Social Interest Group

April 2016

BAME mental health roundtable Imperatives for action

1. Introduction

In April 2016, Penrose and Neil Stewart Associates hosted a private roundtable, supported by the Social Interest Group.

The central question put forward to participants was:

> **How do we shift from a reactive approach to a planned, informed and educated approach – empowering the Black community, including mental health service users and carers, to take care of themselves in their own communities?**

Senior representatives from agencies across the public and third sector attended. All participants had longstanding professional, academic and personal commitment to understanding and solving the challenge of over-representation of specific BAME communities in the mental health system.

We highlighted the challenge in Penrose services. 82% of our current forensic mental health clients are from BAME communities (predominantly Black African and Black Caribbean) – a figure that has been consistent over the last 10 years.

In opening the roundtable, participants were asked by the chair to comment on what was most preoccupying them about the question we posed, and to name their top imperative for action. The discussion broadened over the course of the roundtable, to identify mutual topics and imperatives.

The roundtable discussion was open and spirited, with contributions from participants that were evidenced and informed by research, professional practice, industry knowledge and anecdotal experience. We thank all participants for their frank insights into this challenge that our society faces and how we move forward, together, to prioritise and end this discrimination.

A note about this document: Penrose are well aware of the very respected body of research and evidence about the over-representation of certain BAME groups in crisis/ high support mental health services. This research has taken place over several decades and has eloquently articulated and evidenced the problem and made recurring recommendations. This research informed our preparation for the roundtable.

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This document is not another report, therefore, with another set of new recommendations. Instead, it is a summary of existing imperatives for action, to be refined further over the course of 2016 in service user and carer focus groups. All findings will help to inform the agenda for our conference and broadcast programme on Thursday 13th October 2016 – where we intend to bring about change through collective action.

To find out more about our conference and broadcast programme, please visit:

www.MinorityMentalHealth.co.uk

2. Topics arising from the roundtable discussion

The following eight topics were identified as imperatives for action at the roundtable. These topics were raised in many contexts throughout the discussion.

8 IMPERATIVES FOR ACTION	
	Evidence
	Cultural awareness and trust
	Influencing
	Education
	Funding and governance
	Service design and delivery
	Courage and prioritisation
	Substance misuse

These topics will be discussed in detail across 2016, at a series of Penrose-hosted service user and carer forums, in order to refine further our collective thinking and define the cross-sector top priorities.

Below is a summary of each imperative, including key points made by roundtable participants.

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2.1 Evidence

“Get your data; use the data to get leaders on board; then do something. Don’t wait for the perfect solution. We are all responsible.”

Qualitative and quantitative data to drive change

The message was resoundingly clear: we have ample data and reams of research, which evidences this ongoing injustice in our society. We do not need more reports; the reports we have articulate and evidence the problem very effectively, proposing many useful recommendations for change.

Roundtable participants commented that leaders may not be receiving the available data, in forms which compel them to take action:

“We have the data, masses of data – but, quite often, the powers that be don’t get to see that data. We need incontestable data that gets through to the top.”

Participants also suggested that leaders may choose to ignore the data:

“The problem is the priority and status given to this topic. There is opposition. People in leadership positions do not agree with these positions.”

Evidencing solutions that work

‘There are fantastic solutions and ideas, but they are not commissioned, both locally and nationally. Parity of esteem – well, this is also about Black priorities not being taken seriously. The work never gets mainstreamed and because of that, it’s hard to provide the evidence.”

Participants described many localised projects and initiatives, which were having an impact, but questions of sustainability and visibility were raised. Participants flagged the need for a national observatory, to build transformation knowledge and capacity – acknowledging that some work was already being done to address this:

“An observatory to make data transparent would be helpful. Local solutions, as great as they are, are not sustainable.”

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Social value, return on investment and reducing the cost base

Quantifying social value and return on investment were raised in the roundtable, with participants discussing local initiatives that were doing this, to good effect. Again, this was about proving the case, categorically, with irrefutable evidence of outcomes and value to society.

Over time, participants agreed there were substantial cost-savings that could be made throughout the public and third sector, through investing in early intervention, wherever possible. This could avoid escalation to expensive and reactionary crisis services, reducing the burden on emergency services. One caveat, however, was that cost-savings should not be expected immediately. The challenge of our governmental system was raised and the time required to solve this problem:

> *"The trickiest part is this: we are caught up in a four year cycle of delivery and this challenge is twenty years long. We need to have the courage to say, "here are the deliverables that are possible in four years, but do not expect to see lower demand and less resources required in four years." In the beginning, it will require the same level of resourcing."*

2.2 Cultural awareness and trust

This topic was raised throughout the roundtable from many standpoints, including: Black identity, ongoing marginalisation and discrimination due to structural racism, racial stereotyping, cultural misunderstandings, and lack of trust from Black communities towards the mental health system (often due to bad experiences).

The subject of cultural differences in how people express emotions was raised, as well as the question of whether the prevailing White culture may, at times, misinterpret emotional expression from BAME individuals who are experiencing mental ill health. Participants felt this was a driver for the over-reliance on restriction and containment, particularly for Black African and Black Caribbean men:

> *"Can we not tell the difference between fear and anger? Disproportionate numbers of black men are arrested under section 136. Disproportionate numbers are hospitalised. There must be something more going on. If it is something as simple as the difference between how people of different cultural backgrounds express fear and anger, then let's admit it, train around it. Let's do something about it."*

There was also discussion about how the socio-political climate for mental health initiatives was good, but this was framed against the backdrop of racial equality becoming less of a political imperative:

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"Since 2000, nothing has really happened around race equality – even though there is legislation. We have to get our house in order around race equality. We need a strategic approach to tackle racism in the mental health system."

The discussion also turned to limiting messages given to sections of society, whether consciously or unconsciously, leading to fear and lack of trust in the system from members of BAME communities:

"If your culture expects you to do well, then you do well. It's as simple as that."

"There's a message of uselessness, given so often to Black people. The survival mechanism is then one of resistance, not cooperation, because the system is out to get you."

"Many Black families are fearful to engage in the system."

2.3 Influencing

Influencing national policy

"There's a lack of joined up thinking at the top, when people are making policies."

Roundtable participants discussed influencing national policy through budget oversight, monitoring and creating an observatory correlating evidence and data (see section 2.1 for more on evidence).

There were also discussions about how to embed the Equality Act, creating a legal imperative for change.

"25 years ago we were saying the same things. Will this drastic inequality for Black African and Caribbean men become a legal issue? Where is the Equalities Act in all of this?

"We had to get the data and say we are going to be challenging you on the basis of the law."

Influencing local government

Roundtable participants also discussed influencing through first adopter programmes in pilot authority areas. Many examples of positive local initiatives were cited.

2.4 Education

Early intervention for prevention in schools

> *"All the evidence shows that where we intervene at the earliest possible point, in schools for example, then things change for the better."*

We must equip primary and secondary education teachers with the skills they need to identify early signs of mental ill health in children and young people, including boys and girls from BAME communities. Through early identification, teachers will be more able to signpost promptly and effectively, as well as buy in the training and support they need to address specific requirements.

Roundtable participants commented on a need for early intervention to prevent avoidable exclusions, highlighting the fact that schools should not be penalised with detrimental statistics for identifying and working with children with underlying mental health needs. Education around prevention of violence and substance misuse (see section 2.8) were also raised, as useful early intervention measures.

There were comments about normalising the experience of school children with additional needs including mental ill health. Wherever possible, children with early symptoms of mental ill health should not face marginalisation in schools, due to a lack of specialist knowledge, skills or resources.

Workforce skills and knowledge

> *"We need to take this challenge on and say this is no longer acceptable to our organisation – then come up with solutions."*

How do we train our frontline and management staff to understand better the issues that Black communities are facing? Roundtable participants felt we must aim collectively for an attitudinal shift within the workforce towards BAME groups who experience this discrimination within the mental health system. To do this, we must develop the skills and knowledge right across the public and third sector workforce.

Possible benefits of workforce skills development include: prevention of common mental health conditions progressing to severe and enduring mental ill health; diversion from crisis services to community/ voluntary services; greater cultural awareness (see section 2.2); and saving resources.

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Influencing communities and wider society

> *"Most people in the public have no idea about what we're talking about today. We need to make this common knowledge, common literacy."*

Participants highlighted the lack of general public awareness about the disproportionate numbers of BAME people within crisis mental health services, most notably Black African and Black Caribbean men.

There were calls to identify digestible data, in order to communicate key messages to the public, via media outlets. Coordinated dissemination of the facts will assist with the desired paradigm shift, where this problem becomes common knowledge and then unacceptable to society.

> *"I cannot see the public tolerating an attitude of 'this is just our lot'."*

2.5 Funding and governance

> *"There is a problem in the way we think about how to turn off the tap of crisis. There is a real debate to be had about a cross public sector strategy."*

Incentives and cross sector commissioning

The discussion covered financial and managerial incentives in services, as well as the creation of key budget pools for cross-sector commissioning from the public and third sector, to reduce duplication and improve effective use of resources.

The approach in Manchester was cited as an example to watch:

> *"On integration, the Manchester Mayor now has £6 billion of health spending. Is that the kind of mechanism we need?"*

Participants concurred that place-based funding was crucial to joined-up strategy.

They also discussed the fact that poorer outcomes for certain BAME communities were not limited to the mental health field, again pointing to the need for cross-sector initiatives:

> *"This happens in so many arenas – education, employment, health, criminal justice – it's just that mental health puts a spotlight on it. There's a very different experience for Black African and Black Caribbean communities, across the board."*

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Personal budgets

Greater user choice through developing personal budget options was also highlighted as a mechanism to force change in the marketplace (see section 2.6 for more on user led services).

2.6 Service design and delivery

> *"Support before a crisis is very important, but accessing that care is next to impossible. People aren't being picked up until they are in a crisis."*

How can services be designed and delivered to turn off the tap of crisis amongst the target BAME communities?

Roundtable participants flagged the need to reduce the dependency upon containment solutions, including the upsurge in expensive bed-based estates and heavy reliance upon medication. Early intervention was highlighted as critical, to prevent avoidable crises. Personalisation of services, involving stakeholders in design and delivery of services, was also raised. Participants also spoke about creating a gold standard for service delivery in high support forensic services, where Black African and Black Caribbean service users were drastically over-represented.

Evidence led services

As highlighted in section 2.1, agreeing the data set then collectively communicating it to all relevant decision-makers and stakeholders, is vital to the development of services, which are fit for purpose and match demand. Commissioners must also be accountable for collecting robust data to inform their service commissioning.

There was also a call for a collective oversight body, to hold health trusts to account in each area.

Sector led services

> *"My most pressing concern is having a joined up approach to delivering services to people with mental health needs. There are many things we can work on together."*

The language of cooperation and collaboration was threaded throughout the discussions. Proactive partnership work was highlighted as an example of where power to solve this challenge lies:

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> *"We can be powerful as the public sector together. We don't need to wait for the government to say you must do this or give us their endorsement. We should be taking our offer to government."*

Community led services

> *"We need to be better informed, collaborating with the local communities and community leaders, to create and design better solutions to prevent this pattern."*

Investing within communities, so they are empowered to come up with the right solutions for themselves was discussed:

> *"My one appeal would be more work going on in the community, more organisations that stop people hitting the mental health system in the first place."*

One counterpoint to this was on the issue of detention and crisis services, where communities may be limited in their influence:

> *"When it comes to the use of mental health laws, that's about what goes on in institutions. Black communities don't have much of a say about that. Communities can be involved in prevention, definitely. When you have a problem of large numbers of people locked up, however, that's not a community issue."*

User led services

> *"We need a trusted front door. Black faces and champions and community voices associated with it. How do you reduce all those barriers of fear and distrust? In identity terms, people have to hear trusted voices and see people like themselves."*

Services can only ever be trustworthy to users when they are shaped by ongoing service user involvement. To this end, Penrose is hosting a series of service user and carer focus groups, in order to take these imperatives for action to the people who are most affected by this discrimination. This includes people who are currently using crisis and high support services, many of whom have lost trust in the system.

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2.7 Courage and prioritisation

"We have to ask ourselves why these huge research initiatives and calls for change are so easily ignored?"

With the weight of research papers and evidence presented over the last few decades, why has the over-representation of specific BAME communities in the mental health system not been prioritised nationally? How can we embrace change across the board?

Roundtable participants cited many examples of good work, pointing to the need for prioritisation:

"We have lots of solutions. Many examples of good practice, in the voluntary sector and hospitals for example. The problem is the priority and status given to this topic. There is opposition. People in leadership positions do not agree with these positions. There have been failures of good strategies due to this. The whole issue has got lost."

Participants also discussed the need for a clear focus on opportunities that do exist, then deciding and implementing a bold course of action.

2.8 Substance misuse

"The elephant in the room is substance misuse and the effect that has on mental health and offending and lifestyles. If we could do something about the taking of illicit drugs, that would be very effective."

There were discussions about substance misuse, particularly the use of high strength cannabis and the correlation with mental ill health. Participants agreed that cannabis use was a driver, in terms of incidence of mental ill health and offending.

The discussion turned to how to reduce risk-taking behaviours amongst the BAME communities, especially those most prevalent in crisis/ high support mental health services. In terms of children and young people, roundtable participants discussed more education in schools around the correlation between cannabis use and mental ill health, as well as early intervention where young people were already using cannabis.

On Thursday 13 October 2016, in central London, Penrose will host a national broadcast conference on this topic. Check www.MinorityMentalHealth.co.uk for updates and join the conversation on Twitter **#MinorityMentalHealth16**

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