

‘A CALL TO ACTION’ Conference



**The Rose Green Centre, Bristol
May 9th 2019**

A co-produced one day event, giving voice to BAME women with lived experience of Mental Health Services in Bristol, working together with senior managers from Mental Health Services to share their stories and together find solutions to inequalities

Designed and delivered by **The Nilaari Agency**, working in partnership with: CCG, AWP, CASS, Rethink, Black Carers and Bristol Mind.

The programme on the day was designed around the contributions from the experts by experience women about Mental Health Crisis. These women were the keynote speakers and valuable contributors to every discussion.

Funded by:


Bristol, North Somerset
and South Gloucestershire
Clinical Commissioning Group


Avon and Wiltshire
Mental Health Partnership
NHS Trust

- *Listen*
- *Reflect*
- *Respond* to our 'Call to Action!'

The conference was designed to provide senior representatives from Mental Health Services across Bristol (statutory & voluntary) with an opportunity to listen to service users (BAME women with lived experience) and to reflect on their own and their organisations practices and commit to make changes in order to improve the experiences of all their service users and end stereotyping and discrimination.

The Context:

- March 2018: Nilaari ran a focus group commissioned by the Race Equality Foundation, to consult with and find evidence of BAME service users experiences when detained or caring for someone in Mental Health Crisis
- The outcome was to inform the Independent Review of the Mental Health Act
- 11 women came for a one day workshop and shared their personal experiences. From their testimonies, Nilaari compiled a report which was submitted to the MHA review team
- Nilaari's report was commended- our influence is visible in the revised MHA

However:

- The women told us that they had been asked to tell their stories many, many times over 10 or more years and nothing had changed
- Nilaari has its own twenty years' experience of hearing similar stories from our clients and were determined that these resilient, strong 'experts by experience' would be heard this time and practice changed for the better
- Nilaari took the report to share with Mental Health colleagues at the EDI (Equalities, Diversity & Inclusion) Bristol Mental Health group
- A partnership was formed: Nilaari; CASS; AWP; Rethink; CCG; Mind; Black Carers and of course (most importantly) the women themselves

'A Call To Action is the beginning of a campaign to change practice in Bristol Mental Health Services, to close the gap on inequalities, to increase competence and confidence around ethnicity; faith; disability; gender and age. The recommendations from the BAME women offer simple and practical solutions for practitioners. Please read, absorb, reflect and change practice!'

Our Partners:





Jean Smith (CEO Nlaari & Elaine Flint (CEO Wellspring) Co chairing 'A Call to Action'

The following pages are the documented responses from the three round table workshops which took place on the day:

Before Detention; During Detention; Post Detention:

SESSION 1 BEFORE DETENTION:

'Together we can do this'

Prevention:

- Early intervention —> primary, secondary, tertiary.
- Early and sufficient preventative interventions may prevent crisis/ detention
- Perception / experience is that people are 'allowed' to reach/ enter crisis before they receive intervention
- Communities have little knowledge of prevention focused services
- Voluntary services are being asked to support people in crisis (without being commissioned or funded to work with this cohort)
- No (apparent) funding for preventative work

Family, Carer & Community:

- The whole community are likely to need to can become involved/ effected when there is no response or support forthcoming
- Practitioners should undergo 'cultural awareness'/ unconscious bias training as there is a strong belief that black men (and also women and carers) are perceived by some clinicians as culturally 'loud' and 'aggressive'- and even a threat.
- Family and carers should be recognised as best placed to identify the onset of a crisis developing and to be best placed to assure the service user, with professional support.
- MH Services should ensure that the contributions from the service user and family are valued, heard and acknowledged (which involves practitioners listening)
- MH Services need to improve assessment of the carers circumstances e.g. are they equipped mentally and physically to cope with a crisis and subsequent detention and aftercare? Frequency of mental ill health as a result of responsibility being put back on them

Police A & E & Emergency services 'We should not need to rely on the police- leads to negative/ violent entry to services':

- Carers frequently report the lack of response to requests for help from S136 at times of crisis, when it is felt that there is no alternative but to call police. This suggests an important gap in service provision
- The very use of the police in a mental health crisis suggests that the service user is criminalised.
- Despite the police being first (and sometimes only available) port of call, there are no known mechanisms/ protocols/ procedures in place for referring concerns on to secondary or primary care. The only role appears to be to contain difficult situations
- MH A&E- no consistent known response to MH crisis
- MH services will instruct families/ carers to call police/ ambulance but historically there has been distrust and poor experience with these services
- Experience of being unable to access ambulance service before without police involvement arranged (ie risk assessments)
- In crisis, police can arrive in large numbers (up to 5 police vans because of health and safety rules) but carers not called or informed of actions. Service user can become terrified and uncooperative- can actually escalate panic and distress
- Sometimes SUs are inappropriately held in police cells, before detention in hospital

Suggestions:

- Provide quiet safe space in A & E to de-escalate potential incidents for person in crisis to be offered support/ assessment
- Provide GPs independent triage room/ phone line 24 hours and embed MH practitioners in emergency services (as currently happens for respiratory and other specific conditions)
- Reinstate MH community development workers who can deliver street triage
- Arrange 'unconscious bias' and MH First aid type training to paramedics to encourage greater alliances to other services and to police in appropriate and humane responses
- Find ways to engage SUs before need for detention through timely and effective early interventions



Break the 'Circles of fear: 'Does the societal view of black men cause them to fear accessing MH service?':

- There is a plethora of research and evidence from years of research that the known lack of engagement among BAME communities at an earlier stage before crisis is because of previous (negative) experiences and here say/ rumours which results in insecurity and unwillingness/fear to engage. There can also be stigma of accessing MH services to overcome in some communities/ individuals
- We need to continue to question, effectively monitor and collect data throughout the entire MH system to find adequate answers as to why there is still an over representation of Black Men in MH services despite many years of research, reports and recommendations. Do we need any more evidence? We need to work together to strategically change practice and bring numbers down
- Do the inequalities experienced by BAME MH SUs and carers that are regularly reported impact on trust and engagement?
- Lack of resources increases the pressure on MH services and results in an increase of intolerance and practitioners resorting to stereotypes e.g. of ethnicity/ gender e.g. Arrange 'unconscious bias' training to eliminate beliefs in the need for up to 6/8 personnel to transfer one (black) male!
- We are aware that MH services cannot 'fix' the situation on its own as other social factors need to be considered and practice improved. However, if MH services take the lead in striving to improve practice by reflecting and challenging their own practitioners about stereotypes, prejudice and racism through anti-bias training, they could put their own house in order and influence other MH services.
- We need to examine and reassess the perception of levels of 'risk' which would immediately reduce the need for some detentions.

MH Services in Bristol:

Barriers to improvement 'who are these gatekeepers?':

- 'Gate keepers' are frequently mentioned to describe those who try to prevent carer engagement and are felt to keep the carer 'at arm's length'. Perhaps training is needed to change MH service staff perceptions of carers and SUs and to value their contributions- especially from minority communities?
- Resources are increasingly stretched because of insufficient funding and a lack of resources which can result in a crisis. An increase in funding would improve outcomes. Currently, assessments are taking too long and crises increasing which is counterproductive for SUs and the service: e.g. BMH has twice the demand on services than is commissioned; few or no beds for young people
- MH system under pressure: increased paperwork; pressure to meet targets e.g. 4 hours; recruitment/ retention- staff shortages; the high level of nurses leaving due to stress; lack of skills in existing staff/ inappropriate recruitment to some roles.
- Need to remove inhumane practice of separating service user and practitioner by a door, despite no risk or danger.

Positive action: ‘We should start planning discharge from admission!’:

- Immediate action needed to improve initial contact experiences of SUs who need to be informed of all the pathways available and timescales for an admission
- It is essential that there is a robust plan and a named care coordinator to discuss with carers, family and SU to ensure agreement and best support
- A proactive approach should be taken to ensure that care planning (involving carer and SUs) takes place before crisis and while they are well enough (preadmission) to articulate their needs and choices
- Workforce: ensure recruitment of a workforce that is diverse and reflects the communities
- Encourage plurality of specialist support services to offer choice ‘a mixed economy’
- Early support could be provided by recovery navigator posts
- Can appropriate voluntary and commissioned services/ agencies be commissioned/ funded to work together as consortiums? This would eliminate ‘silos’ and funding insecurity and would increase continuity of care; improve care plan options and ensure are in place
- Create referral chart/ pathway process, which is adhered to, is transparent and circulated widely across those who need to know
- Increase SU/ carer representation in places where decision makers sit (e.g. the BAME women at this conference could form a scrutiny group to monitor effectiveness of new strategy)
- Practitioners should have a clear overview and understanding of a diagnosis and care plan to keep the SU and carers updated and informed. Communication is key
- Improvement needed to pathways to a access treatment
- Consider the terminology/ language used within mental health services: lobby to have the inappropriate derogatory term ‘detention’ changed to ‘admission’
- Need support 24/7: crisis does not only happen 9 am to 5 pm on a weekday – crucial to provide out of hours services including public holidays. Counterproductive for SU and services to not have timely support
- Recognise and provide non-therapeutic alternatives e.g. listening to SUs narratives, more holistic & integrated care, make use of voluntary organisation expertise and services (funded)
- Empower SUs during clinical consultation and throughout engagement with MH services
- Increase continuity of care between services, avoid ‘pillar to post’ experiences and avoid the need to repeat known information- notes should follow SU
- Do not ‘pass buck’ to other organisations - go into communities, inform carers and others how to signpost, to be able to proactively support the SU before a crisis

Training: ‘Staff need training to acknowledge & recognise their own bias

Suggested training:

- Mental Health First Aid & literacy
- Implementing out of area agreements
- Education around cultural behaviour e.g. understanding mannerisms, tone of voice, behaviour (to avoid misunderstanding as threatening or aggressive)

- Competency training around 'protected characteristics' (Equalities Act 2010) involving those with lived experience as well as having experience of facilitation and equalities (funded)
- Diversity & Unconscious Bias training- to eliminate prejudice towards an individual based on being white/ black/ middle class/ student or poor e.g. students classed as low MH risk despite increasing demanded on MH services due to depression and suicidal thoughts
- Skills needed in de-escalation behaviours and techniques e.g. allowing a carer to accompany an SU into a ward (instead of a stranger) – reducing fear and attitude towards particular ethnicities/ cultures etc.
- Working with/ amongst communities e.g. faith venues; "Mental-health first aid"



Crisis team: '*Non-existent when needed*':

SUs/ carers need to be made aware of rights to request appropriate care- 'smarter' Ensure accurate/ evidence-based diagnosis/ early intervention to end 'revolving door' within MH services:

- a) Complex- depends on circumstances (community or hospital)
- b) The SUs- as long as they have capacity
- c) The SUs carer (they may know what is best for SU's recovery- listen)
- d) Time/ funding/ more social prescribing (those prescribing first learn what is funded for SP- avoid referring to non/ underfunded, voluntary services. MH providers should seek funding sources for small cash strapped voluntary organisations to whom you are encouraging GPs to socially prescribe)
- f) Treating people with respect and dignity always
- g) Involving SUs in the process

Research and find solutions to eliminate fear by practitioners of feeling unsafe while providing support for people?

End limitations of services to only providing office based, single points of contact and introduce street triage and control room triage

Existing available services are not widely promoted or offered as choices for people in crisis and are not accessible to everyone e.g. WOT Sanctuary/ safe space (only available to women). All communities should have places like this- cohesion & wellbeing- missing from deprived areas

Crisis team personnel should be given opportunities to experience different parts of the service, to be better informed/ tolerant of the SU in crisis and observe their 'journey'

Service User Perspective ‘Physical v mental health seen differently- people are asked about treatment- things are ‘done to you’:

- Bristol intensive team do get involved until support is needed in a crisis, difficult to engage
- Practitioners need to realise that telephone contact can become very difficult in a crisis- ability to explain- language and cultural barriers to understanding, panic making it more difficult to articulate needs
- Some SUs have been known to resort to deliberately getting arrested as become so desperate for help. They feel the need to exaggerate to get support before anyone will respond to their needs.
- Where is the service user in all this? Surely the person at the centre of the service engagement should be at the centre of decision making (when they have capacity)
- **GPs:** The GP should start the process but lack of clarity about where overall responsibility lies and at what stage in MH process that GPs are and remain involved (either via SU/ or family). There is more ‘weight’ attached to a GP referral, but a nonprofessional referral has less validation

Involvement of carers: ‘Include the family carer in the triangle of care with the service user’:

- There are few KPIs concerning the need to involve carers through MH detention/ crisis
- ‘Confidentiality’- needs ‘myth busting’ as it can and is being used as a way to disengage from carer involvement or to reject further information about the SUs condition, history and methods to calm, engage etc. (is believed to be used as an excuse to not engage)
- SU/ carer not consulted during crisis but asked afterwards in recovery- could be so much earlier for improved outcomes for recovery
- Develop regular, positive 2-way communication with carers & services (staff and carers are drained)
- Carers often blame themselves for being unable to support- practitioners need to put more trust in what families & carers are saying and not ‘pass the buck’ to someone who is willing but is unable to take the responsibility of further looking after the SU because of their own exhaustion. Families are being asked and expected to take on huge responsibilities
- Cease separating families from their loved one when sectioned (location/ access etc.)
- Need a space accessible for people to have open conversations and facilitate SUs and carers being aware of their rights and to assess e.g. holistic spaces (ie nonclinical)

Communication/ information: ‘Essential information is not got general knowledge; people only know when they have to deal with it’

Promote MH contact numbers across communities: peer support emergency line; Bristol MH website; Samaritans; Bristol Mind; Crisis line; 111 service crisis cards
Alternative places

SESSION 2 DURING DETENTION:

Communication between community (carers & family) during detention:

Barriers: Lack of knowledge and training across all the service support providers & also communities in understanding ways to communicate effectively- issues on use of language/ terminology e.g. medical jargon; discriminatory; lacking respect; sometimes incomprehensible

Ways forward '*Communication with carers is the key*':

- Need to have insight into communities by involving them, to understand
- Investigate the 'roots'. Involve SUs network and educate friends/ caregivers
- Raise awareness of services available. Community engagement- everyone should know, not just MH professionals but also SUs & carers
- Community and family- each have rights and responsibilities, so SUs and carers need to be informed and understand
- Take action by writing to commissioners with protest/ complaint/ suggestion/ query

Training: '*Whole day of unconscious bias and cultural competence training for frontline staff*':

- Auditing clinical notes to highlight differences
- Training strategy must include commissioners and representation at all levels which meets requirements to maintain professional qualifications



Experiences of Service User in treatment while detained: '*Myths become record, records lead to labels and labels to stereotypes*':

- A lack of alternative strategies used, other than the frequent resorting to medication (often involuntarily administered) to deal with the agitated service user
- Even offenders who are arrested by police and are in custody are not held down and medicated- why are those who are detained subjected to this inhumane and degrading treatment?
- Ensure that medication is appropriate and avoid changing it while in detention
- An increase in ward visiting times would be beneficial for most SUs
- The SU will benefit from consistency of the care giver while detained.
- Encourage peer mentoring groups while detained
- Carers strongly state that they do not feel that they are being offered adequate services under MHA or are informed of their rights and options, in

fact actively prevented and are not informed as to choices/ what is available. It is as though services are set up in a way that challenges become difficult (even professionals cannot challenge)

- All health interlinked organisations (including Criminal Justice and Education) need to understand, be joined up and collaborate
- SUs can struggle with ancient 'history' 'flags' being brought up and decisions made based on risks that have long since disappeared. Need to be able to update historical records. Seclusion on admission – because of using historical notes and risks- not current
- Discussions should take place with SU and carer about known triggers and what can be mitigated
- Gender matching is considered but in reality, SUs may find themselves being handled or injected by someone of a different gender. Need to consider dignity, faith, cultural taboos, histories of abuse and preferences/ sensitivities
- Cultural competence and confidence around ethnicities, faith and culture can be daunting but if in doubt, ask- Do not make assumptions based on stereotypical societal views
- Language around detention needs to change- even the word 'detention' is unhelpful and derogatory
- Workforce should represent to population but cultural confidence and competence regardless of practitioner ethnicity is important. Some SUs will not wish to have someone from their community involved. If in doubt, ask! Need more access to advocacy
- Some SUs are sent out of area (as far as York and beyond) which isolates them from family, friends and community and discourages frequent contact
- Need balance between reasons for discharging people & bed shortages
- Home treatment available but will only work if SUs on board. If not, only option is detention
- MH support services need to continue through and beyond detained in hospital and not stop at the door. Start process of building relationships with community services while detained
- Ensure notes written are not detrimental to accessing other services e.g. housing
- Ensure that a timescale for being discharged is given

MH Services '*The NHS is not a caring employer: no perks, record low morale*':

Barriers:

- Resource shortage means policy & best practice cannot always be adhered to
- Postcode lottery- services in high demand
- Need workforce that matches the diverse community- currently missing knowledge and expertise
- BAME practitioners leave after seeing inequalities and discriminatory practice

Some reasons why:

Lack of education, unconscious (and conscious) bias; MH Ed in schools; cultural stigma; lack of empathy- need better active listening; stop 'revolving door'- follow up and review

Solutions:

- Need continuity of services between SUs in detention and community
- Leadership & organisational culture shapes quality of care- do not accept culture but instigate positive change
- Carers need to be aware of assessment in place & compulsory carer planning for discharge
- The MHA (revised) is detailed and ensure processes are in place- follow it
- It should require 3 people to implement MH Act assessment for balance: approved health practitioners (AMP) 2 x medics- ensure that this is consistent practice
- Remember that carers are also in crisis- respect, value and listen to them
- Consistency needed in ensuring pathways (clear roles for voluntary/ statutory services which are commissioned and funded to provide these services) stating the process which will be followed - needs to be agreed and understood by all SUs, carers and staff
- Need MH services mapping and gap analysis of statutory and voluntary sectors
- Consistent and clear expectations with minimum standards in legislation
- In recruitment, ensure rigorous qualification register and rules on registration / maintaining standards prioritise passionate experienced representative personnel
- During detention, make contracts and ensure calm relationships between SUs- manage risk through vigilance and having procedures in place
- When unwell, all rational thought is gone, and safety plans don't work- need to know triggers and minimise risk
- Check what steps taken- other options beside secure services- wellbeing over hospital, options other than medication. Reviewing more regularly
- Access to therapies- include other options e.g. music therapy. Finding activities for SUs to do- can be valuable part of the recovery process
- Share information (protocols) —> medication with SUs and carer
- Discuss options and choices with service user. Empower SU and carer by informing them about options/ choices
- Professionals/ practitioners need to be curious —> reflect on what's going on? What was the catalyst?

The stereotype of the 'Large Angry Black Man':

- Misperception of shouting as aggression rather than desire to be heard
- Media: = influences all systems- MH, Education, CJ system- so all systems need to link on 'RE' perceptions
- Proactive prevention- need to demystify/ remove MH stigma by working in schools- there is a wide diversity not just B & W
- There is a tendency to 'pigeonhole' people by their characteristics- need for monitoring internally to assess levels of unconscious bias/ stereotyping- If you treat someone like they are aggressive...

Diagnosis: Sometimes diagnosis is the only way to get intervention but sometimes diagnosis produces barriers by unhelpful 'labels' and generalisations. Policies & protocols need to be informed

Session 3 POST DETENTION/ AFTERCARE:

Service User Experience: '*Mental Health system should be set up for Service Users to thrive, not fail!*'

- Need preparation, referrals and signposting on
- Everything (housing, money, changing GPs) needs to be in place before discharge. The transition should include home family etc.
- Cut-off point only when everyone is comfortable with plan and on-going support
- Feelings of abandonment/ isolation/ hopelessness when 'cut off' from services
- Recovery can be supported by SUs engaging in: volunteering, employment and generally having structure to their days
- SUs need to be involved in clear debriefing and supported to access therapy- though this may not feel like a priority on discharge, it should be encouraged and offered
- Self-discharge while still unwell can be caused through SUs having poor relationships with MH clinicians or being discharged too early- decision should be based on the SUs clinical need - this goes back to funding- happens more in deprived areas.



Housing, benefits etc '*Hostels are so unsafe!*':

- Lack of housing/ inappropriate accommodation can prolong/ prevent MH recovery
- Barriers to accessing benefits can cause stress and anxiety- need support systems in place to help with accessing and getting on waiting lists
- Need up-to-date information about accessible and appropriate services available and how to access them (including social prescribing services)- work across agencies
- Need to be enabled to engage with community/ recovery workers to bridge the support, to help SUs continue to live in the community (benefits, housing etc)

Family/ Carer/ wider support:

- Those close to SU can offer important/ helpful insights/ information while correcting misinformation- give accurate picture. They may also be able to offer skilled and dedicated care (if the care plan is shared with them).
- The valuable support that may be offered by family and primary carers should be acknowledged and encouraged- could be described as 'community assistance'
- Assumptions should not be made about there being someone at home/ community to offer/ be appropriate/ able to care. Check (and document) who will take responsibility post detention (the carer may not be physically/ emotionally able to take on the responsibility)
- Identify all those in the community who may be able to support e.g. faith leaders (though this can be a stereotype, if assuming everyone from BAME community is involved with a faith leader)
- The SU may not want to involve anyone from his/ her own community because of shame, fear or stigma or they may now wish people to know that they have been sectioned. It is simple to ask the SU and find out their preferences
- If family/ carers want to be involved in discharge process, enable this to happen
- Build carer involvement into relapse plan and review previously known triggers
- SU and Carer need to have named MH team member to contact for crisis planning (family/ friends should be invited to engage in support system).



Mental Health Services:

Barriers: There is a belief that practitioners hide behind protocols because they fear some SUs. This leads to inequalities in treatment and wrong assumptions/ diagnoses/ conclusions being drawn

The use of appropriate restraint needs to be known by all personnel- question whether it is appropriate/ effective/ humane?

Need clear care pathway to manage expectations, outcomes and responsibilities

Reduce gap in waiting for assessment (up to one month mentioned)

Needs parity of treatment in mental health services e.g. versus cancer/ diabetes

Reflective practice/ research/ monitoring- see what works and if savings are made then why not pursue?

Crisis team role: Need crisis team to be available for short intervention e.g. phone
Practitioners need to meet with locality communities to understand
Ensure that medical documents do not adversely affect outcomes for housing etc.

Protocols and procedures awareness:

Need consistency with lead practitioner throughout the process
Develop co-ordinated approach between all services: police legislation does not match up with NHS- work towards some co-ordination- needs to be high level and between all services –policies & protocols need to be used

Sections need to be reviewed and SUs given the right to appeal

Protocols & procedures for informing service user & carer of plan- seems very dependent on individual personnel. Local procedures do exist- crisis practitioners should be aware and follow consistently.

National policy: The Care Act- is not always applied

Capacity: How long do decisions regarding capacity stay before review?

Review: listen to the person- don't remove their power- finding a balance of accommodating the SUs wishes

When taking action, stop & think 'is this necessary?'

Meetings: record/ inform more than just the people present?

Detentions: Many different reasons to be sectioned- but so many treated as if assumed aggressive

Consideration of human rights: using elements to inform decision making- feeling that this is not considered routinely

Medication v resources: allow enough time for a longer alternative to the 'quick fix' solution. Variation on practice depending on resources and change in policy' (push to reduce restrictive stay)

Subtle measures: take into account dangers (potential) & prepare but without escalating the situation. If necessary- can use more subtle procedures without compromising safety

Continuity of care across organisations/ agencies:

Risk- perceived very differently by different agencies e.g. police/ clinicians/ voluntary sector services/ CJ system

GPs role: Are they responsible upon discharge? Needs clarification and sign up from all GPs that this is their role and will act accordingly

Involvement of recovery navigators/ care coordinators and support workers are essential to support individual transition back into the community and feel supported to stay there.



APPENDIX 1: The Call to Action Conference May 9th 2019 the Rose green Centre, Bristol. Presentation 1. 'The Context'

Some uncomfortable statistics:

A black man in the UK is 17 times more likely than a white man to be diagnosed with a serious mental health condition such as schizophrenia or bipolar

Black people are also 4 times more likely to be sectioned under the MHA

An overview of some of the plethora of reports & initiatives relating to Mental Health needs of BAME groups in UK:

No organisation needs to commission another piece of research or a study about the inequalities experienced by BAME communities in Mental Health.

Here is a timeline of reports dating back over 25 years. There are depressing similarities between the evidence in these reports and the experiences of our key note speakers today:

1993: 'Mental Health & Britain's Black Communities Report'

1994: 'Ritchie Report', 'Mental Health Task Force', 'Black Mental Health- a dialogue for change', NHS Executive letter on collecting ethnic group data, the Ethnic Health Unit set up

1995: 'Learning the Lessons, Mental Health: towards a better understanding'

1988/9: 'A First Class Service'

1999: 'MacPherson Report', 'The National Service Framework for Mental Health'

2000: The NHS Plan

2002: The Race Relations (Amendment) Act 2000

'Breaking The Circles of Fear' (Sainsburys)

2016: 'Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities'

2017: 'Is there institutional racism in mental health care?'

2018: Review of The Mental Health Act

Applying the model of CBT to our unconscious bias:

'Thoughts... lead to feelings... which leads to behaviour'

Might each of our core beliefs influence our thoughts, feelings and behaviour?

BRISTOL Statistics:

Bristol ranks 7th worst in England & Wales for multiple inequality and disadvantage faced by the BAME community, with this situation worsening over time. (*University of Manchester and Runnymede Trust, 2015*)

There is a greater ethnic minority employment gap in Bristol than nationally (6.4% difference in unemployment rate compared with 2.9%)

Bristol Annual Population Survey, Apr 2017-Mar 2018

Racial biases in the literature:

'Staff are rightly concerned about violence but it would appear that racial biases in perceptions of dangerousness influence patient management'.

In a study comparing Black & White patients, Black patients were perceived as being more dangerous (despite all having low scores on aggressive behaviour)

The negative and damaging side effects of medication negatively influenced the tendency to seek help.

One carer said: 'I talked to the doctor in charge and I said ' I don't want you to give him that sort of medication, he is like a zombie, I can't talk to him, he doesn't know where he is, plus he is frightened you know'

FEAR IS A COMPONENT OF RACE RELATIONSHIPS & RACISM:

Fear is a phenomenon that is inextricably linked with both racism and mental illness. Black people are often cast as 'the Other' and therefore viewed with suspicion, hostility & anger.

If you combine these different layers of fear- fear of Black people, fear of mental illness and fear of mental health services- you arrive at a pernicious circle of fear: that negatively impacts on black people engaging and vice versa

'Mad and/ or Bad and Dangerous':

'We believe that professionals have a particular fear of Black people, but they were not able to directly acknowledge it.

When asked how they deal with individuals who are perceived as dangerous and violent, the most common solution sited was the use of restraint procedures to gain control over the situation'

Recent phone conversations/ emails to Nilaari:

'The last thing she needs is for a middle-class white woman telling her- I mean asking her what to do'. Can I refer her on to you?

'It is the power dynamics of there being a group of middle-class white women here, can I refer her on to you?'

'He is depressed because of an arranged marriage and I don't know enough about that- can I refer him on to you?'

'He is black and having violent thoughts, will you see him?'

Anecdotes from services / users:

'Have 8 people ready to receive this (black) man onto your ward'
(Residential MH hospital)

'I went for my appointment with a psychiatrist, while waiting 4 men appeared and said they were going to walk with me. I was so angry that I felt like kicking off- but they wanted me to do that, so I stayed calm' (client with a very long, distant history of anger)

'I went to the desk and the woman looked at me and moved her bag out of reach behind her'

Shelagh Hetreed Business Office & 'Usawa' Training Co-ordinator Nilaari



APPENDIX 2:

Feedback from BAME service user women's event on 11th APRIL 2019: We responded to 6 statements...

1. For me to be heard, it will take...

Solutions:

Invite me to a part of my care planning. That way I am involved in managing my own care

Communication between all parties about my care plan from admission the treatment in hospital and the discharge and support in the community

Carers and service users' voices need to be imbedded within services to represent communities e.g. engagement workshops, staff training

2. I was view by mental health services as...

Solutions:

Take a care and support approach, rather than a clinical one

See me as a human being, not just a diagnosis or stereotype eg , a threatening loud, intimidating and aggressive black woman

Real training in cultural competence training for commissioners and senior managers

The top needs to meet the bottom on a regular basis and join up the gaps of communication from the real need of people in services

3. For me, a mental health crisis is...

Solutions:

Learn about the black culture and address the stereotyping – “Seen as a strong/work horse.”

Easy access like A&E model that has 24 hours cover

Training for staff on how to support someone in a mental health crisis – GP surgeries, ambulance and Police

Recognising the nature of the crisis where the service user does not have the ability to comprehend the questions being asked

4. For me, confidentiality means...

Solutions:

When unwell it's not always easy understand the impact of signing the confidentiality form therefore this should be explained in clear and simple language. This form should be revisited periodically.

Look at the way the questions are asked. Why not ask open questions for example - 'What don't you want your loved ones to know?' Rather than 'Do you want ...'

Respect the confidentiality of the carer who might share information to assist with a patient – disclosure can affect relationships.

As a carer I need to trust the person I talk to about where the information will go especially when I just wanted a listening ear.

5. The discharge process was...

Solutions:

Discharge policies need to be followed consistently

Start making discharge plans with the patient and loved ones and other support providers at least 4 weeks before the planned day

The need for services like the employment, Rethink, Nilaari and other community providers included in the care plan before discharge

There is a need to create paid positions for experienced carers to provide help and support through services

6. For me to feel included in my recovery...

Solutions:

Provide information about what services/groups/drop ins are available that I can connect with to help me stay well.

Introduce services and groups early in the assessment process or create opportunities for me to maintain the links I have with groups I am already involved in. Think outside of the box. Don't just go down the medication route. Include things like exercise, massage, dancing and music

Everyone should have some sort of recovery plan which should be followed, with all involved in my recovery having a copy

Peer support positions should be created and funded with services. Being able to converse with people with similar life experiences is invaluable to my recovery

Compiled by Nilaari from contributions by the key note speakers



APPENDIX 3:

All participants were asked at the end of the conference, to complete a written pledge in response to what they had learned and discussed during the day. These will be sent to them in August as a reminder. A sample of the pledges:

- Ensure Thrive is embedding cultural and ethnicity issues in the programme (BCC)
- Look at client journey with & through services- how can this improve? (Voluntary service)
- Support and ensure that carers voices are heard at the beginning of a service user journey and throughout (AWP)
- Set up a Carers Strategy Working Group (AWP)
- I pledge to include and involve the carers and families of my patients in the creation of support plans where I am able
- Also, challenge my unconscious bias every day! (BRI)
- Consider carer involvement in high impact use support planning (BRI)
- Take experiences of today and discuss with senior managers to find solutions and changes we can make
- I will try to persuade HR in AWP to relax requirements for applicants for CAMH posts. Encouraging youth workers and counsellors to apply for posts will increase the diversity of the workforce in CAHMS
- I will work with Elaine (chair of BMH EDI group) to capture the asks/ demands for action from the conference today in an open letter to the responsible officers for the MH strategy (CCG)
- I commit to reflecting the views I have heard today back to my colleagues and into Healthier Together MH Programme (NHS)
- Within 3 months, regularly present data on the use of restrictive practices in a way that ensures rates for BAME people are clearly presented to inform practice and improve experience (anon)
- To collaborate with local stakeholders, Nilaari and service users to co produce some impactful and meaningful research on how to improve early access to MH services (Bristol University)
- I will spread the word about what I have heard today- not enough people know! (NHS)
- I pledge to commit ED & I subgroup to a tenacious commitment to hold services to achieving the changes that emerge from this conference (Wellspring)



Nilaari would like to thank:

- **Bristol CCG and AWP for their generous funding to make this conference happen and believe in a small voluntary organisation (Nilaari) that the womens stories should be heard, knowing that there would be some criticism along the way. Thank You**
- **Our partners who worked to make this conference happen and be the best it could be:**

'This was the best conference that I have attended' (AWP)

- **Bristol CCG**
- **AWP**
- **CASS**
- **Bristol Mind**
- **Black Carers**
- **Rethink**

- **The Steering Group:**

Catherine Wevill (CCG)
Glenn Townsend (CCG)
Mayur Bhatt (AWP)
Monira Chowdhury (CASS)
Jean Smith (Nilaari)
Narinder Chana (Rethink Mental Health)
Shelagh Hetreed (Nilaari) (chair)

The BAME Womens Steering Group:

- **Bristol Mind**
- **Black Carers**
- **Rethink**
- **Nilaari (chair)**

And the women who are indeed experts by experience, without whose contributions, there would have been no conference

