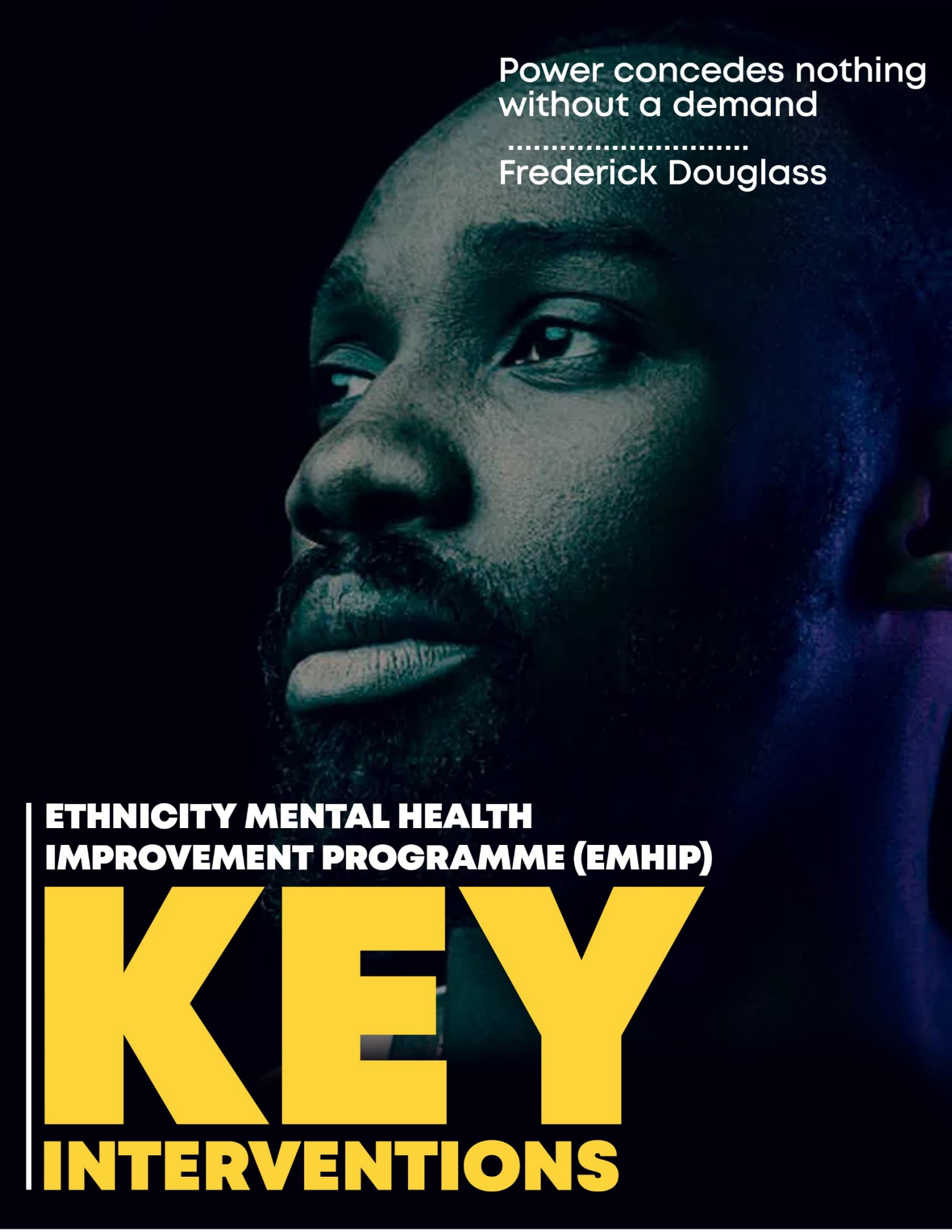

ETHNICITY MENTAL HEALTH IMPROVEMENT PROGRAMME (EMHIP)

KEY INTERVENTIONS

EMHIP
ETHNICITY & MENTAL HEALTH IMPROVEMENT PROJECT

CROYDON BME FORUM

asian resource centre croydon

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Introduction

There are significant and pervasive ethnic inequalities in mental health care in the UK. Compared to the majority white population, Black and Minority Ethnic (BME) communities have poorer access, more negative experiences, and worse outcomes in mental health care. Racialised minorities are more likely to be disadvantaged across all aspects of society than others, and these inequalities are exaggerated and entrenched in every aspect of mental health care.

The nature and extent of ethnic inequalities in the mental health system have been known for several decades but there is still no national strategy or comprehensive plan to address these. Efforts to improve mental health care for BME communities in the NHS have rarely progressed beyond rhetoric and vague commitments. As a result, not only the quality of mental health care and treatment of people from BME communities, but ensuring their basic safety remains deeply compromised.

The Ethnicity and Mental Health Improvement Project (EMHIP) is an attempt to address ethnic inequalities at a local level. This project started in Wandsworth, London, over two years ago. In the last year, NHS agencies in Croydon (Croydon, South West London Clinical Commissioning Group, Croydon Health Service NHS Trust, South London and Maudsley NHS Trust) along with local BME community partner organisations, have come together to commission EMHIP in Croydon. Phase 1 of this work is now complete with the publication of this Report.

The Report sets out the case for EMHIP in Croydon. It is based on a review of all available evidence in relation to ethnic inequalities in mental health and practical efforts to improve mental health care for BME communities. It draws on extensive local stakeholder consultation, review of relevant mental health policies and mental health service use data in Croydon. The report recommends a number of specific, practical clinically grounded interventions to reduce ethnic inequalities and improve the mental health care of BME communities in Croydon.

It is time for action now – Black Lives Matter.

S P Sashidharan
Consultant to EMHIP Croydon

10 March 2020

EXECUTIVE SUUMARY

- There are profound and enduring ethnic inequalities in access, experience, and outcome in mental health services in Croydon.
- Black and Minority Ethnic (BME) communities in Croydon, including BME service users and carers, generally believe that local mental services are "failing" them and are not "fit for purpose".
- There are no plans currently in place in Croydon to reduce ethnic inequalities in mental health or improve the mental health of BME communities.
- Local people lack confidence that "anything will change" without radical changes in the way mental health care for BME communities are commissioned and delivered or without the active involvement of local communities and BME agencies in that process.
- The Ethnicity and Mental Health Improvement Project (EMHIP), commissioned by the local NHS agencies in partnership with BME community and voluntary sector, is welcomed as a much needed and long overdue development. Phase 1 of the project (October 2020 – March 2022) is now completed and the following Key Interventions are identified for immediate implementation across the mental health system in Croydon:

    1. Establish **Mental Health and Wellbeing Hubs** (MH&WB Hubs), specific to the needs of BME communities and owned and managed by local communities, in collaboration with statutory service providers across Croydon.
    2. Develop BME specific service options in the acute and crisis care pathway in Croydon by providing **Crisis Residential Alternatives** to hospital admissions.
    3. **Reduce Coercion** – reduce the disproportionate numbers of black people subject to detention under the Mental Health Act, including Community Treatment Orders, and disproportionate use of force/restrictive interventions against black patients at South London and Maudsley Mental Health Trust (SLaM) through: (i) embedding inclusive and shared decision-making involving family members and Mental Health Mediators from black communities; (ii) making acute inpatient wards more open and appropriate to needs of black patients and their families; and (iii) empowering black communities by developing a network of support and engagement (Seni's Empowerment Network) as part of the implementation of Mental Health Units (Use of Force) Act 2018.
    4. **Establish BME Assertive Outreach Teams** - invest in people with SMI from BME communities and support their care, support, treatment, and rehabilitation at SLaM by establishing BME AOTs.
    5. **Ensure Cultural Competence** – ensure the mental health workforce (at SLaM) have the necessary skills and capabilities to work across culturally diverse communities.

- The next phase of EMHIP should be commissioned to implement these Key Interventions. This will involve: (i) approval of the Key Interventions across the mental health system; (ii) securing sustainable funding; and (iii) developing an implementation plan/change programme.
- It is important that the EMHIP programme of change is subject to monitoring and evaluation from the start.

SECTION 1 – BACKGROUND

1. Ethnic inequalities

There are significant ethnic inequalities 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. These are broad and enduring inequalities. Key statistics are available from several published reports[1].

Despite commitments to address this issue, inequalities in mental healthcare and outcomes between ethnic groups persist. While tackling health inequalities is a public health priority in the UK, there have been very few attempts to address ethnic inequalities in mental health. The racially discriminatory nature of mental health care in the NHS has been recently highlighted in the review of the Mental Health Act in England[2]. The Corona virus pandemic has also brought social and racial injustice and inequity to the forefront of public health in the UK and more widely[3]. Long established ethnic inequalities in mental health have been exacerbated by the pandemic.[4..5]

However, currently, there are no systematic programmes or national initiatives to reduce ethnic inequalities in mental health. This is despite wide agreement that such inequalities are unacceptable and the express commitment of NHS agencies to improve mental health care for all ethnic groups. Unsurprisingly, local services are struggling to address this problem.

Mental health and mental disorders are shaped by the social, economic and physical environments in which people live. Social inequalities are associated with increased risk of many common mental disorders[6]. Minority ethnic communities are at increased risk of mental health problems because of their social and economic circumstances. People from BME communities face significant disadvantages in society. They are more likely: to experience poverty and homelessness, do less well at school, be unemployed, be in contact with the criminal justice system, and face challenges accessing service. There is a growing body of robust evidence demonstrating that racism leads to mental illnesses[7] and compromises resilience and coping with adversity.

There is increasing concern about barriers to early, effective mental health care, especially for children and young peoples[8] in minority ethnic communities. The proportion of young people in BME communities is higher than the majority community and they are exposed to multiple challenges from an early age that compromise their mental wellbeing.

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[1] See, for example, National Institute for Mental Health in England (2003). *Inside Outside*. Improving mental health services for black and minority ethnic communities in England.
Confluence Partnership (2014) Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change. Report of Findings to LankellyChase Foundation, Mind, The Afiya Trust and Centre for Mental Health.
https://lankellychase.org.uk/wp-content/uploads/2015/07/Ethnic-Inequality-in-Mental-Health-Confluence-Full-Report-March2014.pdf Synergi Collaborative Centre (2017) Ethnic inequalities in UK mental health systems.
https://lankellychase.org.uk/wp-content/uploads/2015/07/Ethnic-Inequality-in-Mental-Health-Confluence-Full-Report-March2014.pdf [2] Department of Health and Social Care. Modernising the Mental Health Act – final report from the independent review, 2018.
[3] See, for example,
https://www.ethnicity-facts-figures.service.gov.uk/covid-19
https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html
[4]Bhui K (2021) Ethnic inequalities in health: The interplay of racism and Covid-19 in syndemics. https://doi.org/10.1016/j.eclinm.2021.100953
[5] Smith K, Bhui K, Cipriani A (2020) Covid-19, mental health and ethnic minorities. http://dx.doi.org/10.1136/ebmental-2020-300174
[6] World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf
[7] https://legacy.synergicollaborativecentre.co.uk/wp-content/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf
[8] https://www.nhsconfed.org/news/generation-children-and-young-people-risk-not-getting-mental-health-care-they-need

The independent review of the Mental Health Act 1983 (published 6 December 2018)[1] was commissioned because of increasing concern about the mental health care experiences of BME communities. The review made nearly 150 recommendations. However, it is unlikely there will be any significant shift in the current patterns of ethnic inequality in mental health care even if all these recommendations are fully implemented. The independent review also failed to engage with evidence on the drivers of ethnic inequalities[2]. There have been several previous national inquiries and reports as well as a relatively short-lived national programme on improving mental health care in BME communities[11,3]. However, these have had little impact on the mental health care or treatment of people from BME communities.

The absence of national policies or any comprehensive programme to address ethnic inequalities in mental health has contributed to the lack of progress in this area. Although guidance, including specific advice to commissioners of mental health services, has been available for some time[4], this has not resulted in any improvements in service provision for BME communities, especially in relation to unequal access, experience and outcomes. Historically, much of the burden of providing appropriate help, support, and care for black communities in this country has been carried by the BME community and voluntary sector. This continues to be the case, despite major challenges facing the community and voluntary sector agencies with regard to funding and long-term sustainability. It is in this context that many provider organisations (mental health trusts) have started local initiatives or projects to improve mental health care for their minority ethnic communities[5].

2. Ethnicity and Mental Health Improvement Project (EMHIP)

Two years ago, the Ethnicity and Mental Health Improvement Project (EMHIP) was commissioned jointly in the London borough of Wandsworth by the local mental health trust (South West London and St George's NHS Mental Health Trust), Wandsworth CCG and a local BME voluntary sector organisation, Wandsworth Community Empowerment Network WCEN. This has marked the beginning of a new chapter in improving mental health care for BME communities[6] .

EMHIP sets out a clear methodology for system wide change in mental health care of BME communities. This programme of change is beginning to be implemented in Wandsworth. Croydon CCG, along with system partners including the local mental health trust (South London and Maudsley (SLaM) and local BME community agencies, have accepted and approved Phase 1 of EMHIP, to be completed within the next three months.

The goals of EMHIP Croydon are: (i) to reduce ethnic inequalities in mental health care in Croydon and (ii) improve mental health and mental health care of local BME communities.

This report sets out the initial work carried out as part of EMHIP Croydon (Phase 1) and our proposals for change in current mental health provisions for BME communities in Croydon.

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[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf

[2] Bhui K (2021) Mental Health Act White Paper 2021. A missed opportunity to address ethnic inequalities. https://legacy.synergicollaborativecentre.co.uk/a-missed-opportunity-to-address-ethnic-inequalities/ [11] See, for example, https://irr.org.uk/article/rocky-bennett-killed-by-institutional-racism/

[3] Wilson M (2009) Delivering race equality in mental health care: a review. Department of Health. https://lemosandcrane.co.uk/resources/DoH%20-%20Delivering%20Race%20Equality%20in%20Mental%20Health%20Care%20%20A%20Review.pdf

[4] Joint Commissioning Panel for Mental Health (2014) Guidance for commissioners of mental health services for people from black and minority ethnic communities.

[5] https://legacy.synergicollaborativecentre.co.uk/ethnic-inequalities-pledge/

[6] Sashidharan SP and Gul M (2020) Ethnicity and Mental Health: a new beginning. Lancet Psychiatry. 2020 Jan 20. pii: S2215-0366(19)30514-0. doi: 10.1016/S2215-0366(19)30514-0 [Epub ahead of print]

3. Croydon

Croydon is the second most populous of all London boroughs. The total population of Croydon is 388,563 (2020 estimate, ONS). Croydon has a relatively young population; one in 4 is aged 0-17 years. Nearly 80% of young people under the age of 25 in Croydon are from Black or Minority Ethnic backgrounds (BME). The population of Croydon is expected to grow by nearly 1% annually over the next 15 years.

Croydon population by age

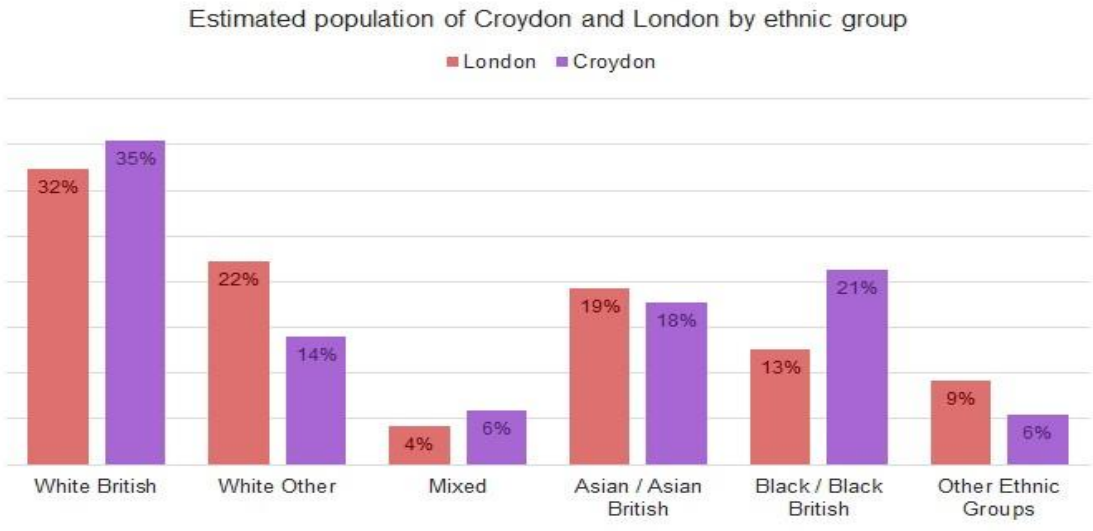
Age Group	Croydon		London		England	
	Count	%	Count	%	Count	%
0 – 15 years	85837	22.1	1853207	20.6	10852240	19.2
16 – 64 years	248678	64.0	6050828	67.2	35233879	62.3
65+ years	54048	13.9	1098453	12.2	10464019	18.5

Croydon has a highly diverse population. It is estimated that up to 65% of Croydon's population is of nonWhite British ethnic group. Compared to London as a whole, Croydon has a higher proportion of population who are Black/Black British.

Croydon population by ethnicity

Ethnic Group	Croydon		London		England	
	n	%	n	%	n	%
White	200195	55.1	4887435	59.8	45281142	85.4
Black/African/Caribbean/Black British	73256	20.2	1088640	13.3	1846614	3.5
Asian/Asian British	59627	16.4	1511546	18.5	4143403	7.8
Mixed/multiple ethnic groups	23895	6.6	405279	5	1192879	2.3
Other ethnic group	6405	1.8	281041	3.4	548418	1.0
Total	363378	100.0	8173941	100.0	53012456	100.0

Census 2011



Source: National Immunisation Management Service, excludes those where ethnicity is recorded as Not Stated

Croydon's BME population is, on average, younger than the white population. The proportion of BME as a percentage of Croydon population is increasing. Compared to 2011 (census), it is estimated that the BME population currently is 54% of the total population in Croydon.

Croydon Ethnic Group Profile: 2011 – 2021 (percentage total resident population)

Ethnic Group	2011	2017	2018	2019	2020	2021
White	55%	49%	48%	48%	47%	46%
Mixed	7%	7%	8%	8%	8%	8%
Asian	16%	19%	19%	19%	19%	20%
Black	20%	23%	23%	23%	24%	24%
Other	2%	2%	2%	2%	2%	2%
Total	100%	100%	100%	100%	100%	100%

Source: GLA 2016 Housing-led projections by ethnicity

Croydon has pockets of high levels of deprivation, a key driver of population morbidity and health inequalities. There is significant geographic inequality in the distribution of deprivation in the borough with the north and east of the borough being more deprived than the south. Five neighbourhoods in Croydon are in the top 10% most deprived areas of the country (10.261 people live there)[7]. According to Croydon Council, over 2,500 families live in poverty. Croydon's non-White-British population are more likely to live in the more deprived areas of Croydon, with 48% of residents who are White British living in areas that are in the least deprived half of the country compared to just 26% of Croydon's non-White-British population.

Children's mental health is a major priority in Croydon. One in three of all unaccompanied asylum-seeking children in London is in Croydon and the number of looked after children is the highest in London (one third of the total number of looked after children in London). The most common reason for a child being in need in Croydon is abuse, neglect or absent parenting. The Croydon Children in Need[17] rate is consistently higher than regional and national rates every year. As of 31 March 2020, the rate was 457.1 children in need for every 10,000 children in Croydon which equates to 4,339 children[18].

There is concern about high crime rates in Croydon. The rate of domestic abuse incidents and offences per 1,000 population has been increasing, year on year. Croydon has the fourth highest rate in London domestic abuse. The overall crime rate in Croydon in 2020 was 83 crimes per 1,000 people is comparable to London's overall crime rate of 87 per 1,000 residents[8]. However, first time entrants to the youth justice system in Croydon (279.9/100,000, age 10 – 17 years) is much higher than the national and London averages[9]. Knife crime is also a concern with nearly 40% of incidents resulting in injury or death.

In a report in November 2021, the Care Quality Commission (CQC) noted that Croydon contains 128 nursing and residential care homes – the largest number in London by some way (the London borough with the second largest number of homes being Barnet, with 81 homes).

[7] Source: 20% Indices of Deprivation, Department of Communities and Local Government [17]
This based on annual statutory census for all local authorities.
It collects data on children referred to local authority social care services because their health or development is at risk. This includes children in local-authority care (in placements in a residential home, in a foster family, or with relatives), children who are getting support from their local authority's social care services, children who are the subject of a child protection plan and unborn children who will potentially need support from social care services. https://www.gov.uk/guidance/children-in-need-census [18] Croydon CCG. Community & Crisis Pathway Transformation Work (July 2019)
[8] https://crimerate.co.uk/london/croydon
[9] https://www.croydonobservatory.org/wp-content/uploads/2021/11/Croydon-Key-Dataset-November-2021.pdf

SECTION 2 EMHIP CROYDON

Process

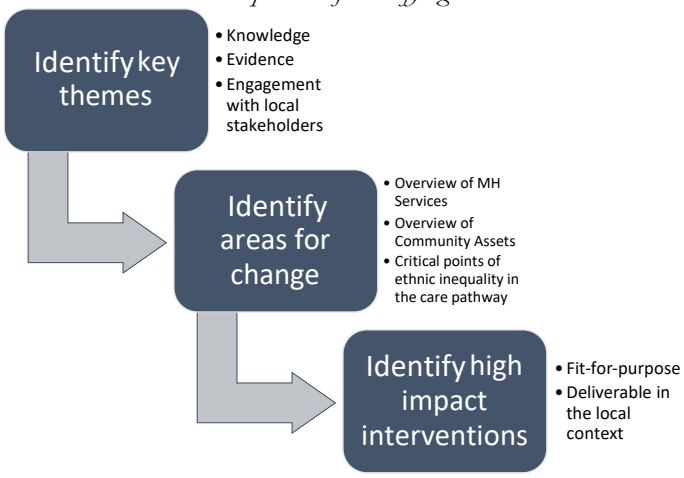
The Ethnicity and Mental Health Project (EMHIP) follows a systematic approach. This involves (i) bringing together all available knowledge and evidence in relation to ethnic inequalities in mental health and changes required to improve BME mental health care; (ii) stakeholder engagement and consultation; (iii) review of local policies; (iv) local service mapping and data in relation to mental health care and current service structure (service mapping); and (iv) identifying local BME community assets (asset mapping).

EMHIP - Process

1. **Evidence reviews (knowledge synthesis) – updated**
2. **Stakeholder engagement and consultation – inside/outside**
    a. **Individual interviews**
    b. **Meetings**
    c. **Focus Groups**
3. **Review of local mental health policies**
4. **Local mental health service structure (service mapping)**
5. **Mapping BME community assets (asset mapping)**
6. **Local mental health data – ethnicity audit**
7. **Identify key themes and areas for change**
8. **Agree Key Interventions**
9. **Implement Key Interventions**
10. **Evaluate, scale up**

The objective of these actions is to identify key themes and critical areas where changes are needed (ethnic disparities) and develop a set of potentially high impact interventions to achieve the set outcomes.

EMHIP process of identifying the Interventions



Evidence Review

The first stage of this process was completed during EMHIP Wandsworth. The focus of the evidence review/knowledge synthesis was ethnic inequalities in mental health care in the UK as well as the strategies and initiatives that make mental health services more appropriate to the needs of minority ethnic communities. 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. Several 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 huge grey literature related to the work and experience of BME voluntary sector over the last five decades outside the conventional, academic, and clinical work. This body of knowledge constitutes a significant evidence base which we marshalled and reviewed as part of our evidence review.

The thematic review of evidence also relied on BME service user experience (their lived experience of mental health problems and psychiatric care) as reported in the literature. This is linked to the wider service user experience of mental health care 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 are examples of 'good practice' and interventions, approaches and treatment that are effective, acceptable and consistent with people's needs and wishes and the underpinning values and principles. We drew on this extensive knowledge base to develop our intervention plans. The details of this review are set out in the first EMHIP report (Wandsworth)[21].

For current purposes, the earlier literature review was updated, taking into account further developments in this area, including the Independent Review of the Mental Health Act (and ensuing White Paper)[22] and the introduction of Mental Health Unit (Use of Force) Act 2018 and related statutory guidance (2021)[23].

Croydon stakeholder consultation and engagement

The needs and priorities in mental health care for local BME communities in Croydon were identified through a series of individual interviews, meetings, and focus groups (Appendix 1). Through this process, we identified *key themes* in relation to ethnicity and mental health in Croydon, in particular the major challenges facing BME communities in relation to service access, experience and outcomes, and potential strategies to overcome them and improve both mental health and mental health care in the local BME communities.

Individual interviews

Sixty people from the community were interviewed, including community and voluntary sector organisations, service users and carers, GPs, local councillors. The key themes emerging from the community interviews were:

1. "no one is listening" to the BME communities and service users
2. "No respect" – BME communities lack agency and not treated with dignity when they encounter mental health services
3. Current service structure is "confusing", not fit for purpose

[21] Sashidharan S P & Gul M (2020) Ethnicity and Mental Health Improvement Project. Five Key Interventions. https://emhip.co.uk/wpcontent/uploads/2021/06/Ethnicity-Mental-Health-Improvement-Project-Report-Final.pdf

[22] Modernising the Mental Health Act: increasing choice and reducing compulsion. Final report of the independent review of Mental Health Act 1983 (December 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf
The White Paper on Reforming the Mental Health Act (December 2021). https://commonslibrary.parliament.uk/research-briefings/cbp-9132/

[23] Mental Health Unit (Use of Force Act) 2018 https://www.legislation.gov.uk/ukpga/2018/27/enacted
Statutory Guidance (2021) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038727/Government-response-toconsultation-Mental-Health-Units-Use-of-Force-Act-2018-statutory-guidance.pdf

4. There is a "disconnect" between mental health services and the local communities and lack of trust in mental health services
5. Community and Voluntary Sector agencies are largely excluded and marginalised
6. There is a crisis in relation to mental health of children and young people in Croydon

Twenty staff from SLaM (Croydon) were also interviewed including, service managers, clinical leads, and front-line clinicians. The key themes that were raised were:

1. Croydon mental health services are an 'outlier' within SLaM
2. There is a lack of focus on BME mental health
3. Lack of choice for service users, current service model is largely "one size fits all"
4. Services and staff are "set in their ways" and unwilling/unable to change
5. Mental health teams are disconnected from the community they serve
6. Significant work force pressures

Details of the community and SLaM interviews and thematic analysis of the feedback are set out in Appendix 1.

Focus Groups

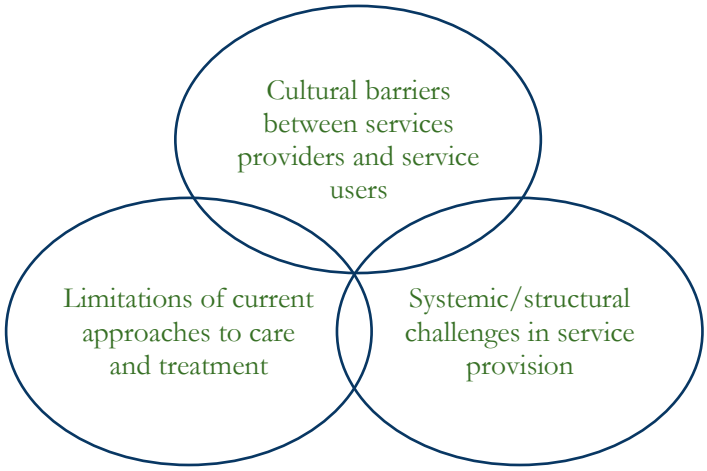
Four Focus Groups were conducted (by SPS and DB), two each for service users and young black people. These groups explored the views, perceptions, and experiences of the participants in relation to mental health and treatment.

Seven key themes emerged during analysis. These were identified as areas of concern and recognised as requiring change/improvement.

1. Services
2. Society
3. Emotional expression
4. Coping & healing
5. Trauma
6. Illness frameworks and understanding
7. Desired solutions and changes

Results of the thematic analysis are given in Appendix 1. The overall perception of current mental health care in Croydon by the BME stakeholders and service providers can be broadly summarised as amounting to entrenched cultural barriers that prevent appropriate access, care and treatment for BME communities in Croydon; systemic organisational factors (including institutional racism) that perpetuate significant ethnic inequality; and limitations of current clinical practice and culture in dealing with mental health problems in a diverse community.

Interviews & Focus Groups: high level themes



Mental health policy

In 2019, the NHS embarked on a major new investment in community mental health based on the NHS Long Term Plan (LTP)[10]. This put community mental health, both routine care and crisis care, at the centre of mental health services. This is to be based on a new Community Mental Health Framework[11], supported by an extra £1.3 billion per year for community mental health, including mental health crisis care in the community. The framework was developed in response to the perception that community mental services had become fragmented, with so many teams that "everyone working in the community knew best which patients they didn't see", leading to excessive and enormously inefficient 'hand-offs'. Community mental health had also become far too bureaucratic, partly as a result of "a preoccupation with risk and formal risk assessments".

Under the NHS Long Term Plan, the NHS has been reorganising into four levels of care. The main stay of care and first port of call will be at the neighbourhood level, within Primary Care Networks formed from a functional merger of all primary care services for a local population of about 30-50,000 people. At the next level up, Place-based care will provide care for populations of 250,000-500,000. Care at this level would be for people in need of inpatient care, for example. System level care will be aimed at 1-2 million populations, provided by Integrated Care Systems and Integrated Care Organisations (ICS/ICO). All health and social care organisations in the ICS/ICO patch will be fully integrated. The fourth level is national provision.

This means 'triple integration' of hospitals and primary care; the NHS and social care; and physical and mental health. These NHS reforms have developed a new landscape for health planning and delivery framed around large geographical footprints; first, sustainability and transformation partnerships, then integrated care systems, which developed into the current levels of delivering care today. Integrated Care Systems will commission and deliver care through a geographically (on a population basis) stratified approach:

- Places – often equivalent to a shared clinical commissioning group (CCG) and local authority area, or part of the footprint for a large council
- Primary Care Networks – partnerships between GP practices which aim to involve community health and care services – generally around 30,000 to 50,000 people
- Neighbourhoods and communities – smaller areas where people may have specific health and care needs.

Mental health services are also poised for major changes under the Sustainability and Transformation Plans, which bring significant new funding[26]. All local areas are required to develop plans[12] 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, published in 2016[13]. The Community Mental Health Framework calls for extra community investment of £1.3 billion at the neighbourhood level, amounting to an extra £1.3 million for each 50,000 population.

These are ambitious plans which are being implemented currently. However, there is nothing in these plans to suggest the current pattern of ethnic inequality in mental health care would be addressed any more meaningfully than before. As with most mental health policies and national initiatives in relation to mental health, neither the Five Year Forward View for Mental Health nor the Community Mental Health

[10] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[11] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf [26] NHS England https://www.england.nhs.uk/mental-health/cyp/transformation/
[12] https://www.wandsworth.gov.uk/planning-and-building-control/sustainability/sw-london-sustainability-and-transformation-plan-stp/
[13] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdfT

Framework makes any specific commitments in relation to improving BME mental health. It is unlikely these policies will have any impact on reducing the entrenched ethnic inequalities in mental health in the NHS.

At the local level, the Croydon Health and Care Plan 2019 – 2024 [14] has set out a five-year strategy for health care in the borough. One Croydon, a new partnership between the local NHS (including the CCG and Croydon Health Services NHS Trust, Croydon Council will be critical to the success of this strategy. One Croydon will align the strategy with the objectives of partner organisations, Croydon Health and Wellbeing Board and Local Strategic Partnership. The Croydon Health and Care Plan has three priorities: (i) a focus on prevention and proactive care; (ii) unlocking the power of the communities; and (iii) putting services back into the heart of the community. What these mean in terms of mental health service structure and delivery of care and treatment are unclear.

Croydon Mental Health Community Transformation Plan[30] published last year is consistent with the ambitions of national policies and strategic vision for mental health. This is part of the Croydon's Health and Care Plan 2029 – 2024.

- The transformation plan promises to "unlock the power of communities by making the most of communities' assets and skills – key to helping local people stay fit and healthy for longer is to connect them with their neighbours and communities". When people need care, a health and care system will support them based on "what matters to them". Personalising care will mean people having "choice and control over the way their care is planned and delivered".

- There is a commitment to "put services back into the heart of the community – make sure local people have access to integrated services that are tailored to the needs of local communities". The intention is to keep people well and out of hospital, making sure local people and families have access to services closer to home, wherever they live in the borough. Services must be accessible and responsive to their individual needs.

Both the Health & Care Plan for Croydon and Mental Health Transformation Plan have set the bar very high for commissioning and delivering health care in the borough, including mental health. If mental health services could be successfully reconfigured according to these principles and commitments, Croydon will have one of the best mental health systems in the country. This will benefit all communities including the BME community and, no doubt, reduce the current patterns of ethnic inequality. However, the commitments in relation to BME mental health (titled as ethnic minority interventions), make no reference to ethnic inequalities nor any plans to reduce them[15]. The proposals will enhance investment in local CVSO but are unlikely to change the existing community mental health system or care pathways.

Croydon's track record of delivering high quality mental health care for BME communities is poor. It is worth noting that two previous reports commissioned to inform the development of appropriate services for BME communities have not resulted in any significant improvement in terms of access, experience, or outcomes for BME communities in mental health.

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[14] https://swlondonccg.nhs.uk/wp-content/uploads/2021/07/4326v14_NHS_One_Croydon_Heath_CarePlan-1.pdf [30] Croydon Community Mental Health Transformation Programme, June 2021. https://democracy.croydon.gov.uk/documents/s29954/Item%209%20-%20Croydon%20Mental%20Health%20Transformation%20Programme%20presentation.pdf

[15] These are: establish (i) a Recovery Space (crisis café) with robust statutory referral links, to increase referral sources e.g., GP's, CMHT's and to target specific under-represented communities (ii) new community based Mental Health Wellbeing Hubs (iii) new MH Personal Independence Coordinators (MHPICs) (iv) MH Local Voluntary Partnership Gran (v) Peer Support workers in Crisis Pathway initiatives, Right Care, Bed Flow to enable SLaM MH Services to align with the MH Wellbeing Hubs.

The Mind the Gap (2013)[16] report was the result of significant concerns about BME mental health in Croydon. The report was produced by three community and voluntary sector agencies working with BME communities in Croydon, *Hear Us* (service user group), Croydon BME Forum (umbrella organisation for Croydon's BME CVS) and *Croydon Drop In* (a community support services for young people and children). The purpose of the report was to provide an insight into the experience of Black and Minority Ethnic (BME) service users accessing mental health services within the Borough of Croydon and make recommendations for improvement. Based on extensive evidence from a variety of sources, the report identified significant challenges within BME mental health, including the dignity of care afforded to BME service users, use of medication, lack of cultural competency and sensitivity in in local services, poor communication at the point of admission and afterwards, staff shortage, stigma around mental illness in BME communities, support for asylum seekers, poor support for carers and need for talking therapies.

The report made 11 recommendations to Croydon's mental health community, including commissioners, service providers and local community organisations. The recommendations to improve BME Mental Health service provision were:

- Provide services which offer patient-centred care, which accounts for individual needs and involves service users in all decisions about treatment and medication
- Provide cultural competency training to staff, professionals and families • Recruit more staff, including personnel from a BME background
- Reduce the burden of bureaucracy to improve services.

In particular, it is important to:

- Provide better information to overcome language barriers:
- Improve awareness and provision of support services
- Improve the support provision for refugees and asylum seekers
- Improve support for carers
- Improve access to talking therapies
- Provide access to mental health advocacy
- The gap in service provision for BME young adults (18-24 years old) should be closed.

The Woodley Review of mental health services in Croydon was commissioned four years later, in 2017, because of ongoing concerns about BME mental health in the borough, to assess progress against Croydon's mental health strategy (2014-19) and identify trends in inequalities[17]. The review had a special focus on how effectively mental health services were supporting BME groups. Like *Mind the Gap* report, this review highlighted ongoing problems with BME mental health service provision in Croydon. These included: long waiting times, delays in hospital admission, the disenfranchisement of voluntary agencies in decision making and strategic thinking, commissioners working in silos and, in the local communities, 'fatigue' with consultation and call for more 'action'.

The Woodley Review made 12 recommendations in total, including a call to reconfigure mental health services, shifting resources towards earlier intervention and prevention. The report emphasised the importance of:

[16] Mind the Gap. A Report on BME Mental Health Service Provision in Croydon (2013). https://www.talkofftherecord.org/media/1090/mind_the_gap_web.pdf
[17] https://croydon.moderngov.co.uk/mgConvert2PDF.aspx?ID=4495

- well-being & primary care, mentally healthy communities, importance of good physical health, suicide prevention, concentrate on high risk factors: loneliness, schools, debt/financial challenge
- co-production in service design, help build community capacity & ensure adequate focus on BME communities.
- better partnership working through improved governance oversight of the Mental Health strategy & improve contract monitoring processes.
- using existing service user & stakeholder forums.
- exploring opportunities to use technology.

The latest effort to focus on BME inequalities in Croydon is the introduction of the Patient and Carer Race Equality Framework (PCREF) by NMS England[18]. SLaM is one of the national pilot sites for this initiative. The programme is still under development (Phase 2), prior to the national roll out this year. While this is a very ambitious programme for monitoring and ensuring race equality in mental health care, currently, it has not resulted in any significant service changes. The programme is primarily focused on people of African and African Caribbean heritage (black communities) and does not include other BME groups.

Mental health in Croydon

The prevalence of mental health problems in Croydon is not dissimilar to other London boroughs which is higher than national average. Nearly 1 in 5 adults in Croydon (18.4% of people aged 16+) is reported as having a 'common mental disorder'[19]. Long-term support for mental health conditions (19 – 64 age group) is estimated as 207.7/100,000 population, the fourth highest in London. However, 7.7% of people (based on GP surveys) report having long-term mental health problems[20].

Prevalence of long-term, complex mental health needs is higher in Croydon than the national average, with an NHSE mental health needs index of 1.21 (where 1.0 is the national average), comparable to many innerLondon boroughs. Croydon CCG has a registered Serious Mental Illness population (SMI Register) of 4,610 people, or 1.11% of the adult population[37] (latest number is 4,939)[21], similar to the reported prevalence of SMI of 1.1% as London average (2020/21).

Croydon SMI profile

Domain	Croydon	London	England
SMI prevalence (all ages)	1.18%	1.11%	0.95%
People under MHA Rate per 100,000 (age 18+)	77.4	69.3	45.6
Estimated new cases of psychosis age 16-64 (R per 100,000)	36.9	40.5	18.1
People with SMI on CPA, % of service users	28.6	17.3	15.0
SMI Register (QOF)	4610 = 1.1% of adult population	1.66%	
BME service users as a % of all service users	35.8%*	36.1%	

Source: https://fingertips.phe.org.uk/profile/severe-mental-illness/data

[18] https://www.slam.nhs.uk/about-us/equality/patient-and-carer-race-equality-framework-pcref/
[19] Croydon Joint Strategic Needs Assessment. https://www.croydonobservatory.org/wp-content/uploads/2021/11/Croydon-Key-DatasetNovember-2021.pdf
[20] Healthy London Partnership. London Mental Health Dashboard. http://lmh.nhsbenchmarking.nhs.uk/toolkit [37] QOF 2017-18.
[21] Wayland Lousley, Croydon CCG: personal communication 4/2/22

* Note: According to the latest analysis for EMHIP, 45.6% of current service users (community and acute care, working age adults, including IAPT) at SLaM (Croydon) are from BME communities (2949 out of 5472 on current combined case load of all teams as on 31 December 2021).

The availability and use of mental health and related services in Croydon do not match population need[22]. Primary care support for people with Serious Mental Illness (SMI) in Croydon is poor when compared with the national picture: 5.5% achievement (of SMI population) compared to national averages of 24.2% (top achievers > 45%), with a significant proportion of practices nationwide meeting the national 60% target. There is a distinct lack of social support for people with mental health problems, especially for people with severe and long-term conditions in Croydon. The majority (56%) of adults who are in contact with secondary care mental health services live in unstable and inappropriate accommodation. We heard during the stakeholder engagement and consultation in Croydon that people have no alternatives to presenting at A&E or contacting the police when there is a mental health crisis or in need of urgent attention.

Previous surveys and engagement with service users in Croydon have highlighted significant 'unmet need', particularly out-of-hours, in community settings and involving non-medical social interventions and support, such as social prescribing assistance with housing, benefits etc[23]. There are also major gaps in services available to children and young people; admissions for mental health conditions for under 18s are higher in Croydon compared to London and national averages[24]. Mental health need profiles vary across the borough, from more affluent areas to more deprived, each presenting mental health and well-being support needs.

There is a dearth of published primary care mental health data in Croydon. We have not been able to access any local primary care mental health data.

South London and Maudsley (SLaM) NHS Trust provides secondary care mental health services in Croydon. The local service structure is complex. There are over 12 community mental health teams serving different functions. Most of the community teams are still based in the local mental hospital, at Bethlem Royal Hospital in Beckenham.

According to previous reports, there have been long standing concerns about specialist mental health services in Croydon. We heard that Croydon is "the poor relation in SLaM, compared to other boroughs", the existing secondary pathway is not working, waiting times are too long, there are multiple teams/assessments which delay and complicate how care and treatment are provided. SLaM services have been criticised as "inefficient/duplicative, and suffer from poor productivity, and variable support for Primary Care/GPs". Most people we spoke to describe current services as falling short of providing appropriate, accessible, or meaningful support or care. There are an estimated 180 - 220 people currently on SLaM CMHT caseload who could be more appropriately cared for under the new community-based Model and LCS, under the responsibility of their GP. It has been recommended that a seamless, singular route is needed for assessment and access to SLaM. The average length of hospital stay is 53.3 days, comparing poorly to the national average of 32 days. It has been suggested that clinicians in Croydon working long-term with patients can have "an entrenched view regarding their treatment, which could be a barrier to more appropriate community-based support"[25].

The Croydon Race Equality Scorecard Report by the Runnymede Trust, based on data on outcomes for different BME groups in seven areas in Croydon in 2011/12 (criminal justice, education, employment,

[22] Croydon Council. Joint Strategic Needs Assessment. https://www.croydonobservatory.org/wp-content/uploads/2021/10/DiagnosedConditions-in-Croydon-GPs-2012-21.pdf
[23] https://swlondonccg.nhs.uk/wp-content/uploads/2021/07/4326v14_NHS_One_Croydon_Heath_CarePlan-1.pdf
[24] Croydon Health and Care Plan 2019/20 – 2024/25. One Croydon
[25] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2021/08/Independent-Investigation-Mr-X-and-Mr-G.pdf

housing, civic participation, support for the BME 3rd sector, and health), found BME population had worse outcomes in all the areas. In relation to mental health, significant ethnic disparity in hospital admissions

(higher than national average for both white people and BME communities) was confirmed. According to this report, "a new approach to race equality in mental health services" was required in Croydon as previous attempts to address race equality in mental health had "not resulted in significant improvement in the outcomes for BME service users".

Unfortunately, the wealth of statistics in relation to mental health is not routinely differentiated or reported by ethnicity, although BME mental health is a major challenge in Croydon. BME service users amount to 35.8% of all mental health service users in Croydon (London average 36.1% - 2014/15 data), much lower than the proportion of people of BME background (current estimate places this as over 50%) in the at-risk population. The lack of comprehensive BME specific data in relation to mental health at the population and service levels is a major impediment to appropriate service planning, likely to be incompatible with equality legislation and inconsistent with the strategic commitments of the local NHS organisations. In routine service use data (MHSDS, for example), ethnicity data is missing in up to 20% of cases in some of the teams.

Notwithstanding the significant numbers where ethnicity is not recorded, the available data in relation to BME service use in Croydon are in keeping with national and London wide trends of ethnic inequalities in mental health. Previously published data from SLaM show significant ethnic inequalities in service access and experience[43]. Current service use data (obtained for the purpose of this report, based on Mental Health Services Data Set – MHSDS)) confirm significant ethnic disparities in access, care and treatment in secondary care mental health services in Croydon. MHSDS does not provide meaningful outcome data. Outcomes based on patient-related outcome measures used by SLaM are available for a very small sample of people who use the services and are not ethnically differentiated.

Current SLaM data show that Black people are over-represented in services for people with SMI, in crisis and acute care and, most significantly, in hospital admissions, detentions under the Mental Health Act and those subject to restrictive interventions. People of Asian background are under-represented (in terms of population numbers) in most specialist mental health services in Croydon SLaM. Access to community mental health services also appears to indicate ethnic disparities (see Appendix 3 for detailed results)

Voluntary, Community and Social Enterprise (VCSE) Organisations in Croydon

As in most urban settings, Croydon has a thriving BME community and voluntary sector, actively engaged in improving mental health and mental health care of BME communities. They are variably resourced and address different but overlapping needs of the local communities in relation to mental health and wellbeing.

There are several BME agencies supporting mental health care in Croydon, some of them highly innovative and making a real impact in addressing BME mental health needs and enhancing mental wellbeing. A list of BME non-governmental sector organisations is currently being compiled and verified as part of EMHIP Croydon.

BME community and voluntary organisations are not fully engaged and rarely involved in strategic planning in relation to mental health in Croydon. For example, The One Croydon Alliance is a partnership between the local NHS, Croydon Council and Age UK Croydon. This was focused initially on improving the health

[43] SLaM Equalities Action Plans. https://www.slam.nhs.uk/about-us/equality/
https://www.slam.nhs.uk/about-us/equality/patient-and-carer-race-equality-framework-pcref/

Also: Chui, Z., Gazard, B., MacCrimmon, S. et al. Inequalities in referral pathways for young people accessing secondary mental health services in south east London. Eur Child Adolesc Psychiatry 30, 1113–1128 (2021). https://doi.org/10.1007/s00787-020-01603-7
Fernandez de la Cruz, E, Llorens M, Jassi A et al Ethnic inequalities in the use of secondary and tertiary mental health services among patients with obsessive–compulsive disorder. The British Journal of Psychiatry,1–6. doi: 10.1192/bjp.bp.114.154062

and wellbeing of older people in the borough but, from April 2018, the Alliance extended its remit to consider the health needs of all adults in the borough. Working together across the alliance, it seeks to joinup services available to offer more co-ordinated support that will help look after peoples' physical and mental health and wellbeing. The One Croydon Alliance partners are Croydon Health Services NHS Trust, Croydon Clinical Commissioning Group, Croydon Council, the Croydon GP Collaborative, South London and the Maudsley NHS Foundation Trust, and Age UK Croydon.

In the last two years, the CCG has commissioned several mental health local voluntary partnerships. These include:

- Turkish Youth & Community Association – MH Community Development Worker (CDW)
- Asian Resource Centre Croydon – MH Champions programme
- Croydon BME Forum – Wellness Advisor and Community Development Workers
- Croydon Drop-in – Young Adult Transition support project
- Body & Soul – Legal and practical support & counselling for HIV+ sufferers
- Disability Croydon – Mental Health Drop-in Centre & café and access to digital support
- Palace for Life Foundation – Coping through Football (with a focus on people with SMI)
- Mind in Croydon – Counselling creating surge capacity and Recovery Space – alternative safe space to A&E for people with mental health crisis.

Unfortunately, the way the BME community and voluntary sector is currently commissioned in Croydon means that relevant organisations work independently of each other and, largely, 'work in silos' with no guarantees of long-term funding or investment in enhancing their reach or capability. While the community and voluntary sector (and social enterprise entities) are readily accessed by the BME communities (compared to statutory services) and are generally acknowledged as helpful by service users and families, they are poorly funded, depend on short term contracts and are, predominantly, commissioned to provide services as an extension of statutory services. The BME community and voluntary sector services are not streamlined or integrated with local NHS community mental health teams or primary care services.

SECTION 3 EMHIP KEY INTERVENTIONS

The main purpose of Phase 1 of EMHIP Croydon is to identify key interventions to bring about the improvements and changes necessary to: (i) reduce ethnic inequalities in mental health care in Croydon; and (ii) improve mental health and the mental health care and treatment of local BME communities.

Key themes and service areas

By bringing together the different strands of evidence, feedback, and local and contextual information, we have identified a number of *key themes* and *key areas for change* to improve BME mental health care in Croydon. Based on these, we propose five *key interventions* to bring about the changes necessary to achieve EMHIP's goals. These interventions are designed to ensure they are fit for purpose and targeted to achieve the desired changes while still preserving the overall integrity of the current service model in Croydon.

The key *themes* or areas of change were identified by local stakeholders (from individual interviews and focus groups), based on available evidence on reducing ethnic inequalities in mental health as well as the local context (service and asset mapping). The themes that emerged in Croydon, critical areas where change is needed, are not dissimilar to what was found in Wandsworth. This is not surprising given the commonality of lived experience of BME communities in London (and across the country) and the uniformity of mental health services and clinical practices across the NHS.

Priorities - Improving mental health care for BME communities

1. Aversive care pathways
2. Cannot get help when it is needed
3. Clinical encounter – power asymmetry and biases in assessment 4. Lack of choice – 'one size fits all'.
5. Lack of autonomy and agency
6. No BME specific services – 'we have to fit in'
7. Services not culturally competent, race and diversity not acknowledged
8. Over-reliance on coercion
9. Lack of BME community involvement in mental health care
10. Stigma/lack of awareness about mental health
11. Social determinants of mental illness, including racism, not recognised or addressed

These themes are consistent with the findings and recommendations of previous research, inquiries, reports, and service user priorities for improving mental health care for BME communities[26,27]. These are the critical drivers of ethnic inequality in mental health care in the UK. No meaningful change is likely without addressing these issues[28,29,30].

Based on these priorities, EMHIP has identified key change areas in the local mental health system. This calls for a renewed focus on care trajectories, experience and outcome for BME service users if current patterns of ethnically discrepant and unequal care and outcomes are to be improved in Croydon.

EMHIP - areas of change

1. *Front end services* – primary care and secondary care access/crisis care and support.
2. *Care Pathways:* improve and enhance pathways to mental health care – less aversive.
3. *Assessment:* introduce a broad-based inclusive assessment process that is person-centred and respectful.
4. *Patient safety and rights:* actions to reduce coercion, including detentions under the Mental Health Act.
5. *Therapeutic benefit:* prioritise patient benefit from intervention/treatment.
6. *Autonomy, agency, and plurality:* personal choices, shared responsibility, and alternatives to current models of 'one size fits all'.
7. *Cultural capability*: make specialist mental health care culturally appropriate to BME needs and ensure the providers are culturally competent in delivering it.
8. *Community:* mobilise and enhance BME community assets and capabilities.
9. *Involvement and ownership*: increase the involvement of BME service users, carers and communities in key decisions about them, ensure greater accountability and invest in BME specific services.

[26] Bignall T, Jeraj S, Helby E & Butt J (2020) Racial disparities in mental health: Literature and evidence review. London. Race Equality Foundation. https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

[27] Synergi Collaborative Centre (2019) Briefing Paper: Synergi National Consultation on priorities to address ethnic inequalities in severe mental illness. London. The Synergi Collaborative Centre. www.synergicollaborativecentre. co.uk

[28] National Institute for Mental Health in England (2003) Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England, National Institute for Mental Health England.

[29] Keating F, Robertson D, McCulloch A et al (2002) Breaking the Circles of Fear. A review of the relationship between mental health services and African and Caribbean communities. London. The Sainsbury Centre for Mental Health. https://www.centreformentalhealth.org.uk/sites/default/files/breaking_the_circles_of_fear.pdf

[30] Department of Health (2005) Delivering race equality in mental health care. http://www.dh.gov.uk/assetRoot/04/10/07/75/04100775.pdf

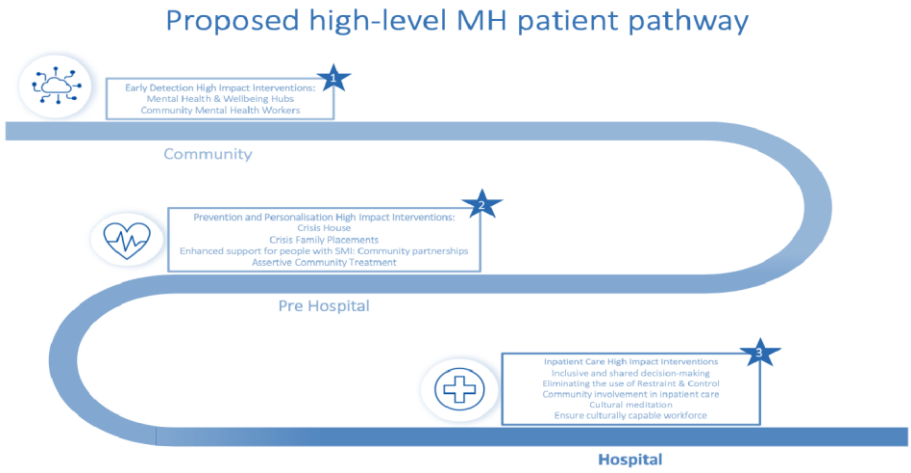
10. *Public Mental Health:* reduce stigma, increase awareness and engagement, initiate specific actions to address social determinants of mental health, including racism.

Based on the above, five key areas and five targeted interventions are identified as necessary to reduce ethnic inequalities in the current mental health care pathway in Croydon.

1. Access to mental health care.
2. Crisis care and acute pathways.
3. Inpatient care, including use of the Mental Health Act and coercive practices.
4. Treatment and support for people with long-term, Severe Mental Illness (SMI).
5. Mental health workforce and mental health services - capability and capacity to provide culturally competent and appropriate mental health care.

<u>The Key Interventions are:</u>

1. Create Mental Health and Wellbeing Hubs (MH&WB Hubs) in local BME communities.
2. Increase service options available to BME communities in acute and crisis care pathway by providing residential crisis alternatives in the form of crisis family placement schemes and BME specific crisis houses.
3. Reduce the use of restrictive/coercive practices in inpatient settings, including detentions under the Mental Health Act, and restraint and seclusion.
4. Establish bespoke, recovery focused care and active psycho-social rehabilitation for BME patients with long-term and severe mental illness in partnership with local BME community agencies.
5. Ensure the mental health workforce is culturally capable and competent in delivering mental health care for diverse communities.



The EMHIP interventions, proposed in Croydon, are in keeping with the NHS Long Term Plan[31] and its aims, redesigning health services to meet the challenges and needs of the 21st century by:

- providing more joined up and coordinated care
- being more proactive in the services the NHS provides • providing more differentiated NHS support to individuals.

The NHS LTP has identified five major changes over the next five years to achieve this[32]:

[31] NHS Long Term Plan (2019). https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[32] NHS Long Term Plan – Implementation Framework (2019). https://www.longtermplan.nhs.uk/implementation-framework/

- 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 Five-Year Forward View for Mental Health[33] recognises the importance of a shift towards prevention and 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.

All local NHS bodies in South West London are committed to equality, diversity and inclusion, improving health outcomes and reducing health inequalities in the local population. The EMHIP Intervention Plan reflects both national and local strategic priorities. In addition, EMHIP programme of improving mental

health care in Croydon is based on what are considered good, effective models of mental health care and service options promoting human rights and recovery by the World Health Organization[34].

EMHIP is based on best evidence in relation to key indices of ethnic inequality in mental health care and the most effective ways of reducing them and improving mental health care for BME communities. The interventions are also underpinned by shared notions of what constitutes good mental health care for BME communities.

Mental health outcomes cannot be improved if we don't address the underlying factors that cause and exacerbate mental health problems, including mental illness. For BME communities, these include disempowerment resulting from structural and identity-based exclusion, socio-economic disadvantage, and racism[35]. Racism is not only experienced as the result of individual, isolated behaviour but as a structural practice embedded in institutional cultures, including the NHS[36].

The current, traditional mental health care delivery system has failed patients and families for too long. We cannot ensure BME parity through existing service arrangements. Changes in the organisation of mental health care, its culture and clinical practice are necessary. These must be community led, with an investment in community assets. This will require changing the current power dynamic in the NHS and enhancing investment in mental health care of BME communities.

[33] Five Year Forward View for Mental Health (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[34] See, for example, http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/publications
[35] Jongsma, H.E., Karlsen, S., Kirkbride, J.B. et al. Understanding the excess psychosis risk in ethnic minorities: the impact of structure and identity. Soc Psychiatry Psychiatr Epidemiol 56, 1913–1921 (2021). https://doi.org/10.1007/s00127-021-02042-8
[36] Kapadia D, Zhang J, Salway S et al (920222) Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race and Health Observatory. https://www.nhsrho.org/wp-content/uploads/2022/02/RHO-Rapid-Review-Final-Report_v.7.pdf

The voluntary, community and social enterprise sector as well as BME faith-based organisations play a key role in supporting those affected by mental illness from BME communities across the country, including in Croydon. They have filled the gap where statutory services are missing, or inadequate to the needs of black and minority ethnic communities, and in specific settings, for example, in the prison system[37]. Ethnic inequalities in health care cannot be addressed without local NHS commissioners and providers working in partnership with local communities "to develop, deliver, evaluate, and improve services, prevention programmes and health promotion activities that are culturally competent and that reach Black and minority ethnic groups"[38].

Implementing the interventions identified in this report will require: (i) additional investment; (ii) changes in clinical practice; (iii) organisational and service changes; and (iv) mobilisation of BME community assets in Croydon and enhancing their capability to deliver mental health care for local communities.

Key Intervention 1: Improving Access and Choice - Mental Health & Wellbeing Hubs

Rationale

The background and rationale for implementing Mental Health & Wellbeing Hubs across local communities are set out in detail in the previous EMHIP Key Interventions Report[39]. Strong evidence attests to the effectiveness of culturally appropriate, community-based and community-owned spaces as the first point of contact/access for people experiencing mental health difficulties across all communities and, in particular, people from BME communities[58,40].

The traditional divide between primary care, community services and hospitals and the rigid demarcation of social and mental health care act as barriers to personalised and coordinated health care. Therefore, "over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries"[41]. Given the problems minority ethnic groups experience in accessing mental health care and negotiating existing care pathways (community to primary care and then to specialist care), dissolving the traditional boundaries allow for easier and earlier access to mental health resources. Mental Health & Wellbeing Hubs

[37] Yap et al, 2018; London Assembly Health Committee, 2017; Faith Action, undated; Mental Health Providers Forum, 2015; Rabiee et al., 2014) Race Equality Foundation

[38] NHS Race & Health Observatory & The King's Fund (2021) Ethnic inequalities and the NHS – driving progress in a changing system. https://www.nhsrho.org/wp-content/uploads/2021/06/Ethnic-Health-Inequalities-Kings-Fund-Report.pdf

[39] https://emhip.co.uk/wp-content/uploads/2021/06/Ethnicity-Mental-Health-Improvement-Project-Report-Final.pdf [58] King's Fund (2006) Briefing. Access to health care and minority ethnic groups. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/access-to-health-care-minority-ethnic-groups-briefing-kings-fundfebruary-2006.pdf

[40] Bhui K, Stansfeld S, Hull S, et al (2005) Ethnic variations in pathways to and use of specialist mental health services in the UK. Br J Psychiatry. 2003;182(2):105–16.

[41] The King's Fund & Royal College of Psychiatrists (2017) Mental health and new models of care. Lessons from the vanguards. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/MH_new_models_care_Kings_Fund_May_2017.pdf [61] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf [62] Croydon Partnership

will be effective in achieving this through their location (in the community and part of the community), their function (mental health as part of overall needs), their connectivity (with all relevant community assets and other services) as well as their reach, and their acceptability and easy accessibility for BME communities.

Improving access to mental health care for BME communities is a priority within national mental health policies[61] and consistent with the objectives of Croydon Health and Wellbeing Board and Local Strategic Partnership[62]. It is also consistent with the overall vision for mental health care, as set out in the Five-Year Forward View for Mental Health: a decisive step "to break down barriers in the way services are provided"[42].

Mental Health & Wellbeing Hubs will reduce ethnic disparities in relation to service access. They provide a more appropriate pathway to specialist help and support for BME communities and a non-aversive way of accessing services. We anticipate these Hubs will function as community-based and community-owned safe spaces, tailored to the needs of the local people. It is important they are connected and integrated within the network of local community assets in addressing individual and local population health needs, including mental ill health and wellbeing, thus ensuring a whole system approach to mental health care from first contact.

In Croydon, significant changes are being introduced to bring about "a transformation of health and social care that is underpinned by the empowerment and active engagement of local people in their communities"[43]. Under this plan, Local Community Partnerships (LCP) will be established in each locality. LCPs will involve local civil societies – including active citizens, faith and community groups, and VCS service-providers. This new locality-based model will support "the interdependency of statutory and VCS

staff". Along with statutory multi-disciplinary teams (for example, community mental health teams), new community hubs will be established in "physical locations or virtual networks facilitating access to joinedup services". This will create an integrated model "with VCS involvement in the MDTs and statutory sector involvement in the LCPs – with all partners interacting and collaborating at the Community Hubs"[44].

It is anticipated there will be additional investment in local communities to implement the new service models. For example, each multidisciplinary team will have a number of Personal Independence Coordinators (PICs), for under fifties, over fifties and in mental health as well as Health and Wellbeing Assessors and Community Builders and Community Facilitators working across localities.

The Mental Health & Wellbeing Hubs we are proposing as part of EMHIP are consistent with the vision and plans for Community Partnerships Plans (LCP) in Croydon and the Croydon Localities Operating Model, currently under consideration.

Intervention – model

A number of Mental Health & Wellbeing Hubs will be established across Croydon. These will provide a new service option for BME groups, not an adaptation or reconfiguration of existing mental health provisions. The Hubs will be part of the new neighbourhood level health care arrangements, closely linked to the Primary Care Networks (PCN)[66], formed through the functional merger of all primary care services for local populations of about 30-50,000 people.

[42] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[43] https://swlondonccg.nhs.uk/wp-content/uploads/2021/07/4326v14_NHS_One_Croydon_Heath_CarePlan-1.pdf
[44] Healthy Communities Together: Empowering and Engaging Local People (draft September 2021) – shared by Wayland Lousley, CCG. [66] Croydon has six primary Care Networks (PCN): East Croydon, Mayday, New Addington / Selsdon, Purley, Thornton Heath and Woodside / Shirley.

It is difficult to estimate the total number of MH&WB Hubs required across Croydon. It will depend on the readiness and capability of host organisations/community assets, distribution of different BME communities and variation in social determinants of the need for mental health care across the borough.

The MH&WB Hubs will be developed in existing community resources that are popular, trusted and traditionally used by local people. These include local churches, mosques, temples and similar faith-based organisations or other community spaces like sports centres, youth centres etc. The Hubs will enhance the capabilities of these community assets by providing a mental health resource specifically geared towards providing early help. They will be invested with the capacity to engage with and support people with mental and physical health and related problems. The Hubs will be able to facilitate seamless onward referral to more specialist mental health services, if required.

The essential components of the Hub are:

1. Embedded in the community
   They will be embedded in local BME community assets, for e.g., around faith communities, youth centres and other facilities commonly used by BME communities.

2. Community safe space
   Act as safe and trusted places in the community for people with mental health and related needs, allowing suffering and illness to be experienced, shared and managed in appropriate socio-cultural contexts to expedite healing and recovery.

3. Place of hospitality
   The Hub will offer hospitality and act as a haven, a place for respite and rescue (a sanctuary) [45]. In this environment, the Hub will help people establish relationships among peers, professionals, and volunteers. The emphasis is on restoring hope and ensuring help through recreating social bonds, solidarity, and support.

4. Integrated and novel care pathways
   Establish novel care pathways in relation to health (mental health) and facilitate referral between services, outreach, and access into and out of care.[46]

5. Local networks of help and support
   The Hub will mobilise and connect with existing networks of support in local communities, make use of existing community capabilities and help people lead better lives as equal citizens. The Hub will create dynamic connections and ensure collaboration between various agencies, sectors in mental health and community networks in a hub and spokes model, including health care agencies (primary and secondary care).

6. Improving mental health
   Hubs will be part of an integrated approach to mental and physical health in the local community. They will promote good mental health and wellbeing and prevent poor mental health in BME

[45] Radical hospitality can be defined as "a practice of putting extraordinary effort and emphasis on making people feel welcome." This concept is also referred to as "radical welcome," and focuses on "breaking down barriers that prevent people from participating in an effort, campaign, or community".
https://metrocouncil.org/Handbook/Files/Community-Engagement/PEP-Toolbox-RadicalHospitality.aspx
https://www.umc.org/en/content/what-is-radical-hospitality

[46] Moffat J, Sass B, McKenzie K & Bhui K (2009) Improving pathways into mental health care for black and ethnic minority groups: A systematic review of the grey literature, International Review of Psychiatry, 21:5, 439-449, DOI: 10.1080/09540260802204105

communities. By enhancing the inter-connectivity of people and services and better community engagement, the Hub will ensure early recognition of mental ill health. The Hubs will provide community-based support, treatment and rehabilitation, and social inclusion for people with SMI.

7. Improving physical health

The Hubs will provide easy access to physical health checks and monitoring as required and as part of the local long-term health care support plans. The Hubs will be aligned to the local PCN networks and current physical health outreach support, particularly in relation to the management of long-term health conditions, could be facilitated through this arrangement. Community health clinics, lifestyle support and advice currently delivered at the population level, primarily for people from BME communities can be hosted and channelled through the MH & WB Hubs as part of collaborative health and wellbeing arrangements at the neighbourhood/PCN level.

Taken together, this will mean a Hub and Spoke arrangement at the local (neighbourhood) level, specifically targeting the needs of local BME communities (diagram). For this to succeed, community connections and inter-agency working as envisaged here will have to be reciprocal, dynamic, and flexible.

Figure: Hub & spokes model

What will the Hub do?

The Hub is not a conventional clinical service; it will not function simply as an extension of current community mental health teams. The Hub offers something more than that: a holistic approach to health and mental health care and support, that recognises the social determinants of mental ill health and need for fostering community support and engagement.

The work of the Hub will be guided by principles and values that underpin good mental health care.

Community safe space Safe space for people with mental health problems or related issues in the community, provided by the community
Whole Person/Whole system Health and illness are broadly defined – you are not your diagnosis. We will stay with you and support you through your journey and struggles. We will support you and those close to you in your plans and daily needs.
Relationship - Social Recovery Human connection is therapeutic and can be more impactful than psychiatric interventions. Kinship family, friends, social networks all matter.
Rights-based care You have a right to good health – mental health care should not compromise your rights as a citizen.
System Accountability You will not be left to figure out the system alone. You don't have to accept a system that compromises your safety and wellbeing. We will catch you if you fall. You will be served by familiar faces, people like you.
Radical Hospitality You are welcome here and you are safe. You are seen and heard. You will be our guest - as humans we are all equal.
Open Door All welcome, at all times – no exclusions
Person or person on behalf of person We will see anyone at any time – it could be about you or someone else.

Activities/Functions

The Hubs will:

- Provide safe spaces in the community with an emphasis on hospitality for people with mental health problems
- Serve as an access point (including walk-in, self-referral) for people with any difficulty related to mental health or general wellbeing
- Provide assessment, treatment, and support for people with mental health problems, including joint working with mental health/primary care services
- Facilitate direct referral to secondary care services
- Support and help people with psycho-social difficulties/mental health problems to access work, vocational and pre-vocational training, return to employment
- Support, advise, provide practical help and ongoing engagement in relation to a broad range of life/social difficulties
- Help people access other agencies and services, such as benefits, housing, debt services etc and build partnerships with CAB, Advice First Aid etc.

- Work with community partners to mentor, support and monitor young people 'at risk' of mental health problems
- Work with all community partners and mobilise local assets to create and maintain a Hub and spokes model to deliver community based mental health care and support
- Offer self-help, peer support groups and activities at the Hub
- Host and support local GPs and others to improve physical health, such as health screening and advice, health advice and self-management of long-term health conditions[47]

Resources and Staffing

The success of the Hub will depend on close working with the host organisation (where the Hub is located) and in creating a network of community assets/agencies as part of the hub and spokes model. The Hub will be integrated within the overall structure and functioning of the host organisation; for example, having access to and overlap with their facilities (space, activities etc). Most host organisations/assets will 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 and experience with activities around mental health.

Upgrading the host organisation facilities, to make them fit for purpose for the use of the Hub, will require additional resources (refurbishment, monthly rental, running costs etc). There may be additional management costs, but this will depend on the particular circumstances.

To deliver specific mental health and wellbeing activities, the Hub will employ a number of staff. The following is based on previous work in Wandsworth, the core staffing requirement for implementing a Mental Health & Wellbeing Hub.

Currently, Croydon CCG funds a number of positions in the local community and voluntary sector (Mental Health Personal Independence Co-ordinators (MHPIC), for example) to improve the reach and scope of mental health support and improve mental wellbeing. There is the potential to align these posts to the MH&WB Hubs. The following posts are in addition to current posts in the community already commissioned by the CCG.

1. Community-embedded Community Psychiatric Nurse (CPN).

In Croydon, community mental health services are not seen as, nor do they function as, part of the local community networks in supporting people with health care needs. Although specialist 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 for their local population, this rarely happens in practice. This is not unique to Croydon. EMHIP in Wandsworth faced similar challenges. The new Community Mental Health Framework in England[48] has come about partly from the failure of current community mental health service arrangements across most areas in England. As in Wandsworth, the evidence from local BME communities is that community mental health staff in Croydon are inaccessible. The teams have "over-complicated" arrangements regarding access and support and have multiple exclusions. Their inability to work closely with other community assets was repeatedly raised in Croydon as a major concern, similar to community feedback in Wandsworth.

[47] Health Innovation Network South London https://healthinnovationnetwork.com/about/what-we-do/
[48] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

In Croydon, most of the community teams are based at hospital sites and most patient reviews and assessments are carried out during clinic-based appointments at these team bases. Community mental health staff are "rarely present in the community" and are seen as struggling with high workloads and inadequate resources. This makes it difficult for them to extend their work beyond medication management and clinical supervision. There is little liaison between specialist community mental health teams and other community resources, like churches and mosques, which are the first points of contact for many people in BME communities, both individuals with mental health problems and their families. No community organisation has direct access to specialist mental health teams and all concerns regarding mental health are currently channelled through the conventional care pathway, which is highly challenging and often subject to long delays.

In this context, new innovations like the MH&WB Hubs cannot rely on current service provisions to bring about the changes required to improve mental health care in local communities. Problems with access cannot be addressed by creating yet another channel within the existing care pathway, when that pathway is already experienced as inefficient and unfit for purpose. It is necessary, therefore, to create new arrangements to ensure easy and appropriate access to mental health care. This means equipping new innovations, like the Hub, with the capacity to provide mental health assessment, care and treatment. This will embed professional skills and expertise in specialist services within local BME community assets that local people use without the barriers currently preventing them for accessing established services. This will allow MH&WB Hubs to function flexibly and in ways that fully meet the requirements of local people. The Hubs will have the capacity to build and sustain therapeutic alliances that respect people's choice and

preferences, developed in familiar living environments in the community, that is, on 'their turf and terms' [49].

There are good examples of embedding specialist mental health workers in agencies and resources outside specialist mental health care; for example, in relation to crisis care and policing[72,50]. Specialist mental health staff in the Hubs will help with early detection of mental illness as well as providing evidence-based, professional interventions for people with mental health problems. Mental health professionals will also be able to facilitate direct, seamless access to specialist care, and ongoing treatment and support for the whole spectrum of mental health problems in the community.

The role of the Community-embedded CPN:

- Act as the main liaison/link between the Hub and secondary mental health care
- Provide professional mental health assessment and initiate treatment
- Act as a pathway co-ordinator/facilitate access to secondary mental health care
- Contribute to mental health training/increasing awareness
- Provide clinical supervision for other Hub staff, for example, Community Mental Health Workers

[49] Mezzina R, Rosen A, Amering M and Javed A (2019) The practice of freedom: Human rights and the global mental health agenda. In Javed A and Fountoulakis KN (eds), Advances in Psychiatry. Cham: Springer, pp. 483–515. https://doi.org/10.1007/978-3-319-70554-5_30 [72] See, for example, https://www.ahsnnetwork.com/about-academic-health-science-networks/national-programmes-priorities/serenityintegrated-mentoring
Also, the process of developing Sustainability and Transformation Plans (STP) is "an opportunity to rethink the approach taken to mental health and wellbeing across their local systems" by embedding mental health in every strand of their work. This includes all community mental health resources. https://www.kingsfund.org.uk/blog/2016/12/doing-justice-mental-health-stps
[50] https://www.gov.scot/publications/works-collaborative-police-health-interventions-mental-health-distress/pages/4/

2. Community Mental Health Workers

Engaging local communities in mental health care and the provision of community-based support are critical to facilitating early detection, engagement and sustained care and treatment for those with recognised mental health problems[51]. Two of the biggest challenges in mental health care for BME communities are: first, engagement i.e., people who need mental health treatment the most tend to be the least likely to seek help; and second, very little attention is paid to the patient's journey, and, even less, the needs of families. Recruiting people from local BME communities and providing them with support and training in relation to mental health can help address these problems.

Many of the key tasks in community mental health, including delivery of psycho-social 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, this provides a better option for delivering key aspects of mental health care to these communities than entrenching current service models (for example, support, engagement, psycho-social rehabilitation (PSR) recovery-focused work). Including such workers in the MH&WB Hubs will ensure their work is properly co-ordinated, supervised, and supported.

During the consultation/engagement process in Croydon we heard that existing specialist services (community mental health teams) fail to deliver some of the core interventions in community mental health to BME communities. 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 Mental Health Workers, would help deliver effective and comprehensive care for local communities. Community Mental Health Workers have become increasingly integral members of mental health teams in the NHS. They are effective in delivering care and support[52]. Based on the experience of the community and voluntary sector in mental health in England, a number of key themes emerge in relation to successful community engagement: trust within the community and between community members and service providers; respect for community members' expertise; allowing sufficient time for relationships to establish and for outcomes to be seen; commitment of key people; and flexibility[53]. Recruiting and integrating local people in mental health care will help facilitate this.

Based on previous experience in Wandsworth, we are proposing the recruitment of two Community Mental Health Workers at each Hub. They will work alongside the Embedded CPN. The Community MH Workers will be recruited from local minority ethnic communities the Hubs will serve. No professional background or specific mental health training is required as a pre-requisite for applying to these positions. What is important is a commitment and interest in BME mental health and the ability to work collaboratively as part of a team. People with significant life experience or lived experience of mental health problems in the local communities will be particularly suitable for this position.

Community Mental Health Workers will provide:

[51] Thornicroft G, Tansella M (2004) Components of modern mental health service: a pragmatic balance of community and hospital care. Br J Psychiatry, 185, 283-290

[52] Liana L, Windarwati HD The effectivity role of community mental health worker for rehabilitation of mental health illness: A systematic review. Clinical Epidemiology and Global Health, 11, July–September 2021. https://doi.org/10.1016/j.cegh.2021.100709. https://www.sciencedirect.com/science/article/pii/S2213398421000130

[53] Bagnall AM; Kinsella K; Trigwell J et al (2016) Community engagement – approaches to improve health: map of current practice based on a case study approach. National Institute for Health and Care Excellence Primary Research Report 1: https://www.nice.org.uk/guidance/ng44/resources/primary-research-report-1-community-engagement-approaches-to-improve-health-pdf2368402382

- 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.
- With bespoke training and support, there is the potential for delivering: (i) psychological interventions (ii) social skills training (iii) psycho-social rehabilitation, including vocational and prevocational support (iv) family support and (v) psychoeducation.
- Ensure social inclusion and active citizenship for people with 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 behaviour, suicidal thoughts etc) in the community and provide support and follow up.
- Help to ensure treatment adherence and detect early relapse.
- Mental health advocacy.

3. Community Family Therapists

Based on the Wandsworth model of Mental Health & Wellbeing Hubs, the Hubs in Croydon will recruit and train people from the local BME community to provide systemic family therapy and general psychological support for those using the Hub. A Network of Lay Family Practitioners was developed in Wandsworth[54] and their work is now aligned to the local MH&WB Hubs[55]. Community Family Therapy practitioners are people from local BME communities. They all complete a 2-year programme of training in systemic family therapy. We will replicate this model in Croydon, with each Hub connected to the network of Lay Family Practitioners. Training lay health workers to deliver psychological interventions is an effective way of addressing gaps in service provision[56].

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. An external, professional supervision programme will be 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 IAPT services and collaborative working.
- Provide joint working with other mental health assets at the Hub.
- Act as a point of community contact/access for those experiencing mental health problems and their families in the local community.

4. BME Mental Health Champions

[54] WCEN – Networks for Family Care. http://wcen.co.uk/training/
See also: Burgess R. & Ali H. (2015) Church based family therapy in Wandsworth: Improving access to mental health services. Program evaluation: Phase one, Black Pastor Training. London: spaa.
[55] The Community Networks for Family Care was developed between the Family Therapy Department of South West London and St George's Mental Health Trust, Wandsworth Community Empowerment Network and local leaders of black majority churches. The partnership subsequently broadened to include the Wandsworth Clinical Commissioning Group and leaders in the Muslim community in Wandsworth.
[56] Shahmalak, U., Blakemore, A., Waheed, M.W. *et al.* The experiences of lay health workers trained in task-shifting psychological interventions: a qualitative systematic review. *Int J Ment Health Syst* **13,** 64 (2019). https://doi.org/10.1186/s13033-019-0320-9.

The Mental Health Champions Development Programme in the NHS was introduced as a structured education programme for people with no professional qualifications to improve the provision of care for individuals with mental health problems[57]. The model has been widely used and implemented successfully in different communities and settings[58], including at SLAM[59]. These are lay people from the local African and African Caribbean community who undergo 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[60]. In Croydon, we suggest that the MH Champions should align their work with the new MH&WB 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.

5. Hub Manager

Each Hub will have a full time Hub Manager. The primary task is to realise the idea of the Hub as set out here and as imagined by various stakeholders. This will require someone with imagination and an ability to think creatively about translating this vision into reality. Given the position of the Hub (in the liminal space between traditional health care and the community) and the nature of the challenge (mobilising and aligning community assets in common purpose), the task of setting up this innovation and ensuring it remains fit for purpose will require more than traditional management or professional skills.

The Hub Manager, ideally, should come from the local community. Familiarity with the local history, culture and services/assets will all be important. Prior experience of health/mental health is not essential; more important is the ability to think creatively, have experience of innovation and appropriate personal attributes, such as an ability to work with diverse stakeholders.

The Hub Manager role:

- Be responsible for managing the Hub and delivering the various services designated as core activities of the Hub. This includes delivering of high quality, safe, community mental health care, support and assistance for mental health and related problems.
- Ensure appropriate community support and help for those accessing the Hub and working towards improving overall mental health care for the local communities.

[57] https://www.nice.org.uk/sharedlearning/mental-health-champions-development-programme
[58] Mantovani, N., Pizzolati, M. & Gillard, S. (2014) "Using my knowledge to support people": A qualitative study of an early intervention adopting community wellbeing champions to improve the mental health and wellbeing of African and African Caribbean communities. London: St George's University of London. May 2014. ISBN: 978-0-9575142-0-1 http://spaa.info/wp-content/uploads/2014/11/Report-EvaluationNTA-Study-27-05-2014-F-V-with-ISBN.pdf.
[59] https://slam.nhs.uk/media/18343/health-champions-volunteer-leaflet.pdf
[60] https://www.mentalhealthcamden.co.uk/services/mental-health-champions

- Mobilise and align local community assets and create the network of care and support in relation to mental health (hub and spokes).
- Facilitate citizen/community participation and involvement in the Hub.
- Provide leadership for the Hub team, co-ordinate and manage all Hub activities and ensure delivery of high quality, person-centred care, support and treatment.
- Develop, agree and be responsible for all aspects of governance, along with the various partner agencies and the Hub-hosting organisation.

Hub: outcomes

Each of the Hubs will be part of a collaborative effort between various partner agencies to improve the mental health and wellbeing of local BME communities. The key partners will each have their priorities, but they will come together in common purpose to support and enhance the wellbeing (in its broadest sense) of the local communities. The Hub, therefore, is an attempt to bring together and mobilise the capabilities of all the local community assets (including the statutory sector services), to support population health and wellbeing and, more specifically, help tackle the social determinants of ill health. The following outcomes are specific to mental health, but these will only be achieved by taking a broader approach to health and wellbeing, than simply the better management of specific health conditions.

- 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.
- Provide less aversive pathways into specialist mental health care.
- Provide easier availability and access to help (including specialist intervention) in crisis.
- Facilitate 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.
- Provide greater uptake of physical health screening/monitoring/checks for people with SMI.
- Facilitate greater ownership and involvement in mental health services by the local BME communities.

Potential MH & WB Hubs in Croydon

At this stage, it is difficult to estimate the total number of MH & WB Hubs that will be required in Croydon. Further consultation with relevant community agencies, BME voluntary groups, faith organisations and primary care partners (PCN) will determine the actual number and locations of the Hubs. In Wandsworth, 10 potential Hubs are planned for a population of 329,735 (mid-year estimate 2020, with 22% BME), as part of EMHIP. Croydon has a bigger population (386,710, 2019 mid-year estimate) and significantly larger BME population (50.7%).

For the service model to be effective, the new BME specific MH &WB Hubs in Croydon will need to locate and work collaboratively with BME community assets in the local area, such as black-led churches,

mosques, temples and other faith organisations, or youth and community centres. These places and facilities are commonly used by the local communities, and, unlike current mental health services, they are trusted by people as places where they can receive support, advice, and help.

During the engagement and consultation process with the BME communities in Croydon, there was a strong consensus to prioritise the mental health needs of young black people for EMHIP Croydon. Many different people told us about an urgent need to develop new options for BME young people (especially black boys and youth) around existing resources connected with youth services and youth support. There is a very strong case for commissioning one of the first BME MH & WB Hubs in Croydon to be in relation to young black people's needs.

Intervention 2: Improving Crisis Care and Choice

Background

BME communities experience aversive care pathways into mental health care. Over the years, improving pathways to care is a primary aim identified in plans to improve mental health services for people from black and minority ethnic communities[61]. They are more likely than white people to come into healthcare via crisis pathways. Nowhere is the need to improve service experience for BME communities more urgent than in acute and urgent care pathways within specialist mental health care.

At the heart of ethnic inequalities in mental health is the lack of choice and plurality in service provision for BME communities[62]. Current services are experienced as inflexible, providing a 'one size fits all' model. Where ethnic inequalities are most pronounced and its effects most damaging (in acute and crisis care, involuntary treatment), the lack of alternatives to traditional models of care remains a major impediment to achieving parity of care for black and minority communities. Furthermore, current arrangements relating to crisis and urgent care prevent person-centred and consensual treatment.

The stakeholder consultation and engagement work in Croydon confirms this. Local BME communities are deeply unhappy with current arrangements in relation to crisis and urgent mental health care. We heard from service users and carers of considerable difficulties in getting urgent help (even for people well known to the services with a history of severe mental illness). The local Home Treatment team (one team for the whole borough of over 380,00 population) is seen as inaccessible and unavailable round the clock. We heard of aversive experiences in managing mental health crises both in the community and in the local hospital. There are no readily available community resources for crisis support and no crisis residential alternatives to acute hospital admission in Croydon. All the crisis assessment facilities prior to admission, are hospitalbased services with limited outreach or support functions.

Timely and direct access to mental health support and resources are described as "impossible" when someone is in crisis, irrespective of whether they are known to the local services or not. Pathways into care, including urgent access, are "far too complicated and always changing" and described as "confusing" and "inflexible". Even experienced GPs find it "difficult to negotiate the system". When you need help and support most, as in crisis situations, "you are least likely to get it". The only option for most people is "to go the A&E". There is huge concern about involving police in managing mental health crises and the low threshold for detention under the Mental Health Act in crisis situations. Despite the ambition of the NHS Long Term Plan that every crisis service in England will be open access by 2021, "meaning that people and

[61] Moffat J, Sass B, McKenzie K, Bhui K. Enhancing pathways & mental healthcare for BME groups: learning between the ideological and operational. Int Rev Psychiatry. 2009;21(5):450-9. doi: 10.1080/09540260802202075. PMID: 20374160.
[62] Joint Commissioning Panel for Mental Health (2014) Guidance for commissioners of mental health services for people from black and minority ethnic communities. https://www.jcpmh.info/wp-content/uploads/jcpmh-bme-guide.pd [86] NHS Long Term Plan. https://www.england.nhs.uk/mental-health/adults/crisis-and-acute-care/

families can self-refer, including those who are not already known to services"[86], the experience of BME communities, service users and carers in Croydon tells a very different story.

Crisis assessments often have only one outcome, namely hospital admission. This is described as "much more of a problem" for local black communities. There are no crisis residential alternatives to hospital admission in Croydon. As with most NHS mental health services in England, acute inpatient wards at the local hospital (Bethlem Royal Hospital) are "always under pressure". This can delay timely access to crisis

and urgent care, compromising patient safety and quality of care[63]. The people we spoke to in local BME communities reported that acute inpatient care at Bethlem Royal Hospital is rarely helpful and, in many cases, "make things worse".

An essential component in reducing ethnic inequalities is the provision of alternatives to current acute and urgent care provision. Crisis residential options are well tested alternatives to hospital admission[64]. They provide choice to service users and their families and allow greater flexibility (individualised care) in managing mental health crisis. Home Treatment (HT) is the most widely used alternative to hospital admission. For Home Treatment to work effectively, options other than hospital admission must be available, especially when home-based treatment may not be clinically appropriate or feasible. Community alternatives to hospital admission address this gap and are associated with greater service user satisfaction and fewer negative experiences[65].

According to the NHS Long Term Plan, crisis alternatives to inpatient admissions will be an integral part of mental health care in England. Every area has been allocated funding to invest in alternative models of crisis support, "such as crisis cafes, safe havens, and crisis houses, providing an alternative to A&E or inpatient psychiatric admission". This funding is expected to continue over 5 years, with a total of £179 million invested in all areas to increase the range of alternative services to meet the range of different needs and preferences for accessing crisis support. So far, much of this investment has gone to voluntary sector providers of these services, "which tend to have high levels of patient satisfaction". This is "ringfenced investment to identify local inequalities in access, experience and outcomes among people who use crisis services, and to … implement alternative services that better meet needs of these groups, which will be prioritised based on local demographics"[41]. However, the Long-Term Plan, like other NHS mental health policy initiatives, makes no specific commitment to BME mental health.

In Croydon, the CCG recently commissioned a service, *Recovery Space* (in 2020) through Croydon Mind, to provide support for people aged 18 and over, between 6 pm and 11 pm[66]. The service is aimed at people experiencing "mental health crisis as a result of social issues" and deemed as not requiring "inpatient admission or clinical input". The service can be accessed only through professional referrals.

In the first year this service received over 591 referrals, mostly (46%) from A&E and related services of the general hospital (Croydon University Hospital), followed by the GP. The majority were White British (271 out of 520 amongst those with recorded ethnicity) with suicidal ideation as the most common presentation[91]. This client profile is very different to those using the acute and crisis pathway of South

[63] According to latest comparable data, number of acute inpatient beds (including PICU) in SWLSTG is below the South London average: 178 beds (16.2/100,000 population compared to 18.2 /100,000).
[64] Lloyd-Evans B, Slade M, Jagielska D, Johnson S (2009) Residential alternatives to acute psychiatric hospital admission – systematic review. Br J Psychiatry. 195(2):109-17. DOI: https://doi.org/10.1192/bjp.bp.108.058347
[65] Osborn DP, Lloyd-Evans B, Johnson S, Gilburt H, Byford S, Leese M, Slade M. Residential alternatives to acute in-patient care in England: satisfaction, ward atmosphere and service user experiences. Br J Psychiatry 197:s41-s45 http://dx.doi.org/10.1192/bjp.bp.110.081109
[66] https://www.mindincroydon.org.uk/how-we-can-help/support/recovery-space/ [91]
Information provided by Wayland Lousley, Croydon CCG, 16/9/21.

London and Maudsley (SLAM) Mental Health Trust (local secondary care service provider) and those admitted to hospital (predominantly black, with diagnosis of psychosis). There are no other communitybased crisis resources in Croydon to support people experiencing mental health crisis or presenting with urgent mental health problems. There is no BME specific community crisis facility in Croydon, either as part of the secondary care service or in the community.

Intervention

To improve crisis and urgent care for people from BME communities in Croydon, we propose investment in and commissioning new services, aligned to the existing acute and urgent care pathway, to provide crisis residential alternatives to acute hospital admissions, BME specific crisis family placement schemes and crisis houses.

1. *Crisis House*

Mental health crisis houses have operated as part of mental health services for a long time[67][68]. They were established in response to service user demands for alternatives to acute psychiatric inpatient hospital admissions. The Crisis House is now very much part of acute and crisis care pathways in many settings and provides a safe and effective residential alternative to hospital admissions[69]. Crisis Houses offer an alternative to people in mental health crisis who would otherwise be admitted to hospital[70].

In England, mental health crisis houses are mostly offered by voluntary sector providers or jointly with statutory services. Crisis Houses work collaboratively with local crisis services (Crisis and Home Treatment Teams). Houses are staffed 24/7 (in most places) and supported by Home Treatment teams. Clinical care, including treatment and management of patients in crisis houses, are usually undertaken by the Home Treatment Team[71].

Evidence over the last 30 years in the UK shows that Crisis Houses are safe and effective alternatives to hospital admission, providing increased choice to service users and fostering rights and recovery. They are valued as an alternative to hospital admission by people from BME communities[72]. A review of crisis houses aligned to NHS service in 2013[73] concluded that there is a role for crisis houses in the management of acute mental health problems, with potential advantages compared to other care models, such as improved user satisfaction. The review found a wide variety of crisis houses and identified the need to develop and share a best practice framework. Cost--effectiveness data was limited and there were "unresolved issues relating to risk management".

[67] Joint Commissioning Panel for Mental Health. https://www.jcpmh.info/commissioning-tools/cases-for-change/crisis/what-works/crisishouses/
[68] National Institute of Clinical Excellence. https://www.evidence.nhs.uk/search?q=crisis%20houses
[69] MIND (2011) Listening to experience. An independent Inquiry into acute and crisis mental health care. London. MIND. https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf
[70] MIND. Crisis Services and Planning for a Crisis: *What are crisis houses?* https://www.mind.org.uk/information-support/guides-to-support-andservices/crisis-services/crisis-houses/#.XatCdZNKjOQ
[71] See, for example: https://www.rethink.org/help-in-your-area/services/crisis/. https://www.turning-point.co.uk/services/mental-health/crisis-support.html. https://www.nhft.nhs.uk/crisis-houses/ https://www.shsc.nhs.uk/services/crisis-house
[72] MIND (2013) Mental health crisis care: commissioning excellence for Black and minority ethnic groups. https://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf
[73] Obuaya C, Stanton E, Baggaley M. Is there a crisis about crisis houses? J R Soc Med. 2013 Aug;106(8):300-2. doi: 10.1177/0141076813498585. PMID: 23897446; PMCID: PMC3725866.

Activities/Functions

Initially, we propose 2 Crisis Houses in Croydon, one for Black African/African Caribbean men and the second targeted at Asian (Muslim) women. These groups are prioritised because they are more likely to report adverse experiences in acute admission wards, as we heard during community consultation. Inpatient stay is experienced as generally negative by black men. Many Muslim women find mental health inpatient wards unsafe and alienating. Black men are significantly over-represented in acute inpatient admissions in

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Croydon (and nationally). Black people are also more likely than others to be subject to coercive and restrictive interventions as inpatients, both nationally and in London (including Croydon). The disproportionately high numbers of black men being admitted to hospital under the Mental Health Act at Bethlem Royal Hospital also indicate a general unwillingness on the part of these communities to engage with mental health services.

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 be part of the acute and urgent care pathway in Croydon, with clinical care and treatment provided by the local Home Treatment (HT) Team. 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. The Crisis House will provide an alternative to hospital admission in managing mental health crisis and ensuring support and treatment in the community. Crisis House placement may also be considered as a post-discharge option, a way of shortening inpatient stay. However, the primary objective of crisis residential alternatives for BME communities is to prevent acute hospital admission.

Crisis Houses in Croydon should be set up and managed jointly by local BME agencies and NHS services. Ideally, Crisis Houses should be developed and manged jointly with local BME community and voluntary sector agencies.

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 a crisis care plan.
- Placement for up to 6 – 8 people at any one time.
- Length of stay up to 8 weeks.
- Provide independent living options.
- Prioritise hospitality, relational security, and support in crisis.
- Employ 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.
- Provide treatment and care as well as supervision, 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

Each Crisis House will employ up to 6 staff as crisis support workers. There will also be a Crisis House Manager. All staff will be recruited from the relevant BME communities and will receive appropriate training; including mental health first aid, crisis support, de-escalation of crisis, working with families and

utilising community assets to support care and treatment. The Crisis House staff will work with the HT team. The community partner agency will manage the residential facility and its day to day running.

2. Crisis Family Placement

The second proposal in relation to crisis care is to develop and commission a Crisis Family Placement Scheme (CFPS) in Croydon. There are well-established models of crisis family placement, for example, the *Shared Lives* service, which supports and treats people in the community as an alternative to hospital admission[74]. Similar schemes have also been commissioned as part of NHS mental health services[75].

CFPS depends on appropriate families being chosen from the local community to act as host families to support people in mental health crisis. The families, selected according to specific criteria, will be given sufficient training to provide home based support, supervision, and care for people with mental health problems and a variety of psycho-social disability. Patients (as guests) will be placed with the family as an alternative to them being admitted to hospital. Specialist crisis teams, such as the Home Treatment team, will work closely with host families and provide 24/7 support, supervision, ongoing assessment, and treatment.

The host families will be selected based on their compatibility and personal qualities to provide the level of support, supervision and informal care required under the scheme. Their training will include Mental Health First Aid, de-escalation, crisis support and their inclusion in CFPS will be subject to review and ongoing scrutiny. The families will receive ongoing supervision and support.

We are proposing that a Crisis Family Placement Scheme (CFPS) should be commissioned in Croydon, specifically targeting BME communities. This scheme should be aligned to the local Home Treatment service. Home Treatment will act as the gateway to family support placements. This is similar to arrangements for those placed in Crisis Houses.

The HT team will place individuals who need crisis residential support with the host family, for a short period, as an alternative to hospital admission. Placements with the host family will follow a crisis assessment by the HT team. There will be a process of matching of the service user/guest and the host family. Placement can only proceed if both parties agree and either party can terminate the placement at any time.

Guests placed with host families will remain under the care of the HT team throughout the placement. The HT team will ensure 24/7 support for the guest and the host family, including crisis access in an emergency.

According to the *Shared Lives* model, a Personal Plan is co-produced with the service user (guest), host family and the HT team. This plan will set out the specific interventions/actions required to meet the individual's well-being, care and support needs during the placement, and how the guest wishes to be supported to achieve their personal outcomes. It includes all the information the carer needs to ensure the support offered is compatible with the needs and preferences of the guests. This plan will be reviewed regularly by the HT team with the service user and host family to ensure it remains relevant to meet their day-to-day needs and chosen outcomes. The plan will be consistent with and integrated into their Home Treatment care plan.

[74] Shared Lives Plus. https://sharedlivesplus.org.uk/news-campaigns-and-jobs/growing-shared-lives/mental-ill-health/
[75] https://www.hpft.nhs.uk/services/acute-and-rehabilitation-services/alternative-services-to-an-inpatient-stay/host-families-scheme/

Guests will have the option of continuing engagement with the host families (if both parties agree) as part of their aftercare/follow up plans. This could help with seeking early placement with host families as part of a crisis care plan.

CFPS is a well-tested model providing support for people with psycho-social disability, including in mental health crisis[76]. *Shared Lives*, who have pioneered this service in the UK, 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. It is highly valued by service users[77] and recognised by the WHO as one of two examples of good practice in providing person-centred and rights based mental health care in the UK[78].

We are proposing two CFPS in Croydon, one for people from Black African and African Caribbean communities and the second to support people from South Asian communities. Initially, each scheme will aim to support 4 placements at any one time.

Activities and functions

- CFPS will provide community placements for BME patients in mental health crisis as an alternative to hospital admission.
- Placement may also be considered to facilitate early discharge from hospital as an alternative to continued hospital-based treatment.
- The care and support to those under the CFPS will be the same as that provided by the HT team for their clients.
- Individuals remain under the care of HT throughout their stay in family placement.
- Crisis access 24/7 through HT will be guaranteed to service user and the host family.
- Three-way plans (service user, placement family and HT) to ensure support, safety and supervision.

Resource/staffing

A Family Placement coordinator/manager will be required to manage this scheme. 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. There should be provision for administrative support in running the scheme, and training and support costs for the families.

Host families will be paid for their service/input. The CFPS service will aim to recruit 12 families into the programme to provide a large pool of families to accommodate placements (4 placements at any one time). Creating a large pool of potential placement options enables appropriate matching of client and families, ready availability, and a greater chance of successful placements.

[76] See, for example, https://sharedlivesplus.org.uk/wp-content/uploads/2019/04/Evaluation-of-the-Shared-Lives-mental-health-report.pdf. Also: https://www.hpft.nhs.uk/services/acute-and-rehabilitation-services/alternative-services-to-an-inpatient-stay/host-families-scheme/

[77] Harflett N, & Jennings Y (2016) Evaluation of the Shared Lives Mental Health Project. Home Page—Shared Lives Plus. https://sharedlivesplus.org.uk/

[78] World Health Organization (2021) Guidance on community mental health services: promoting person-centred and rights-based approaches. WHO, Geneva. https://www.who.int/publications/i/item/9789240025707 [104]

The annual cost of this service (based on a similar initiative in Wandsworth) is estimated as £355,553 (12 families offering up to 4 places at any time)[104].

Outcomes

- Increased choice for BME service users and families in mental health crisis.
- Community-based living options in mental health crisis, including crisis care plans.
- Provision of person-centred and rights-based care in mental health crisis.

- Establishing crisis residential alternatives to hospital admissions and reducing disproportionate numbers of admissions of people from BME communities.
- Early discharge from hospital, reducing length of stay.
- Involvement of local communities in care and support.
- Improved strength and capacity of the local community through working in partnership with the NHS.

Intervention 3: Reducing Coercion, Improving Inpatient Care

Background and context

People of Black African and African Caribbean backgrounds are at much greater risk than any other ethnic group of being detained under the Mental Health Act[79] and subjected to restrictive interventions, like restraint and seclusion. Use of force is disproportionately used on people from Black and Minority Ethnic backgrounds. In the last ten years in England, there has been a nearly 50 per cent increase in detentions under the Mental Health Act, with significantly more black people being subject to detention than ever before. Black people are also up to eight times more likely than white people to be subject to Community Treatment Orders (CTO) under the Mental Health Act, as part of their community treatment and followup.

The disproportionate use of force and compulsion against black people in psychiatric hospitals is a key driver for other ethnic disparities in mental health, resulting in disengagement from services, treatment nonadherence, delayed help seeking and high levels of dissatisfaction. Coercive interventions and use of force result in patients feeling violated and dehumanised, and "a range of negative responses both immediately and after discharge"[80]. Use of force can be a frightening, traumatising and humiliating experience that can have a lasting impact long after the incident. There can also be a negative impact on staff who witness and use force on patients, and on others who witness it, patients for example.

Coercive interventions undermine patient safety and quality of care in mental health in a fundamental way. The service user is placed at risk of physical and psychological harm through procedures such as restraint, seclusion, rapid tranquillisation etc.[81]. Over the years, there are several instances of people dying in psychiatric hospitals as a result of being subject to force, this risk being highest for black people. Coercion in mental health weakens and damages therapeutic relationships, dissuades people from seeking further treatment, increases the risk of non-adherence with treatment and, as a result, increases the chance of further involuntary treatment. Coercive practices also 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"[108]. Unfortunately, use of force has come to be accepted as the norm in mental health inpatient units in the UK.

The principles underpinning good mental health care – namely, promoting choice and autonomy, least restrictive care, and therapeutic benefit – are all compromised by involuntary treatment and use of force. Reducing coercion in mental health care is a global priority[109,82,83] and considered a prerequisite for developing good mental health care[84]. Coercion or forcible/involuntary treatment in mental health

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[79] Latest figures show that in the year to March 2020, Black people were more than 4 times as likely as White people to be detained under the Mental Health Act – 321.7 detentions per 100,000 people, compared with 73.4 per 100,000 people. NHS Digital Mental Health Act Statistics, Annual Figures - 2020-21. 6 October 2021.
https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures

[80] Wong AH, Ray JM, Rosenberg A, et al. (2019) Experiences of Individuals Who Were Physically Restrained in the Emergency Department. *JAMA Netw Open.* 2020;3(1):e1919381. doi:10.1001/jamanetworkopen.2019.19381

[81] See, for example, Cusack P, Cusack FP, McAndrew S, McKeown M, Duxbury J. (2018) An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. Int J Ment Health Nurs. 2018 Jan 19. doi: 10.1111/inm.12432. [108] Turnpenny A, Petri G, Finn A, Beadle-Brown J and Nyman M (2017) Mapping and understanding exclusion: institutional, coercive and community-based services and practices across Europe. Mental Health Europe & University of Kent, December 2017. [109] Funk M and Drew N (2017) WHO Quality Rights: transforming mental health services. The Lancet Psychiatry 4, 826–827.

[82] Pūras D (2017) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN General Assembly A/HRC/35/21. March 2017. Available at http://undocs.org/A/HRC/35/21.

[83] Sashidharan SP, Mezzina R, Puras R (2019) Reducing coercion in mental health care. Epidemiol Psychiatr Sci. 2019 Jul 9: 1–8. Published online 2019 Jul 9. doi: 10.1017/S2045796019000350

[84] Funk M and Drew N (2017) WHO Quality Rights: transforming mental health services. The Lancet Psychiatry 4, 826–827.

amounts to a 'system failure', that is a deviation from or violation of standards of good practice[85]. Any intervention violating the patient's human rights reduces patient safety and compromises quality of care and should have no place in a modern healthcare system. If such an intervention is considered necessary, there should be strong justifications and appropriate safeguards in place. Unfortunately, the ubiquity and routine use of coercive practices in mental health care, particularly against specific BME groups, means that these system failures have become normalised in current mental health care practice in the UK. The case against the use of restrictive practices within therapeutic environments has never been stronger[86].

The disproportionate rates of involuntary psychiatric admissions (through the Mental Health Act) and use of force have been a major concern for BME service users and communities for over 40 years. The recent review of the Mental Health Act in England[87] was prompted by long-standing concerns over BME overrepresentation in involuntary psychiatric treatment. This review called for the development of alternatives to coercive services and specific actions to reduce detention of black people under the Mental Health Act. It recommended that use of the Act should *always* be guided by the principles of 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) and treating the person as an individual (ensuring patients are viewed and treated as rounded individuals). Sadly, this is not currently happening when the Mental Health Act is invoked to detain black people in hospital or when they are subjected to further coercive measures under the Act. Despite this recent review of the Mental Health Act and subsequent calls for a more principled approach to involuntary treatment, rates of detention under the Act and use of force in mental health settings continue to rise, especially for black people. This is why reducing the rate of detention under the Mental Health Act and reducing coercive and restrictive interventions in psychiatric hospitals are key priorities for EMHIP.

The national (England) rate for detention under the Mental Health Act is 94.8/100,000 population for men and 87.9/1000,00 for women[88]. The risk of being detained under the Mental Health Act is substantially higher for black people than for other ethnic groups (more than four times as likely as for white people, 321.7/100,000 people).

Number of detentions under the Mental Health Act per 100,000 people, by aggregated ethnic group

(Standardised rates) Number / 100,000[89]

Ethnicity	2017/18	2018/19	2019/20
Asian	91.9	103.4	104.6
Black	288.7	306.8	321.7
Mixed	158.4	232.8	214.0
White	71.8	72.9	73.4
Other	180.3	173.4	195.6

[85] Bhugra D, Tasman A, Pathare S et al (2017) The WPA-Lancet Psychiatry Commission on the Future of Psychiatry. The Lancet Psychiatry 4, 775–818.

[86] MIND (2013) Mental health crisis care - physical restraints in crisis. https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf.
Also, MIND / NSUN (2015) Restraint in mental health services - what the guidance says. https://www.mind.org.uk/media/24416468/restraintguidanceweb1.pdf

[87] GOV.UK (2018) Modernising the Mental Health Act – final report from the independent review. https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

[88] https://files.digital.nhs.uk/ED/8F6815/ment-heal-act-stat-eng-2020-21-summ-rep.pdf

[89] https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest#by-ethnicity-5ethnic-groups

People of African and African Caribbean origin are also significantly more likely than other ethnic groups to be under Community Treatment Orders (ten times more likely than the white group – 78.9 and 7.8 uses per 100,000 population respectively) and twice more likely subject to the use of force in inpatient wards.

This is a major concern for BME community groups, service users and carers in Croydon, as we heard during the EMHIP consultation and engagement process with local stakeholders, service users and carers. Many people described inpatient care at the Bethlem Royal Hospital (local psychiatric hospital) as "damaging" and "very bad". Despite high profile incidents involving patient safety at Bethlem Royal and subsequent 'action plans' to improve inpatient care and reduce the use of restrictive interventions, "there has been no change" in the experience of inpatient care by BME communities.

Reducing the high rates of detention under the Mental Health Act for BME patients (in particular, Black Caribbean and Black African groups) and use of force against black people in inpatient care is not an easy task. There has been concern about the rise in detention rates under the Mental Health Act for years, but this trend has not been halted or reversed. Over the years, there have also been systematic attempts to improve patient safety in inpatient wards, with several local initiatives to reduce the use of restrictive interventions, based on staff training and cultural changes in inpatient care. However, there is no robust evidence of their long-term effectiveness.

Reducing coercion requires a systematic approach[90]. We propose a specific, systemic programme across acute and urgent care in Croydon to achieve this. Our proposals are consistent with the recommendations arising from the recent review of the Mental Health Act and requirements following the Mental Health Units (Use of Force) Act 2018 or Seni's Law.[91,92].

There are two strands to the EMHIP programme to reduce detentions under the Mental Health Act 1983 and the use of force:

i. Ensure a process of shared decision making (three-way decision-making involving patient/mental health professional/Mental Health Mediator who is nominated or agreed by the patient) in relation to the use of the Mental Health Act and all use of force/restrictive interventions in inpatient wards.

ii. Make inpatient wards more open and inclusive, through greater community involvement and participation.

Specific interventions are required under each of these to bring about the necessary changes to achieve this:

[90] Masters KJ; Huckshorn KA (2020) The role of the psychiatrist in seclusion and restraint. Psychiatric Services in Advance (doi: 10.1176/appi.ps.201900321).

[91] The Mental Health Units (Use of Force) Act or Seni's Law was given Royal Assent in Parliament in 2018. Statutory guidance on implementing the law was issued in December 2021 and will come into force in March 2022. The law is named after Olaseni 'Seni' Lewis. Seni was a 23-yearold Black man from South London. He died as a result of prolonged restraint by Metropolitan police officers at Bethlem Royal Hospital in Beckenham on 31 August 2010, within hours after admission there as a voluntary patient. Legislation can be found here- https://www.legislation.gov.uk/ukpga/2018/27/contents/enacted Statutory guidance here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1038727/Government-response-toconsultation-Mental-Health-Units-Use-of-Force-Act-2018-statutory-guidance.pdf
Circumstances of Sen's death and the subsequent campaign by Sen's parents and others here: https://www.huckmag.com/perspectives/restrained-and-killed-by-police-justice-for-seni-lewis/ https://www.justiceforseni.com/senis-law/

[92] This new law increases protections and oversight on use of force in mental health settings. There are three elements to this new legislation: (i) psychiatric hospitals must actively take steps to reduce the use of force against patients, including by providing better training on managing difficult situations (ii) better data will have to be collected, which will enable monitor progress and highlight any problem areas and (iii) police will need to wear body cameras when called to mental health settings, which can be used in evidence. The guidance to hospitals in relation to Seni's Law calls for "ending the disproportionate use of force and discrimination against people sharing certain protected characteristics" and that this should be part of the policy regarding the use of force (required under the law).

1 Shared Decision Making – Mental Health Mediators

The over-representation of minority ethnic groups in the high-intensity, coercive end of the treatment spectrum may be the product of more severe illness presentation, delay in receiving treatment, comorbidities, and cultural and social factors. However, the nature of clinical care is also powerfully shaped by the prevailing culture of mental health services, including models of psychiatric treatment. Clinical decisions in mental health, especially when it comes to assessment and attribution of risk, are neither objective nor based on agreed, reliable criteria. Establishing the nature and extent of risk as a result of mental disorder is not an exact science and subject to significant bias, depending on the context in which the decision is made, the personal attributes of the clinician taking the decision, and that of the individual about whom decisions are being made[93].

Risk assessments as part of the Mental Health Act assessment (establishing the criteria for detention) or use of coercive interventions are often made in crisis situations. More often than not, such decisions are driven by the immediate behaviour and actions of the patient (how they present) rather than a full or detailed understanding of that person. This is especially true when the person is unknown to the service or being assessed in what may be perceived as a hostile environment. Key decision-making processes in relation to the Mental Health Act and use of restraint are closed and opaque, not collaborative or inclusive. Third party information (views of people who may know the patient much better) are rarely elicited or used to inform such assessments. Similarly, external mediation is rarely sought, even when the patient and clinician are completely at odds with each other. Best practice guidelines recommend multi-disciplinary input into clinical decisions, but this is often considered impractical or ruled out because of clinical urgency and perception of risk.

There is evidence that joint or collaborative 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[94]. However, shared decision-making is not currently routine clinical practice. Shared or inclusive decision-making, especially if it could be broadened to include a trusted third party (family member, carer, friend, an advocate, or someone from the local community) has the potential to reduce forcible treatment of black people. This would expand the information available to the clinicians when making critical decisions concerning risks and the potential for mitigating risks. The presence of someone known to the patient while such decisions are being considered could also reduce the oppositional dynamics that often pervade encounters between clinicians and black patients. This is particularly important in situations where the patient is faced with the threat of loss of freedom and choice; for example, detention in hospital, compulsory treatment, or the use of force against him/her. A third party (who knows the patient and his life circumstances) could also act as an honest broker in mediating between the patient and professionals trying to meet their statutory duties.

Engaging ethnic minority clients requires clinicians to construct the clinical encounter as an egalitarian collaboration that addresses 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 all important in bridging the social identities of clinicians and clients to promote more consensual and collaborative

[93] For a review of errors / biases in clinical decision making, see: Lilienfeld, S.O. and Lynn, S.J. (2014). Errors/Biases in Clinical Decision Making. In The Encyclopaedia of Clinical Psychology (eds R.L. Cautin and S.O. Lilienfeld). doi:10.1002/9781118625392.wbecp567

[94] Thornicroft G and Henderson C (2016) Joint decision making and reduced need for compulsory psychiatric admission. JAMA Psychiatry 73, 647–648.

approaches[123,124]. The best way to achieve this in relation to involuntary and forcible treatment is to ensure that the patient and those who know the patient are involved in the decision-making process from the start.

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, that is, on 'their turf and terms'[125].

As part of EMHIP, a new decision-making process (shared decision-making) will be introduced in relation to: (i) detention under the Mental Health Act; (ii) involuntary/forcible treatment; and (iii) restrictive interventions, such as the use of restraint. 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 and his or her family/nominated friend/patient advocate in all such decisions. The CPA care planning process already allows for the input of the patient and family but, in practice, 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, there is very limited involvement of the Nearest Relative in the decision to detain someone under the MHA[126]. The Nearest Relative also has a role in Section 3 detention and compulsory treatment, although there is no established mechanism to ensure their involvement in related decisions. The role of Independent Mental Health Advocates (IMHA) under the Mental Health Act is also limited, and they are not included in the decision-making process.

We propose a three-party decision-making process, including the patient, mental health professional(s) and Mental Health Mediator in relation to detentions under Part 2 of the Mental Health Act (section 2 and section 3 initially) and the use of force/restrictive interventions in inpatient wards. This will apply across the acute and urgent care pathways in Croydon. The key decision points are: (i) detention under the MHA (section 2 and 3); (ii) enforcing treatment against the patient's wishes or without his/her agreement; and (iii) use of any restrictive intervention, such as restraint and seclusion.

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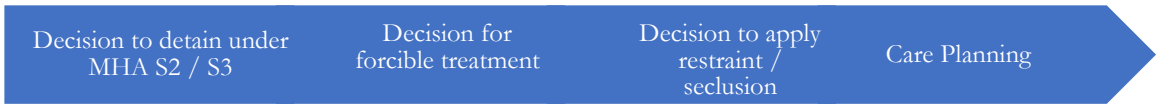
123 Alegria M., Falgas-Bague I. and Fong H.-f. (2020), Engagement of ethnic minorities in mental health care. World Psychiatry, 19: 35-36. doi:10.1002/wps.20695

124 Unützer J., Carlo.D. and Collins, P.Y. (2020), Leveraging collaborative care to improve access to mental health care on a global scale. World Psychiatry, 19: 36-37. doi:10.1002/wps.20696

125 Mezzina R, Rosen A, Amering M and Javed A (2019) The practice of freedom: Human rights and the global mental health agenda. In Javed A and Fountoulakis KN (eds), Advances in Psychiatry. Cham: Springer, pp. 483–515.

126 The rights of the Nearest Relative under the Mental Health Act are:

- Apply for detention under the Mental Health Act or Guardianship
- Object to being sectioned or placed under a Guardianship
- Apply to discharge from section and apply to the Mental Health Tribunal if this is refused
- Ask for an independent advocate to give support
- To be consulted and/or given information about the patient if sectioned
- Appoint someone else to be the Nearest Relative



How will shared decision making work?

- Every person referred through the acute/urgent care pathway (including all inpatients) will have the option of identifying a family member, friend or advocate as a Mental Health Mediator (MHM).
- If a family member, friend, advocate is not available, service users will have the option of choosing a MHM from a list of MHMs, recruited and trained for this purpose, by SLAM.
- Mental Health Mediators will be recruited from the local communities for this purpose and will be available to act as MHMs at any time.
- The service user will consent to the involvement of the MHM in all decisions about him/her in relation to detention under the Mental Health Act and use of restrictive interventions.
- It will be the responsibility of the Mental Health Trust (SLAM) to ensure the nomination and participation of the MHM in decision-making processes involving all coercive interventions.
- These include:
  - detention and involuntary treatment under the MHA (section 2 and 3)
  - initiating restraint procedures or seclusion ○ care planning in relation to all aspects of involuntary treatment.
- The MHM will be required to be present during the assessment prior to the intervention, with the agreement/consent of the service user.
- Provisions will be made to facilitate the MHM's participation in the joint decision-making process. The MHM will: (i) act on behalf of the service user; (ii) contribute to assessment and decisions concerning the best course of action; (iii) help explore less restrictive and more consensual options with the service user and professionals; and (iv) express agreement or disagreement with the final decision.
- The clinician with responsibility for making the relevant decision will be required to discuss the reasons for it, give 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 MHM.
- The process will be open, collaborative, and transparent, and will be recorded in the clinical notes.
- A process of debriefing and learning following every instance of coercion (detention under the Mental Health Act and use of restrictive interventions) will be developed.

Actions

- Recruitment and training of Mental Health Mediators (who will act on behalf of the patient when the patient is unable to nominate or designate a family member/carer as MHM).
- All decisions relating to an application for detention under the Mental Health Act and use of force/coercion will involve shared decision-making that includes nominated Mental Health Mediators.
- All incidents involving the use of restrictive interventions (restraint and seclusion) will be designated as Critical Incidents, amounting to system failure.
- Debriefing and support will be provided for staff and patients after each incident.
- All coercive interventions/restrictive care incidents will be subject to reporting and review, in keeping with SLaM's Critical Incident Policy[95], to identify the immediate learning from the incident (a fact-finding review). This will develop a reflective practice – what prompted the intervention,

[95] https://www.SLaM.nhs.uk/media/6904/incident-policy.pdf

what alternatives could have been used, how further incidents might be prevented. This process can be integrated as a QI initiative (PDSA) undertaken by the Patient Safety Team.

- Use of restraint, rapid tranquillisation and seclusion will be considered psychiatric emergencies that require the presence of a doctor/psychiatrist.
- Avoid prescribing PRN medication for anticipatory management of behavioural problems.
- All front-line staff working in inpatient wards will receive training to reduce/avoid the use of restraint and seclusion and promote alternatives, based on established models of restrictive care reduction[96]. The training will be co-produced and delivered with BME service users and carers.

Shared decision making and its integration into day-to-day clinical practice/care and management will need to be supported by:

i. A policy and framework, co-produced with service users, families and the local BME communities, for reducing the use of coercion in inpatient wards at Bethlem Royal Hospital, and ii. Establishing an inclusive process of monitoring and reporting the use of involuntary care (through the Mental Health Act) and use of force in inpatient wards by ethnicity, co-produced with service users and local BME communities.

From March 2022, these will be statutory requirements under the guidance in relation to the Mental Health Units (Use of Force) Act 2018 (otherwise known as Seni's Law).

i. A policy framework to reduce the use of force/coercion in inpatient wards

The second strand to reducing coercive care is to develop an overall framework for reducing the use of force in inpatient settings. There is national guidance on the use of physical and mechanical restraints in health care settings as well as local policies and procedures on the use of restrictive interventions. The expectation is that service providers and clinical staff will act within the principles set out in such guidance and use of restrictive interventions will be in line with the MHA Code of Practice 2015, Mental Capacity Act 2005, Human Rights Act 1998, and the common law. However, none of this guidance advises specific changes in current practices regarding the use of restraint and related interventions. There are no BME specific recommendations or plans to reduce disproportionately high numbers of black people subject to restraint and other restrictive interventions in psychiatric inpatient care.

The Mental Health Unit (Use of Force) Act or Seni's Law stipulates that all mental health units should "ensure accountability and transparency about the use of force in our mental health units". Under Section 3 of the Act, "the responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit. The written policy will set out the steps that the unit is taking to reduce (and minimise) the use of force by staff who work in the unit".

Currently, there is no agreed framework to reduce restrictive interventions in inpatient wards in Croydon (Bethlem Royal Hospital). Under the Integrated Equality Action Plan of SLaM, reducing ethnic variation in the use of restraint and reducing restraint in absolute numbers is a strategic priority. The Quality Improvement Programme of the Trust identifies consultation, co-design and co-production with service users and carers as a key principle in improving services. However, there is no evidence that BME service users, carers and community groups in Croydon have been consulted about reducing ethnic disparities in the use of the MHA and other coercive interventions.

[96] See, for example, CQC (2017) Mental Health Act: a focus on restrictive intervention reduction programmes in inpatient settings. https://www.cqc.org.uk/sites/default/files/201701207b_restrictivepractice_resource.pdf

ii. Measuring and monitoring coercion

The third strand of this key intervention to reduce coercive care in acute admission wards of Bethlem Royal Hospital is to establish a Restrictive Care Data Dashboard, including demographic, dynamic and transactional data on the use of the Mental Health Act and use of force in relation to BME patients. The data should include the reasons and context of restrictive care. This should be co-produced with BME service users and families, be made available to all key stakeholders, and used as a benchmark for improving clinical practice. Monitoring and reporting on the use of force in mental health units is a requirement under Seni's Law.

Unless the use of coercive interventions by ethnicity (including the use of the Mental Health Act) is monitored and reported regularly, it will be difficult to understand the extent and nature of these practices. There are systems already in place to gather information regarding the use of coercive interventions and detentions under the Mental Health Act at SLaM, but much of the relevant data is not readily available nor shared with key stakeholders.

Dynamic monitoring of the use of coercion in inpatient wards at SLaM will be consistent with this plan. One of its strategic objectives is to reduce the use of restraints. However, data in relation to the use of coercion at borough level (Croydon, for example) or pertaining to individual wards or teams (for example, acute admission wards at Bethlem Royal) are not easily available. BME service users, carers, community groups that we spoke to were unaware of data relating to coercion. More assertive reporting and wider sharing of all relevant data is a pre-requisite for the success of a programme like EMHIP and similar projects wishing to improve the quality and safety of mental health care. Coercive interventions in mental health care could potentially violate their rights and compromise patient safety. All data relating to such incidents should, therefore, be shared routinely with the relevant stakeholders.

Restraint dashboards can provide timely and efficient access to granular data elements and metrics relating to restraint events, beyond the reporting requirement of any national quality programmes. Such data dashboards can reveal variations in restraint use at the local level and yield important opportunities for clinical quality improvement[97].

Actions

i. Policy & Framework

- Develop and implement a policy and framework for reducing the use of the Mental Health Act and force against BME patients in all acute admission wards (Croydon).
- This will be co-produced with service users, carers and local BME communities.
- This framework will be aligned and, where possible, integrated with other initiatives at Bethlem Royal Hospital to reduce the use of restrictive practices on the acute inpatient wards.
- Seni Empowerment Network:[98]

    - To develop the awareness of African and Caribbean communities of the guidance and their rights under the Mental Health (Use of Force) Act 2018 and associated legislations.
    - To ensure the historical and personal lived experiences of this community informs and challenges the definitions of force (physical, mechanical, chemical, seclusion, segregation) to address new practices of race equality.

[97] Li L, Barnes T, (2021) A Visual Dashboard to Monitor Restraint Use in Hospitalized Psychiatry Patients. The Joint Commission Journal on Quality and Patient Safety, 47 (5), 281-287.
[98] This is based on a model of service user / carer empowerment developed by Ajibola Lewis and Dr Colin King

- To ensure Mental Health Units, responsible persons and practitioners incorporate the lived experience of African-Caribbean good practice models in policy, Human Rights, data analysis, recording, annual reviews, training standards (Restrain Reduction Training Standards Certification) and associated legislations.
- To ensure a co-production model of recognising lived experiences of the African and Caribbean community is enshrined in all aspects of Mental Health Unit Use of Forces Act, assessment, care plan, risk assessments and discharge.
- To set up and develop a Lived Experience African and Caribbean inspection model and framework and a national cultural competencies framework for Mental Health Units.

ii. Monitoring restrictive practice

- A restrictive practices data dashboard/information system in relation to BME patients in Croydon should be set up – this can help track, analyse, and provide deeper insight into the extent, nature, and consequences of the use of force/coercion in inpatient wards.
- This work should be co-produced with BME service users, carers, and community groups.
- The data should be customised to provide, live, dynamic, up to date data using data points and metrics relating to all aspects of coercive interventions in mental health services in Croydon.

2 Making inpatient wards more open and inclusive

The use of coercion in mental health settings is driven by several factors. Variations in clinical presentation, severity of illness and other patient characteristics, staff attitudes and organisational procedures and policies are all important, but the key determinant of the type and quality of patient care is the culture and dynamics of the setting (inpatient wards).

All acute inpatient wards at Bethlem Royal Hospital operate as 'closed' environments[99]. They have locked doors and access is strictly regulated. These facilities are remote from the communities they serve and there is very little community outreach or carer/family involvement in how wards operate. Like most acute inpatient psychiatric wards in the country, we heard that patient safety and risk management are prioritised in these wards over hospitality, support, or therapeutic engagement. The wards are "forced" to function as "high intensity" settings because of various pressures, including shortage of beds, most patients being under compulsory detention, high levels of disturbed behaviour and staffing pressures. We heard from staff that the wards are "always busy" and of difficulties with staff turnover and nursing shortage.

Service users experience the inpatient wards at Bethlem Royal as "distressing", "challenging" and "very scary". BME service users and carers that we spoke to describe the inpatient environment as "unsafe", "threatening", "appalling", "making problems worse rather than better". Treatment is not individualised and largely based on "medication and more medication". Clinical care is "one size fits all" despite the huge diversity amongst patients and their differing needs. Very few people reported their inpatient experience as helpful or aiding their recovery.

We heard from Link Workers in *Hear Us,* a mental health service user group in Croydon[100]. They are part of the Peer Navigator and Support Project of *Hear Us* and SLaM and they regularly visit the inpatient wards at Bethlem Royal Hospital. Link Workers monitor services, ask other service users what they think about the services, support inpatients, signposting patients to other activities and services. According to their

[99] Currently, there are 5 acute wards (general adult) for Croydon patients at Bethlem Royal Hospital, with a total of 83 beds: They are - Fitzmary 1 (women patients, 14 beds), Gresham 1 (women, 20 beds), Gresham 2 (male, 22 beds), Tyson West 1 (male, 17 beds) and one Psychiatric Intensive Care Unit - Croydon PICU (male, 10 beds).
[100] https://www.hear-us.org/hear-us/linkworking/

evidence, the inpatient units are "always busy", with "an emphasis on coercion and control". People are discharged "far too early", especially if they are "difficult to engage". This leads to the 'revolving door' experience for many patients as they keep getting discharged and then re-admitted to hospital.

Fundamental changes in the way inpatient wards at Bethlem Royal Hospital function are beyond the scope of EMHIP. However, we recognise that, without improving the culture and dynamics of the inpatient wards, it will be difficult to reduce the use of coercion, a key objective of EMHIP. Ward environment and culture are critical to reducing coercion. Coercive environments and culture will result in greater need for coercion and further entrenchment of the prevailing culture.

Intervention

As part of EMHIP, we propose greater community involvement (with families, carers, service users and community agencies) in the wards. Investing in and facilitating greater involvement of families, carers, peer workers and, more broadly, local community agencies in inpatient wards will help open these spaces and develop more collaborative care. Inpatient facilities should be part of the community, extensions of community safe spaces for support, care and treatment. We recommend 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 *Hear Us* Link workers and develops it to ensure active participation of carers and families as well as other external agencies in improving and diversifying inpatient care and treatment.

Actions

- The current programme of work involving Inpatient Link Workers will be expanded to ensure greater focus on BME service users.
- There should be an increase in the number of Link Workers and their involvement in acute inpatient wards.
- In addition, Inpatient Community Support Workers from BME communities/people with lived experience should be recruited and trained to work on the wards.
- Community Support Workers will facilitate better patient engagement, individual support and advocacy, contribute to individual care planning and expedite progress/early discharge.
- The Community Inpatient Worker will act as the main link with the service user's family and carers, help mobilise all relevant community assets and resources in support of individual care plans.
- The Community Inpatient Worker will provide continued support and remain in contact with the patient post-discharge.
- Inpatient Community Support Workers will help facilitate the involvement of community agencies in wards around activities and therapeutic support for inpatients using community resources, including ward visiting by volunteers from local BME communities.
- They will help forge closer working relationships with the hospital chaplaincy service and faith organisations in the community to address spiritual and faith needs of service users in hospital.

Resources

i. *Shared decision making – MHM*

New resources will be required in relation to setting up and delivering this intervention - managing the process (nomination, ensuring a register), training of MHM, advice and support (clinicians and MHMs), facilitation (travel and related expenses) and staff training.

- Based on EMHIP Wandsworth, 2 new posts will be required to support this programme, a project lead and a post for staff development and training. Their responsibilities will include:

- Leadership and managing the implementation of Key Intervention 3 of EMHIP (reducing coercion) in adult acute inpatient wards at Bethlem Royal Hospital.
- Developing a detailed programme of implementation.
- Liaison with service users and staff to facilitate and manage implementation.
- Managing and supporting the development and training for all inpatient staff.
- Recruitment, training, and ongoing support of Mental Health Mediators.
- Operational responsibility for all components of KI 3 intervention.

- Costs associated with MHMs: in addition to recruitment and training costs, MHMs will be paid for their input and travel costs.

- Costs associated with co-producing the use of force policy and framework.

- Additional resources will be required for: (i) Community Inpatient Workers; (ii) expansion of ward visiting and befriending programme; and (iii) staff training in relation to collaborative working in acute inpatient wards.

There are several initiatives at SLaM that could be aligned with the task of improving inpatient care, such as enhancing community participation in ward activities[101]. The Involvement Register is a way for South London and Maudsley NHS Trusts (SLaM) to advertise and allocate opportunities to people who want to use their experience of services to help SLaM develop and improve their mental health services. The Register is open to people who have used SLaM services and their carers, and who have been involved with the Trust in the last 5 years. *Msaada* (a Swahili word meaning 'giving back') is a volunteering programme for people from the Black and Minority Ethnic (BME) communities who want to support BME people with a mental illness. SUITE is another programme that supports, coaches and trains service users, carers and family members to ensure a better care experience.

We heard from community and voluntary groups about their desire to become involved in supporting inpatients and improving inpatient care at Bethlem Royal Hospital. There is a shared recognition in the community that current inpatient provisions and care and support fall far short of what is required. However, this was seen as "a difficult thing to do" because of the lack of interest from the mental health trust and commissioners in joint working with community partners or any meaningful collaboration to improve secondary care services, including inpatient care.

Outcomes

[101] https://www.SLaM.nhs.uk/about-us/get-involved/volunteering-and-other-opportunities/involvement-register/

- Implementing a new collaborative model of shared decision-making in acute mental health care, taking into account the will and preferences of service users and carers.
- Integration of joint decision-making process into routine clinical practice.
- 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.
- Service user ownership of decisions concerning their care and treatment.
- Improved family involvement in care and treatment.
- Improved therapeutic engagement and therapeutic alliance between service users and staff.
- Reducing involuntary admissions (Mental Health Act) and the use of force and restrictive/coercive interventions in inpatient wards.
- Broadening family/community participation in inpatient care.
- Enhance the quality of clinical care, reduce crisis and increase therapeutic engagement.
- Encourage development of self-management interventions and personal crisis management plans.
- Equitable access to least restrictive environment.
- Reduction in coercion.
- More consensual care.
- Better treatment adherence.

The cumulative impact of these outcomes will be:

- Reduction in the use of Mental Health Act and the ethnic differentials in the use of the Act.
- Reduction in the use of restraints and other restrictive practices in Bethlem Royal acute inpatient wards and in the ethnic differentials in the use of force.
- This intervention (to reduce coercion in secondary care mental health services) goes beyond improving patient safety and quality of care. Successful implementation of KI3 in acute inpatient wards at Bethlem Royal Hospital will contribute to developing mental health services in Croydon that promote human rights and recovery[102,103,104].

[102] Mezzina R (2016) Creating mental health services without exclusion or restraint but with open doors Trieste, Italy. L'information Psychiatrique 92, 747–754.
[103] Szmukler G and Appelbaum PS (2008) Treatment pressures, leverage, coercion, and compulsion in mental health care. Journal of Mental Health 17, 233–244.
[104] Szmukler G (2015) Compulsion and "coercion" in mental health care. World Psychiatry 14, 259

Intervention 4: SMI – BME specific Assertive Outreach Team

Background and context

Prevalence of Severe or Serious Mental Illness[105] (SMI) is higher in people from BME backgrounds, in particular, Black African and African Caribbean ethnic groups[106]. BME patients with SMI are overrepresented within high intensity services (admissions, detentions under the Mental Health Act (MHA), referrals to Psychiatric Intensive Care Units, forensic mental health). While this suggests a high degree of mental health needs in the BME communities, it is not matched by the resources available to these groups. Currently, there are no BME specialist services for rehabilitation/recovery within the mental health secondary care provisions in Croydon.

People with SMI are high users of inpatient services, at greater risk of coercive care, and likely to be kept in institutional care longer. People with SMI experience stark inequalities, poorer health outcomes and die, on average, 15 - 20 years earlier than the general population. The mortality gap between individuals with SMI and the general population in the UK is widening[107].

These inequalities are more pronounced in BME communities, compounded, arguably, by the lack of BME specific services for people with SMI that address their overall needs.

A group of patients adversely affected by the lack of long-term support is BME people with SMI. In particular, many black men with mental health problems are repeatedly failed by multiple systems, including education, social services, criminal justice, and mental health[108]. In London (and most urban areas in the country), there is a core group of black service users with SMI who experience repeated admissions to hospital under the Mental Health Act. They are seen as 'difficult' or 'hard to engage' and treat. Predominantly, they are young men of Black Caribbean or Black African background. Many of them present with a history of co-morbid substance misuse and a pattern of non-engagement with services and nonadherence to treatment. Over time, many of them become disaffiliated from conventional NHS mental health care. This group are also at high risk of social exclusion and repeated contact with the criminal justice system. Conventional treatment approaches for this group of people with SMI, such as hospital admissions (often for lengthy periods), forcible treatment (in hospital and under CTO), assertive case management by generic community mental health teams, do not appear to have a significant impact on their care trajectories or confer enduring clinical benefit. Thus, they constitute a 'high risk' group with complex needs but poor treatment outcomes, and at risk of exclusion from conventional community services. Most of them 'end up' in long-term institutional care or are managed under Community Treatment Orders which alienate them further from any form of therapeutic engagement. They present 'a confluence of complexity' and significant 'service gap' in terms of their needs, management, support, and treatment. This is an example of a treatment paradox in mental health, where the most vulnerable people or 'at risk' clients with complex SMI receive the least appropriate services[109].

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[105] The phrase severe mental illness (SMI) refers to people with psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired. Schizophrenia and bipolar disorder are often referred to as an SMI. https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-healthinequalities-briefing.

[106] Adult Psychiatric Morbidity Survey, England, 2014. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatricmorbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

[107] Hayes, J., Marston, L., Walters, K., King, M., & Osborn, D. (2017). Mortality gap for people with bipolar disorder and schizophrenia: UKbased cohort study 2000–2014. British Journal of Psychiatry, 211(3), 175-181. doi:10.1192/bjp.bp.117.202606

[108] Centre for Mental Health – The Bradley Commission (2013) Black and Minority Ethnic Communities, mental health, criminal justice. https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Bradley_Commission_briefing1_BME.pdf

[109] The Sainsbury Centre for Mental Health (1998) Keys to Engagement: review of care of people with serious mental illness who are hard to engage with services. London. Centre for Mental Health.

Currently, a major challenge in addressing the long-term needs of BME clients with SMI is the high degree of disaffiliation and risk of disengagement shown by BME service users. Generic community mental health services struggle to engage or support people from all ethnic groups with complex long-term needs due to their level of disengagement. The care trajectory of these patients is generally one of poor compliance, relapse, high levels of risk and (often lengthy) re-detention[110]. Many people with complex SMI (especially with a history of substance use and criminal recidivism) are excluded from generic mental health services, such as community rehabilitation teams. As a result, they risk becoming entrenched in the more coercive end of psychiatric care, within secure or forensic care facilities[111]. These challenges are much greater and the outcomes poorer for BME patients and they amount to a significant service gap.

The foremost requirement in addressing this service gap experienced by people with SMI from BME communities is to ensure they are more actively and positively engaged with mental health services than is currently the case. As with most aspects of mental health care, positive engagement with service users and their families is a pre-requisite for successful care and treatment. Without positive engagement, mental health services will flounder, fail to deliver appropriate care, and increasingly gravitate towards prioritising control and compulsion over care and treatment.

This is at the heart of the challenge faced by black communities in relation to mental health services. Mental health teams, especially services for people with SMI, are seen as unwelcoming and inflexible, as reported to us by BME service users. This was a key theme emerging from stakeholder consultation in Croydon. The inhospitable, unwelcoming nature of local services was also identified in Focus Groups as a major challenge facing BME communities in Croydon, in keeping with similar findings in Wandsworth.

Current mental health services offer a 'one size fits all' model of care and treatment which is rarely adapted to meet the specific needs of racialised minorities. Increasingly, mental health teams have become inflexible in their approach and practice and exclusionary (i.e., with too many exclusion criteria), leaving people disenchanted with their care and treatment or simply excluded from mainstream care. Underfunding of community mental health services and staff shortages have made teams focus more on delivering treatment, with less time to promote engagement or develop long-term relationships with clients and their families. These problems are more pronounced when dealing with black service users, especially those presenting with complex problems and high-risk profiles, a sub-group of people who have been sensitised to exclusion, marginalisation, and coercion from an early age. The burgeoning numbers of black people being managed under Community Treatment Orders (CTO) is evidence of this system failure. In all mental health services serving diverse communities in England, one can see a significant over-representation of black people (around eight times more likely than white people) on CTO with higher rates of involuntary treatment and readmissions.

Evidence from the EMHIP community consultation and engagement process confirms the absence of culturally informed care and support for people with SMI from BME backgrounds in Croydon. There was a strong view that black communities in Croydon had "no choice" when it came to acute and complex care. Current services for people with SMI from black communities were described as limited in their ability to ensure effective follow up and long-term support people. It was felt there was hardly any investment in long-term support in the community and "it is hospital or nothing" for people with long-term, severe mental health problems. Carers and families of people with SMI reported receiving very little formal support from mental health services. Many people felt that current services were failing to deliver optimum care and support. We heard of pervasive use of coercion in mental health care of black people, of repeated

[110] Dr Nuwan Dissanayaka, Consultant Psychiatrist, Leeds Assertive Outreach Team. Personal communication

[111] The Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear: a review of the relationship between mental health services and African and Caribbean communities. https://www.centreformentalhealth.org.uk/sites/default/files/breaking_the_circles_of_fear.pdf

involuntary admissions under the Mental Health Act, and lengthy stays in locked inpatient facilities. There was particular concern about the disproportionate use of Community Treatment Orders (CTO) in the black community.

Intervention

To address the Croydon 'service gap' in relation to people with SMI from BME communities, we propose commissioning a specialist Assertive Outreach Team (AOT) to facilitate positive engagement, long-term care, support, and treatment of people with complex and severe mental illness. This will be a bespoke service based on a culturally adapted model of the Programme of Assertive Community Treatment (PACT)[112].

The Programme of Assertive Community Treatment (PACT) is an evidence-based service model for people with complex SMI. PACT has better evidence for effectiveness than any other form of community treatment for people with SMI[113]. Assertive outreach through Assertive Outreach Teams (AOT) is a wellestablished way to deliver PACT. AOTs were first introduced in England in the mid 1990s. They worked as specialist community teams to deliver PACT model of care targeted at people with complex needs and a history non-engagement with services. Provision of AOT was expanded in England after the adoption of the National Service Framework for Mental Health (2000) and National Mental Health Policy (2001). At one stage, AOT services were commissioned in every area in England, totalling over 270 teams. However, over the last 10 years, AOT services have been increasingly reconfigured as AOT 'functions' within generic mental health teams, thus abandoning the original AOT model.

One of the reasons for the retraction of AOT in England may have been the lack of effectiveness of AOT in reducing hospital admissions and the costs associated with such highly specialist teams. While the evidence for the effectiveness of PACT in the care of people with SMI is well established, the introduction of Assertive Outreach Teams in England has had mixed outcomes. Research in relation to AOT within the English mental health system has not shown distinct advantages over generic community mental health services, in terms of reducing admissions or achieving better clinical outcomes, social functioning, compared to standard treatment[114],[115], However, all studies of AOT (including English studies) have demonstrated higher levels of retention of clients, better engagement and greater patient satisfaction, compared to generic community mental health care. Engagement within AOT is a strong predictor of outcome[116].

There is a striking overlap between risk factors for violence, non-engagement and illness relapse, the criteria for Assertive Outreach, and use of CTO. These include: a history of aggression or violence, involvement with the criminal justice system, substance use, poor engagement and treatment non-adherence, unstable housing, poor social support, and ongoing and persistent symptoms or frequent relapses. This group of people tend to be excluded from generic community services and usually end up spending a long time in hospital (in secure care) or subject to CTO. Alternatively, they can be managed and supported better in AOT. National figures show an 8-fold excess of black people under CTO. Multi-agency working and

[112] Stein L, Santos AB (1998) Assertive Community Treatment of persons with severe mental illness. WW Norton & Co.
[113] Marshall M, Lockwood A (2001) Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 2011, Issue 4. Art. No.: CD001089. DOI: 10.1002/14651858.CD001089.pub2.
[114] Kent, A., & Burns, T. (2005). Assertive community treatment in UK practice: Revisiting setting up an Assertive Community Treatment Team. *Advances in Psychiatric Treatment, 11*(6), 388-397. doi:10.1192/apt.11.6.388
[115] Killaspy, H, Bebbington, P, Blizard, R, Johnson, S, Nolan, F, Pilling, S, King, M. (2006) The REACT study: randomised evaluation of assertive community treatment in north London. BMJ, 332, 815-8120.
[116] Paget, A., Meaden, A., & Amphlett, C. (2009). Can engagement predict outcome in Assertive Outreach. Journal of Mental Health, 18(1), 7381.

relationships with agencies outside the health system, such as police and criminal justice, are prioritised in most AOTs.

AOT models of care and treatment have been successfully implemented in London for African-Caribbean origin service users aged 16-25 with positive outcomes. Evidence from one such initiative shows that a BME specific service for people with complex mental health problems can be successful with people seen as 'difficult to engage'[117]. BME specific options to address multiple social disadvantages in the context of mental illness have also been pursued successfully by the BME voluntary sector in the past[118]. This suggests that assertive outreach services can be highly effective in engaging currently disaffiliated group of BME service users with severe mental illness[151] and minority ethnic groups more generally[119].

We propose a bespoke, intensive, person-centred, and culturally informed package of community mental health support and care for people with SMI from BME communities in Croydon, modelled on PACT and AOT. This culturally bespoke AOT (for black people with SMI) must be embedded in the local assets of the black communities and draw upon the material and social resources of the community. The service should be commissioned and provided jointly with local BME community agencies. Services based in the community and managed by the community (the voluntary, community and social enterprise sector) are more likely to develop relationships of trust that promote access to mental health services for diverse communities[120]. This proposal is consistent with the recommendation of a recent independent investigation into treatment and care provided at SLaM, that a new care pathway be developed by the Trust for submission to the CCG to provide treatment and onward referral for patients with complex mental ill health and co-morbid substance misuse[121].

People from minority ethnic communities often see concepts such as 'recovery' within mental health services as a professionally led process, rarely adapted, or refined to address their needs. Such concepts do not resonate with the definitions and meanings used and valued by diverse communities[122]. Models of recovery within local black community agencies are more likely to integrate cultural and linguistic expressions and experiences as well as the importance of social factors that underpin wellbeing.

Actions

A small, specialist mental health team would be commissioned, using the AOT model, to support and treat BME service users with SMI, presenting with a 'confluence of complexity'. Specific criteria for inclusion in this service will be the same as for AOT.

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[117] Reports on Antenna Outreach, an innovative service that includes assertive outreach, community-based rehabilitation, and education schemes, a 24-hour crisis line, a volunteer group, primary prevention, and the development of the capacity of mainstream services to allow access to people with mental health problems. It targets African and African-Caribbean service users aged 16-25 who are difficult to engage or who have complex mental health problems. McKenzie, K (2005) Mental Health Review, 8(3), September 2003, pp.16-21. See also, https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/out-of-maze-reaching-supporting-londoners-severe-mentalhealth-problems-publication-angela-greatley-kings-fund-1-november-2002.pdf

[118] http://www.opportunitynottingham.co.uk/uploadedfiles/documents/39-1569928209-final_awaaz_report._sep_2019._.pdf [151] Dissanayake, N (2019) Good partners – why we need assertive outreach teams now more than ever. https://www.centreformentalhealth.org.uk/blog/centre-mental-health-blog/good-partners-assertive-outreach

[119] Yang J, Chow W, Law S et al (2005) Best Practices in mental Health: Community Treatment for Persons with Severe and Persistent mental Illness in Ethnic Minority Groups. Psych Services. DOI: 10.1176/appi.ps.56.9.1053

[120] Bignall T, Jeraj S et al (2019) Racial disparities in mental health: literature and evidence review. London. Race Equality Foundation https://raceequalityfoundation.org.uk/wp-content/uploads/2020/03/mental-health-report-v5-2.pdf

[121] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2021/08/Independent-Investigation-Mr-X-and-Mr-G.pdf

[122] Kalathil, J (2011) Recovery and resilience: African, African Caribbean and South Asian women's narratives of recovering from mental distress. London: Mental Health Foundation and Survivor Research.," Archive of mental health recovery stories. https://mentalhealthrecovery.omeka.net/items/show/80.

There are well established criteria for inclusion in AOT. These are based on early research on PACT and the sub-group of people with SMI most likely to benefit from intensive, long-term care, treatment and support.

Department of Health (2001) Policy Implementation Guide. London: Department of Health.

- Diagnosis of SMI
- History of violence or offending
- Risk of self-harm or self-neglect
- Poor response to previous treatment
- Dual diagnosis
- Detention under the Mental Health Act 1983 in past 2 years
- Unstable accommodation or homelessness.

The following criteria will be applied for identifying BME service users for inclusion in the new service in Croydon:

- African/African Caribbean background
- Diagnosis of SMI
- History of violence or offending
- Risk of self-harm or self-neglect
- Poor response to previous treatment (clinical and social outcomes)
- History of disengagement
- Substance misuse
- Two or detentions under the Mental Health Act 1983 in past 2 years
- On CTO for > 2 years
- Unstable accommodation or homelessness

The precise number of people who will benefit from this intervention in Croydon is difficult to estimate without more detailed analysis of service use data in relation to ethnicity and SMI. During the Croydon EMHIP consultation process with BME community organisations and clinicians at SLaM, it was suggested that there is a core group of service users under the care of SLaM who may meet the criteria for AOT. Currently, they are under the care of CMHTs (mostly under CTOs) or detained in SLaM inpatient wards (with a longer than average length of stay) or other secure care facilities.

<u>The new service will provide the following:</u>

- Intensive support, care, and treatment for young black men with a diagnosis of SMI, a history of multiple admissions, complex risk, poor treatment response, co-morbid substance misuse, service disengagement and non-compliance with treatment, unstable social circumstances, and involvement with the criminal justice system.
- The service will be co-produced and jointly 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.
- Local BME community members will be recruited as part of the team to provide personal support, mentoring and social inclusion.
- Priority intervention will be around engagement and developing a trusting relationship using an assertive outreach approach.

- Engagement will not be conditional on treatment adherence – a policy of 'no case closure'.
- Multi-disciplinary team working, 'black on black' service options, in the form of a black-led service located outside the formal mental health system.
- Joint working, where necessary, with non-health service agencies, such as the criminal justice system, probation, police, and prison.
- Specific interventions relating to substance misuse and risk reduction.
- Emphasis on community-based psycho-social rehabilitation, education, vocational and peer support work.
- Social inclusion strategies, such as engendering social purpose through mentoring schemes.
- Re-integration with family/social networks, family-based interventions.
- Access to 24-hour crisis support and intervention

Key elements of the assertive community treatment model

- A core services team is responsible for helping individual patients meet *all* their needs and provides the bulk of clinical care.
- A multidisciplinary community mental health team.
- Improved patient functioning (in employment, social relations, and activities of daily living) is a primary goal.
- Patients are directly assisted in symptom management.
- The ratio of trained staff to patients should be small (no greater than 1:10 in this proposal).
- Each patient is assigned a named staff member (professional) responsible for ensuring comprehensive assessment, care, and review by themselves and by the whole team.
- Treatment plans are individual to each patient and may change over time.
- Patients are engaged and followed up in an assertive manner.
- Treatment is provided in community settings.
- Care is continuous both over time and across functional areas (for e.g., in hospital, prison etc).
- No 'case closure'.

Resources/staffing

Clinical staffing will follow a high intensity ACT/AOT model: 1:5 staff/patient ratio for case work. There will be specialist input from a consultant psychiatrist, psychologist, social worker, OT. A key element of this service is the recruitment of people from local black communities as Mental Health Support Workers. They will be people with life experience or lived experience of mental health problems who can act as mentors and role models. The following is an example of a successful AOT currently operating in a multiethnic, urban setting (Leeds) for a total population of 750,000. The resources are split between two AOTs covering two halves of the city[123].

Annual cost of AOT (2020 figures)

[123] Data from Tom Hitchen-Loudon, Manager, Leeds AOT, 22/2/21

Total annual costs Pay
£1,164,829

NonStaffing from (pay WTE NHS pay scale)-Pay £126,994

- 1 x Consultant Psychiatrist
- 1 x Band 7 Clinical team manager
- 12.2 x Band 6 nurses
- 5.62 x Band 3 HSW
- 2 x Band 6 OT
- 11 x Band 5 OT x Band 4 admin
- 1.43 x Band 3 admin
- 0.5 8C Clinical psychologist
- 0.35 8B Clinical psychologist

Staffing (from non-pay)

- 0.3 x Band 4 equivalent drug and alcohol Harm reduction Worker (3rd Sector) (21,121)
- 0.20.3 x Band 4 equivalent homeless prevention worker (3rd sector x Senior Grade Social Worker (Leeds City Council) (33,015)) (15,749)

Employed by their respective agencies (i.e., non-NHS) and contracted to work in the team.

Leeds AOT has 155 – 160 people on their case load. There are 2 teams covering east and west of Leeds, with the staffing split between the two. The staff/patient ratio (caseload) is set at a maximum of 1: 12 pro rata, full time equivalent.

In Croydon, we will adjust the staffing in AOT to include Community Mental Health Workers, recruited from the local black community, especially black men who could provide mentoring and support with the personal development of the young people on the caseload of the team. The service will be closely linked with local black, community assets and ensure collaborative working with all relevant support structures and agencies working with young black men in Croydon.

Outcomes

- Rehabilitation and recovery of a core group of young black men at risk of institutionalisation, prolonged detention, and high risk of criminal recidivism.
- Reduction in hospital-based and coercive care for black people, who are frequent users of high intensity services.
- Reduction of risk of co-morbid alcohol/substance misuse.
- Diversion from the criminal justice system.
- Prevent transition to secure/forensic care and out of area placements.
- Improved engagement and positive clinical and social outcomes.
- Improved functioning and social integration of young people with SMI and complex history.
- Re-engagement and re-integration with families and the local community.
- Cost savings in mental health care, through reduced use of hospital beds and better social recovery

Intervention 5: Culturally Capable Workforce

Health care providers and health systems contribute to and maintain ethnic and racial inequities in the way services are organised, and care and treatment provided. This is often compounded by the lack of capability

in the workforce (power or ability) at every level to meet the health care needs of people from minority ethnic groups. Organisations, such as the NHS, that are responsible for providing healthcare, may not have the competency (the ability to do something successfully or efficiently) to ensure high quality and appropriate care and treatment for the diverse communities they serve[124].

Cultural capability and competency are broad concepts with various definitions drawing from multiple frameworks (for example, cultural awareness, safety, respect etc)[125] and varying interpretations within and between countries. By and large, they refer to the skills, ability, values and knowledge of people providing health care for culturally diverse communities.

All previous guidance and policies on improving mental health care for BME communities in England have identified the importance of improving cultural competence within organisations and the workforce to deliver effective, equitable care and treatment[126]. This includes the commitment to increasing BME representation in the workforce (reducing the current discriminatory structures operating at every level), ensuring culturally informed clinical practice and organisations able to serve culturally diverse communities, and reducing ethnic inequalities in service experience and outcomes. Actions to reduce ethnic inequalities in mental health are unlikely to be successful without equipping the workforce with the required capabilities related to ethnicity, race and racism and culture. Cultural competence at service and organisational levels can be measured by the commitment and plans to ensure ethnic monitoring, specific evaluation of service outcomes, and accountability and ownership in reducing ethnic inequalities. Understanding and addressing racism both at an institutional and personal level – how racism impacts on mental health and wellbeing (of both service users and staff) and impedes appropriate, equitable care – is an important feature of a culturally competent organisation and workforce. Training the workforce to improve their cultural capability/competence is accepted as part of a larger mosaic in creating culturally responsive services[127,128].

Cultural competence in this context 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"[129]. Cultural competency training is best conceptualised as a systemic, 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 dynamics resulting from cultural differences, the expansion of cultural knowledge, and adaptation of services to meet culturally distinct needs[130]. Acknowledging and addressing racism at an individual as well as organisational and

structural level is a pre-requisite in ensuring a culturally competent organisation and services. Cultural competence training is increasingly adopted by many organisations to improve the capabilities and skills of staff, including the recognition of service users' cultural background in order to develop skills, knowledge,

[124] Curtis, E., Jones, R., Tipene-Leach, D. et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 18, 174 (2019). https://doi.org/10.1186/s12939-019-1082-3

[125] Truong, M., Paradies, Y. & Priest, N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res 14, 99 (2014). https://doi.org/10.1186/1472-6963-14-99

[126] For example, Inside /Outside, DRE and JCPMH all made specific recommendations for investment and training in making mental health workforce culturally competent.

[127] Department of Health (2005) Delivering Race Equality in Mental Health Care. An action plan for reform inside and outside services and the Government's response to the Independent Inquiry into the death of David Bennett. London: Department of Health.

[128] Bennett J; Kalathil, J; Keating F (2007) Race Equality Training in Mental Health in England: Does One Size Fit All? London: Sainsbury Centre for Mental Health.

[129] Cross T, Bazron B, Dennis K et al (1989). Towards A Culturally Competent System of Care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

[130] Betancourt JR, Green AR, Caprillo JE et al (2003) Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118: 293-302.

and policies to deliver effective treatments[131]. However, there is no agreed model or programme for cultural competency training in mental health.

Underlying such an approach is the belief that services tailored to culture are more inviting, encourage ethnic minorities to access treatment, and improve their outcome once in treatment[132]. This approach is particularly relevant in organisations and services where there are ethnic or cultural disparities in service experience and outcomes. Services should be competent in working with diverse cultures, especially in areas like Croydon with its huge cultural diversity.

Cultural competence, understood in this way, 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"[133]. The aim of training is to transform the organisation and delivery of all mental health services to meet the diverse needs of patients[134]. This overlaps and complements other health care improvement priorities[135]. Specific training in cultural competency is required to make services more appropriate and relevant to the needs of minority communities and to ensure that the workforce has the necessary competence to engage with service users in a positive and productive way.

The Five Key Interventions of EMHIP comprise specific actions at the level of community, organisation, and services. The development and successful implementation of these actions and their integration within mental health services in Croydon depend on the relevant organisations (SLaM, primary care, and the CCG) having the cultural capability and competencies to address the needs of culturally and ethnically diverse local communities.

There have been several previous attempts to introduce cultural competency training in mental health services. However, much of this was limited to particular staff groups (for example, front line staff). Routinely commissioned capability training has largely been ineffective because these have not been part of integrated programmes of change and have failed to address deep seated organisational culture and attitudes. Unfortunately, cultural competency training in the NHS has not been subject to systematic or rigorous evaluation (nationally or locally) for its impact on key service outcomes for BME service users or staff.

As part of EMHIP, we propose a programme to improve the cultural capability of mental health services in Croydon. This will be part of the current commitment in the local NHS systems and organisations to develop appropriate (anti-racist) policies, programmes, and clinical practice that will address and correct ethnic inequalities in access, treatment, and outcomes[136]. A key element of cultural capability - ensuring culturally appropriate and culturally safe clinical practice – will be addressed through a programme of cultural competency training of the workforce.

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[131] Sue D and Sue D (1990). Sue, D. and D. Sue. Counselling the Culturally Different: Theory and Practice, 2nd edn. New York: Wiley, 1990.
[132] Kilshaw S, Ndwega D, Curran J (2002) Between Worlds: interpreting conflict between black patients and their clinicians. Health Action Zone, Lambeth, Southwark &. Lewisham
[133] US Department of Health and Human Services (2001) Mental Health, Culture, Race and Ethnicity: supplement to Mental health: a report of the Surgeon General Rockville MD.
[134] Bhui, K., Warfa, N., Edonya, P. *et al.* Cultural competence in mental health care: a review of model evaluations. *BMC Health Serv Res* **7,** 15 (2007). https://doi.org/10.1186/1472-6963-7-15
[135] Agency for Health care Research and Quality (2014) https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/culturalcompetence_research-protocol.pdf
[136] Bennett J; Kalathil, J; Keating F (2007) Race Equality Training in Mental Health in England: Does One Size Fit All? London: Sainsbury Centre for Mental Health.

Ensuring culturally capable organisations

There are no readily available or uniform models of a cultural capability training programme. While the key elements of such training are understood, they require to be developed and refined further, depending on local conditions and context. It is also important that local BME communities as well as the workforce are involved in identifying priorities for training/change and developing the training. Any training should be subject to evaluation, not only to measure the impact but also as an opportunity to further develop and improve it.

Actions/functions

- A programme of cultural competency training of mental health workforce in Croydon will be developed through a process of co-production, involving local BME communities, BME organisations, service users and carers and BME staff.
- This will be introduced in SLaM (Croydon working age adult mental health services).
- Audit and review current training in relation to cultural competency and race equality at SLaM and align this programme of cultural competency training with similar initiatives and programmes.
- Training will be mandatory and subject to monitoring and evaluation.

Resources

- Resources will be required to: (i) lead, facilitate and accomplish the development of a cultural competency training programme; (ii) audit and align existing programmes and relevant training at SLaM (Croydon); (iii) deliver training systematically across Croydon mental health services; and (iv) provide effective ongoing monitoring and evaluation of the outcome of the training programme.

Outcomes:

- A capable workforce that can provide appropriate, culturally congruent, and safe mental health care for diverse communities in Croydon.
- Improve clinical care and outcomes for BME communities in Croydon, including better person-centred care.
- Increase organisational capability in relation to race, culture, and difference.

- Address unwitting/unconscious racism and structural barriers to equal care in Croydon mental health services.
- Help address the differential care trajectories and outcomes, according to ethnic and cultural differences in Croydon.
- Increased support for BME staff in Croydon mental health services and their active engagement in the care and treatment of BME people.

SECTION 4
RECOMMENDATIONS AND WAY FORWARD

1. The Key Interventions to reduce ethnic inequalities in mental health care and services in Croydon, as set out in this paper, should accepted fully and approved for implementation across the mental health systems in Croydon as a priority.

2. As part of the implementation process, a further round of stake-holder consultation, including BME communities in Croydon, service users and carers, local voluntary and community sector organisations and NHS partner agencies, including South London and Maudsley NHS Mental Health Trust, should be commissioned and completed within 4 to 6 weeks. The purpose of this is to share the intervention plans with the community and NMS stakeholders, receive feedback and comments, provide a further iteration of the final report, and identify potential opportunities and challenges to the full implementation of Key Interventions across systems and communities in Croydon.

3. To maximise impact and ensure whole system change, the Five Key Intervention of EMHIP Croydon should be considered as one integrated programme of service improvement. The impact of individual interventions will be considerably weakened and unlikely to be sustained if they are not implemented as an integrated change programme.

4. The Key Interventions set out here are designed to make best use of available resources, both within the specialist mental health system and in the community. The success of this will depend on ownership, commitment, and involvement by all stakeholder groups. A coproduction model is essential to further develop and implement these changes. This approach should be embedded throughout implementation.

5. The Five Key interventions are, primarily, clinical/service interventions across the current mental health care pathways. Therefore, the implementation process should be owned and driven by the relevant clinical services (SLaM, primarily). This should be done in close collaboration with and involvement of local BME communities and BME service users and carers.

6. This programme should be implemented systematically across Croydon and the process and outcomes subject to ongoing monitoring and evaluation from the start.

7. As the interventions are implemented, there should be opportunities for further fine-tuning and adaptation to the local context and needs as required. The coherence and fidelity of each of the programmes should be maintained for optimum benefits.

APPENDIX 1 INDIVIDUAL MEETINGS & FOCUS GROUPS - CROYDON

Section 1: Interviews

A series of individual interviews (1:1) were conducted with a wide range of stakeholders in Croydon. They included service users and carers of local mental health service, BME community leaders and activists, people working in the mental health community and voluntary sector, faith community leaders, managers and clinicians from the NHS organisations (mental health commissioning, primary care, public health, and South London & Maudsley Mental Health Trust (SLaM), and local councillors.

The purpose of these interviews was to gain an understanding of local experiences and views in relation to BME mental health in Croydon. The interviews were asked about what they saw as major challenges in addressing to BME mental health problems in and, more specifically, how to reduce ethnic inequalities in mental health care in Croydon.

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 areas of interest relevant to the interviewee. Notes were taken during the interviews. The interviews were conducted by SPS with interviews lasting up to 90 minutes.

Interview findings

The findings emerging from the interviews are summarised in two sections, relating to community participants and NHS / SLaM staff.

- Community:

1. "No one is listening".

There was a general sense of disempowerment conveyed through an overwhelming sense of failure by the local NHS services to take BME mental health seriously. While the problems facing BME communities are "well known" and "widely shared" these concerns are not taken seriously and not acted upon. People generally felt they had "no option" but "just put up with" what is on offer. There is no confidence that the views of the community, that of BME service users and carers will be listened to – "too much talk but nothing happens". There is "no real understanding of what we are having to go through", as a community and as individuals within the mental system.

2. "No respect"

The service experience of many of the black people was negative. On top of the list of complaints was that BME people felt they were not shown "respect" when they came into contact with mental health services. People noted a general failure within the current system "to listen to our stories" and that service providers generally "failed to connect the dots". This engendered lack of individual or collective agency "in getting things right for us" and erosion of dignity. Carers in particular spoke about being marginalised and excluded from care and treatment, especially in inpatient settings.

3. "Confusing"

The community mental health services (teams) in Croydon are described as "confusing"; people do not know how to navigate the complex system of mental health care. There are "too many teams but not able to help when you need it". People working the community and voluntary sector as well as GPs thought that the current service structure as "byzantine", hard to make sense of, "constantly changing" with "too many exclusions". Individual care (particularly long-term care, is often fragmented with "nobody in charge". There is a consensus that crisis and urgent care arrangements are "a complete nightmare", most people left with no option other than to "pitch up at the A&E" or to call the police. "It is often impossible to get help when you need it".

4. Person, Place and Purpose

Current mental health services are remote and "hard to get", both at the primary and secondary care level. There are too many barriers and "lots of push back" when people try to get help – "it is never easy". The services on offer are not "person-centred", especially "if you don't fit their model", "they don't see you as people". Mental health teams do not recognise different needs of different communities or the diversity of local challenges – there is a strong preference for more localised (and locally connected) services.

5. Disconnect between SLaM and community

Statutory services, even community mental health teams, are seen as "completely disconnected" from local communities. They rarely interact with BME community resources or seek to involve families or he broader community in delivering care and treatment. Usually, "they are far too busy to talk to us". Most of the "community" teams are based in the local psychiatric hospital where most of the interactions with service users and families take place. The teams "are not really part of our communities". All this contributes to "lack of trust" in statutory services, "they do what they do which is mostly about medication".

6. CVSA

Without exception, those working in the community and voluntary sector complained about lack of investment in BME mental health, absence of any strategic plans or co-ordination and *ad hoc* funding of community services. As a result, BME specific services in the CVS are fragmented, at risk of duplication and often means "too little or too late". Communities and voluntary agencies are pitted against each other "competing for the small amounts of funding available". Community and voluntary sector leaders are rarely involved in mental health planning or policies – "never at the big table". People who use the CVS services rate their experience very highly and there is a strong desire for more of such services – "people who understand what is going on who we can trust" – "we can do a lot better by ourselves, but all the money is in the system".

7. Children and Young People – the real crisis in the community

Croydon is facing "a huge challenge" in relation to the mental health, wellbeing, and safety of young people in the borough, especially those of African and African Caribbean heritage. There are long standing concerns about youth crime, drug use, schooling, children's services and a host of adverse childhood experiences that make young people highly vulnerable to poor mental health. The children's services in the borough are seen as "broken", "failing" and "not fit for purpose". There are very few mental health resources to support BME children and young people. This is seen as "a time bomb" and as "the start of a conveyor belt" that will end with more and more black people becoming mentally ill and, in the future, needing long-term psychiatric care.

- NHS staff (SLaM)

1. Croydon is an outlier

Croydon is one of the four boroughs covered by SLaM as part of south London mental health services (including Lewisham, Southwark and Lambeth). Staff working in Croydon generally believe that Croydon is an "outlier" within the Trust services, described as "the poor relation", with less funding and given lower priority than the other boroughs. As a result, relatively speaking, there is less attention being paid to ensuring that local services are fully resourced. This has been "a historical problem" and the fact that Croydon is under a different CCG to other boroughs presents an additional challenge.

2. Disconnected from the community

Staff at SLaM recognise that the mental health teams in Croydon are not fully integrated in the communities that they serve. Part of the problem is that most of the teams are borough-wide (total resident population of over 380,000) which make it difficult to develop and sustain meaningful community connections, except across organisational lines (for example, local authority arrangements). This precludes local integration (neighbourhood, place, PCN etc) or working with specific communities or joint working with local community assets. The teams are seen as 'too big, too diffuse" and organised around service functions (for example, assessment, long term support, home treatment etc) rather than configured around local community or population needs. The teams are also remote from the local communities, working mostly from institutional settings (central site, Bethlem Royal Hospital) with "no real community footprint". This means "community care is only on paper, not in actual practice".

3. Lack of focus on BME

There is general agreement that, currently, there is no focus on the specific needs of BME communities or the unique challenges faced by BME service users and their families. Most staff recognise that there are significant ethnic inequalities in terms of service access, experience and outcomes in Croydon but are unclear what can be done about these and unaware of any plans to improve BME mental health care. Many people share a sense of helplessness in relation to the treatment of black people, acknowledging that "there is not much we can do" and see the challenges black patients face as resulting from larger societal problems.

4. Service model – one size fits all – no choice

Most of the staff accept that the services they offer should be culturally informed i.e., that it is important to recognise and respect patient's cultural background and heritage. However, when it comes to dealing with / helping people from diverse cultural backgrounds "it is the same for everyone". There is no flexibility in the system to adapt or diversify services according to individual patient needs and this means "everybody is treated the same". There is little choice and no alternative to "regular, standard" services – "we try our best, but we know it is not the same for everyone". There are some "good things going on" (ward visiting and befriending programme and specific support arrangements for carers were mentioned as examples) but these are limited by a lack of resources.

5. Services and staff set in their ways

Some of the senior clinicians and managers recognise that a major barrier to system change, adapting and improving clinical practice and clinical culture, is the "way we think" and "our attitudes". These are entrenched "we are set in our ways". There is a ready acknowledgement that this has to change (and a willingness to do that) but "very difficult to do" given it is "not a priority for anyone".

6. Workforce pressures – too much, too little

SLaM staff feel they are constantly "under tremendous pressure" because of workforce challenges (vacancies, recruitment problems) and "increasing workload". There is a lack of resources made worse by increase in demand, both in the urgent and acute care pathway and community mental health services; there "less time to do what needs to be done with patients and families".

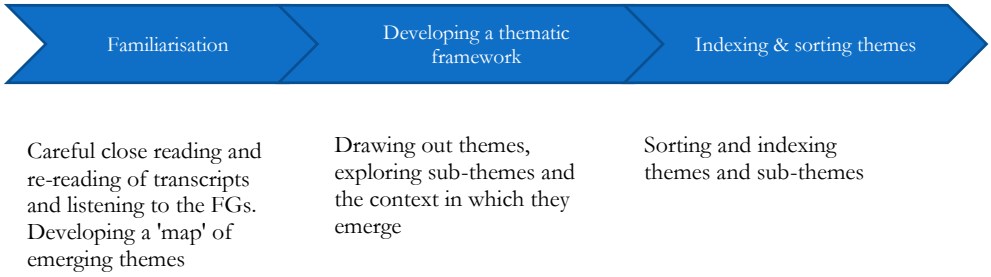
Section 2: Focus Groups

Four Focus Groups were held (by Dr Sashidharan and Debi Roberts), 2 each for service users and young black people.

These groups explored the views, perceptions, and experiences of the participants in relation to mental health and treatment.

The FGs were recorded, and transcripts (1 service user group and 1 young people) were made available for analysis. Thematic analysis was completed by Dr Narinder Bansal & Dr Petros Andreadis.

The purpose of the analysis was to extract key themes using standard qualitative thematic process.



Focus Group Findings
Seven key themes emerged during analysis.

1. Services
2.Society
3.Emotional expression
4.Coping & healing
5.Trauma
6.Illness frameworks and understanding
7.Desired solutions and changes

1. Services
The current model of service access and delivery is perceived and experienced to be rigid and inflexible and not responsive to mental health needs of black people (system focused and not person focused). This includes lack of sensitivity to difficult social circumstances and disadvantage.

- Barriers and blockades to timely access

Participants discussed "barriers and blockades" to timely service provision. Participants feel like there is a mismatch between expectations and reality, between what is advertised as a service and what is delivered. Support, such as talking therapy, is not immediately available. The presence of long waiting lists leaves participants feeling like they are "always being set up" to fail in their healing journey. This is experienced as disappointment and results in a pulling away from services "we pull back and we become reclusive once again and go into our shells". The absence of readily available support is perceived to be particularly hard for the Black community who have had to overcome significant disadvantage and challenges to "step forward" into a service "they've climbed over all that burden, dealt with all the stigma, all the frustrations". Participants also discussed the absence of resources to access support such as time and money.

- "Process you like a piece of shit"

Hospital is not perceived to be a safe place for black people. Hospital is experienced as a place of neglect, dehumanisation where "they process you like a piece of shit". It is a form of social control "locked up and put away from society". Participants experience isolation, loss of autonomy, oppression, and alienation in hospital "you're in another world". Services do not listen to people which exacerbate feelings of panic and distress, and services are experienced as a form of stigma, oppression and testimonial injustice related to their identity as a patient with mental illness "we're talking but they're not listening... the consultants have heard it so many times their ears are blocked, they're not listening". Participants desire to be listened to and heard without judgement but described a culture of care that is robotic and devoid of compassion.

- Reactive services

Participants experienced existing services as reactive rather than proactive. They feel that there is no opportunity for prevention, promotion, or early intervention in relation to mental health. Medication-asfirst line-of treatment is seen interpreted as part of this reactive-service narrative. Patients are perceived to be immediately pathologised and medicated in the absence of a fuller understanding of their context and situation. Mental health system is 'symptoms-focused' as opposed to trying to prevent and understand cause of what has wrong, leaving patients feeling that their needs and concerns are "swept underneath the carpet" until things deteriorate. "The only time we're not swept under the carpet is when we're in the hospital because we've tried to commit suicide and then it's just about doctors seeing your tablets, medication, that's it. But why not catch us now, why not help us now before we get to that stage?". Medication is perceived to be harmful by some "they mess you up". This leads to attempts to avoid the services; primary care services and GPs are seen as "so quick to issue anti-depressants", particularly to ethnic minority communities and in deprived settings. For some, private therapy is seen to be the only solution however access is limited by financial constraints. Other challenges include conflicting advice about medication, or little to no advice about potential side effects of medication and dependency.

- Signposting

Where there are signposting materials (e.g., pamphlets) these are not tailored to BME communities. This includes a lack of positive "survivor" stories from BME communities. Furthermore, services provide poor signposting, with no pathways or resources where patients might access practitioners of a similar ethnic background. Where this has been requested, people are told that no lists or information resources are held by professional bodies to connect service users to professionals of a same / similar ethnicity. Participants express that there are "no services" for people who want to be seen by ethnically similar practitioners.

- The importance of relationships

Participant emphasised the importance of good relationships for timely help-seeking. This includes the importance of having a good GP and supportive family members. As one participant said, having a trusting relationship with her GP was critical to being heard and helped during a crisis - the absence of this could result in her falling through the net "But God forbid if he's not there". Participants expressed the need for better inclusion of family/carer voices in care and treatment.

2. Society

Participants discussed the impact of societal factors on their mental health, wellbeing, and help-seeking for mental illness.

- Community and family culture

Participants talked about the "toxic denial" of mental health and illness within families and communities. Some participants described unsupportive parents and families, with 'older' generations perceived to have a lack of knowledge or understanding of mental health and illness. This leads to illness being overlooked or dismissed. Where there is an acknowledgement of a challenge or illness, this is sometimes interpreted negatively resulting in further distress and isolation "I had a massive breakdown and my parents, forget it, they did not want to know… I was doomed to be the devil child, I was possessed, because of the things I was saying." There was a feeling that stigma and shame around mental illness remains a significant challenge within the community the consequences of which include marginalisation of individuals in families and communities "I had no family member to support me because everybody think I was a bit doolally." This lack of support and validation was compounded for individuals when family members were the source of their trauma. Conversely, some participants experienced their cultures and family structures as therapeutic "thank God for the way how the Black African and Black African Caribbean family structure is built because a lot of the things that we've got so many advantages and disadvantages to the way how we are structured, but as a people when we do need support, a lot of the time we do get that level of support".

- Pressures of life

Young people identified several everyday pressures and stressors including high expectations to adhere to cultural stereotypes of success such as financial, material "being rich and looking good" and academic. These pressures stemmed from parents, peers and social media and were perceived to be toxic for mental health. Socioeconomic pressures to earn money and support the family can leave young people vulnerable to recruitment by drug gangs. Academic hierarchies at school where pupils are segregated by perceived academic ability were seen to be stigmatising and self-fulfilling "the teacher will make you feel dumb, the people in your year will make you feel dumb. So, then you'll keep saying I'm dumb, I'm dumb, and you won't want to try".

- Systemic factors

Participants spoke about the presence of social and racial inequality and prejudice in society. This included personal experiences of racialisation and racial profiling at school. A low level of trust in the medical system and government was identified as an important systemic issue contributing to low utilisation of services in Black communities.

3. Emotional expression

- Facilitating emotional expression

Participants from the young person focus groups discussed the importance of processing and releasing emotions for mental wellbeing. Talking was seen as a form of emotional release however participants emphasised the importance of having a safe, trusting, and reliable person to talk to. Some participants identified their large family networks and school as a source of support and respite from difficult home environments. Participants identified several positive ways to support their peers. This included supportive listening, comforting, distracting, providing love, care, empathy, and compassion, and understanding others through a trauma-informed lens. Young people spoke about the need for safe spaces for emotional and energetic expression and release. Youth centres, sports and arts activities were seen to be positive for mental health. Time in the playground at school was seen to help facilitate physical release of emotions and "let all of that energy out". After school clubs were seen to be an important distraction and form of engagement especially for those whose parents worked during those hours. Engagement in conflict and violence was seen as a negative form of emotional release and associated with the absence of other options.

- Barriers to emotional expression

Home and social circumstances

Participants discussed the struggles of growing up in single parent families and the absence of father figures in the Black community. This was associated with difficult home circumstances, low emotional availability of parent, and toxic parenting. For these young people, home was not perceived to be a safe or comfortable place for emotional talk. Participants also identified generational differences in mental health literacy and coping mechanisms as barriers to emotional expression. This included parents not being able to see the root emotional causes of negative behaviour and the intergenerational transmission of emotional suppression as a way of coping.

School environment

The classroom was experienced as oppressive "you've got to sit down for eight hours a day" and a barrier to releasing emotions for boys "it takes the boy out of you and that masculine part because you don't really get to express yourself unless you're in the playground". For some, schoolteachers were seen as the "last person" to go to for help due to perceived lack of relatability.

Fear of betrayal

Participants described how fear of betrayal and ruptures in trust have negative implications for showing and sharing emotional vulnerability and seeking support. This includes fear of community gossip.

Toxic masculinity

Participants discussed how gender stereotypes influenced emotional expression and suppression. Pressures to "block out your emotions" was felt to be greater for young men who were expected to "man up". Perceived negative consequences of "bottling up" included negative coping mechanisms such as substance use and violence.

4. Coping & healing

- Silent suffering

Participants spoke about mental illness as being an isolating experience. They felt that it was hard to ask for help and find genuine empathy, trust, and care. Difficulties in finding a trusting person to talk to was associated with silent suffering. For some "shutting down" felt like the only option in the face of emotional overwhelm. Participants spoke about the difficult process of acknowledging trauma and that it can take time to come to terms with mental illness. In some instances, it was not possible to verbalise distress. Silent suffering was also discussed as a form of learnt intergenerational behaviour and resilience.

- Saved by faith

Participants spoke about their faith as being grounding and healing. Religion was described as a safety net.

- Work as a distraction

Engaging in work was described as a positive distraction and safety net.

- Try everything

Participants discussed seeking help from multiple sources in the search for support. This included charities including Scope and Mind, music and musical spaces, spiritual social/cultural/ancestral connections and spaces, and alternative medicine. Some of these spaces did not prove to be safe. People with mental illness were seen to be vulnerable to exploitation and abuse by charlatan alternative medicine practitioners.

- Self-reliance and resilience

Participants discussed the importance of resilience and having a resilient mindset. Some participants preferred self-reliance as a coping mechanism and made connections with the resilience and survival of their ancestors. This was seen as a positive and empowering connection.

- Solidarity

Participants found solidarity in connecting with other lived experience. This was seen as a helpful way to break up feelings of isolation and helped provide validation.

- Healing

Participants experienced nature as grounding and healing and found solidarity and strength in connecting with other lived experience. This included participating in this focus group.

5. Trauma

Participant accounts revealed how experiences of trauma cause deep ruptures in trust and lead to a lack of trust in others and silent suffering. Particularly where family members are identified as perpetrators and there is a lack of acceptance and validation of abuse and trauma by close family members "I was sexually abused by my own father… my own mother took his side; I couldn't understand that". In this respect, ruptures in trust and lack of trauma validation had implications for informal support networks and formal help-seeking "I don't know if I will ever trust anyone, because people let me down".

6. Illness frameworks and understanding

Participants discussed the presence of differing interpretations and understandings of mental illness in the community. This included spiritual interpretations of illness and supernatural causes such as witchcraft. Participants in the young people's focus groups attributed spiritual interpretations to ignorance. Some participants felt that faith as a form of help-seeking was not enough and there was a need for medical help too. A service user discussed the difficulties in making sense of auditory hallucinations and navigating informal and formal pathways to support. Service avoidance was attributed to a fear that the "voices" would be pathologised in services "they were just, you know, a lot of my ancestors from the past speaking my language which I'd lost, and I think it did help me in the sense that when I went to Zimbabwe, they were shocked about how well I could speak". The lack of alternative support "you have no-one on earth to help you" left service users vulnerable to abuse by charlatans described by one service user as "spiritual predators". Participants spoke about the power of speaking to God and connecting with ancestral coping mechanisms "our people were enslaved, so you have to think what got them through that? They sang, you know. How did they get through that? And why would you not speak to God? I spoke to God; he was guiding me to safety".

7. Desired solutions and changes

- Pro-active and preventive approach

Desired solutions and interventions discussed by participants include more proactive and preventive support services in the community. This included earlier intervention and education and awareness initiatives that would help address social stigma and strengthen social networks. Participants felt that considerable work would need to be done to help build trust in talking therapy in the community. Young people expressed the mental health benefits of after school spaces such as youth centres.

- Service response

Participants expressed the need for early intervention and equal opportunity in relation to treatment within services. Participants desired a range of treatment choices, as well as more open and frank communication with service providers, especially with respect to conversations about treatment efficacy and medication side-effects. Participants would like to see service providers receive compulsory training in areas of cultural capability and competence, as well better training in person centred care. Participants expressed a desire for easier access to staff from a similar ethnic background. Along with this, GPs should be more aware of resources for BME communities including BME practitioners and should be able to signpost people when requested. Better inclusion of family and carers during care planning was also desired.

- Training

Respondents would like to see service providers receive compulsory training in areas of cultural capability and competence, as well as person centred care. They also desired services to be less medication-focused, and more holistic in response to the healing journey.

- Community asset approach

Participants discussed the need and benefits of using existing community assets and taking a communityservice integrated approach. This included integrating faith approaches with services and training youth leaders in mental health.

- School support

Participants from the young person focus groups felt like there was a need for more mental health conversations and awareness raising at school. This includes more personal support and education on emotional wellbeing, resilience, and healthy relationships. Participants suggested that the creation of safe spaces to talk in person and online and written information for parents on how to support child during mental illness would be helpful.

APPENDIX 2 MENTAL HEALTH DATA - CROYDON

Data

The data presented here are based on cross sectional audit of SLaM mental health teams in Croydon (18 – 65 age group, community, and acute mental health teams). Data was sought on all current cases (as of 31 December 2021) of the following teams, based on routine MHSDS (Mental Health Service Data Set) at SLaM.

Preliminary data analysis was done by Mr John Duffy.

Community Mental Health Teams
MH 1 Croydon MH Primary Care Support Service
MH 2 A&L (Assessment and Liaison services)
i. North
ii. South
iii. Central
MH 3 Treatment services (CMHT for those with mood, anxiety, and personality disorders)
i. Treatment East
ii. Treatment West
MH 4 COAST (Early Intervention in Psychosis)
MH 5 PRT (Promoting Recovery Team – Psychosis)
i. PRT Mayday
ii. PRT THW
iii. PRT East
MH 6 Rehabilitation & Recovery Team
MH 7 CORES (Croydon Opportunities, Reablement and Engagement Service)
MH 8 Touchstone (Personality Disorder service)
MH 9 FISS (Family Intervention Support Service)
MH 10 CIPTS (Croydon Integrated Psychological Therapy Service)
Note: MH3 and MH5 have since been combined as three teams across Croydon, North Central & South.
Crisis & acute inpatient teams
MH11 Croydon MH Liaison Services / General Hospital
MH 12 Croydon
Home Treatment MH13
Inpatients
i. Gresham 1 ii.
Gresham 2 iii.
Tyson West 1 iv.
Fitzmary 1
v. Croydon PICU

In addition to the above, aggregated data in relation to IAPT (Increasing Access to Psychological Therapies) referrals was made available by Croydon CCG (July 2020 – June 2021).

Note:

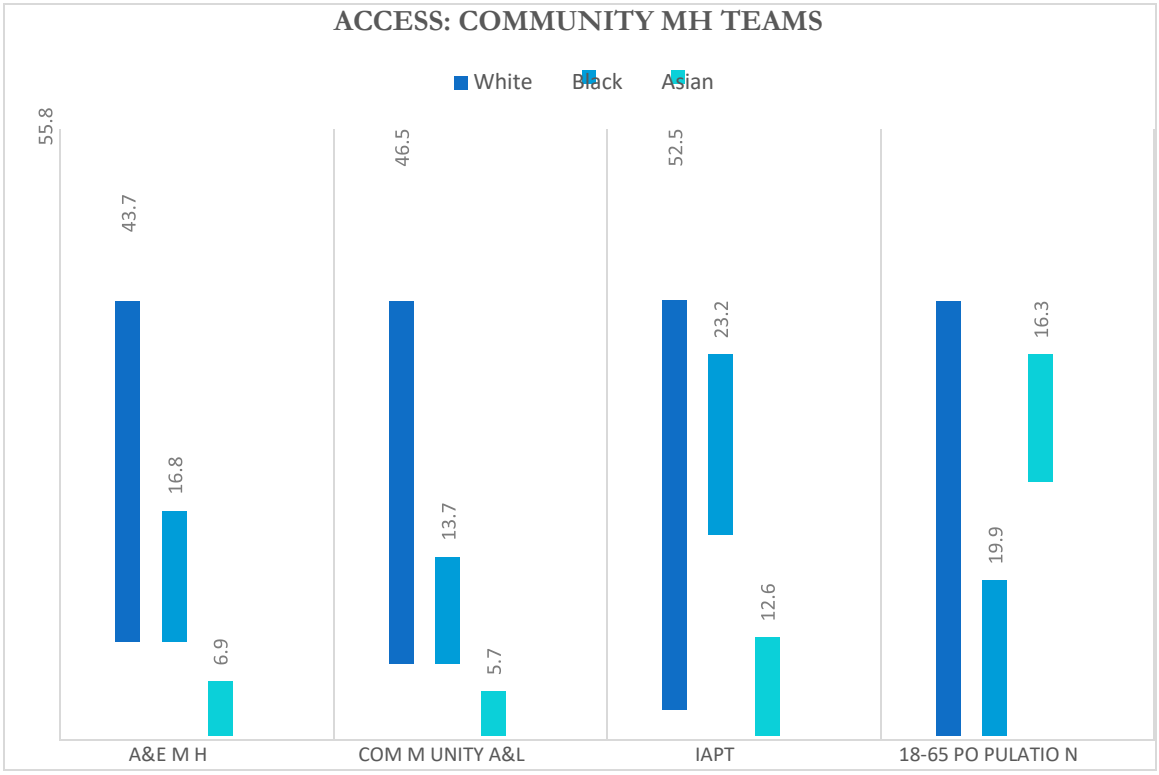
i. No additional data checks have been carried out, all results relate to routine MHSDS data as available
ii. Ethnicity data is missing in 10% of cases (across all teams – as high as 20 - 25% in some teams – see table)
iii. There is also high % of other missing data items (source of referral, type of referral, diagnosis, outcomes etc) which prevents detailed analysis by key variables.

Table
Missing ethnicity data (MHSDS - SLaM)

Team	% Ethnicity missing
IAPT	N/K
A&MH Liaison	24.7
Community Assessment & Liaison	24.9
Home Treatment	19.0
Acute admissions	14.0
Mental Health Act	12.0
Use of restraint	5.6
Community Treatment Service	9.7
COAST (Early Intervention)	22.2
PRT	13.0
Primary Care MH Support Team	1.0
R&R	2.1
Touchstone PD service	14.3
CORES	8.2
FIS – Family Intervention	Data not available
Psychological Therapy service	2.3
All teams (excluding IAPT and Psychological Therapy)	9.5

Community Mental Health Teams

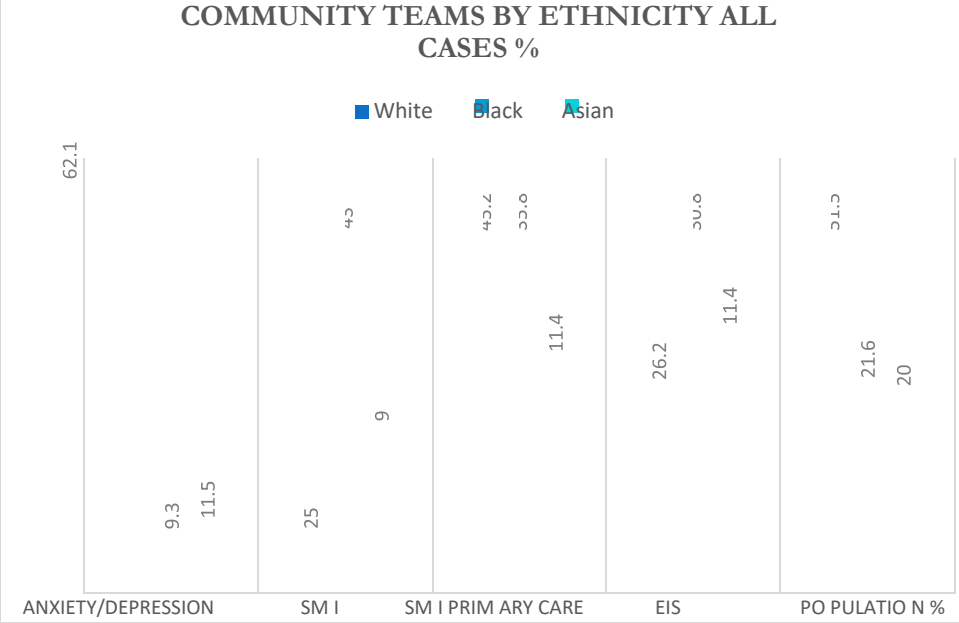
Access: There are different routes into secondary care mental health services at SLaM. The following shows ethnic disparities in access to community mental health teams that usually act as gateways to secondary care services - A&E Mental Health services (crisis and urgent referrals), Community Assessment & Liaison Team and IAPT, compared to the resident population (age 18-65) in Croydon. BME groups are less likely than white people to access to A&E Mental Health and also the Community Assessment and Liaison services. Asian people are under-represented in IAPT services.



Ethnic Group	A&E MH Liaison		Community Assessment & Liaison Team		I APT		Croydon Population Age 18-65 (2011 census)		
	n	%	n	%	n	%	n	%	%
									GLA 2021 projection
White	1261	43.7	780	46.5	4837	52.5	200195	55.1	55.8
Black	484	16.8	230	13.7	2140	23.2	73256	20.2	19.9
Asian	199	6.9	95	5.7	1158	12.6	59627	16.4	16.3
Mixed	126	4.3	74	4.4	843	9.1	23895	6.6	4.8
Other	102	3.5	80	4.7	242	2.6	6405	1.8	3.3
Missing	711	24,7	418	24.9					
Total	2883	100.0	1677	100.00	9220	100.0	363378	100.0	100.0

Data – all cases 2021 (SLaM)
IAPT.CCG data July 2020 – June 2021

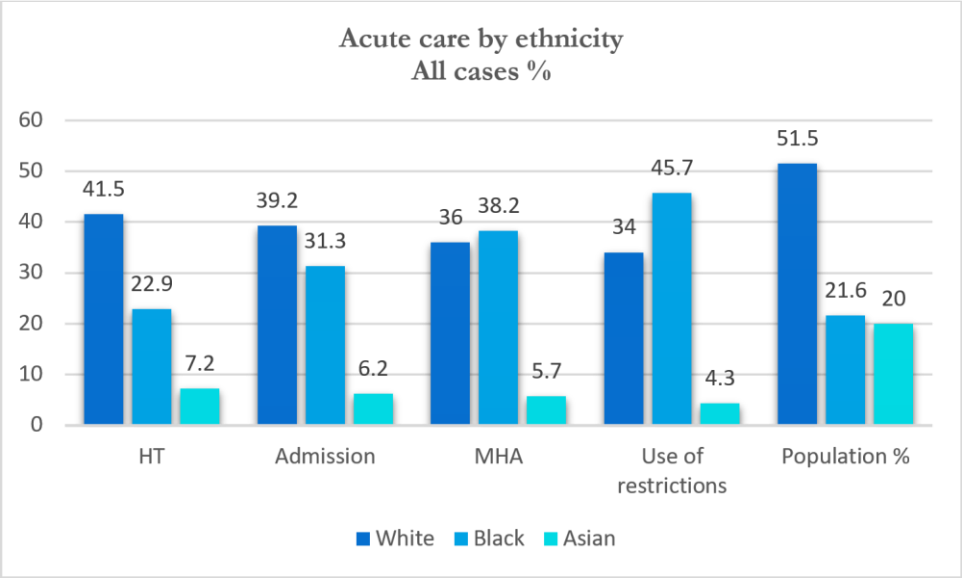
Case load: There are significant ethnic disparities across community mental health teams. There is over-representation of white ethnic group (compared to general population) in community mental health team supporting people with anxiety and depression, but they are under-represented in teams supporting people with SMI. The reverse is true for Black people, with significantly higher proportion of black people compared to other ethnic groups in psychosis services in the community. People of Asian background are under-represented in all services.

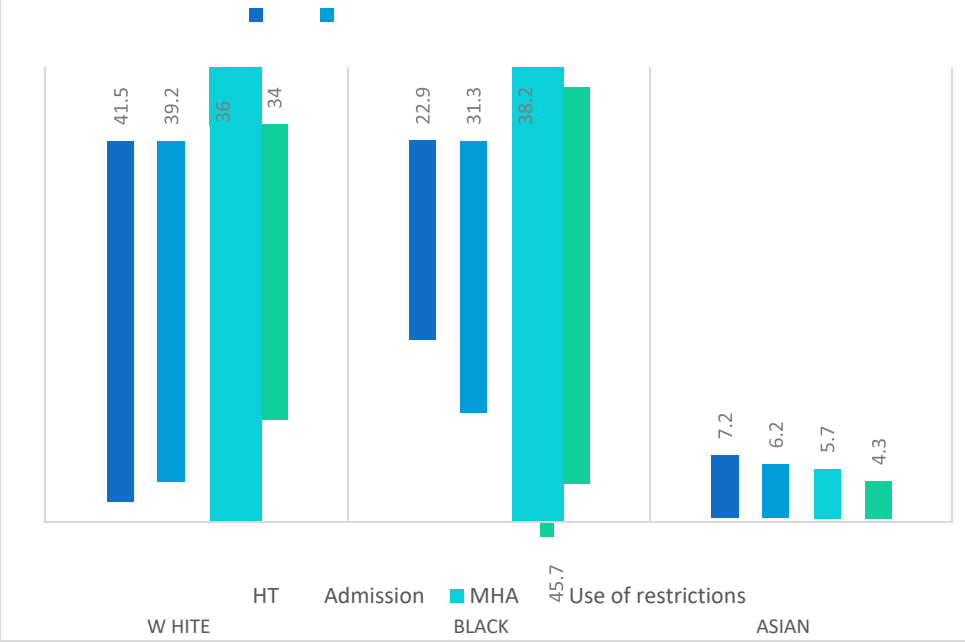


Ethnic Group	Treatment (anxiety & depression)		EIS		Treatment (psychosis)		Primary Care MH Support (SMI)		&R		Croydon population (2011)			
											All ages		Age 18-65	
	n	%	n	%	n	%	n	%	n	%	n	%	2011 %	GLA (2016) 2021 projection %
White	141	62.1	122	26.2	25	25.0	174	45.2	49	50.5	200195	55.1	55.8	51.1
Black	21	9.3	143	30.8	43	43.0	138	35.8	28	28.9	73256	20.2	19.9	21.6
Asian	26	11.5	53	11.4	9	9.0	44	11.4	10	10.3	59627	16.4	16.3	20.0
Mixed	10	4.4	22	4.7	1	1.0	13	3.4	4	4.1	23895	6.6	4.8	5.2
Other	7	3.1	22	4.7	2	2.0	12	3.1	2	2.1	6405	1.8	3.3	2.2
Missing	22	9.7	103	22.2	13	13.0	4	1.0	2	2.1				
Total	227	100.0	465	100.0	100	100.0	385	100.00	97	100.0	363378	100.0	100.0	100.0

Acute care

There are marked ethnic disparities across acute care services, Home Treatment, acute admission, use of Mental Health Act and use of restrictive care. The percentage of Black people in acute care goes up with increasing service intensity (HT → Admission → MHA → Use of restraint). This trend is reversed in white and Asian groups. People of South Asian origin are significantly under-represented across all acute care teams.





Ethnic Group	Home Treatment		Acute admissions		MHA		Use of restrictions		Croydon population (2011)		
									All ages		18-65
	n	%	n	%	n	%	n	%	n	%	%
White	490	41.5	362	39.2	214	36.0	55	34.0	200195	55.1	55.8
Black	270	22.9	289	31.3	215	38.2	74	45.7	73256	20.2	19.9
Asian	85	7.2	57	6.2	34	5.7	7	4.3	59627	16.4	16.3

Mixed	43	3.6	38	4.1	26	4.4	7	4.3	23895	6.6	4.8
Other	68	5.8	49	5.3	33	5.6	10	6.2	6405	1.8	3.3
Missing	224	19.0	129	14.0	72	12.1	9	5.6			
Total	1180	100.0	924	100.00	594	100.0	162	100.0	363378	100.0	100.0

Current cases (point prevalence)

The following table sets out the current case load (30 December 2021) of all the mental health teams in Croydon. This may be taken as the total prevalence (one day) of people receiving mental health care from the secondary care services at SLaM. Excluding IAPT, there are 2882 individuals currently in contact with mental health services, nearly 40% (n = 1139) from BME communities (ethnicity unknown = 9.5%). Based on 2011 census, there are 239, 206 individuals (age 18 -64) in Croydon.

Team ID	Team	Ethnic Groups												Total	
		White		Black		Asian		Mixed		Other		N/K			
		n	%	n	%	n	%	n	%	n	%	n	%	n	%
MH1	Primary Care SMI	156	46.2	122	36.1	37	10.9	9	2.7	12	3.6	2	0.6	338	100.0
MH2	A&L Team	124	44.9	43	15.6	15	5.4	11	4.0	19	6.9	64	23.1	276	100.0
MH3A	CMHT	582	44.9	421	32.5	117	9.0	56	4.3	45	3.5	74	5.7	1297	100.0
MH4	EIS	72	2.3	92	29.8	29	9.4	14	4.5	19	6.2	83	26.9	309	
MH6	R& R	46	51.1	27	30.0	8	8.9	4	4.4	4	4.4	1	1.1	90	
MH7	CORES	45	45.9	32	32.7	7	7.1	3	3.1	3	3.1	8	8.2	98	
MH8	PD	5	71.5	1	14.3							1	14.3	7	
MH9	Family Intervention	Data not available													
MH10	Psychological therapy	54	62.8	12	14.0	8	9.3	6	7.0	4	4.7	2	2.3	86	
MH12	HT	24	37.5	14	21.9	3	4.7	0		1	1.6	22	34.4	64	
MH13	Inpatients	31	33.0	36	38.3	4	4.3	1	1.1	6	6.4	16	17.0	94	
CCG	IAPT	1334	52.3	609	23.9	327	12.8	217	8.5	63	2.5			2550	
All Teams	Total (Excluding IAPT)	1139	39.5	800	27.8	228	7.9	131	4.6	111	3.9	273	9.5	2882	
All Teams	Total (Including IAPT)	2473		1409		555		348		174		273		5432	

IAPT data (CCG) 3 months April – June 2021 (excluding ethnicity Null)

Further analysis

Given the incomplete nature of the data provided, it is difficult to ascertain the extent of ethnic disparities in service and outcomes with any confidence. There are huge gaps in the data in relation to most of the

key variables. For example, diagnosis is missing in over 80% and discharge outcomes 100% in some of the teams (one year data).

Based on the limited analysis (data sets with least missing data), the following trends are identified.

1. Across the 3 CMHTs, 903 out of the 1437 individuals or (62.8% - one-year case load) were referred through the A&E - over three quarters of black people (76.1%) and over half of (54.3%) of white people were referred via the A&E mental health team. Only 8.1% of all cases were identified as being referred via the GP (6.4% black and 9.3% white patients). Source of referral N/K = 5.8%.
2. One in twenty (5.6%) of current cases of the three CMHTs is on a Community Treatment Order (2.9% white and 9.3% black).
3. Based on 2020 data, overall, MHA detention rate in Croydon is higher than national average. MHA detention rate for white people in Croydon is higher than the national average and lower than national average for BME groups (except other ethnicity). However, black people are still nearly three times more likely to be detained under the MHA Act than white people (excluding 12% missing data).

Ethnic Group	Croydon 2021			England (2019/20)
	n	Total population age 1865 (2011 census)	R/100,000	R/100,000
White	214	200195	106.9	73.4
Black	215	73256	293.5	321.7
Asian	34	59627	57.0	104.6
Mixed	26	23895	108.8	214.0
Other	33	6405	515.2	195.6
Missing	72			
Total	594	363,378	162.6	98.1 men 84.4 women

4. Across all community and acute care teams, there is a greater proportion of black people (and an under-representation of Asian people at 7.9%) in contact with services (overall, 27.8% of case load) than in the general population of 18-65 age group (20.2% and 16.4% respectively). The overrepresentation of black people is higher in mental health teams for people with SMI and in acute care.
5. The differential rates by ethnicity in acute and urgent care services in the current audit are similar to what has been previously reported at SLaM (2019/20 data).

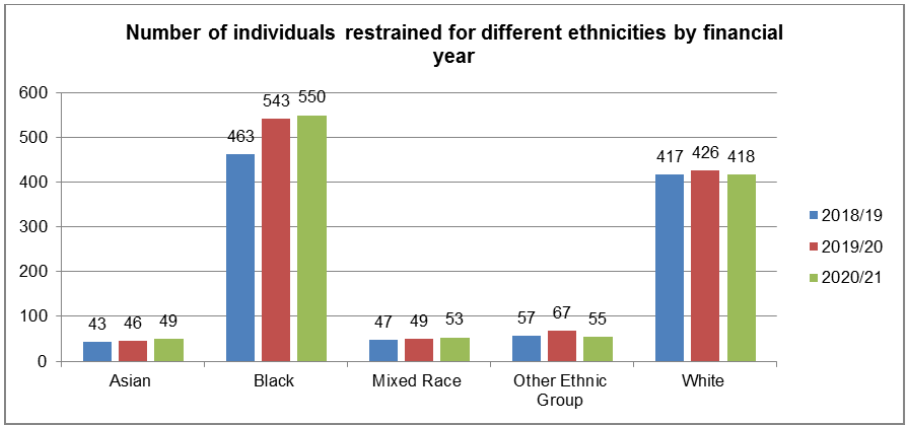
Ethnic disparities over time – acute care 2019/20* and 2021

Ethnic categories	Age 18-65 Population (Census 2011) (%)	Hospital MH Liaison Team (%)			Home ment Treat (%)			Acute admission wards (%)		
			2019/20	2021	2019/20		2021	2018/19	2019/20	2021
White	55.8		51.2	43.7	46.3		41.5	55.1	40.3	39.2
Black	19.9		15.1	6.9	24.6		7.2	20.2	33.9	31.3
Asian	16.3		6.6	16.8	9.8		22.9	16.4	8.4	6.2
Mixed	4.8		2.7	4.3	3.3		3.6	6.6	4.7	4.1
Other	3.3		3.9	3.5	3.5		5.8	1.8	3.5	5.3
N/K	0.0		20.6	24.7	12.6		19.0	0.0	9.1	14.0

*Meeting the public sector equalities duties at SLaM, 2020/21 Croydon Information

Other reported data

According to the latest SLaM Integrated Equalities Action Plan Progress Report (2020/21), the highest of individuals restrained, in each of the previous three years (across all SLaM services) were Black service users. The number of Asian, Black and Mixed-Race individuals restrained increased in 2020/21 while the number of individuals restrained from White and other ethnic groups reduced. Based on the number of individuals admitted to acute care, use of restraints against black people is disproportionately higher than in any other ethnic group.



APPENDIX 3 EMHIP – CROYDON PROJECT TEAM & STEERING GROUP

Terms of Reference

1. Role/Purpose

The Croydon Ethnicity and Mental Health Improvement Programme (EMHIP) is an 'inside-outside' project co-produced and co-led by Croydon CCG, South London and Maudsley NHS Foundation NHS Trust (SLaM), Croydon BME Forum, collaborating with other key Croydon stakeholders (e.g., Public Health, local community and faith groups and charities) and in partnership with Wandsworth Community Empowerment Network

Croydon EMHIP builds on the learning from Wandsworth EMHIP and sits within the Southwest London Integrated Care System administrative area (SWL CCG).

The Croydon EMHIP Project Team will serve as the operational group of the Croydon EMHIP Oversight Panel, which includes the wider group of Croydon stakeholders, and will report to the Southwest London Mental Health Transformation Board

1. Aims

The Croydon EMHIP Project Team aims to perform the following key activities in coordination with SWL system partners:

1. Establish Programme Governance and reporting to the One Croydon Place Mental Health Transformation Programme Board.
2. Provide support for the development, approval, implementation, delivery, and oversight of the Croydon EMHIP business case.
3. Support and oversight of the development of implementation plans for sustainable delivery of EMHIP in Croydon, wider cultural and system change and improvement across Southwest London

2. Objectives and Commitments
   a. Ensure that this group has the appropriate senior-level support to deliver the programme aims (e.g., clinical, financial, commissioning, etc.), and co-opt members as necessary
   b. Develop and finalise the EMHIP Phase 1 scoping exercise, including:
      i. Asset Mobilisation and Alignment
      ii. Project Socialisation and consultation with key stakeholders
      iii. Developing Key Interventions

3. Term

The Croydon EMHIP Project Team will continue for a period of 6 months.

6. Meeting Arrangements and Frequency

The Croydon EMHIP Project Team will meet monthly chaired by Croydon GP Lead (Dr Agnelo Fernandes) who, with support from SWL CCG and Croydon BME Forum will oversee the co-ordination and servicing of the meeting.

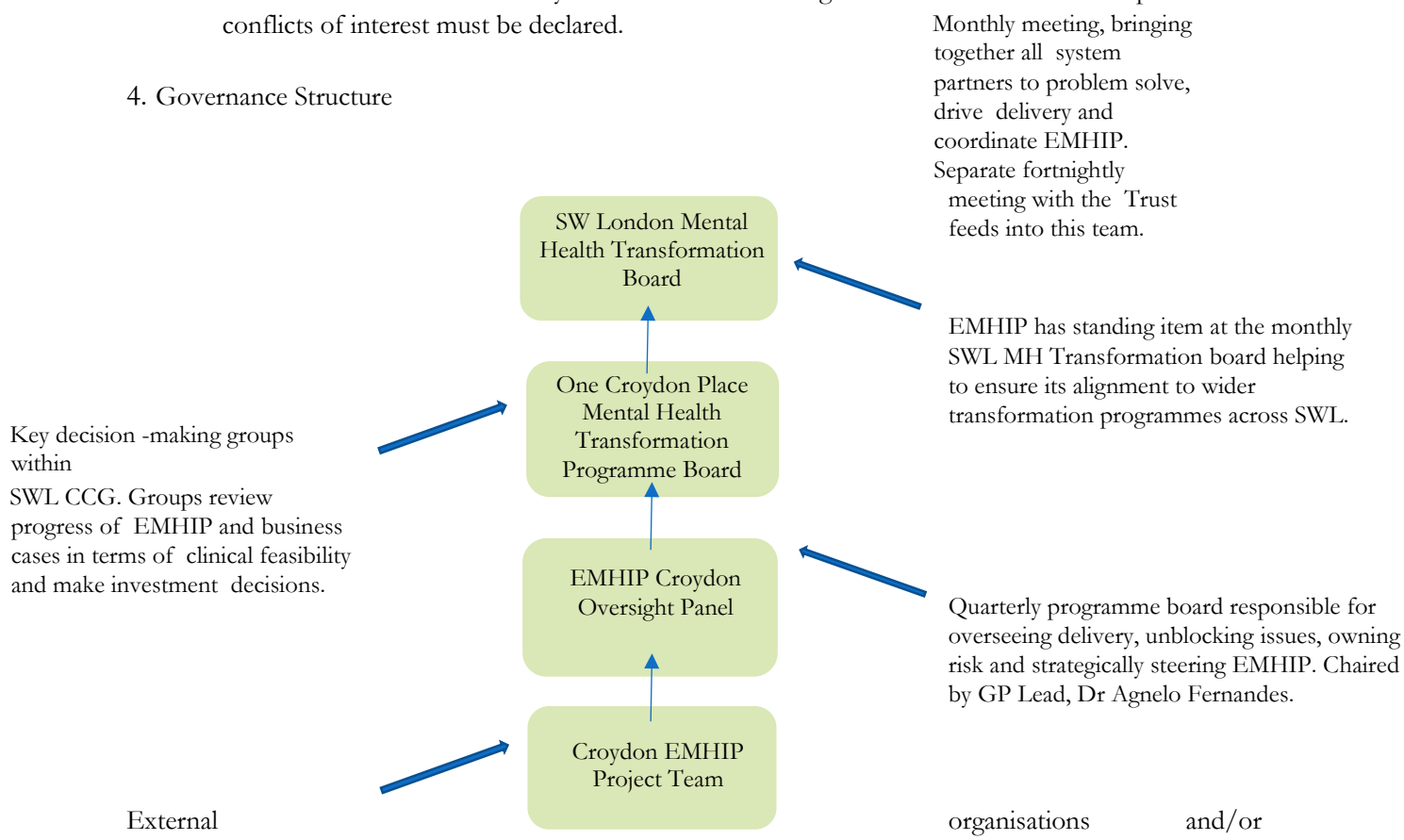
A schedule of meetings will be circulated to Members of the Group.

7. Project and meeting support
   a. Funding for the project and meeting support will be provided by Croydon CCG and SLaM
   b. Administrative support will be provided Croydon BME Forum

c. The agenda will be pre-agreed with the Chair
d. The meeting agenda and supporting papers will be shared with the members of the group at least three working days ahead of the meeting
e. Apologies will be sent in advance to the administrative support
f. Minutes, notes and actions will be circulated within five working days of the meeting.

8. Accountability
a. The EMHIP Project Team will report directly into the EMHIP Oversight Panel
b. Reports will be sent to the One Croydon Place Mental Health Transformation Programme Board
c. Members will be responsible for information sharing between the group and their organisations
d. Confidential items will be clearly identified at the meeting and in the notes and action points. All conflicts of interest must be declared.

4. Governance Structure



External organisations and/or representatives will be invited as and when required to provide relevant expertise, support the work and share good practice.

5. Membership

EMHIP Croydon Project Group

Dr Agnelo Fernandes	Croydon GP Lead, Chair EMHIP Project Group
Dr Dev Malhotra	Clinical Subject Matter Expert Mental Health SW London CCG, Croydon Place
Dr Vaishali Shetty	Mental Health Clinical Senior Responsible Officer, Croydon Place
Andrew Brown	CEO, Croydon BME Forum
Debi Roberts	EMHIP Croydon project co-ordinator, BME Forum
Malik Gul	Wandsworth Community Empowerment Network, Co-convenor, EMHIP South West London
Ruth McKinney	Wandsworth Community Empowerment Network
Claudette Webley	Service User
Ima Miah	Director, Asian Resource Centre, Croydon
Councillor Janet Williams	Croydon Council

Wayland Lousley	Head of Mental Health Commissioning, Croydon
Jo Austin	Senior Engagement Manager, Croydon, SWL CCG
Yewande Adekunle	Adult Mental Health Commissioning Manager
Prof. S P Sashidharan	Consultant to EMHIP
Debi Roberts	EMHIP Lead, Croydon BME Forum
Mathew Kershaw	CEO, Croydon Health Services NHS Trust
David Bradley	CEO, SLaM
Hillary Williams	Service Director, Croydon, SLaM
Dr Kevin Vento	PCREF Lead, Croydon & Consultant Clinical Psychologist, SLaM
Rachael Flagg	Director of Transformation and Commissioning, NHS South West London CCG (Croydon)

EMHIP Croydon Steering Group

Dr Agnelo Fernandes	Chair
All members of Project Team	As above
Beena Ali	MH Lead, Asian Resource Centre, Croydon
Colbert Ncube	Head of Mental Health and Learning Disabilities (Croydon), CCG
Gemma Dawson	Head of Projects & Strategy, Merton CCG/ EMHIP Project Lead
Jayne Thorpe	Deputy Director, Transformation and Long-Term Conditions, SWL CCG
Bishop Delroy Powell	Senior Pastor, New Testament Assembly/ Pastors Network for Family Care/ Wandsworth
Darren Fernandes	Associate Director, Mental Health Transformation, SWLSTG
Imam Shaykh Suliman Gani	Purley Masjid/ Muslim Network for Family Care/ Al-Khaleel Institute/ Chaplain, St. George's Hospital
Naseem Aboobaker	Mushkil Aasaan & The Zakia Centre/ EMHIP Wandsworth Hub #2
Councillor Bernadette Khan	Mushkil Aasaan & The Zakia Centre/ Croydon Council
Claion Grandison	Bishop, New Testament Church of God West Croydon
Janet Campbell	Local Councillor, SLaM Council of Governors