions*

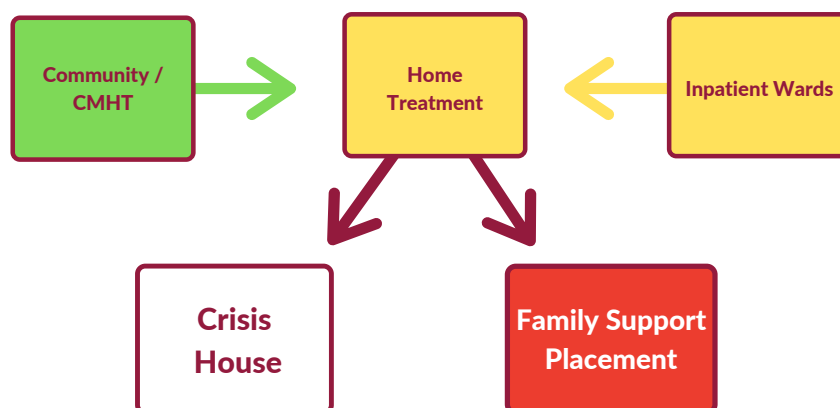
- The care and support to those under the scheme will be the same as in Crisis House
- Individuals remain under the care of HT throughout their stay in family placement
- Crisis access 24/7 through HT
- Three-way plans (service user, placement family and HT) to ensure support, safety and supervision

Home Treatment will act as the gateway to family support placements.

This is similar to the arrangements for those placed in the Crisis Houses.



**Figure 7: Family Placements - care pathway**



#### Resources/staffing

A Family Placement coordinator will be required to manage this work. This person will work as part of the Home Treatment Team. His/her responsibilities will include (i) coordination and management of placements (ii) ensuring joint working and support for the families/carers (iii) training and supervision of families/carers and (iv) overall governance of the programme.

#### Outcomes

- Increased choice for service users and families in mental health crisis
- Establishing crisis residential alternatives to hospital admissions
- Greater flexibility
- Early discharge from hospital
- Community-based living options in mental health crisis
- Involvement of local communities in care and support

### Service Model: Crisis Family Placement

#### Shared Lives for Mental Health Crisis Scheme

The South East Wales Shared Lives scheme (SEW Shared Lives) provides community-based support whereby an adult who needs support and/or accommodation can move in or regularly visit the home of an approved Shared Lives carer, after they have been matched for compatibility. The service is delivered as a partnership between the six local authorities and Aneurin Bevan University Health Board, with Caerphilly County Borough Council as the lead authority.

As part of the SEW Shared Lives scheme, a bespoke service provides support to individuals who are experiencing a mental health crisis. This is funded by the Welsh Government Transformation Fund through the Health Board's Mental Health and Learning Disability Division. This service provides an alternative to hospital admission, including early discharge, from inpatient hospital settings. The service offers emergency placements with selected and trained families for people presenting to mental health crisis teams. Individuals offered the scheme are supported in these short-term arrangements (for up to six weeks) by crisis team staff. Training, support and guidance are provided to help carers with their new roles and update them on good practices. They also have a link nurse within the Crisis team whom they meet regularly and maintains contact throughout. Carers are paid up to £588 per week to reflect the fact that they are asked to provide a high level of support to the person.

[Link](#)



## *Intervention 2.2: Joint working to improve psychosocial rehabilitation and community follow-up for BME service users*

### *Background and context*

Diagnosis of severe forms of mental health problems is more prevalent in people from BME backgrounds in Wandsworth (in particular, Black African and African Caribbean ethnic groups). This is consistent with national trends. BME patients are also over-represented within high intensity services (admissions, detentions under the MHA, referrals to PICU). While this suggests a high degree of mental health needs in the BME community, it is not matched by the resources available to these groups within community or rehabilitation services. Currently, within SWLSTG services, there are no specialist resources available for rehabilitation/recovery of BME service users. The experience of Black voluntary service providers in Wandsworth confirms there is a lack of investment and absence of any culturally informed care and support for people from African and African Caribbean backgrounds. Since the key to successful rehabilitation and recovery programme in mental health is the active engagement and collaboration with service users, there is an urgent need to commission culturally informed, black-led initiatives in providing such services.

### *Intervention*

We are not proposing a new service but investment in and use of existing community resources to meet the needs of BME service users currently over-represented in the CMHT case load in terms of diagnosis, risks, poor treatment adherence and long-term care. In Wandsworth, this means increasing the capacity and capability of CMHT based services to develop and deliver culturally informed and recovery-oriented care for this vulnerable client group with high levels of need. Effective support and care of people with long-term mental health needs, based on a recovery model, is possible through a CMHT-based service<sup>41</sup>. This is a core capability identified in most models of good practice in mental health care. Such a programme values personal recovery, autonomy and social inclusion and is highly appropriate for BME service users. There is a lack of such care interventions in the current CMHT provisions in Wandsworth and there are no service partnerships with local Black community agencies.

We propose a collaborative arrangement with BME voluntary agencies in the borough to deliver a recovery-focused model of care for BME service users with long term and complex mental health needs. Through such collaborative frameworks, CMHTs can provide intensive support and recovery focused work for BME service users under the CPA. There are many community agencies in BME voluntary sector in Wandsworth who have the capacity and commitment to work in this way. Collaborative/joint working agreement with these community assets will ensure long-term support and rehabilitation/recovery activities of BME service users with long-term mental health needs.

### *Actions/functions*

A precise estimate of the number of individuals who would benefit from this arrangement has not been established. People of African and African Caribbean backgrounds currently on CPA (with a diagnosis of severe mental health problems and long-term needs) will be eligible for this service.



Currently 36% of the CPA clients of the CMHTs in Wandsworth are identified as Black or Black British (compared to 10.7% of the total resident population)<sup>42</sup>. It is likely many of them are receiving standard treatment and support. However, we heard during the stakeholder consultation process that a significant proportion of this group (estimated as up to a third on CPA with a diagnosis of severe mental illness) are BME and would benefit from a BME specific programme of support. This suggests an estimate of around 50-60 people (men and women) currently managed by the CMHTs in Wandsworth who would benefit from such a service. A culturally enhanced service would allow greater community engagement and integration.

*The actions include:*

- BME NGO service partners need to be identified who can develop the capability and reach to work collaboratively with the community services of SWLSTG
- A co-production model will be adopted to develop the collaborative care framework and service delivery
- Service users who would benefit from this initiative can be identified through a standard process using established measures of need and service history. This will involve joint assessment and care planning with the relevant BME NGO service providers
- There will be co-working by the CMHT and the BME organisations, using the CPA care planning process
- Service delivery will emphasise core psychosocial rehabilitation (PSR) methods, promoting rights and recovery, underpinned by culturally informed care and support. A 'whole system', 'whole life' approach will be adopted, including active connections with other community agencies and resources
- Vocational and pre-vocational support and training will be provided, including intensive placement and support schemes, in collaboration with specialist services in these areas
- The potential for social co-operative model for employment and inclusion will be explored
- Where required, there will be support with activities of daily living
- This service will ensure close linkage with MH&WB Hubs
- Family/carer support, advice and training will be prioritised
- The service will have 24/7 crisis access through the Crisis/HT team

*Resources/staffing*

Additional investment will be required to increase the capacity and capability of NGO partners. This will include recruiting and training Community Support Workers to deliver culturally informed care. There is also the potential to align with Intervention 1 (MH&WB Hubs), including the new staffing resources (Community Support Workers and MH Champions) with this service. Case management and care coordination as well as clinical support, treatment and supervision, are ensured through the CPA process and are, therefore, cost neutral.



## Outcomes

- Improvement in quality of clinical care and better outcomes for BME service users
- Relapse prevention, early recognition and treatment
- Increased engagement with mental health services, better treatment adherence
- Greater involvement of family and carers in care and treatment
- Regular physical health checks/screening and better physical health
- Wider engagement with the local community assets and agencies

## Service Model: Community Mental Health Service for people with severe mental health problems

### Trieste Mental Health System (Italy)

Mental health services in Trieste, Italy are generally considered to offer the best mental health care in the world. This is based on a 'whole system, whole community' approach to care with an emphasis on working with the wider community to develop a fully integrated system of care and support. The service seeks to change the clinical model of service delivery by applying a wider concept of mental health that looks at the whole person in his/her social background.

Promoting the citizenship of people with mental health conditions and psychosocial disabilities lies at the heart of all service efforts in Trieste. In the city, 'mental health' is not simply a medical or clinical issue but a matter of freedom, rights and access to supports that enable people to live outside institutions and to flourish. It is also about creating the conditions for social inclusion and cultural participation.

One of the significant achievements of the services in Trieste is the level of integration of mental health work with other forms of activity. The mental health service is not something separate from housing, employment, education, creativity. The Department of Mental Health works closely with the local administration in the city to directly fund and manage a wide series of social enterprises involved in all these areas. The four Community Mental Health Centres encourage service users to maintain their usual daily activities to avoid getting cut off from community involvement.

This also applies to people who are admitted to the CMHC as inpatients. For people with complex needs, personalised plans are made which come with a health care budget that can be used creatively to help them both with autonomy and community inclusion. As a result of an explicit policy of 'open door-no restraint' in both the CMHTs and other inpatient psychiatric unit (acute admissions in a general hospital ward) and the emphasis on negotiation as a way of avoiding confrontation and coercion, Trieste has one of the lowest rates of involuntary treatments reported in a high income country (less than 10/100,000 in a year). There is also a virtual absence of any form of restrictive interventions such as control and restraint.

Evaluation of Trieste services has consistently shown very low reliance on hospital beds, better clinical and social outcomes for people with severe mental illness, and greater treatment adherence than other comparable mental health systems.

Muusse C, van Rooijen S (2015) Freedom First. A Study of the Experiences with Community-based Mental Health Care in Trieste, Italy, and its Significance for the Netherlands. Utrecht: Trimbos-Instituut



***Intervention 2.3: Bespoke, community-based service for Black men with a history of repeated hospital admissions under the Mental Health Act.***

*Background and context*

As with most mental health services in London (and in most urban areas in the country), in Wandsworth there is a small group of service users with a diagnosis of severe mental illness who experience repeated admissions to hospital, mostly under the Mental Health Act. They are often considered ‘difficult’ or ‘hard’ to treat and engage. Predominantly, they are young men of Black Caribbean or Black African background. Many of them report co-morbid substance misuse and have a pattern of non-engagement with services and on-adherence to treatment. More often than not, they become disaffiliated from conventional NHS mental health care systems over time. This group of men (usually young men) are also at high risk of social exclusion and involvement in the criminal justice system as a result of their mental health problems. Conventional treatment approaches, such as repeated spells in hospital followed by CMHT follow up, do not appear to benefit this group of service users. They constitute a ‘high risk’ group with complex needs but poor treatment outcomes and are likely to be excluded from conventional community treatment approaches. Paradoxically, in specialist mental health services, the most vulnerable people may end up receiving the least appropriate services.<sup>43</sup>

*Intervention*

There is no specialist or enhanced service provision for this (largely) BME client group in Wandsworth. To address this ‘service gap’, we propose a small specialist team to facilitate the engagement, care, support and treatment of this group of service users. The team will deliver a bespoke service based on a culturally adapted model of Assertive Community Treatment (ACT).<sup>44</sup> It is precisely this client group (with a diagnosis of severe mental illness, multiple hospital admissions, frequent relapses, non-adherence with treatment, poor engagement, co-morbid substance misuse, involvement with criminal justice system) that would benefit most from care and treatment options based on Assertive Community Treatment (ACT). There is more evidence for the effectiveness of ACT models than any other form of community treatment for people with severe mental illness.<sup>45</sup>

We propose a bespoke, intensive, person-centred and culturally informed package of community care, very similar to ACT; that is, a culturally adapted ACT delivered by BME staff for BME clients. Similar models of care and treatment have been implemented previously in London for African-Caribbean service users aged 16-25 who had complex mental health problems and were considered ‘difficult to engage’.<sup>46</sup> Assertive outreach services are also reported<sup>47</sup> as particularly effective in engaging African Caribbean service users with severe mental illness and minority ethnic groups in general.<sup>48</sup>





### *Actions/functions*

This will be a new service development – commissioning a small, specialist mental health team. It is estimated that there are about 15 – 20 young black men in Wandsworth who will meet the criteria for this service. Currently, they are followed up under the CPA by the CMHTs (mostly under CTOs) or detained in hospital (with longer than average LOS) or in secure care (out of area placement).

### *The new service will provide the following:*

- Intensive support, care and treatment for young black men with a diagnosis of severe mental illness, who have had multiple admissions and a history of coercive care
- The service will be co-produced and collaboratively delivered with the local black community and BME groups. The service will be culturally informed, BME led and closely aligned with local black assets and resources
- Priority intervention will be around engagement and developing a trusting relationship using an assertive outreach approach
- Engagement will not be conditional on treatment adherence – central to it will be a policy of ‘no case closure’
- This will involve multidisciplinary team working, black on black service options in the way of a black-led service located outside the formal mental health system
- Specific interventions will be provided relating to substance misuse and risk reduction
- Other interventions will include community-based rehabilitation, education and vocational schemes, peer support work
- Social inclusion strategies will be included, such as engendering social purpose through mentoring schemes
- Re-integration of family/social networks, family-based interventions
- Access to 24-hour crisis line

### *Resources/staffing*

Clinical staffing will be based on a high intensity ACT/AOT model; 1:5 staff/patient ratio for case work. In addition, sessional inputs from psychiatrist/clinical psychologist will be required. There will be additional (and specialist) staff recruited from the local black community, people with life experience (as mentors and role models) as well as people with lived experience of mental health problems.



## Outcomes

- Reduction in hospital based and coercive care for black people who are frequent users of high intensity services
- Reduction of risk of comorbid alcohol/substance misuse
- Prevent transition to secure/forensic care and out of area placements
- Improved engagement and clinical and social outcomes
- Rehabilitation and recovery of a core group of young black men at risk of institutionalisation, prolonged detention and high risk of criminal recidivism
- Improved functioning and social integration of young people with a complex history of institutional care
- Re-engagement with and reintegration with families and the local community
- Cost savings in mental health care





## Intervention 3

### Reducing Coercion

#### *Background and context*

There are significant ethnic differences in the use of coercion within mental health care. People of Black African and African Caribbean backgrounds are at greater risk of being subjected to such interventions than any other ethnic group. This is a key driver for other aspects of ethnic disparities in mental health care, such as engagement with services, treatment adherence, mental health help seeking etc. The use of coercion also has profound implications for service users in terms of their safety and trust and achieving therapeutic relationships which are fundamental to effective mental health care. As a result of coercive interventions such as control and restraint, patients feel violated and dehumanized, with a lack of connection to and understanding of the clinical decisions, processes and events leading up to the use of restraints. This can result in “a range of negative responses both immediately and after discharge”.<sup>49</sup>

Coercive interventions compromise patient safety and quality of health care. They can weaken or damage therapeutic relationships and dissuade people from seeking further treatment, thus increasing the risk of non-adherence and involuntary treatment. Coercive practices associated with mental health care and treatment contribute to social stigma against people experiencing mental health problems. The persistent and ubiquitous nature of coercion in mental health care means that “the human rights of users of psychiatry are systematically ignored”.<sup>50</sup>

Reducing coercion in mental health care is recognised as a global priority.<sup>51,52,53</sup> This is a critical issue for BME service users and has implications for any attempt to improve mental health care for BME communities. The recent Review of the Mental Health Act<sup>54</sup> in England was prompted by long-standing concerns over BME over-representation in involuntary psychiatric treatment. The Review has called for the development of alternatives to coercive services and specific actions to reduce detentions under the Mental Health Act. Four fundamental principles have been identified as underpinning all actions carried out under the Act. We have applied these principles in developing the EMHIP intervention to reduce coercive care for BME communities in Wandsworth.



**Table 3: Key principles underpinning the Mental Health Act**

- **Choice and autonomy** – ensuring service users' views and choices are respected
- **Least restriction** – ensuring the Act's powers are used in the least restrictive way
- **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from the Act
- **The person as an individual** – ensuring patients are viewed and treated as rounded individuals

EMHIP identifies reduction in the use of coercive practices as one of the key priorities/outcomes of the project. To achieve this, we propose two sets of interventions across the acute and urgent care pathway in Wandsworth. These are: (i) Shared Decision Making in relation to the Mental Health Act and (ii) Eliminating coercion through treating all coercive interventions, such as C&R, forcible treatment and seclusion, as a Serious Untoward Incident, ensuring a transparent and inclusive process for the use of any force or coercion and staff training to reduce coercion and ensure consensual care.

### Intervention 3.1: Shared Decision Making

#### *Background and context*

Arguably, the most alarming aspect of ethnic inequalities in mental health is the huge over-representation of BME communities, in particular, people of Black African and African Caribbean backgrounds, in involuntary treatment and in those subject to coercive and restrictive interventions. This is an intractable and increasing challenge for mental health services across the country. It is unlikely that reforming and redesigning services by themselves will help tackle this problem. Partly, the over-representation of particular ethnic groups in the high-intensity and coercive end of the treatment spectrum may be due to underlying variations in illness onset and presentation and psychosocial antecedents. However, the nature of clinical care is also shaped by clinical decisions taken at various points along the care pathway. Clinical decisions in mental health, especially when it comes to assessment/attribution of risk and safety, are not based on objective or reliable criteria. They can be subject to significant biases, depending on the context and attributes of the person taking the decision as well as the individual about whom decisions are being made.<sup>55</sup>

Many key decisions about risk, detention in hospital and use of coercive interventions are made in crisis situations. More often than not, such decisions are driven by the immediate behaviour and actions of the patient rather than a full or detailed understanding of that person. Often the key decision-making processes are closed and opaque and not sufficiently collaborative or inclusive. Best practice guidelines recommend multidisciplinary input into clinical decisions, but this is often considered impractical or ruled out on the basis of clinical urgency and risks.



There is evidence that joint decision making, involving service user and professionals in detailed care planning, could potentially avoid the need for compulsory treatment in the event of a psychiatric crisis.<sup>56</sup> However, shared decision making is not usually part of routine clinical practice. This is an important consideration in any attempt to make psychiatric treatment more consensual and, thereby, reduce coercion and involuntary treatment. Shared decision making could encourage people from BME backgrounds to become more involved in their care and treatment. Such an approach has the potential to reduce the oppositional dynamics that often pervade encounters between clinicians and black clients, especially in the context of hospital admission and treatment. Engaging ethnic minority clients requires clinicians to construct the clinical encounter as an egalitarian collaboration that addresses the clients' needs, empowers their decision making, and amplifies their voice in treatment. Shared decision-making means shared responsibility and setting treatment goals that are important for the client. Consideration of ethnicity, class, gender and background are important in bridging the social identities of clinicians and clients to promote more consensual and collaborative approaches in mental health care.<sup>57,58</sup>

### *Intervention*

Introducing shared decision making is an important part of EMHIP. This will engender a culture of consensual, rights based and collaborative care. The key to it is building therapeutic alliances that respect people's will and preferences, developed in their living environments, on 'their turf and terms'.<sup>59</sup> On this basis, we propose the introduction of a new decision-making methodology in relation to key clinical decisions about (i) detention under the Mental Health Act (ii) involuntary/forcible treatment (iii) restrictive interventions, such as control and restraint and (iv) CPA care planning. This will amount to a significant change in current clinical practice.

Clinicians will be required to ensure the involvement and participation of the service user/his or her family/nominated friend/patient advocate in all these decisions. CPA care planning process already allows for the input of the patient and family but, in practice, this does not always happen. While decisions regarding detentions under the Mental Health Act require the involvement of an Approved Mental Health Act Practitioner (AMHP), the AMHP's role is limited to "organising, co-ordinating and contributing to" the assessment. Under section 2 of the Act, the AMHP is also expected to make "reasonable efforts" to contact the Nearest Relative and invite their views. However, more often than not, there is very limited involvement of the Nearest Relative in the decision to detain someone under the MHA.<sup>60</sup>



The Nearest Relative also has a role in Section 3 detention and compulsory treatment although there is no established mechanism to facilitate/ensure their involvement in related decisions. The role of Independent Mental Health Advocates (IMHA) under the Mental Health Act is also limited and they do not contribute to the decision-making process.

We propose a uniform process of decision making in relation to all non-consensual care and treatment as well as CPA care planning to be put in place across the acute and urgent care pathway in Wandsworth. The key decision points are: (i) detention under the MHA (ii) decision to enforce treatment against the service. This will involve joint decision making by the clinician and the service user/person nominated by the service user for this purpose.

**Figure 7: Family Placements - care pathway**



#### Activities/functions

- A nominated person is identified for everyone referred through acute/urgent care pathway. This could be a family member, relative, friend or advocate
- Service user will be given the option of nominating such a person and the details recorded in the clinical notes.
- Service user will consent to the involvement of the nominated person in decisions concerning him/her.
- The participation of the nominated person in decision-making process will be facilitated by SWLSTG
- Participation and involvement of the service user and his/her nominated person in all decisions:
  - detention and involuntary treatment under the MHA (section 2 and 3)
  - initiating restraint and control procedures or seclusion
  - care planning including s117 agreement
- Wherever possible, a joint decision is reached with input from the service user and the nominated person
- The clinician with responsibility for making the relevant decision will be required to discuss the reasons for it, details of the assessment and concerns regarding risks, the likely benefits and harms during the joint decision-making process with the service user and the nominated person
- The process will be open, collaborative and transparent and will be recorded in the clinical notes.

#### Resources/staffing

It is expected that this procedure will be integrated into the mainstream service. There are resources implications in relation to managing the process (nomination, ensuring a register), training, advice and support (clinicians and nominees), facilitation (travel and related expenses).



### Intervention 3.2: reducing / eliminating the use of Control & Restraint (C&R)

#### *Background and context*

The use of coercion or forcible/involuntary treatment in mental health has been identified as a “system failure”<sup>61</sup>. This suggests a deviation from or violation of standard or good practice. Given the ubiquity and routine use of coercive practices, particularly in relation to specific BME groups, it would appear that system failures have become normalised in current mental health care in the UK. However, the case against the use of restrictive practices within therapeutic environments has never been stronger<sup>62</sup>. Black African and African Caribbean people are at greatest risk of being subject to such interventions in mental health services. Any attempt to improve mental health care for these communities must have a commitment to reduce/eliminate such practices if they are to be successful. Irrespective of ethnicity, it should be a priority to seek remedies for such “system failure” in order to ensure rights based mental health care that promotes recovery. The first step in achieving this is identifying and categorising coercive practices as ‘untoward’ incidents and, therefore, events that should be prevented/avoided.

Coercive interventions invariably compromise patient/clinical safety. The service user is placed at risk of physical and psychological harm through procedures such as C&R, seclusion, rapid tranquillisation etc.<sup>63</sup> although, paradoxically, such interventions are often initiated to reduce such risks. Arguably, every C&R intervention detracts from the quality of patient care. The principles underpinning good mental health care, namely, promoting choice and autonomy, least restrictive care, therapeutic benefit are compromised by such interventions, especially repetitive use of C&R and seclusion for the same individual. While mental health professionals should seek to reduce coercion in clinical practice, this requires a systematic approach.<sup>64</sup> Globally, reducing coercion in mental health is a priority, strongly supported as a prerequisite for developing good mental health care.<sup>65</sup>

#### *Intervention*

This consists of specific actions in inpatient settings in relation to (usually) emergency interventions involving coercion or force against the service user to deal with behavioural crisis or minimise risks. Mostly, they take the form of Control & Restraint procedures<sup>66</sup>. There is already national guidance available on the use of physical and mechanical restraints in health care settings<sup>67</sup> and SWLSTG, like other mental health trusts in the country, have policies and procedures on the use of restrictive interventions. The expectation is that service providers and clinical staff should act within the principles set out in such guidance<sup>68</sup> and use all restrictive interventions in line with the MHA Code of Practice 2015, Mental Capacity Act 2005, Human Rights Act 1998 and the common law. There are also several examples of changing clinical practice and inpatient environments (the culture of the wards) that can successfully reduce the use of control and restraint. What we are proposing is a more detailed framework for clinical decision making and implementation of any form of restrictive care involving force or compulsion against the service user.



## Actions

- Develop and agree a framework for the use of C&R/seclusion and implementation in all acute selected admission wards (Wandsworth admissions) and PICU at SWLSTG
- C&R, rapid tranquillisation and seclusion will be designated psychiatric emergencies that require the presence of a doctor/psychiatrist
- Prescription of PRN medication for behavioural management in crisis situations will be avoided
- Service users faced with control/restraint and forcible treatment (for example, rapid tranquillisation) will have the option of contacting a nominated person prior to being subjected to such intervention with a view towards discussing alternative, less restrictive options to manage the situation
- The nominated person along with the service user will be involved in decisions to initiate coercive/restrictive interventions
- Use of coercive interventions/restrictive care incidents will be considered Serious Untoward Incidents (SUIs)
- Established SUI procedure will be followed, including clinical and root cause review, learning from the incident (reflective practice - what prompted the intervention, what alternative could have been used, prevention of further incidents etc)
- There will be debriefing after each coercive intervention. This will involve the service user, family or nominated person and staff involved in the incident and will include emotional support for the service user and staff
- The clinical team will routinely review all coercive practices/incidents in a multidisciplinary setting
- Staff will receive training to reduce/avoid the use of C&R and seclusion and promote alternatives, based on established models of restrictive care reduction.<sup>69</sup>

## Resources/staffing

The programme will be integrated into routine/standard practice in SWLSTG. However, additional resources will be required in relation to facilitating (i) the process - setting up emergency contacts with the nominated person (mobile phones), travel costs and easy access (ii) training of staff and implementation of the programme and framework with service user participation.

An important asset in SWLSTG is the significant number of clinical (nursing) staff from black and minority ethnic backgrounds. Most of them are working on the 'front line' of clinical care across SWLSTG. For example, there are over 350 nursing staff from BME backgrounds employed at Band 3 - 6 at SWLSTG.



As part of the overall programme to reduce coercion and improve the cultural competency of the organisation, this resource will be mobilised through the relevant staff group (such as BME staff group, EVOLVE) and actively engaged in the delivery of the of EMHIP interventions. The programme will also be linked to similar initiatives that are planned, such as the application for Burdett funding.<sup>70</sup>

## Outcomes

Reducing coercion will have a profound impact on the organisation, delivery and experience of mental health care. This is a necessary component of achieving effective care, support and treatment for people with mental health problems and promoting public mental health. This will be a key driver for reducing ethnic inequalities in mental health care in Wandsworth, the main aim of EMHIP.

By implementing this intervention in SWLSTG services, EMHIP will deliver the following outcomes:

- Reduction in coercion
- More consensual care
- Improved therapeutic engagement and therapeutic alliance between service users and staff
- Service user ownership of decisions concerning their care and treatment
- Better treatment adherence
- Improved family involvement in care and treatment
- More accountable and transparent clinical decision-making



## Service Model: reducing coercive interventions

### PROactive Management of Integrated Services and Environments (PROMISE)

The aim of the project was to reduce the use of restraint and promote a more proactive and positive approach to care delivery in inpatient settings, a positive reframe around enhancing patient experience. The initial focus was on prone restraints and the goal was to eliminate its use within wards over a 3- year period, from 2014.

The core elements of the programme consist of:

**Report:** essential data relating to how many incidents and qualitative information regarding the antecedents through meaningful post incident debriefs with patients and staff. This information enables the ward team to make real-time changes to patients' individual care plans.

**Reflect:** weekly reflection within the multidisciplinary team helped clinicians share and learn from the incidents or near misses and from what worked well.

**Review:** monthly review of reported summative information and translating summative knowledge into concrete contextual formative actions.

**Rethink:** quarterly meetings with the wider leadership to help maintain momentum for the improvement agenda.

**Refresh:** annual business planning cycles used to refresh goals and propose trajectories.

There was a significant reduction in the use of C&R over a three-year period (by 27% and 13% in two successive years) as well as registering high patient experience scores.

Lombardo C, et al. *BMJ Open Quality* 2018;7:e000332. doi:10.1136/bmjog-2018-000332





### PROactive Management of Integrated Services and Environments (PROMISE)

This project used an adapted version of the Six Core Strategies© approach that was originally used in the US. The aim of this initiative was to reduce the use of physical restraint by 40% and to improve experience and outcomes for patients.

This was a four-year programme (2011 – 2017) designed to challenge staff assumptions and expectations of using restraint. It adapted the Six Core Strategies approach originally used in the US. The aim of this initiative was to reduce the use of physical restraint by 40% and to improve experience and outcomes for patients.

Seven mental health trusts took part in the project, with two acute inpatient wards per trust; one receiving the intervention and the other (the comparator ward). The initiative involved monthly reporting, training for ward staff and an improvement adviser offering support, advice and coaching. Project evaluation involved ethnographic methods alongside quantitative data collection, surveys, interviews and focus groups.

Four out of the seven trusts exceeded the 40% reduction in restraint target when comparing baseline to either the implementation or adoption phase. There was a 21% reduction in restraint use overall across the four trusts for which data was available for the full adoption phase. This reduction was statistically significant compared with changes in the comparator wards. This is particularly noteworthy as it is derived from the final phase of the project where there was no further active support for the intervention. This suggests that RY was successfully embedded into the participating ward cultures and was having an effect on reducing staff reliance on coercive measures

[Link](#)



Reducing coercion in mental health care will have a profound and pervasive impact on mental health services and overall quality of care. It is essential in developing mental health services that promote human rights and recovery.<sup>71,72,73</sup> The importance of this intervention, therefore, goes beyond improvement in patient safety and quality of care.

**Table 4: Reducing coercion and ensuring effective mental health care**

- Equitable access to least restrictive environment
- Service users' self-determination and participation in his/her treatment
- Involvement of families in decisions concerning assessment and treatment
- Shifting the focus of mental health care from:
  - Patient to citizenship
    - i.e. being concerned with persons with mental disorders as citizens and not, merely, as patients
  - Guardianship to free will
  - Substituted decision making to supported decision making and shared responsibility.
- Social mandate of psychiatry, from controlling behaviour to social mediation between stakeholders and the community
- The ethos of mental health care becomes truly 'person-centred' with a 'rights-based' approach and vision.



## Intervention 4

### Enhancing inpatient care for BME communities

#### *Background and context*

The inpatient settings at SWLSTG are all ‘closed’ spaces located within the hospital. They have locked doors and access is strictly regulated. Both in form and function, these wards are remote from the communities they serve. We heard that patient safety and risk management are prioritised in the acute wards over hospitality, support or therapeutic engagement. These wards function as ‘high intensity’ settings which could preclude engagement with families or other community assets. They are also very busy and disruptive environments. As with most such facilities in mental health services, people from minority ethnic backgrounds often feel that they are not safe places for them. Despite the best efforts of staff, BME service users report high levels of distress and threat experienced in these wards. All this is hardly conducive to recovery or achieving stability during crisis or distress.

A related problem is the apparent difficulty in engaging BME clients in their care plan and treatment. This may be due, partly, to the fact that much of the treatment and care in inpatient settings is coercive in nature.<sup>74</sup> Compulsion is inherent in all involuntary admission which often leads to oppositional dynamics between service users and those responsible for their care. In Wandsworth, we heard that many BME clients experience this as a significant barrier to engagement. BME service users generally feel disempowered during their inpatient stay.

For a variety of reasons, it would be difficult to ‘open up’ these inpatient spaces and render them wholly therapeutic. For example, we heard during our consultation with local clinicians that there is great pressure on acute admission and PICU wards as a result of an apparent bed shortage in South West London. There is a general ‘bed shortage’ in acute care which is an ongoing challenge and, if anything, this situation is getting worse. There is also a dearth of post-discharge options and “nowhere for people to move on to” once their acute care needs are addressed. As a result, patients stay in acute wards for longer than necessary. The wards are not locality based i.e. they accommodate patients from across the Trust catchment area and are not delineated by individual boroughs nor linked to specific CMHTs. This makes it difficult to resolve some of these difficulties. Staff recruitment and morale are ongoing challenges in SWLSTG.

A fundamental change in the way acute and urgent care is currently organised in SWLSTG is beyond the scope of this project. Instead, we propose a series of actions aimed at enhancing therapeutic benefit and increasing engagement in inpatient settings. There are two strands to this initiative (i)<sup>75</sup> facilitating community input in the wards and (ii) introducing a process of mediation to improve the dynamics of care.



### Intervention 4.1: Community involvement in inpatient care

#### Background and context

The purpose is to make inpatient care more open and collaborative, to consider these places extensions of community safe spaces for support, care and treatment. One way to achieve this is through developing an extended programme of inpatient support and advocacy by community agencies, both BME voluntary sector and BME service users. This initiative builds on the current work of Canerows, the black service user network of Sound Minds, a well-established mental health voluntary agency in Battersea.<sup>76</sup>

#### Actions

- Recruitment and training of Inpatient Community Support Workers from BME communities/people with lived experience and their involvement in inpatient settings
- This will be based on the Canerows ward visiting and befriending programme
- The programme will be enhanced to include individual patient advocacy and planning and delivery of individual care plans.
- Individual support and advice to service users to expedite progress/early discharge
- The Community Inpatient Worker will act as the main link with the service user's family, help mobilise all relevant community assets and resources in support of individual care plans
- Forging closer working relationships with the hospital chaplaincy service in addressing spiritual and faith needs of service users in hospital

#### Resources

The extra resources required are (i) Community Inpatient Worker costs (ii) expansion of ward visiting and befriending programme and (iii) staff training in relation to collaborative working in acute inpatient wards.

### Outcomes

- The expectation is that this enhancement of decision-making process will be integrated into current clinical practice.
- Improved engagement of service users and families in care and treatment
- Care planning will reflect service user wishes, priorities and needs
- Broadening family/community participation in inpatient care will enhance the quality of clinical care, reduce crisis and increase therapeutic engagement.
- Clinical decision making based on a collaborative/shared approach involving service users and family/carers will contribute to service user ownership concerning decisions about his/her care and treatment
- Encourage development of self-management interventions and personal crisis management plans



## Service Model: Community input into inpatient wards

### Canerows Peer Support for inpatients

In 2008, Canerows and Plaits (Canerows) formed under the umbrella of the user-led mental health organisation, Sound Minds, based in Battersea, South West London. Due to higher rates of (a) admissions to acute wards (b) sectioning (c) admission to services via police contact and (d) negative reported experiences of control and restraint among local BME groups, Canerows was set up to address these difficulties through peer-led services. In 2008, funding from three sources was pooled to employ a part-time project worker (a service user) and the Ward Visiting Scheme was piloted for one year. A positive independent evaluation in 2009 helped Canerows to secure further funding.

The Ward Visiting Scheme provides dedicated non-professional time to talk and 'ordinary human kindnesses' from people who have lived experience of mental health difficulties and use of local services. The Canerows Community Service is envisaged as complementary to existing mental health services and interventions include a variety of social and practical activities to support people with mental health problems. There is also an informal drop-in facility, Mama Low's Kitchen, at a local community centre, staffed and managed by service users. With shared staff between the Ward Visiting Scheme, the Community Service and Mama Low's Kitchen, a coherent system of peer support and consultation has been developed.

[Link 1](#) [Link 2](#)

ReynoldsD (2010) Human kindness, compassion and love: the hospital wards visiting scheme designed and delivered by Canerows and Plaits. *Mental Health and Social Inclusion*, 14, 3.

### Intervention 4.2: Cultural consultation / mediation / formulation

#### Background and context

One of the key dynamics in the mental health care of BME communities is the lack of understanding and trust between service users and mental health workers. Different views of illness and experience, difficulties in communicating, mistrust by service users and lack of cultural sensitivity/awareness by mental health professionals can result in conflict and disengagement. The apparent inflexibility of current models of clinical and risk assessments can compound these problems. This is an unsatisfactory framework for therapeutic engagement and collaborative working between service users and mental health workers. Addressing the fear and lack of trust in mental health services has been long identified as a key challenge in improving mental health care for minority ethnic communities in England.<sup>77</sup>

Over the years, there have been several strategies designed to understand and ameliorate this tension in clinical encounters between service users and clinicians. Generally, these were based on a model of mediation (as in conflict mediation) or consultancy (as in improving understanding) in health care. The aim of such efforts is to offer a structured and positive way to reconcile the different explanatory models between the parties concerned. For example, using the framework of 'cultural interpretation', the cultural meanings of particular symptoms are explored in the social context of distress.



The draws heavily on models used in medical anthropology and involves enhancing the clinical encounter by a focus on difference and culture and cultural constructions of mental illness.<sup>78</sup> The underlying premise is that cultural factors of both users and providers of mental health services shape the very experience of suffering, help seeking, assessment, diagnosis and the nature of treatment.<sup>79</sup> Although there have been several practical attempts to introduce cultural mediation in mental health care of minority ethnic communities in the UK, none of them has been fully integrated into routine clinical practice or in supporting the care and treatment for people from cultural/ethnic minorities.<sup>80,81</sup>

As part of EMHIP, we are proposing the introduction of Cultural Mediation as an option for service users and clinical staff in inpatient settings to reduce oppositional dynamics, enhance communication, improve the diagnostic formulation and also joint care planning and therapeutic engagement.

#### Actions

- A framework for Cultural Mediation (CM) in clinical practice will be developed for use in inpatient settings in Wandsworth
- A CM team will be commissioned to train staff on CM and to deliver the service initially
- CM will be integrated into routine clinical care/care planning in the inpatient wards
- Service users who are identified as 'difficult to engage' or otherwise entrenched in oppositional dynamics with clinical staff will be eligible for this service

#### Resources

- Additional costs will be in relation to commissioning a CM service to be provided by appropriately trained mediators.
- Training in CM for inpatient staff
- Additionally, BME staff resources within SWLSTG will be mobilised and aligned with this intervention

### Outcomes

- Improvement in the dynamics of clinical care between black patients and staff in inpatient wards
- Improvement in clinical practice – culturally informed formulations and diagnostic process
- Increased engagement of service users who are seen as 'difficult to engage' in inpatient settings
- More consensual care and reduction in coercive and compulsion
- Increase in satisfaction with inpatient care and other Patient Reported Outcomes
- Improvement in staff competency and morale in dealing with BME service users



## Service Model: Cultural mediation

### Tower Hamlets Cultural Consultation Service

The Tower Hamlets Cultural Consultation Service (was set up to improve service user outcomes by offering cultural consultation to mental health practitioners. This involved practitioners working alongside cultural consultants to address immediate clinical challenges among BME groups and to produce a shared care plan. The team consisted of a clinical psychiatrist, forensic trained mental health nurse and an outcomes manager. An evaluation based on nearly 900 contacts and 36 complex cases over an 18-month period showed positive outcomes in terms of the clinician's perception of the usefulness of the service and significantly reduced service usage by the clients. The service also provided organisational consultation and training to other mental health teams. Cultural consultation is both an effective and direct clinical intervention that improves functioning, meets patient needs, and drives down costs per patient by reducing reliance on emergency care and nursing care.

Palinski A, Owiti J, Ascoli M et al (2012) A cultural consultation service in East London: experiences and outcomes from implementation of an innovative service. London: National Mental Health Development Unit.



## Intervention 5

### Culturally Capable Workforce

All previous guidance and policies on improving mental health care for BME communities in England have identified the importance of developing cultural competence in delivering effective and equitable care and treatment.<sup>82</sup> This includes commitments to increasing BME representation in the workforce, ensuring culturally informed clinical practice and organisations that are capable of serving culturally diverse communities. Specific actions to reduce inequalities and involve BME community sector in mental health are unlikely to be effective without equipping the workforce with the required capabilities. Proposals around ethnic monitoring, research, ensuring accountability and ownership as well as setting standards, targets and outcome measures are key elements in ensuring cultural competence at service and organisational levels. Improved understanding of racism both at the institutional and personal level, how these impact on mental health and wellbeing as well as how racism might impede appropriate and equitable care is also recognised as an important element within the cultural competency framework. Training of the workforce to improve their cultural capability/competence is accepted as part of a larger mosaic of creating culturally responsive services.<sup>83,84</sup>

Cultural competence is defined as “a set of congruent behaviours, attitudes and policies that come together in a system, agency or professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations”<sup>85</sup> and as “the set of behaviours, attitudes, skills, policies and procedures that come together in a system, agency, or individuals to enable mental health caregivers to work effectively and efficiently in multicultural situations”.<sup>86</sup> Cultural competency training is best conceptualised as a systemic and deep-seated process of change in both organisations and professional practice.

A “culturally competent” health care system is one that acknowledges and incorporates – at all levels – the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.<sup>87</sup>

Cultural competence training is a well-established method that helps organisations and staff to recognise the importance of service users’ cultural background in order to develop skills, knowledge, and policies to deliver effective treatments.<sup>88</sup> Underlying such an approach is the belief that services tailored to culture are more inviting, encourage ethnic minorities to access treatment, and improves their outcome once in treatment.<sup>89</sup> This approach is particularly relevant in organisations and services where there are ethnic or cultural disparities in service experience and outcomes.





It is argued that services should be competent in working with diverse cultures. However, such competence is currently lacking within most aspects of mental health care. An underlying principle of cultural competence is that it makes “treatment effectiveness for a culturally diverse clientele the responsibility of the system, not of the people seeking treatment”.<sup>90</sup> Cultural competence/capability is a broad-based approach to transform the organisation and delivery of all mental health services to meet the diverse needs of all patients.<sup>91</sup> A culturally competent health care system has been defined as one that acknowledges and incorporates – at all levels – the importance of culture, assessment of cross-cultural relations, vigilance in relation to the dynamics produced by cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs.<sup>92</sup>

Training in cultural competence overlaps with other health care improvement priorities and can help the organisation address these as well (Figure 9).<sup>93</sup> Similar concepts to cultural competency have also been advocated in ensuring effective and appropriate treatment and care for cultural/ethnic minorities, such as ‘cultural responsiveness’, ‘cultural humility’ and ‘cultural safety’. Underpinning all these approaches is the need to make services more appropriate and relevant to the needs of minority communities and ensure the workforce has the necessary competence to engage with them in a positive and productive way.

**Figure 9: Cultural Competency – overlap with other health care priorities**



The EMHIP Intervention Programme recognises the importance of a broad-based approach in reducing ethnic inequalities in mental health care in South West London.



The Five Key Interventions set out above amount to specific actions at the community and service level to achieve this purpose. However, the development, delivery and integration of such actions are dependent on a culturally competent organisation and capable workforce. In SWLSTG, there have been previous attempts to introduce cultural capability training for staff. However, this did not involve all staff groups and, more importantly, it was not linked to an overall programme of change. The training was not monitored or evaluated for its impact on key service outcomes for BME service users or staff.

We are proposing a programme of cultural competency training for all staff in Wandsworth. This is to ensure organisational and workforce capability to bring about the changes necessary to reduce ethnic inequalities in service access, experience and outcome. This will focus on the main areas of inequality in mental health services emphasising the impact of racial discrimination. The training will promote the development of professional practice emphasising interpersonal interactions between service users and practitioners and organization processes that leads to unequal treatment and outcomes. This will run in tandem with the existing equality schemes in SWLSTG and requires a real sense of involvement and ownership to be nurtured alongside the provision of training and support.<sup>94</sup>

#### *Actions/functions*

- A competency framework will be introduced to ensure cultural capability at the level of organisation, workforce and service intervention to reduce ethnic health inequalities<sup>95</sup>
- This will be developed through a collaborative approach involving BME service users, community organisations and staff
- Existing models of cultural competency training in mental health in the UK will provide the template but this will be modified as a bespoke programme for Wandsworth.
- CC training will be rolled out across all levels of the organisation and new staff will complete the programme as part of their induction
- The training will be mandatory and subject to monitoring and evaluation

#### *Resource*

- Cultural awareness is already part of the training agenda for clinical staff; the CC training will be linked to this
- Consultancy cost for developing and delivering the training in Wandsworth
- Staff backfill costs to attend training
- Cost of room hire and related support for training
- BME staff resources within SWLST will be mobilised and aligned with this intervention



## Outcomes

- A capable workforce that can provide appropriate and culturally congruent care for diverse communities
- Increase in organisational capability in relation to race, culture and difference
- Address unwitting/unconscious racism and structural barriers to equal care
- Tracking and monitoring differential care trajectories and outcomes according to ethnic and cultural differences
- More person-centred care
- Integrated and ongoing monitoring, review and incorporation of lessons learned to inform service delivery
- Mobilisation of support for BME staff in Wandsworth and their active engagement in the care and treatment of BME people.



## **3** Section 3: Recommendations and Way Forward

- 1) We recommend that the Key Interventions set out in this paper are accepted and approved for implementation in Wandsworth.
- 2) To maximise their impact and ensure whole system change, these interventions should be considered as one integrated programme. The impact of individual interventions will be weakened and is unlikely to be sustained if they are not implemented as a single programme of change.
- 3) The Key Interventions are designed to make the best use of available resources, both within the specialist mental health system and in the community. The success of this programme will depend on the ownership, commitment and involvement of all stakeholder groups. A co-production model is essential to further develop and implement these changes. We strongly recommend that this approach is embedded throughout the implementation.
- 4) Consistent with the EMHIP Project Proposal, we recommend that this programme is first implemented in a systematic manner in Wandsworth and the process, changes and outcomes are monitored and evaluated.
- 5) The next stage involves further adaptation of the interventions to the local context and needs as required, costing and development of a detailed implementation plan.
- 6) This should include sharing the intervention plans with all stakeholder groups for further feedback and comments, as previously agreed.



## AP Appendices

### Appendix 1 : Evidence Review

#### Background

EMHIP is not a research project. It is a programme to develop and implement a specific intervention programme to reduce ethnic inequalities in the local mental health system.

A key step in developing an intervention programme is to identify what has worked in this area before. Traditional approaches include undertaking a formal process of knowledge or evidence synthesis.<sup>96</sup> Unfortunately, there is a lack of formal or high-level evidence on interventions to reduce ethnic inequalities in mental health or, more generally, in health care. However, given the magnitude and health care consequences of ethnic inequalities mental health care, their impact on BME communities and repeated calls over the years to address this problem, there is a compelling need for urgent service change and reform.

Much of the published work relates to the nature and extent of ethnic differences in mental health care (general population, primary care, secondary and specialist care) and, to a lesser extent, the likely antecedents of such differentials. Comparatively, there is little outcome research or how to make mental health services more equitable and appropriate to the needs of BME communities. We are unaware of any experimental evidence in this area. This is unsurprising as there have been no systematic interventions to reduce ethnic inequalities in mental health care in the UK, locally or nationally. This is true both in terms of research and service development. This contrasts with a much clearer understanding of how ethnic inequalities are patterned within the mental health care system and how such disparities impact on the effectiveness, appropriateness and quality of care and treatment.

Although investment and engagement with this topic in the NHS and other statutory agencies has been poor, over the last five decades there have been several attempts to improve mental health care for BME communities by BME community organisations within the voluntary sector and other non-statutory agencies. This has produced a trail of evidence of strategies to improve the care and treatment of people from minority communities. However, much of this evidence is not easily accessible (through routine search methods, for example). Most of the work is not systematically documented, garnered, marshalled or otherwise curated. Nevertheless, it forms a potential source of evidence or knowledge.

A third source of evidence as to what actions are necessary to reduce ethnic inequalities in mental health is the various reports and national inquiries on BME mental Health. The recommendations of these reports are based on a review of evidence, expert opinion and, in some cases, interviews or more formal consultation with BME service users and other stakeholder groups. Again, we believe this is a rich source of evidence that we can use in developing an intervention programme to reduce ethnic inequalities in mental health services.



A fourth source evidence informing mental health service change is what we know about good mental health care. Compared to the relative paucity of formal evidence in relation to BME inequalities in mental health, there is a wealth of information on what constitutes effective mental health care. Key ingredients include good practice models and what service users and their families want. This evidence is well documented, systematised and formulated in the way of guidelines and good practice models. It is worth stating that these values, objectives and practices are equally relevant for all communities. Any intervention programme designed to improve mental health care should be underpinned by these principles and practices. We can, therefore, draw on this knowledge in formulating a specific change programme targeting BME communities.

### Process

Our aim was to undertake a detailed thematic review of what is known about strategies / interventions / expert, service-user and BME community-based recommendations to reduce ethnic disparities in mental health care in the UK. This is an established form of knowledge synthesis which, in this area, is defined as “research relating to health care delivery that evaluates and summarises all available evidence through comprehensive literature searches and advanced qualitative and quantitative synthesis methods”. Knowledge synthesis attempts to summarise all pertinent studies on a specific question.<sup>97</sup>

There are several types of knowledge syntheses. For example, thematic review summarises a range of evidence in order to understand broadly what is known about a phenomenon. It helps identify main sources and types of evidence available and is particularly appropriate when studying a complex area. Scoping reviews are particularly useful when the topic has not been reviewed comprehensively before<sup>98</sup> and a broad approach is important for identifying gaps in the literature and where there is limited empirical evidence.

This review first sought relevant literature from diverse sources. We collated, summarised and used this as the basis for identifying key themes / areas relevant to reducing ethnic inequalities in mental health care.

First, through a formal process of literature search we sought all studies (both quantitative and qualitative) since 1980 on strategies / interventions to reduce ethnic inequalities in mental health care in the UK. Ethnic inequalities were defined as differential service use, access, pathways to care, hospital admission, coercion and outcomes by ethnicity. The initial search strategy involved two key elements: (1) differences by ethnicity and (2) plans / strategies / trials / interventions to reduce them. We excluded from the search (i) non-psychiatric population (ii) substance misuse / alcohol use (iii) dementia (iv) children (under age 16) and (v) older adults (over age 65). The search was limited to publications in English.

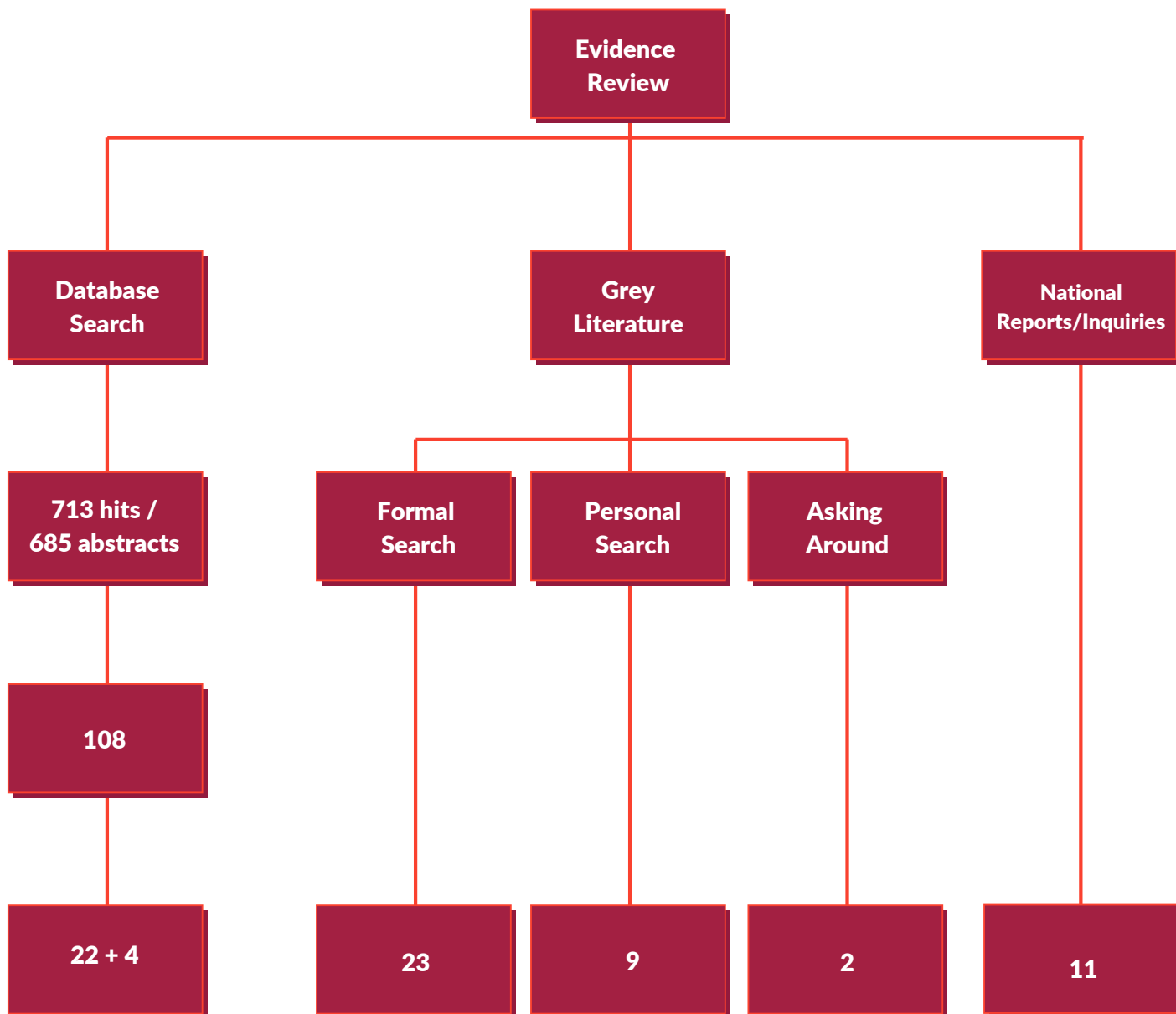


Second, we sought out grey literature in this area. This included (i) evidence search using NHS Evidence and NICE, King's Fund, Race Equality Foundation, MIND, Synergi Collaborative (ii) Google searching by current and previous BME mental health organisations (iii) through personal knowledge of the authors and contacts with BME voluntary mental health organisations and other BME focused initiatives to improve mental health care (there have been over 50 such organisations across the country going back to 1980) and we accessed these sources through published reports (not all identifiable or available using conventional searches) and through personal contacts and (iv) informal approaches including browsing and "asking around" or local enquiry to enhance our search.

Third. we searched the national reviews / reports /inquiries in relation to ethnicity and mental health. In addition to identifying key THEMES in relation to improving mental health care and reducing ethnic inequalities in mental health, we collated the recommendations of the inquiries and models of good practice in mental health care for BME communities.

### Results

Database searches yielded 713 hits (685 with abstracts). This was reduced to 108 by scrutinising the abstracts. After full-text review 22 were selected (based on any change programme for reducing ethnic inequalities / improving mental health services for BME communities) and discarding duplicates. Relevant references from these yielded another 4 additional sources. The grey literature search including hand-searching personal collection of documents (BME MH NGOs) which yielded 31 papers / reports, including unpublished reports. As a result of "asking around" and consulting several individuals who have been involved in attempts and campaigns to address ethnic inequality in mental health care (mostly from BME voluntary sector), we identified a further 2 reports. We also reviewed 8 key national reports on mental health and ethnicity, spanning a period of 20 years (1993 to 2014).



*Evidence*

We identified the nine major themes in relation to addressing ethnic inequalities in mental health on the basis of reviewing these papers and reports (n = 175).

These are set out in the main report.





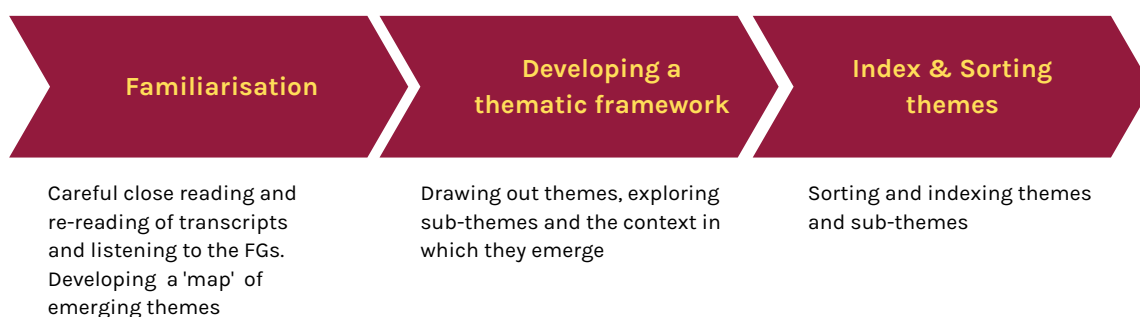
## Appendix 2 : Focus Groups and Interviews

### Section 1 : Focus Groups

Focus Group analysis was completed by Dr Narinder Bansal and Dr Petros Andreadis. The following is based on their final report.

An important part of developing the Intervention Programme (Key Interventions) of EMHIP is seeking, obtaining and collating the views of local stakeholders. We conducted a series of Focus Groups involving staff (management and clinical staff) at SWLSTG, the latter mostly front-line staff in Wandsworth (acute and urgent care pathway and community mental health) and community stakeholders (including service users, BME community agencies, mental health voluntary groups working with BME communities, faith groups and other formal and informal service providers. In total we conducted 13 Focus Groups. Nine of the groups were in the community and four with staff at SWLSTG.

These groups explored the views, perceptions, and experiences of a wide range of community stakeholders and mental health service providers on the challenges in providing appropriate mental health services for black and minority ethnic (BME) communities in Wandsworth as part of the Ethnicity and Mental Health Improvement Project (EMHIP). The purpose of the analysis was to extract key themes using a standard qualitative thematic process.



#### Findings

The focus group analysis shows significant and persistent shortcomings in mental health service provision for BME communities in Wandsworth. Three broad areas are identified

- 1) perceptions and experiences in relation to mental health services and BME communities;
- 2) challenges within the BME community;
- 3) participant recommendations, priorities and wish-lists for change.



## 1: Perceptions and experiences in relation to mental health services and BME communities

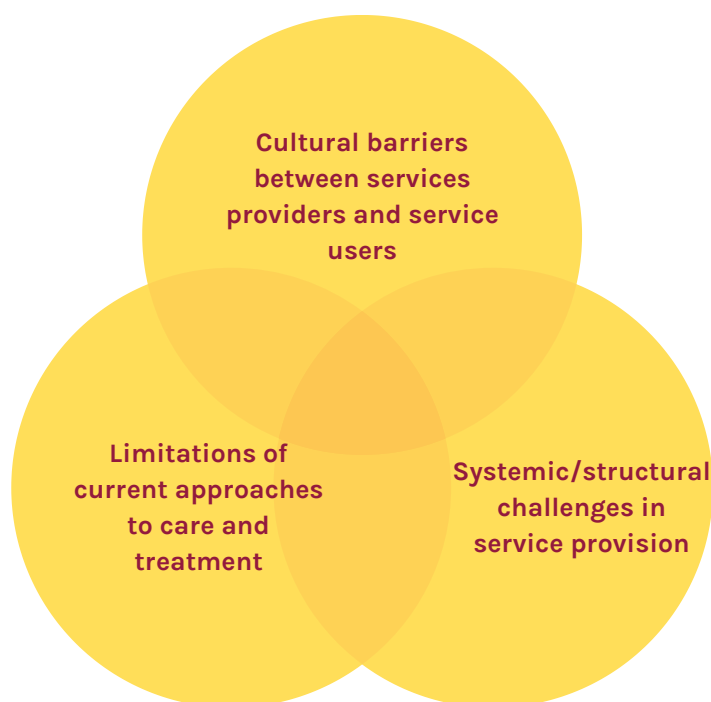
Participants from both inside and outside groups were keenly aware of the existing challenges in mental health service provision. Discussions highlighted a number of areas where services are currently failing BME individuals and communities.

The key themes identified were:

- the differential service provision to patients depending on a wide range of factors including social characteristics, perceived class, education, eloquence, appearance, speech and articulation, and perceived intelligence
- the disproportionate detention of people from BME communities
- the disproportionate numbers of BME patients detained on wards longer than necessary
- the differential service provision depending on the presence or absence of family
- the stereotyping of BME patients, e.g., 'the angry/aggressive black man'

These can be categorised as falling within three broad themes:

**Figure 1: Perceptions and experience in relation to mental health services and BME communities**





### 1.1: Limitations of current approaches to care and treatment

The current psychiatric approach to diagnosis and treatment was recognised as a significant barrier to help-seeking in BME communities. The key themes identified were:

- the pressure on health professionals to provide a rapid diagnosis can result in incomplete /inadequate assessment
- a lack of recognition of cultural differences or nuances at assessment. This contributes to a conflation between ‘culturally specific behaviours’ and narrow biomedical pathology
- the general absence of person-centred care. Medical professionals were seen to prioritise diagnostic categories and pathologies over individual personal and cultural nuances and values
- services were viewed as overly controlling, impinging on patient autonomy and choice. The current approach towards assessment and treatment was seen as a system that lent disproportionate power to professionals to make decisions, such as detaining and secluding individuals
- outside participants felt that mainstream services did not allow space for adequate listening and communication.
- medical language is a significant barrier to lay people.

### 1.2: Systemic/structural challenges in service provision

Systemic or structural challenges refer to the way services are organised and run. This includes a variety of issues from staffing, lack of diversity in the workforce, to time and resource constraints. The key themes were:

- services are over-stretched as a result of inpatient bed and human resource shortages i.e., a lack of psychiatric consultants and nurses.
- Staffing challenges and attrition impact on continuity of care high caseloads coupled with resource and time constraints meant that practitioners are unable to fully engage with patients and provide holistic care. Time constraints also result in crowding-out of appropriate training for staff, preventing practitioners building relationships with other organisations (e.g., community and faith organisations) and limiting opportunities to build rapport with service users. Furthermore, a target-oriented culture left service providers feeling that they needed to value clinical efficiency and output over patient-centred care
- fragmented services limit opportunities for continuity in care
- there was widespread acknowledgement of the lack of cultural and ethnic diversity within the mental health workforce. There is a perception amongst service providers that there are challenges in hiring BME psychiatrists. Senior leadership within mental health services are usually white: there are “white services” and “white decision makers”. There were also concerns that BME practitioners faced racial barriers to progression to senior positions (the ‘glass ceiling’)
- services are also viewed as intrinsically racist and discriminatory against BME individuals, with racial stereotyping - e.g., the ‘aggressive black male’.



### 1.3: Cultural barriers between service providers and service users

Service providers acknowledged that culture is a distinct barrier to appropriate service provision. The key themes were:

- a cultural knowledge gap - i.e. service providers often have challenges in understanding patients from different cultures
- BME patients are often misunderstood and culturally distinct behaviours are sometimes pathologised leading to misdiagnosis and labelling
- a lack of diversity within staff teams contributes to cultural blind-spots. It was acknowledged that if staff diversity was increased this would significantly improve communication and outreach to BME communities
- it was widely expressed by outside participants that services are geared towards white people
- there are difficulties relating to white practitioners who do not understand cultural context
- it was widely acknowledged that the recognition of cultural barriers within services are not novel insights or findings. In particular, service providers accepted that training resources in cultural capability are established and available, however, training is not widely adopted or considered mandatory despite effectiveness.

## 2: Challenges in the BME community

Barriers to timely help-seeking for mental health in the BME community emerged as a key theme; for example, delayed presentation and help-seeking due to several barriers including fear, stigma, active avoidance of services, low mental health literacy in relation to mental health, illness and services, and low hope for recovery. These issues are closely interrelated and discussed in more detail below:

### 2.1: Low mental health literacy in BME communities

There was widespread acknowledgement that there is a significant lack of knowledge and awareness in relation to mental health, illness and mental health services in BME communities. This includes a lack of knowledge of how and when to seek support; lack of awareness of symptoms and signs of mental illness; and ambiguity around illness-thresholds that require clinical intervention.

### 2.2: Little hope for recovery

Mental illness is largely seen as a binary state and perceived to be synonymous with “madness”. Hence, mental health problems / illness are seen to be a permanent / incurable states. There is little hope for recovery or any understanding of whether recovery is possible: ‘once mad always mad’.

### 2.3: Community and family silence around mental health and illness

There was widespread acknowledgement that there is a lack of community support to legitimise help-seeking for mental illness. Mental illness remains a collective taboo subject in BME families and communities. This community silence and denial extend to faith groups.



## 2.4: Stigma

Social stigma is widely recognised as a significant and critical barrier to timely presentation and help-seeking for mental health. Stigma is highly associated with the use of the word 'mental' and there is little distinction between mental health problems and mental illness in BME communities. Social stigma disrupts the social identity and biography of the individual and also threatens to spoil the identity of the family and local community.

## 2.5: Previous negative experiences of services within the community

Perceptions of mental health services and treatment are influenced by previous negative experiences in the local community. These negative experiences of services in the local community are felt, seen and remembered by BME communities and this appears to perpetuate silent suffering and delayed help-seeking in these groups

## 2.6: Models of Illness

The way mental illness is currently treated within mental health services conflicts with religious and cultural interpretations of illness and suffering.

## 2.7: Cultural expectations / familial conformity

There is a culture of keeping things 'in the house' and the sharing of personal information outside the family is discouraged. There are also cultural expectations of stoicism, with help-seeking seen as a failure of resilience.

## 2.8: Fears around the implications of formal help-seeking

Fears of accessing services included: 'white' services are not perceived to be accessible to BME communities; the fear of being misunderstood and stereotyped; fear of medication and sectioning; fear of the implications of help-seeking, such as authorities coming in and removing children from parents.

## 2.9: Generational differences and conflict

The different cultural and social expectations and norms between first and subsequent generations, and particularly young people, were acknowledged. This included: the challenges younger people face in negotiating two conflicting cultures; significant academic pressure and stress for young BME people to do well at school; the general mistrust of services and authority amongst first generation BME adults; first and subsequent generations have different concepts and understanding of emotional self-care and mental health; there is limited 'space' for conversations at home on emotional health for young people whose parents are 'first generation'.



### 3: Recommendations, priorities for change

There is considerable overlap between the narratives of service providers and local BME communities (including service users) on the challenges of accessing and providing timely, appropriate and adequate mental health care to the BME community. There is a common understanding that these challenges are long-entrenched, complex and systemic and require a dual approach to tackle barriers within the services and in the community.

The following section outlines the key themes that emerged when participants were encouraged to think about an 'ideal- world' scenario or what would constitute good mental health care. This includes aspects of the complex problems that participants would like to see prioritised for intervention and a wish-list of ideal changes and solutions.

Participants from inside and outside groups would like to see:

#### 3.1: Holistic patient-centred care

- interventions and systems that adopt a more holistic approach to patient care
- service staff who are able to tend to the personal social-cultural context and narrative of the patient, including culture, adversity, discrimination, and life experience

#### 3.2: Greater staff diversity and cultural intelligence within the services

- practitioners in services that 'look like us' and 'sound like us'
- greater staff cultural diversity, particularly during patient assessment and at senior level
- services and staff that have greater cultural awareness and intelligence services and staff that have a better understanding of the challenges faced by BME communities

#### 3.3: Initiatives that tackle discrimination and stereotyping

- services and practitioners should not stereotype BME service users

#### 3.4: Located in local communities

- community-focused and community-integrated approaches
- inclusion of third sector organisations and support in service delivery and utilising community assets
- Greater participation and involvement of BME communities in mental health care through BME workers in existing services, creation of new roles (e.g., peer support, support workers, link workers, mental health advocates)



### 3.5: Humane services and care

- services that promote trust, dignity, respect and kindness
- services that align with principles of equality

### 3.6: Destigmatising approaches

- services that allow and preserve anonymity during the help-seeking process
- services that are less visibly focused on mental illness
- treatment choices to include more non-pharmaceutical options
- Raising awareness and tackling stigma
- concerted efforts to tackle stigma and a normalising of conversations about mental illness in families and communities
- creating opportunities and safe spaces to enable open discussions and exploration of fears around help-seeking for mental illness.



## Overarching Themes

Six overarching themes emerged from the FG analysis relating to solutions and priorities between the inside and outside groups (Table 1). Three of the six key themes were common to both inside and outside FGs. In addition, three divergent themes emerged, including an emphasis in the outside groups on looking beyond existing services for alternative community-based services and interventions.

These themes are further detailed below:

**Table 1: Key Themes**

<u>INSIDE GROUPS</u>	Theme 1	<u>OUTSIDE GROUPS</u>
<ul style="list-style-type: none"> <li>• Training/education to improve awareness, knowledge and understanding</li> </ul>		<ul style="list-style-type: none"> <li>• Training/education to improve awareness, knowledge and understanding</li> </ul>
<b>Theme 2</b>		
<ul style="list-style-type: none"> <li>• Increasing engagement between communities and services</li> </ul>		<ul style="list-style-type: none"> <li>• Increasing engagement between communities and services</li> </ul>
<b>Theme 3</b>		
<ul style="list-style-type: none"> <li>• Enacting structural changes within services</li> </ul>		<ul style="list-style-type: none"> <li>• Enacting structural changes within services</li> </ul>
<b>Theme 4</b>		<b>Theme 5</b>
<ul style="list-style-type: none"> <li>• Using data to fully evidence ethnic inequalities and monitor service performance</li> </ul>		<ul style="list-style-type: none"> <li>• Developing community-based assets - particularly faith-based institutions</li> </ul>
<b>Theme 6</b>		
		<ul style="list-style-type: none"> <li>• Plurality and choice around interventions and care pathways</li> </ul>





**Theme 1:**

**Training / education to improve awareness, knowledge and understanding**

The inside and outside groups expressed a need for greater cultural awareness, knowledge and cultural intelligence within mental health services and staff teams. The outside groups recognised a need for significant psychoeducation and awareness-raising of mental health services to tackle stigma and help facilitate timely help-seeking in BME families and communities.

Inside Groups	Outside Groups
<p>Increasing cultural capability of services through training which includes awareness raising of cultural norms and specific needs of BME groups.</p> <p>Unconscious bias training to specifically address issues of racial discrimination and stereotyping.</p> <p>Training on how to carry out more holistic assessments that recognise and value patience spiritual and cultural needs.</p> <p>Training should be mandatory and embedded within routine practice.</p>	<p>Staff training in many mainstream mental health services to improve cultural intelligence and awareness and reduce stereotyping of BME groups.</p> <p>Training that encourages service providers to adopt a more holistic and humane, person- centred approach in mainstream services.</p> <p>Increase awareness in the community of the benefits of talking therapy.</p> <p>Providing training to communities, families schools and faith centres on how to start early conversations on mental health at home.</p> <p>Psychoeducation in BME families and communities.</p> <p>Workshops to educate the BME community on the detection and management of mental health symptoms, self-care and when to seek help and how.</p> <p>Creating hope and the positive image of mental health and treatment by sharing and highlighting positive stories of recovery.</p> <p>Specific training for communities in the ‘right language’ to help them navigate mental health services.</p>



**Theme 2:**

**Increasing engagement between services and communities**

Both inside and outside groups acknowledged the lack of engagement between service providers and local communities and the need for community coproduction in services. There was agreement between service providers and community members that improved links with communities and existing community groups and assets (e.g., faith groups) may be a fruitful approach to improving mental health care and support in BME communities.

Inside Groups	Outside Groups
<p><b>Codesign and coproduction of solutions with service users.</b></p> <p><b>Encouraging and allowing time and space for greater contact between clinicians and community leaders.</b></p> <p><b>Community leaders are largely seen as faith group leaders but could include any defined groups.</b></p> <p><b>Employ community outreach workers to act as a link between services and communities.</b></p> <p><b>Increase grassroots community engagement.</b></p>	<p><b>Having support staff from the same ethnic group located in the community to help signpost and tackle cultural and language barriers between individuals and service providers (e.g., cultural brokerage).</b></p> <p><b>Develop a system that allows service users, communities and service providers to engage in coproduction.</b></p> <p><b>Services should be designed by people who understand the cultural context of the community.</b></p> <p><b>Encourage connections between service providers and communities to help facilitate pathways that allow for a more family-centered approach.</b></p> <p><b>Develop a pathway in which faith leaders are able to engage with hospitals and services.</b></p> <p><b>Establish community mental health champions who can provide advice and signpost to services.</b></p> <p><b>Develop systems so that referrals to services can be made from community groups (e.g., temples, mosques).</b></p>



**Theme 3:**  
**Structural changes within services**

Both inside and outside groups acknowledged the lack of engagement between service providers and local communities and the need for community coproduction in services. There was agreement between service providers and community members that improved links with communities and existing community groups and assets (e.g., faith groups) may be a fruitful approach to improving mental health care and support in BME communities.

Inside Groups	Outside Groups
<p>Increasing ethnic and language diversity within staff teams.</p> <p>Bringing new cadres of mental health workers into services who can provide psychosocial support.</p> <p>Address staff attrition.Excessive staff turnover results in lost institutional and local knowledge</p> <p>Nomenclature. Terminology is seen as a structural barrier and inside participants suggested that professionals consider using more patient-friendly language e.g., ‘patient consultation’ as opposed to ‘patient assessment’.</p> <p>Expand primary care and build resources within community settings.</p> <p>Use community-based rather than hospital-based facilities as settings for assessment/consultation.</p> <p>Develop teams and systems that can assist in post-discharge support.</p>	<p>Increase staff ethnic diversity in mental health services and the availability of mental health professionals who speak the same language.</p> <p>Services that are able to bridge the cultural gap between providers and communities.</p> <p>A need for therapists and clinicians with similar social and cultural backgrounds to patients to improve relatability.</p> <p>IAPT needs to be more user-friendly and links between IAPT and GPs needs improving.</p> <p>Greater provision of advocacy support for patients in hospitals.</p> <p>Support services that recognise and adopt non-stigmatising language and preserve anonymity i.e., wellbeing services as opposed to mental health services.</p> <p>Avoid development of inferior/ghettoised BME services.</p> <p>Services that are introspective enough to realise when equality of treatment-access needs to be addressed.</p>



#### Theme 4:

#### Using data to evidence ethnic inequalities and monitor service performance (inside groups)

- general information about local communities (e.g., demographic data)
- gathering qualitative data on service user experience
- the need for more granular data on ethnic inequalities in service provision and outcomes.
- learning from successful services and practices in other locales. i.e., share examples of good practice

#### Theme 5:

#### Developing Community-based assets (outside groups) particularly faith-based communities

- allowing for a more diverse ecosystem of community assets to provide a network for mental health support and signposting
- establish facilities in faith centres that integrate mental and physical health and focus on wellbeing as opposed to mental health
- establishment of community-based hubs for drop-in advice and signposting and, potentially, treatment
- identify, establish and promote confidential spaces in faith-based and non-faith-based facilities use community assets to build social cohesion, establish community
- activities for younger people, and begin to address the wider determinants (risks) of mental illness
- culturally informed family therapists embedded within communities
- provision of spaces in which people from BME communities feel they are being heard and understood
- recognise the importance of environment and place in crafting solutions – familiar places put patients at ease

#### Theme 6:

#### Plurality and choice around interventions and care pathways

Outside group participants explicitly identified a desire for greater plurality and choice in treatment and care pathways. It was suggested that more options and choice would allow for multiple avenues and pathways to deal with the many different types of barriers that exist within services and communities. It was recognised that some BME individuals may want to be seen by a professional or a facilitator from their own community. Conversely, some individuals may prefer not to interact with someone from their community to avoid stigma.



A number of service-oriented and community-based approaches to dealing with mental illness and distress were proposed. These included:

- the adoption of a biopsychosocial approach to mental illness
- the provision of trauma-informed care within the community
- the promotion of talking therapies
- connecting and healing in the community through creative art interests/hobbies
- provision of creative spaces and opportunities to share stories
- the provision of mental health first aid in churches
- locating mental health professionals within the local community
- training community workers to provide support, and to refer people when necessary
- establishing sign-posting facilities in faith-based organisations
- a wider choice of non-pharmaceutical interventions

## Focus Groups

Inside Focus Groups			
FG No.	Stakeholder Group	Venue	No. of Participants
1	Staff	SWLSTG	10
2	Staff	SWLSTG	5
3	Staff	SWLSTG	6
4	Staff	SWLSTG	5
Outside Focus Groups			
5	Black African/ African Caribbean	Deeper Christin Life Ministry	12
6	Somali / Black African	Elays Network	13
7	Muslim / Pakistani men	Gatton Road Mosque	9
8	African Caribbean	New Testament assembly Church	12
9	Muslim / Pakistani women	Mushkill Aasaan	16
10	Hindu / Tamil (professionals)	Shree Ghanapathy Temple	5
11	Hindu / Tamil	Shree Ghanapathy Temple	6
Special Groups			
12	BME Service Users	Sound Minds	10
13	BME Young People	Black Minds Matter	8



## Section 2: Individual Meetings

We completed individual (1:1) meetings with a wide range of stakeholders including service users of local mental health service, SWLSTG staff (clinicians and managers), community leaders, people in the mental health voluntary sector (including BME NGOs), faith groups, mental health commissioning and health improvement, primary care, local authority and academic institutions. The purpose of the interview, as with the Focus Groups (described separately), was to gain an understanding of local experiences and views in relation to BME mental health services and care, to identify the major challenges in this area and what should be the priorities for improving mental health care for BME communities and reducing ethnic inequalities in mental health.

We met and interviewed over 90 people (60% working in SWLSTG). The interviews were not formally structured and allowed for free-flowing discussion. The purpose and scope of EMHIP was shared, including the overall methodology. Discussions tended to focus on particular / specific areas of interest, relevant to the interviewee. Notes were taken during the interviews. The interviews lasted between 30 to 90 minutes.

We also had several meetings to discuss the project with some of the stakeholder groups (7 in all – Local Authority x 2, Community Leaders x 1, Community meetings x 2. Staff groups x 2 – one with BME staff). During the meetings, the participants spoke about their experience and expressed their views about BME mental health issues in Wandsworth and what they saw as barriers to effective and equitable mental health care. Notes were made during the meetings.

The individual meetings and group meetings revealed general themes similar to the Focus Group findings.

- the secondary care mental health services are under “tremendous pressure”. There is a
- lack of resources made worse by increase in demands, both in the urgent and acute care pathway and community mental health services. This is compromising the safety and clinical effectiveness of services and it affects all people irrespective of ethnicity
- front-line staff are having to spend more and more time on “paperwork” and less time “doing what needs to be done with patients and families”
- front-line staff often feel dispirited and workforce morale is not high
- BME staff, in particular, feel disengaged from the organisation, believe their concerns are not taken



- seriously, and that the organisational culture is discriminatory
- no time or resources to implement holistic / biopsychosocial care
- good practices, such as ward visiting / befriending programmes, are not extended across the system
- secondary care services are “basically, a doctor and nurse service” and “not truly multidisciplinary” the “language” of professionals makes it difficult to engage with them
- doctors and nurses need to listen to what people are saying and understand their lives – “they don’t understand us”
- care experience is fragmented – there is no continuity of care or relationships
- community mental health services are not in the community – “everything is in the hospital”
- there is a virtual absence of community mental health professionals in community spaces
- it is often impossible to get help when you need it
- current referral system and care pathways (community / primary care / secondary care) are not working
- there is limited involvement of BME communities in service provision, service planning – they are not being taken seriously
- families are rarely involved or consulted about key clinical decisions, especially detention and forcible treatment
- community assets are not aligned with or used by mental health services
- there is strong community and civic leadership but difficulty in engaging with service providers
- stigma and ignorance about mental health in the communities are major barriers
- BME communities are diverse and have different needs and problems
- there is stress amongst BME young people, with limited support or help.



## Appendix 3 : Mental Health Assets - Wandsworth

### List 1: WCEN Members and Partners

	NAME	LOCATION	MAIN ACTIVITY
1	Elays Network	Battersea	Somali and North / East African communities - particularly Young People
2	STORM Empowerment	Battersea	Women and Parents Support- including employment support and young people
3	Islamic Cultural and Education Centre	Battersea	Including Battersea Mosque
4	Sound Minds	Battersea	Arts based Mental Health Charity,including drop-in
5	EMCA - Eritrean Community Muslim Association	Battersea	Social welfare support Mosque
6	Doddington and Rollo Community Association	Battersea	Business Centre and Community Hall
7	KWAA Africa	Battersea	Information network
8	Older Peoples Forum	Battersea	Arts based Mental Health Charity,including drop-in
9	Deeper Christian Life Ministry	Battersea	Church - African (mainly Nigerian) fellowship



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	NAME	LOCATION	MAIN ACTIVITY
10	Supporting Relationships & Families (SRF)	Battersea	Focus on Mental Health and Well Being
11	St Marys C of E	Battersea	Including multi-purpose centre (+ Wandsworth Foodbank)
12	Citizens Advice Wandsworth	Battersea	Advice and Information
13	Little Village	Battersea	Family support through donation of clothes /equipment
14	Ransom AME Zion Church	Battersea	African Caribbean fellowship
15	CDARS - Community Drugs and Alcohol Recovery Service	Battersea	Drugs and alcohol services project
16	Katherine Low Settlement	Battersea	Multi-Purpose Community Centre
17	Wandsworth Carers Centre	Tooting	Carers information and support
18	AGE UK	Tooting	Advice and support for Older people
19	New Testament Assembly Church	Tooting	African Caribbean fellowship
20	Wandsworth Carers Centre	Tooting	Mosque and social welfare across two sites
21	Mushkill Aasaan	Tooting	Domiciliary care provider, with focus on South Asian Communities



	NAME	LOCATION	MAIN ACTIVITY
22	Sunni Muslim Association	Tooting	Including Mosque
23	Lynwood Christian Fellowship Church	Tooting	African Caribbean Fellowship
24	Community Action for Refugees and Asylum Seekers (CARAS)	Tooting	Particularly unaccompanied minors
25	Hope for Well Being Centre	Tooting	Mental Health Drop In Centre, particularly BME communities
26	Idara-e-Jaffiriya Mosque	Tooting	Mosque: Shia Muslim Community
27	Wandsworth MIND	Tooting	Mental Health Charity
28	Katherine Low Settlement	Tooting	Support for people with Mental Health + Drugs and Alcohol Misuse
29	Yahweh Christian Fellowship Church	Tooting	African Caribbean fellowship
30	Wandsworth Hindu Society	Tooting	Place of worship and community activities for Hindu community
31	Balham Autumn Rose Club	Tooting	Support for older African Caribbean communities
32	The Inner Attitude	Tooting	Support for young BME girls and women, particularly through arts

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	NAME	LOCATION	MAIN ACTIVITY
33	St Barnabus CoE	Tooting	Church: Including community halls
34	South West London Tamil Welfare Group	Tooting	Support for Tamil community
35	Khalsa Centre	Tooting	Gurdwara: Sikh community
36	Holy Trinity CoE	Tooting	Church: including small projects
37	Hope Atrium	Tooting	Mental Health project, particularly BME communities
38	Shree Ganapathy Temple	Tooting	Hindu temple and community activities
39	A2 dyslexia	Tooting	Dyslexia support charity
40	Balham Baptist Church	Tooting	Church: Christian Fellowship
41	Generate	Tooting	Working with people with learning disabilities
42	Mindwork UK	Tooting	Psychological therapy services
43	Regenerate	Roehampton	Young people and families
44	Holy Trinity CoE	Roehampton	Church: Christian Fellowship
45	Putney Wellbeing Friends	Roehampton	Wellbeing support / working with libraries



## List 2: Other Partners & Stakeholders

	NAME	LOCATION	MAIN ACTIVITY
1	FASTT Charity	Battersea	Young People drop in and support - Patmore Estate
2	Carneys Community	Battersea	Young people drop in and support including boxing club- St Marys Ward
3	DEVAS	Battersea	Youth Centre - Battersea
4	CIAUS House	Battersea	Youth Centre- Battersea
5	SHARE community	Battersea	Working with people with learning disabilities
6	Wandsworth Care Alliance	Tooting	Multi-purpose charity: including Wandsworth Healthwatch, Wandsworth Voluntary Sector Coordination project
7	Lifetimes	Tooting	Council for Voluntary Services, including information and support
8	Family Action	Tooting	Family Support and service provision
9	Transition Town Tooting	Tooting	Environment and re-cycling/reuse network including annual festivals
10	Wandsworth Violence against Women and Girls' Forum	Tooting	Network / Advice / Drop In



	NAME	LOCATION	MAIN ACTIVITY
11	LGBT Forum	Tooting	Network / signposting and advice services
12	Rethink	Tooting	Mental Health advocacy
13	Springfield Law Centre	Tooting	Legal advice and advocacy
14	Wandsworth Plus Credit Union	Tooting	Community banking
15	Alzheimer's Society	Tooting	Support and information

### List 3: Statutory Partners & Stakeholders

1	Wandsworth Public Health (WBC)	Commissioning of public health and prevention services and support
2	Battersea Health care	GP Federation (including 46 practices) - provider
3	South West London and St George's Mental Health NHS Trust	Secondary Mental Health Provider (including Springfield Hospital)
4	NHS Wandsworth	Accountable body and commissioner of local health services  Including Voluntary Sector Coordination project and Well Being Hubs
5	Wandsworth Council (WBC)	Partnership team (including Health and Well Being Partnership) Adult Care
6	Wandsworth Lifelong Learning (WBC)	Commissioning for ESOL and other learning projects
7	South West London Health and Care Partnership	From April 2020 - new collaborative commissioning partnership superseding borough based clinical commissioning groups



## Appendix 4 : BME Mental Health Expert Panel

- James Blyth, Managing Director, Merton and Wandsworth Clinical Commissioning Groups
- David Bradley, Chief Executive, South West London and Maudsley NHS Trust
- Dr Rochelle Burgess, Expert Advisor, University College London
- Dr Tom Coffey, Clinical Lead Mental Health and Children's Services, Wandsworth Clinical Commissioning Group
- Darren Fernandes, Associate Director Transformation, South West London and St George's Mental Health NHS Trust
- Sheba Forbes, Expert by Experience
- Vanessa Ford, Acting Chief Executive, South West London and St George's Mental Health NHS Trust
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- Dr Ranti Lawumi, Chair, Evolve Staff Network, South West London and St George's Mental Health NHS Trust
- Professor Sashi Sashidharan, Expert Advisor, University of Glasgow
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