DataKind UK

sobus
strengthening communities

Exploring the prevalence of mental health issues in the Black, Asian and Minority Ethnic population in Hammersmith & Fulham

Contents

Introduction

Sobus' aim is to strengthen local communities, primarily through infrastructure support to the voluntary and community sector (VCS), providing support, advice, and facilitating and empowering the voice and representation of the VCS to enable it to be at the heart of providing local solutions to local issues.

We have over 20 years' experience of supporting and bringing organisations together, working alongside statutory bodies to effect change, leading and facilitating partnerships with and between the VCS, ensuring they are valued, heard, respected and understood.

Our focus is to enable and empower organisations to be engaged and be heard, champion and advocate for the residents they support, and to develop and contribute their skills to securing a sustainable and inclusive community in Hammersmith & Fulham.

Our **vision** is of strong and engaged communities, where residents and organisations are empowered to make a difference to the causes they believe in, and our **mission** is to achieve this through providing voice, representation and support to residents through the organisations that support them.

One of **Sobus'** aims is to identify and improve social care in all sectors where there is under representation. One of the key areas of this in the past has been to support the Black, Asian and Minority Ethnic (BAME) community and the organisations which support them, to deliver our values of promoting and supporting diversity, equalities and inclusion.

Mental health has been a repeated concern for the BAME community, with a range of projects and services developed. We hope this piece of research will provide a useful information source for local organisations, commissioners, statutory bodies and decision makers to further our collective understanding of the issues facing our residents, and to work together to design solutions to address them.

We look forward to working with local residents and our partners from the voluntary & community and statutory sectors to explore how the findings and recommendations in this report can be taken forward.

Sobus, February 2021

Executive Summary

The Sobus BAME Mental Health group was established in 2018 in response to feedback from community groups and residents, identifying that a key area of concern related to mental health support and BAME (Black, Asian, Minority Ethnic) communities.

The aim of this project was to paint a picture of BAME mental health within West London, including understanding the prevalence of mental health conditions within BAME communities and understanding where specialist mental health support exists.

The overarching question explored in this research is: What is the demand/need for mental health support in BAME communities?

Two lines of enquiry were explored:

1. Are BAME communities over or under-represented in mental health services vs other demographics? What can we infer about mental health needs in the BAME community vs other demographics?
2. Are BAME communities more likely to live in higher areas of deprivation

Predominantly, this research interrogated data from statutory mental health services, or mental health services commissioned by local statutory bodies. In addition, some initial research to understand the prevalence of mental health issues for residents accessing generic community and voluntary sector services is included, and further exploration of this will be developed in phase 2 of this project.

The analysis completed for this project suggests there is a large unmet need for mental health support in the BAME community with the specific findings of:

1. BAME communities are over-represented in occupied beds and referrals at the West London Trust
2. Black communities (excluding other) are more likely to be re-admitted than the white community.
3. BAME patients are more likely to have been admitted with schizophrenia and substance abuse than non-BAME (white)
4. BAME admissions per quarter have also been increasing since 2017, whereas non-BAME admissions are slightly decreasing
5. The areas with the most referrals are Shepherds Bush, Acton and Fulham.
6. Overall, there was a strong positive correlation between the % of the population that is BAME and various indices of deprivation. This means that areas with the highest level of deprivation were also the areas that had the highest BAME population
7. The % BAME population positively correlates with many indices of deprivation.
8. Hammersmith and Fulham have the fewest mental healthcare providers (aside

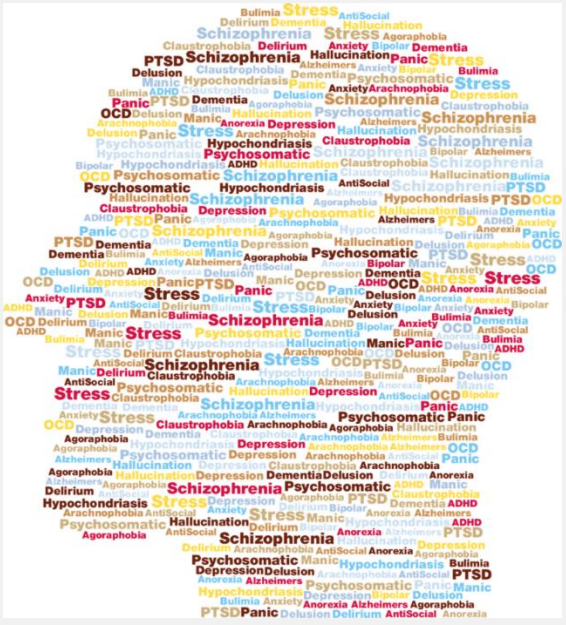
from City of London)

9. The majority of mental health providers are community based adult social care services
10. Hammersmith and Fulham are below the average value in London for proportion of mental health providers with good or outstanding ratings
11. % BAME population in a Local Authority negatively correlates with the proportion of good/outstanding mental health providers.
12. % BAME population in a Ward in H&F negatively correlates with the density of Mental health providers
13. There may be a mismatch in demand and supply for mental health providers

This paints a stark picture.

"Mental health services are not well promoted in the BAME communities and they assume that they will not receive appropriate support". **BAME Community Organisation**

The findings from this stage of the research project provides a starting point that we will build on in developing stage 2, which will further explore the prevalence of mental health and dementia in particular in the BAME community, within generalist community and voluntary sector services. This, combined with this report will, we hope, be a catalyst to improve mental health provision in West London in general, and for the BAME community in particular.



Support for H&F residents with mental health needs

Mental health services

Statutory mental health services, including psychology assessment and treatment services, specialist support programmes, IAPT (Improving Access to Psychological Therapies) services, day care and supported housing are not necessarily accessible to all who need them. These services are comprehensive, but limited – and with demand increasing, particularly during the Covid-19 crisis in 2020, are perceived to be difficult to access without persistence or reaching a significant mental health crisis.

Mental Health is primarily supported in the community, including medication, and talking therapies available through primary care services – with GPs often regarded as the primary source of information and support for those seeking help with mental health issues. In addition, the borough has a wide range of private therapists, counsellors, support groups and condition-specific support organisations.

A range of community mental health services are delivered directly by, or funded by statutory services in the borough, including H&F Mind and Richmond Fellowship. These offer a wide range of therapeutic and community based support, ranging from CBT, meditation, individual and group talking therapies and mindfulness, as well as clinical psychology services. Private sector mental health services are also widely available, from psychotherapists, hypnotherapists, individual and family counsellors, support groups, yoga, Pilates, meditation, and much more.

Mental Health and the BAME community

Even before the Covid-19 pandemic, there was evidence of mental health inequalities within the BAME population[1]. This presents as both an over representation of BAME communities in acute mental health services, but also a lack of take-up of community mental health services by the BAME community. Generic services report increasing contacts with BAME (and non BAME) residents with mental health issues – from low-level depression, through to significant cognitive impairment, such as dementia, that are not in contact with statutory or specialist mental health services.

This is often for a range of reasons:

1. Fear of statutory services – with all too often an assumption that individuals will be sectioned, or “locked up”
2. Stigma or negative perception of mental health issues – particularly within some BAME communities, where historically mental health difficulties have been hidden – seen as unacceptable or shameful in their communities
3. Lack of awareness of their own mental health decline – often the case where mental health decline is the result of other stresses or factors

[1] https://ebmh.bmj.com/content/23/3/89

4. Lack of awareness of mental health support that is available
5. Reluctance to access mental health support - preferring to access support from already known organisations/sources, friends of family
6. Inaccessibility or barriers to mental health services – language, culture, cost, transport, location etc.

Impact of Covid-19

A worrying increase in mental health issues was widely reported during 2020 as the impact of the Covid-19 restrictions began to be felt. An increase in information and services to support mental health needs were rapidly put in place, with information about these often provided in community languages. Due to the Covid-19 crisis, few community services were able to offer face-to-face support, but instead offered online or digital services and information.

Examples of remotely delivered interventions include one-to-one and group-based therapy or support provided by phone, messaging or videoconferencing, through to self-guided interventions such as online quizzes, apps and games.

However, these remained inaccessible for those facing digital exclusion, language and cultural barriers, or those needing a higher level of encouragement and/or support to access mental health services. A range of evidence began to emerge[2] that some communities were being disproportionately affected by Covid-19, both in terms of being at risk of contracting the virus, but also at risk of poor mental health as a result of the national restrictions in place for much of the year[3].

With all face to face services not able to be delivered through most of 2020, a number of community organisations struggled to support clients who were experiencing mental health issues from a distance[4], with remote services regarded as significantly less effective than face-to-face support.

A local VCS supporting Somali Women contacted Sobus as they were struggling to provide their previous high-level support to 6 clients with dementia. None of them were in contact with or receiving support from statutory services, largely as the language barrier was considerable, but primarily because they had a high trust relationship with the organisation. The organsiation was delivering hot meals to each client daily, but was unable to provide any meaningful face to face support, or support the client to accept the offer of an assessment by Adult Social care.

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

[3] https://www.london.gov.uk/press-releases/assembly/the-impact-of-covid-19-on-bame-londoners-and-menta

[4] https://www.eif.org.uk/report/covid-19-and-early-intervention-evidence-challenges-and-risks-relating-to-virtual-and-digital-delivery

It's not the only issue

For the vast majority of people, mental health is unlikely to be the only issue or difficulty that they are experiencing, with poverty, deprivation and inequality being key underlying factors for many. Individual's mental health is significantly impacted on by the challenges and situations that occur on a day to day basis – be that housing, work, money, relationships, physical health, loneliness and isolation – all of which can both result *in*, and be the result *of* mental health difficulties.

As well as offering emergency food parcels, H&F Foodbank also offers on-site legal advice from Citizen's Advice H&F, and in partnership with Anchor Counselling, free psychotherapy sessions to support those experiencing food poverty crisis

It is often the case that the individual seeks to focus on dealing with what they regard as the predominant issue (e.g. housing, money, work, relationships, or physical health), and do not focus on their emotional wellbeing, despite a decline in their mental health being a direct result of the issue they are trying to manage. Agencies and services come into contact with these individuals all the time. Whilst many front line staff are both sympathetic and encouraged to ensure clients are provided with information about other sources of support that they might need, it is also the case that all too often, a focus on the task at hand, the lack of insight, time or resources do not afford the opportunity to tease out, signpost or refer potentially vulnerable clients to other sources of support.

The VCS in general, tend to build longer term, trust based relationships with their clients – more often than not, providing a life-journey approach service for the individual, supporting them with a wide range of issues and problems that they encounter. For example:

- An H&F day care services for older African Caribbean elders – will also support clients to deal with issues around housing, social care, health, income/benefits and family relationships
- A parenting support service for H&F Somali women will also support clients with education, employment, housing and benefits and accessing primary care services
- An older people's social club supports users to access pension credit advice, get help with home repairs and maintenance and help to access health appointments

Asking about mental health

Theoretically, all front line staff and many volunteers are well placed to help identify mental health issues or concerns of clients in front of them – but often, the reality is that they do not have time, expertise, or are reluctant to ask or probe clients on these sensitive issues. Staff and volunteers often lack the confidence to discuss mental health, and are usually operating in a single function or service role. Whilst many organisations train and encourage staff and volunteers to ask clients if they have any other problems that they need help with, the view or perception for many is that doing so can often result in a highly reactive, negative and sometimes aggressive response from the client.

Staff or volunteers may not recognise the indicators of poor mental health. At the same time, organisations often provide pastoral type support – offering a welcoming and friendly person to turn to for help and advice, but there is a significant risk that the advice or suggestions they make, whilst entirely well meant, are not appropriate.

Most organisations recognise that their client's issues and problems are multi-faceted, and take a "whole person" approach to help the individual deal with a wide range of issues and problems – commendably so. Whilst much of this work is based on previous experience and knowledge, a determination and commitment to helping others and the understanding of the barriers, both actual and perceived, to the client accessing mainstream services, there are times when generalist organisations provide support to people with complex and serious mental health issues inappropriately.

Whilst well intended, without expert knowledge or skills, information that is out of date or well-intended but misguided suggestions from colleagues or contacts, there is an inherent risk that the support can, at worst, result in more harm than good. At the very least, the service user's recovery and improved mental health can be unnecessarily delayed, and at worst, an avoidable crisis point could be needlessly reached.

Project and Data Analysis Development

Sobus

In 2018 Sobus started work on a BAME (Black and Minority Ethnic) Mental health project with the support of BAME led organisations and other voluntary and community organisations who were interested in the issue. This included the Young Hammersmith & Fulham Foundation, Nubian Life, People Arise Now, Community Education Forum and others.

The work arose out of ongoing concerns about the disproportionate numbers of BAME people diagnosed with mental health conditions, under the care of mental health services and that there was inadequate service provision to these communities. This is a concern that has been around for decades both locally and nationally. For example over 30 years ago 80% of the acute admissions at the local mental health facility, St Bernard's Hospital, were young black men.

Mapping the BAME mental health landscape locally needed to be the starting point, despite some feeling that there was already enough evidence to negate the need for any further work in this area. It was however agreed that up to date local evidence was important in order to highlight the continuing disproportionate impact of mental health issues, and any inequalities in mental health provision for BAME communities locally.

The project sought and received data from West London NHS Trust (the main provider of mental health services in 3 west London boroughs namely Hammersmith & Fulham, Ealing and Hounslow), primary care data from Hammersmith & Fulham GP Federation along with LBH&F Social Care data, as well as our own survey of the sector. This was a huge amount of data that included ethnic, gender, age, location and diagnosis breakdown. We could have attempted to analyse the data ourselves but this would have been challenging on several grounds. The datasets were large, we did not have the data analysis skillset and resources in our team and therefore the validity and legitimacy of the results would have been compromised.

Contact was made with the GLA Superhighways Project in October 2019, where there was an introduction to DataKind UK. DataKind UK manages and co-ordinates a large number of data scientists who offer their services on a pro bono basis to undertake major data analysis, or *data dives*. The connection with the GLA Superhighways programme and DataKind gave real impetus to the BAME Mental Health project in offering their professional support on data development, management and analysis.

One of the first challenges was the type of data that was accessible from statutory providers, particularly in terms of ethnicity breakdown. The project requested ethnicity

data from statutory providers that reflected the current diverse population to be found locally. Although some detailed ethnicity data was initially received the project was later informed that only data that reflected broad categories could be provided, on the grounds that it was difficult to extract more detailed data and reliability of more granular data was difficult to determine.

Current ethnicity definitions used are broad and in line with the last and previous national census. As an example African ethnicity subsumes ethnicities from across Africa and may therefore not give a true picture of needs for specific subgroups. This was a shortcoming in identifying emerging needs in any particular community and potentially the direction of resources and development of appropriate and culturally sensitive services. Sobus and other voluntary sector partners, through their work, were aware that mental health was a growing concern in some specific communities.

DataKind UK

DataKind UK supports charities and social enterprises large and small across a variety of issue areas. We run DataDive weekends focused on exploratory analysis and prototyping; and we undertake ambitious DataCorps projects with non-profits to deliver cutting-edge data science solutions.

We have been working with Sobus, the CVS (Council for Voluntary Service) for Hammersmith and Fulham. One of sobus' aims is to identify and improve social care in all sectors where there is under representation. As part of this, a BAME Mental Health Working group has been set up and has been running for a year to investigate the issue of mental health in BAME communities. Sobus want to present concrete evidence through various datasets to show that BAME community is in need to more mental health support in addition to the stories they have been hearing from the local community.

After meeting with charity representatives and discussing various demands and needs of the charity, we divided the question for the DataDive into two parts based on the available data: one is to understand the need for mental health services by the BAME communities and the other one is to understand the supply of the mental health services to the BAME communities.

Findings from the DataDive

Section 1: Understanding Need

The overarching question is: What is the demand/need for mental health support in BAME communities?

The data used:

- West London Trust Referral Data (2017-2020): Referrals for mental health conditions from West London NHS Trust
- West London Trust Admission Beds Data (2017-2020): Admissions (number of beds occupied) for mental health conditions from West London NHS Trust.
- 2011 Census data on borough and ward level
- 2016-2019 Census projection data for population breakdown by ethnic groups: This data projects what the expected population would be for different years, based on the 2011 census
- 2018 Public Health England Electoral Ward Deprivation data by Ward/Borough

Two lines of enquiry were explored:

1. Are BAME communities over or under-represented in mental health services vs other demographics? What can we infer about mental health needs in the BAME community vs other demographics?

2. Are BAME communities more likely to live in areas of high deprivation?

Question 1: Are BAME communities over or under-represented in mental health services vs other demographics? What can we infer about mental health needs in the BAME community vs other demographics?

Finding 1: BAME communities are over-represented in occupied beds and referrals at the West London Trust.

This is especially stark for the Black community which is 1.6x as likely to be referred (Figure 1.2) and 3.1x as likely to be admitted (Figure 1.1) than the white community. Interestingly, the Asian/Asian British population shows the lowest rate of hospital admission.

Figure 1

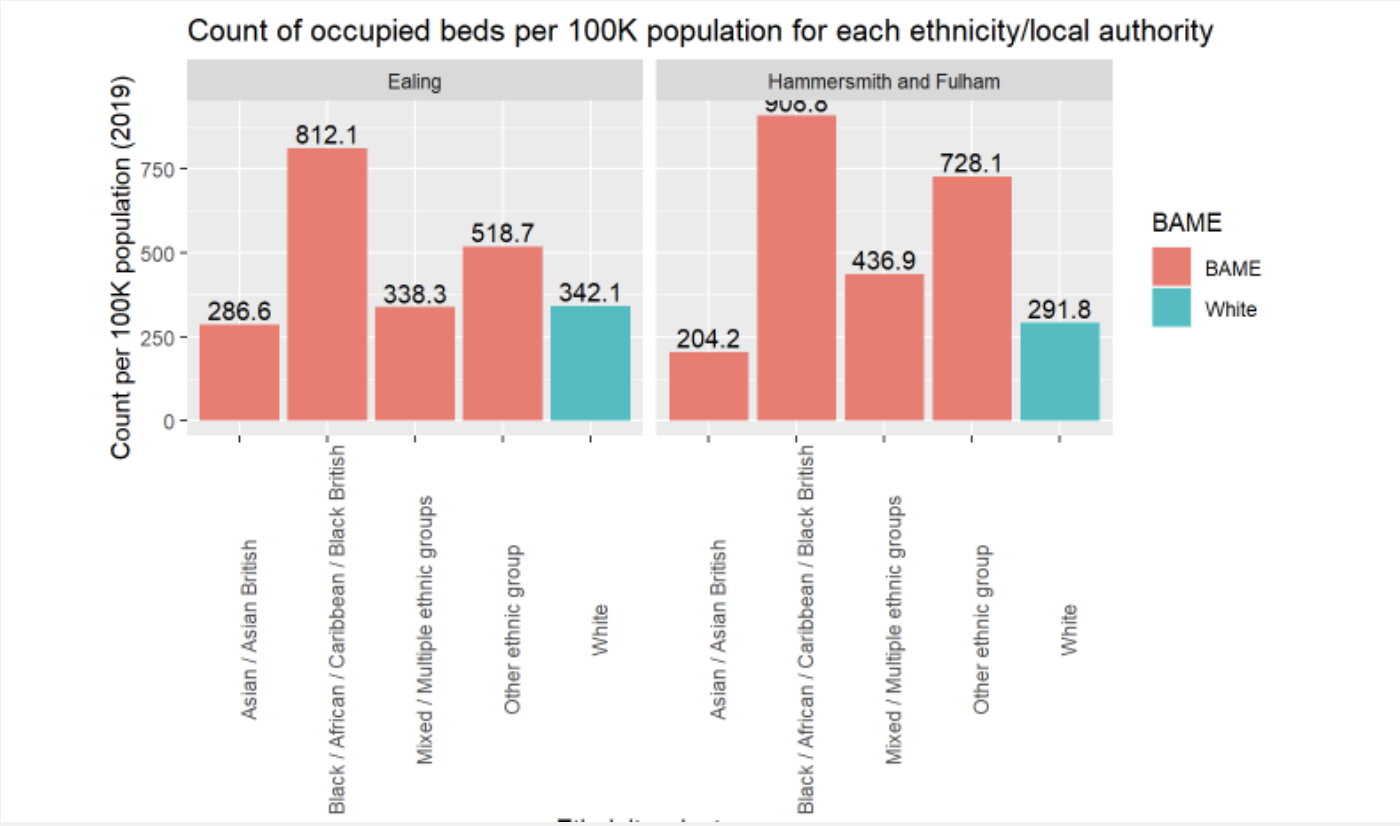


Figure 1: Count of occupied beds in 2017-20 per 100k population by ethnicity and local authority. This shows the number of individuals per 100,000 people who were admitted to a West London Trust hospital for mental health support over a 3 year period. This shows that a higher proportion of Black/African/Caribbean/Black British people were admitted than other ethnic groups, both in Ealing and Hammersmith and Fulham. Note that the total population (e.g. the number of Asian/Asian British people in Ealing total) comes from the 2019 population projection. This means that the Count per 100 k = Total number of patients of each ethnicity admitted between 2017-2020 / The projected population of that ethnicity in 2019 * 100,000.

The following figure shows the same data broken down by ethnicity

Figure 2

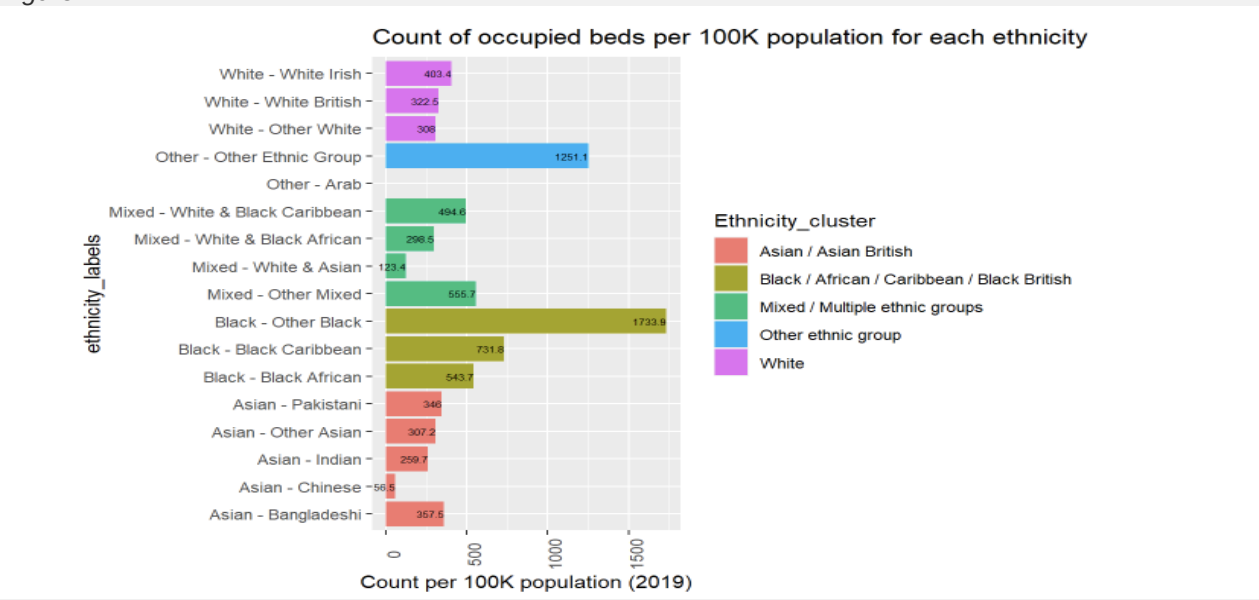


Figure 2: Count of occupied beds in 2017-20 per 100k population (Hammersmith & Fulham and Ealing combined). Here we see that the highest rate of hospital admission in Black - Other Black and Other Ethnic Group patients.

Figure 3

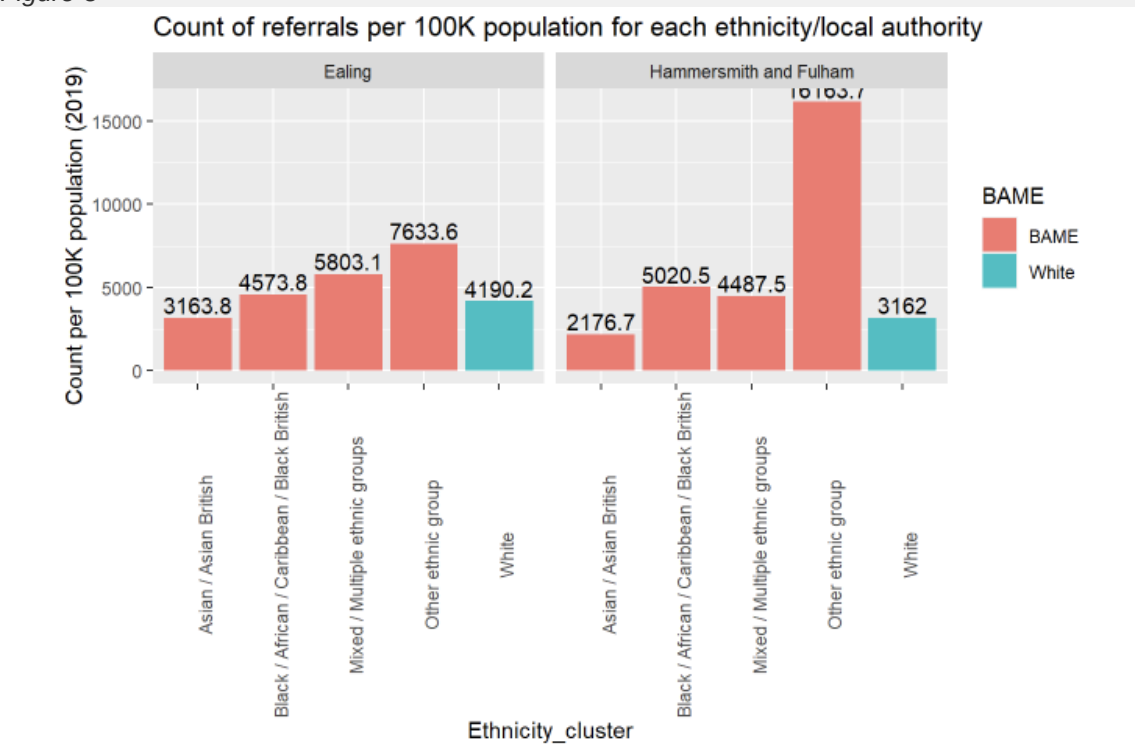


Figure 3: Count of referrals in 2017-20 per 100k population by ethnicity and local authority. While the previous figure looked at admissions, this looks at the number of referrals. The Black community was still more likely to be referred for mental health services, but the ethnicity cluster with the highest proportion of referrals was the group comprising non-Asian, non-Black, non-Mixed ethnicities.

Finding 2: Black communities (excluding other) are more likely to be re-admitted than the white community.

Again, this is most stark for the Black community. Whereas 72% of white admissions will be re-admitted, 81% of black admissions will, a 14% relative increase. This is either due to poorer treatment, or more likely due to being admitted for more serious and chronic diseases.

Figure 4

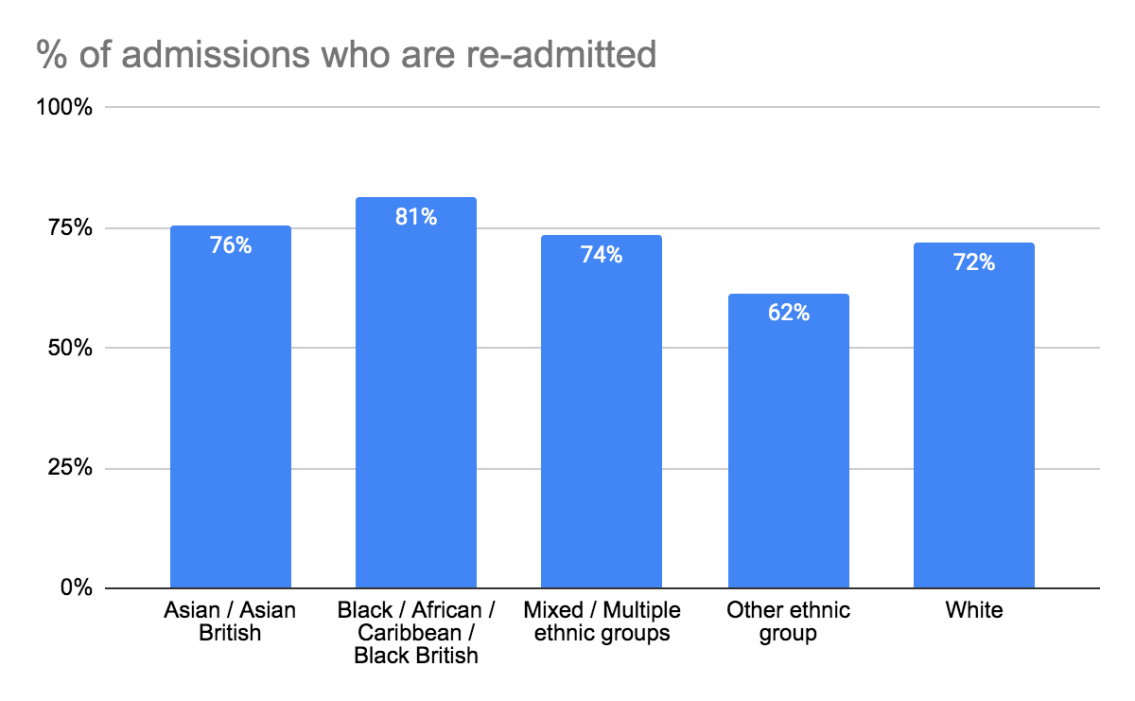


Figure 4: Re-admission rate by ethnic group. This shows the percent of patients who were admitted more than once for mental health treatment in the West London Trust (over 2017-2020).

Finding 3: BAME patients are more likely to have been admitted with schizophrenia and substance abuse than non-BAME (white)

As seen in Figure 5, 32% of BAME patients are admitted with schizophrenia, compared to just 20% of white (non-BAME) admissions.

Since the rate of hospital admissions for mental health is higher for the BAME population, we would expect that the rate of admissions might be higher across all diagnoses; however, we found that the BAME community was particularly likely to be admitted for schizophrenia. In fact, when adjusting for the actual population size, we can see that admissions for schizophrenia are 3x more prevalent in the Black community than the white one (Table 1.1).

It's important to note that schizophrenia is often initially diagnosed in the mid 20s; the average age of those admitted is younger for the Black community vs white population - therefore the prevalence of schizophrenia amongst the Black community may be due to differences in ages (Table 1.2) as there was a higher percentage of young people

(0-15) in Black/Mixed communities in the 2011 census.

The BAME community was also more likely to be admitted for substance abuse (15% of admissions were BAME vs 12% non-BAME); however, this small difference may not be statistically significant.

Figure 5

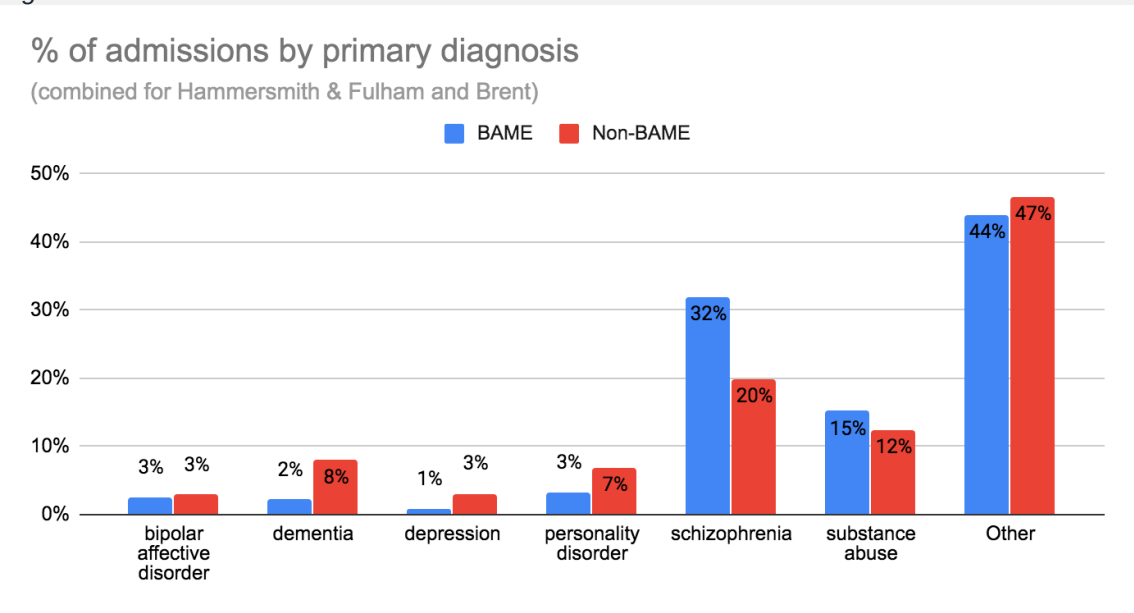


Table 1

Ethnicity cluster	# Admissions	# Population	% Admitted
Asian / Asian British	37	13,572	0.27%
Black / African / Caribbean / Black British	78	4,212	1.86%
Mixed / Multiple ethnic groups	11	7,488	0.15%
Other ethnic group	12	7,956	0.15%
White	67	10,764	0.62%

Table 1: Admissions for schizophrenia by ethnic group. This shows the proportion of the population that were admitted for schizophrenia. The population column shows the population of that ethnicity cluster in the 2011 census. The admissions are from 2017-2020, so the dates are not perfectly comparable.

Table 2

	Asian / Asian British	Black / African / Caribbean / Black British	Mixed / Multiple ethnic groups	Other ethnic group	White
Age 0 to 15	12%	26%	30%	21%	13%
Age 16 to 24	17%	13%	15%	15%	12%
Age 25 to 49	54%	41%	44%	50%	51%
Age 50 to 64	12%	11%	7%	11%	13%
Age 65 to 74	4%	5%	2%	3%	6%
Age 75 and over	2%	4%	2%	1%	5%

Table 2: Age breakdown of populations in Hammersmith & Fulham - 2011 census. This shows the percentage of the population in each age group according to

the 2011 census. There is a higher proportion of young people (age 0-15) in the Black/African/Caribbean/Black British and Mixed/Multiple groups, compared to the Asian/White groups.

This is mostly driven by the Black community (the top line in Figure 1.5) which has increased from 131 per 100k to 166, an increase of 27%. In the same period, white admissions per quarter have decreased by 12%.

Finding 4: BAME admissions per quarter have also been increasing since 2017, whereas non-BAME admissions are slightly decreasing.

Figure 6

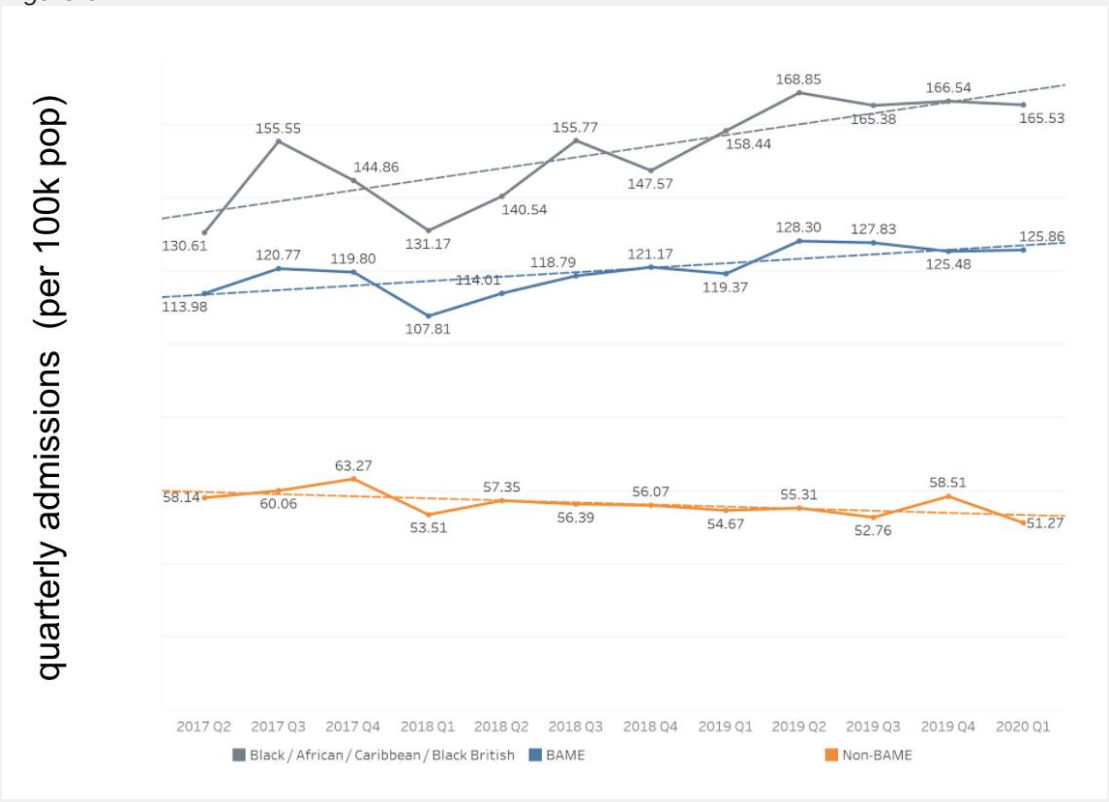


Figure 6: Quarterly admissions per 100k population by ethnic group. This shows the average number of admissions per quarter, per 100,000 people in the population (based on 2019 projections). The solid line is the real data, while the dotted line is the best-fit line which shows the general trend. While the Black/African/ Caribbean/Black British trend line is increasing. In the future, this should be examined using the true population at each quarter since it's possible there was a large efflux/influx of one ethnic group between 2017-2020 that could affect the results.

Finding 5: The areas with the most referrals are Shepherds Bush, Acton and Fulham.

Unsurprisingly these are areas with large BAME communities.

Figure 7

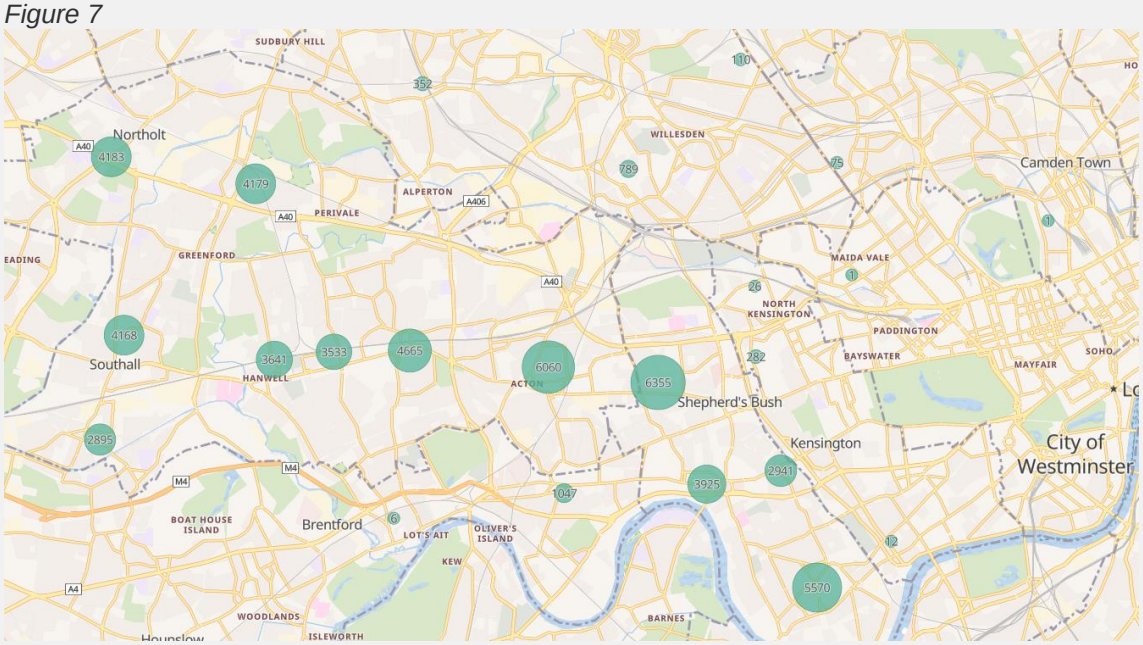


Figure 7: Map of referrals for those from the BAME community. This figure shows the number of people referred for mental health support within each area. Ideally this map should be used in conjunction with a map showing the population in each area, as it's possible these are the areas with the highest population.

Question 2: Are BAME communities more likely to live in areas of high deprivation?

We know that deprivation can be a risk factor for mental health challenges. The goal of this question is to understand whether the areas with high degrees of deprivation also have a higher proportion of BAME people. If true, this won't be conclusive, but it could suggest that the BAME population is at risk of higher deprivation, and thus potentially higher risk of poor mental health.

We looked at the following questions:

- Where are the areas of high deprivation in West London (Hammersmith & Fulham, Brent & Ealing)? Likewise for London more broadly?
- Is there a correlation between high indices of deprivation and % BAME population?

The data used:

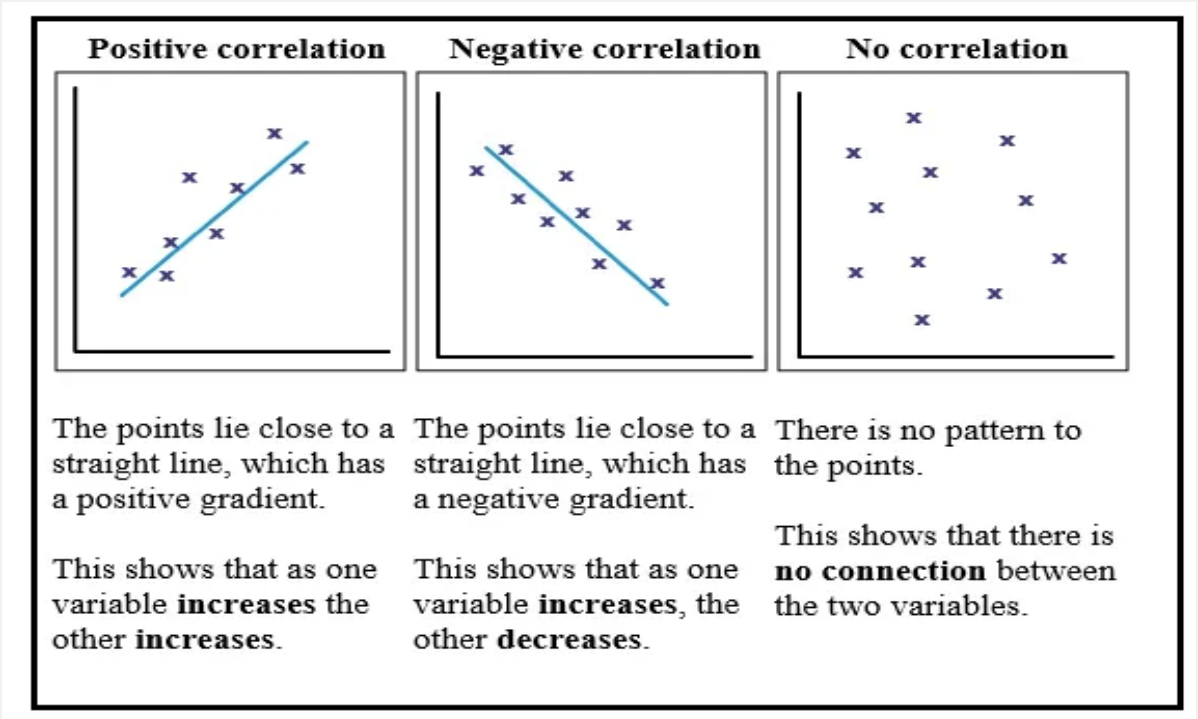
- Public Health England Deprivation Stats by Ward/Borough (2018)
- 2011 Census by Ethnicity (by ward/borough)

Here we worked with the NHS England deprivation data available publicly on the local health authority website. Deprivation data includes stats on multiple indices deprivation, unemployment, education, poverty, proficiency in English and multiple

health metrics (including emergency admissions, long term disability, alcohol and self harm). We also used the 2011 Census by Ethnicity (by ward/borough).

Finding 6: Overall, there was a strong positive correlation between the % of the population that is BAME and various indices of deprivation. This means that areas with the highest level of deprivation were also the areas that had the highest BAME population.

Correlation measures the strength of the (linear) relationship between two factors, or in other words, how one factor changes when the other changes. A value of 0 means there's no relationship. A value of 1 means a perfect, uphill relationship - ie as one variable goes up, the other goes up. A value of -1 means a perfect downhill relationship - i.e. as one variable goes up, the other goes down.



From: https://www.simplypsychology.org/correlation.html

Finding 7: The % BAME population positively correlates with many indices of deprivation.

Figure 8

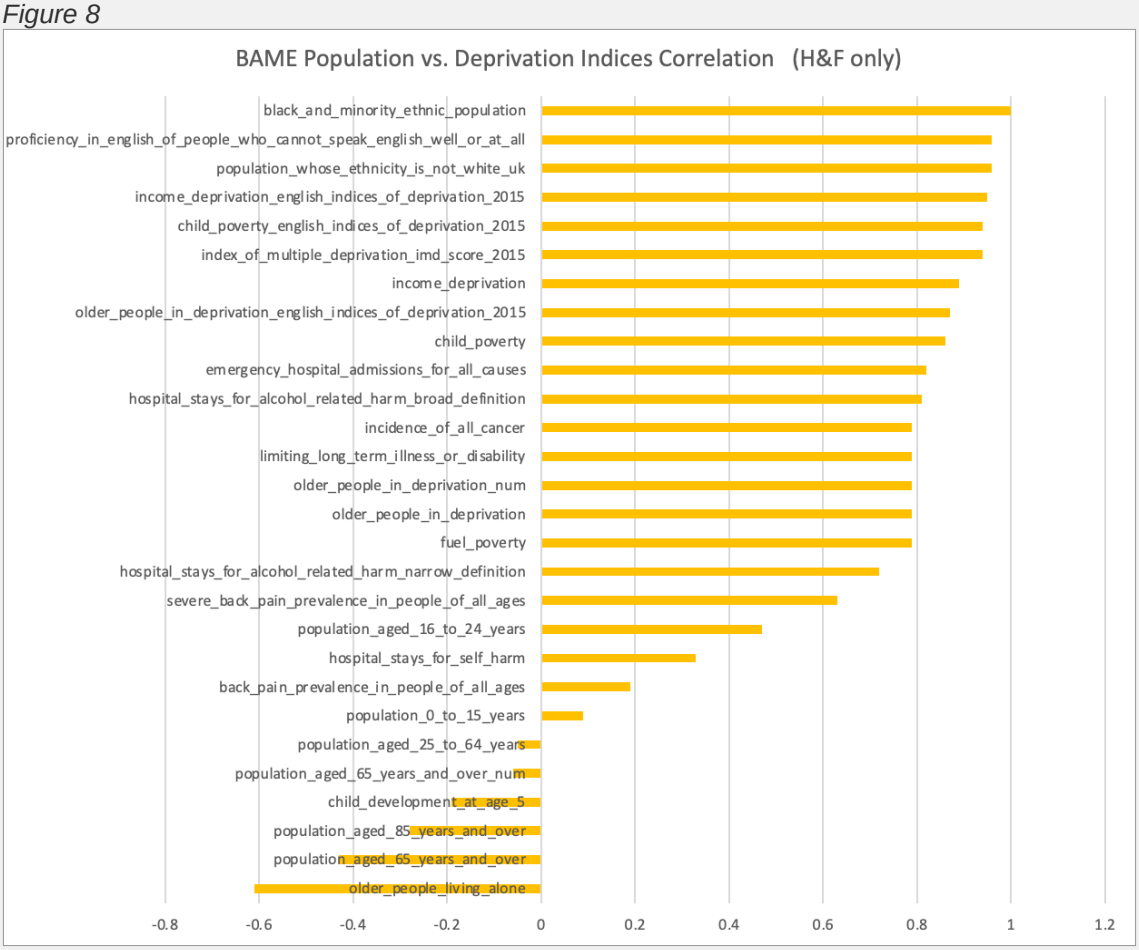


Figure 8: This figure shows the correlation between the % of BAME people in H&F Ward and various metrics of deprivation (e.g. Income deprivation score). A value close to 1 means that the 2 variables are very highly correlated. For example, the % of BAME people correlates very highly with the percentage of people who cannot speak English well or at all (correlation value > 0.9). This means that as the population of BAME people goes up, the percentage of people who cannot speak English also goes up which makes intuitive sense. What is striking about this figure, is that the % BAME people also correlates very highly with the Indices of multiple deprivation score, child poverty score, hospital stays for alcohol related harm, fuel poverty, cancer risk, and older people living in deprivation. Note This data is for Hammersmith and Fulham only.

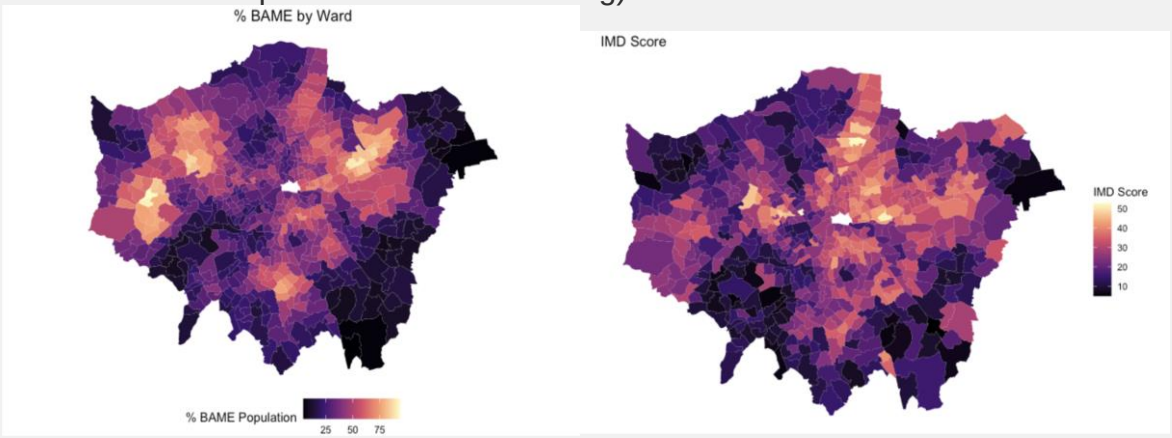
The following data compares the correlation values for Hammersmith and Fulham to those for London. The % of BAME population is **more highly correlated** with **overall deprivation** as well as with specific deprivation indices. In other words, in Hammersmith and Fulham, the % BAME population more closely predicts the deprivation level (and vice versa) than in London as a whole.

Table 3

Ward Level correlations between % BAME population and other metrics of deprivation	**correlation coefficient (All London Wards)**	**correlation coefficient (H&F)**
Overall Index of Multiple Deprivation (2015)	0.56	0.94
Income deprivation from English IMDs 2015	0.57	0.95
Older people in deprivation (from IMDs)	0.62	0.87
Population with limiting long-term illness/disability	0.13	0.79
Older people in deprivation	0.56	0.79
Hospital stays for alcohol related harm (broad definition)	0.54	0.81
Emergency hospital admissions for all causes	0.50	0.82
Child poverty (from IMDs 2015)	0.48	0.94

Visualising the relationship between BAME population and deprivation

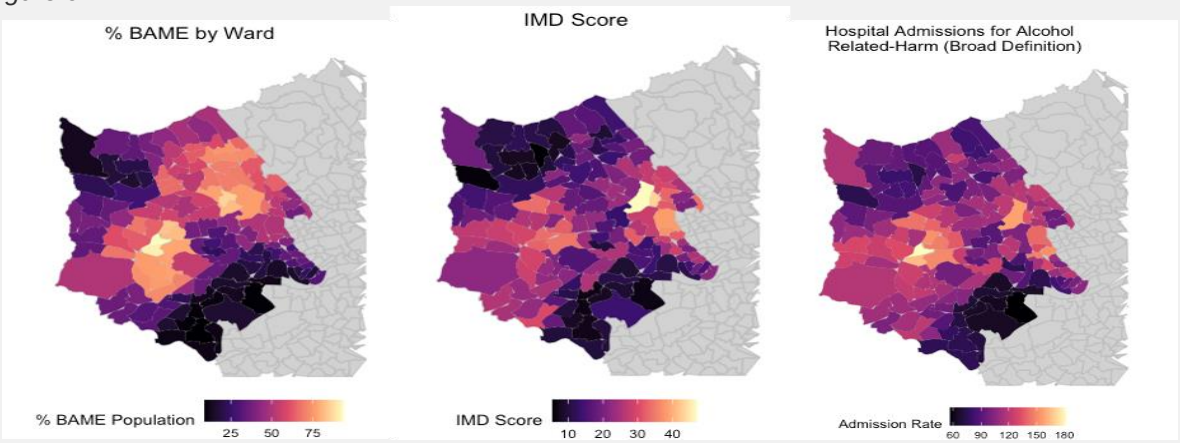
One way to visualise the relationship between two variables is with maps.
For all the maps below, the lighter, orange and yellow colours indicate higher numbers. For example, the map on the left shows the % of the population that is BAME by Ward. And the one on the right shows the IMD Score. Note that in the government statistics, a **low** IMD score means relatively more deprivation, and a high IMD score means relatively less deprivation. However, to make the maps comparable, we switched this, so that a high IMD score means more deprived (that way a bright colour on both maps means the same thing).



There appears to be correlation across the whole of London between higher percentage BAME population and higher levels of deprivation including income deprivation, child poverty and fuel poverty.

The subsequent maps focus on West London Boroughs

Figure 9



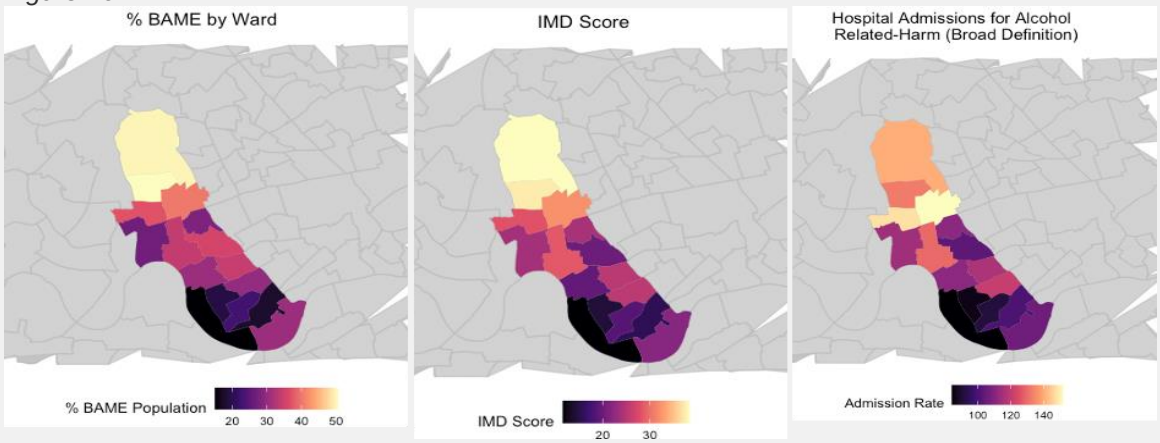
Similar to the maps above but focused on the wards in the West London boroughs of Hammersmith & Fulham, Brent, Ealing, Harrow, Hillingdon, Hounslow and Richmond upon Thames. Again the lighter yellow colours indicate higher numbers and there does seem to be correlation in this area of London between proportion of BAME population and indices of deprivation.

Lastly, the maps below show that the wards in the South of the borough have the lowest percent BAME population and have the lowest levels of unemployment, people in income deprivation and people in fuel poverty. Hospital admissions for alcohol related harm are higher in the North of the borough, where the proportion of BAME population is also higher.

Important context for understanding correlations:

These results *don't show* that BAME people are more likely to be admitted for hospital related self harm. They show that where there is a high BAME population, there is *also* a high rate of hospital admissions for self harm. However, it is *possible* that all the folks admitted for self-harm are none-BAME, for example.

Figure 10



Section 2: Understanding supply

We don't have data on mental health provision by ethnic group, as the majority of mental health services are provided at a whole-population level. However, we do have data on where NHS and community mental health providers are located and on where mental-health related charities are located.

The goal of this question is to understand: Are BAME communities under-served by mental health providers?

The data used:

We have two major datasets that we worked with:

1. Care Quality Commission dataset (CQC dataset).
   The CQC are an independent regulator of all health and social care services in England. They inspect different health providers and give ratings. For this analysis, we pulled all the health providers in London. Organisations were classified as a 'mental health provider' if either:
   - Inspection category is one of:
     - "Mental health - community & residential – NHS"
       - "Community substance misuse"
       - "Community based adult social care services"

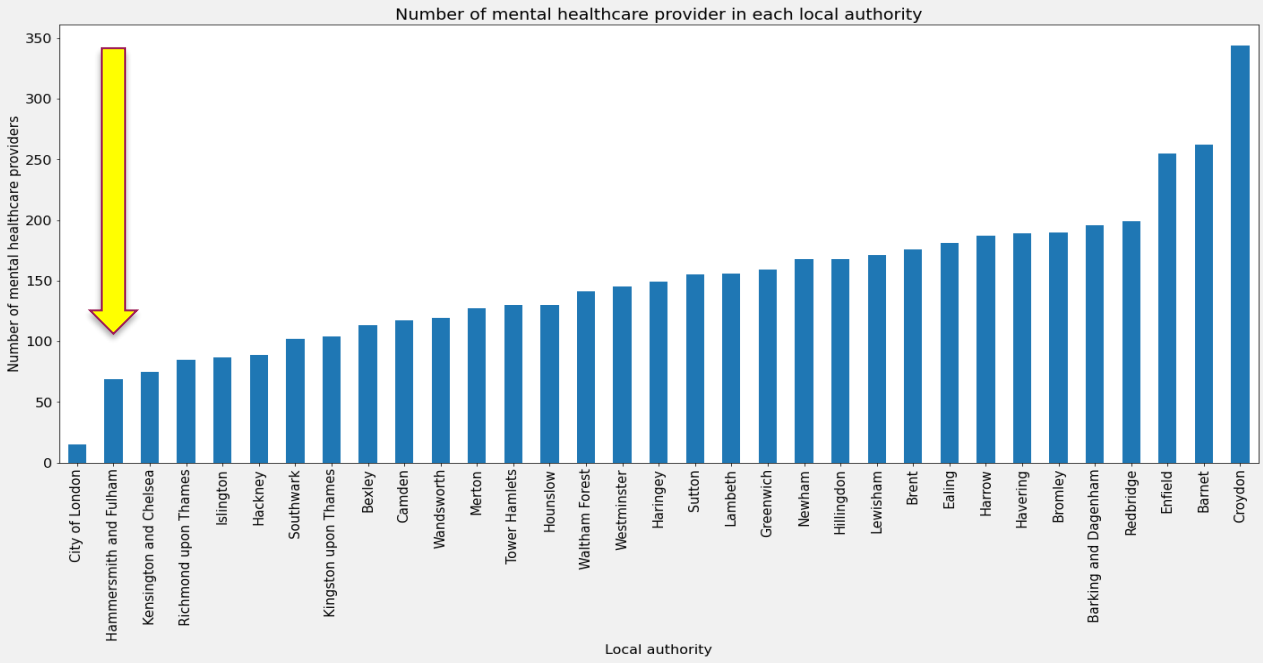
   - OR Specialism is one of:
     - Caring for people whose rights are restricted under the Mental Health Act
     - Dementia
     - Eating disorders
     - Substance misuse problems
     - Learning Disabilities
     - Mental health conditions

2. Charity Commission Data
   The other dataset is the Charity Commission data where the London health charities are extracted from the government official database. Here it is harder to identify whether a charity has mental health provision. We first included only charities that worked in "*The Advancement Of Health Or Saving Of Lives".* We identified charities as mental health charity if the charity's objective contains keywords like 'mental health, welling being, psychological…'. The key word list was not exhaustive so this might lose out some charities that we didn't capture.

Limitations: we may be missing some mental health providers that are registered as social enterprises. This could be extracted from Company House if we roughly know the names of the social enterprises but that is not done here. We may also be missing smaller groups that are not required to register with the Charity commission.

Figure 11 looks at the number of mental health providers in the CQC dataset in each local authority. Dental healthcare providers were excluded, even if they said they provided mental health services. This bar chart shows that Hammersmith and Fulham have amongst the lowest number of mental healthcare providers. Brent and Ealing fair better.

Figure 11

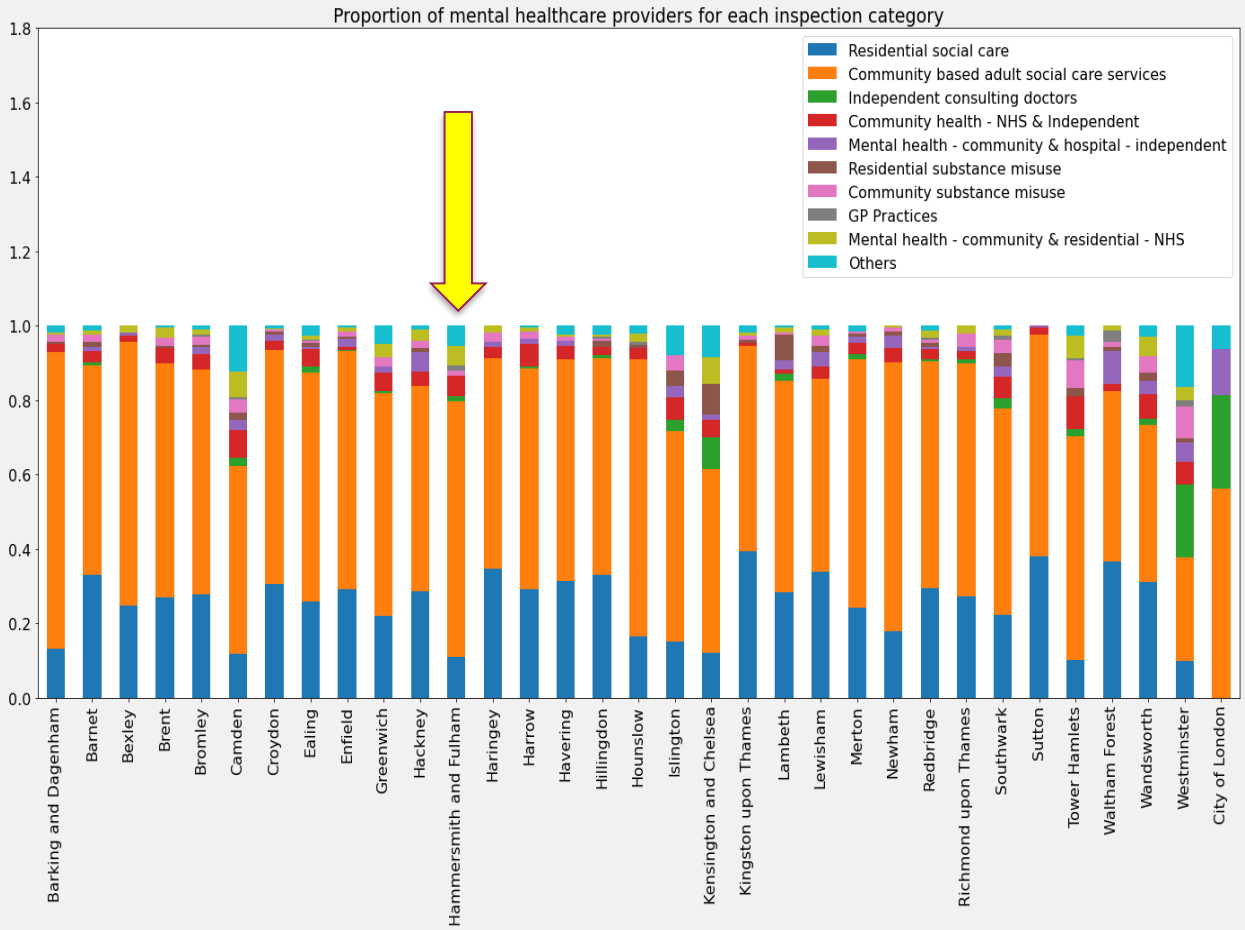


A limitation of this figure is that this is not divided over the population of each borough. In addition, only MH providers inspected by the CQC are included in this dataset.

Finding 8: Hammersmith and Fulham have the fewest mental healthcare providers (aside from City of London)

Next is a stacked bar chart on the type of mental health care providers that exist in the CQC dataset for each local authority. Here you can see the percentages of categories in H&F compared to all other London boroughs. There is a big percentage of the mental health providers in community based adult social care services.

Figure 12



Finding 9: The majority of mental health providers are community based adult social care services

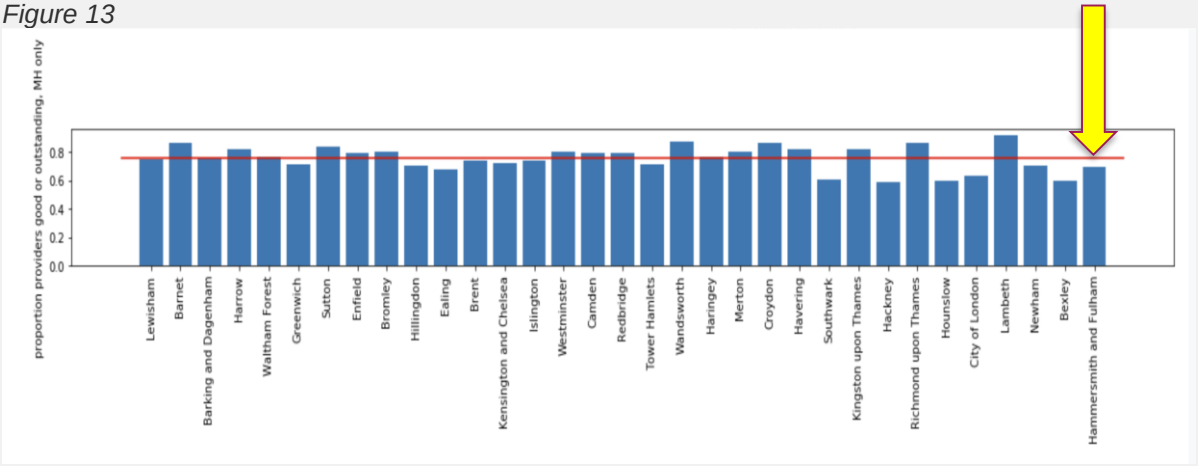
Table 4

Figure Facts	
Dataset used *What data did you use? Was it subset?*	CQC Dataset used to study number of mental healthcare providers in each local authority. We excluded all primary dental healthcare providers.
Interpretation *How should the charity interpret this?*	Proportion of residential social care providers in Hammersmith and Fulham and Kensington and Chelsea is lesser than for example in neighbouring borough of Ealing/Brent.
X-axis/predictor variable(s)	Local authority
Y-axis/dependent variable(s)	Proportion of mental healthcare providers according to different inspection categories. Others include: Ambulance service, Acute hospital - Independent non-specialist, Out of hours, Acute hospital - NHS non-specialist, Acute hospital - NHS specialist, Dentists, Acute Services - Non Hospital, Prison Healthcare, Slimming Clinics, Remote clinical advice, Acute hospital - Independent specialist, Hospice services, Urgent care services & mobile doctors

Finding 10: Hammersmith and Fulham are below the average value in London for proportion of mental health providers with good or outstanding ratings

Figure 13 looks at the proportion of mental health providers in a Local Authority that were given a good or outstanding rating by the CQC. Hammersmith and Fulham are slightly below the average proportion of providers with good/outstanding ratings.

Figure 13



Finding 11: % BAME population in a Local Authority negatively correlates with the proportion of good/outstanding mental health providers.

In looking at *all London authorities* in general, the presence of mental health providers with good ratings is negatively correlated with BAME population density within that local authority: the higher the BAME population density is in that local authority, the fewer good/outstanding mental health providers are in that local authority in general. Here BAME population density means the percentage of the population that is BAME. It's not a very strong correlation (correlation coefficient is -0.33, where -1 would be the strongest), but it's still a trend.

Figure 14

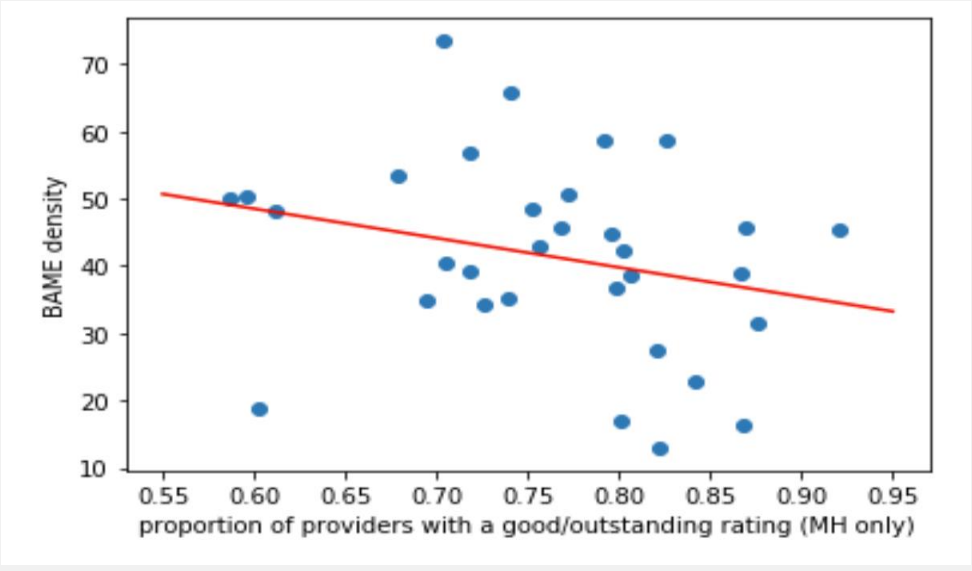


Table 5

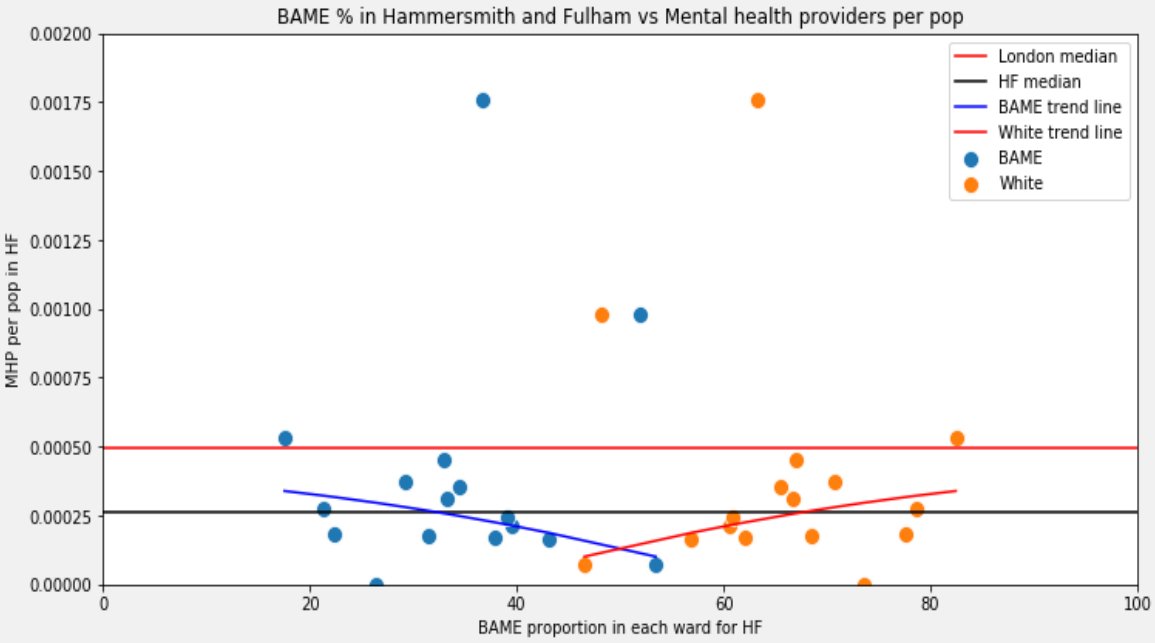
Figure Facts	
Dataset used *What data did you use? Was it subset?*	Clinical quality commission data. Each point is a Local Authority.
Interpretation *How should the charity interpret this?*	This scatter plot shows local authorities' BAME density plotted against the proportion of providers in that area rated good or outstanding. There is a significant negative correlation between BAME density and proportion of providers rated good or outstanding.
X-axis/predictor variable(s)	proportion of providers with a good or outstanding rating: (good + outstanding)/(good + outstanding + inadequate + requires improvement).
Y-axis/dependent variable(s)	Proportion of population in a Local authority that is BAME
Model/Technique (if applicable) *What sort of model did you use?*	Spearmans R
Limitations *Any caveats? How confident are you in the results?*	There is quite high variability, and a couple of datapoints clearly deviate from the trend.

Finding 12: % BAME population in a Ward in H&F negatively correlates with the density of Mental health providers

Here we dive into different wards that exist in H&F and map down the number of mental health services to the ward level. The total number of mental health providers (MHP) was then divided by the population of the ward, to give the MHP per pop in HF.

A value of 0.0005 means that there is 0.0005 MHP per person in that ward, or 1 MHP per 2000 people. What we found out is that there seems to be a negative correlation between the BAME population proportion at the ward level and the mental health providers per population i.e. when the proportion of BAME people living in the ward goes up, the density of mental health provision goes down.

Figure 15



One thing to note about this figure is that the data shown for the white population is by definition going to look the mirror image of the data shown for the BAME population. This is because in this data, everyone not white was deemed BAME - i.e if 40% of the population is BAME, 60% of the population is non-BAME (white). That's why the blue and orange data on this image are the mirror image of each other.

Table 6

Dataset used *What data did you use? Was it subset?*	CQC data, Ethnicity by ward (mapped to postcode)
Interpretation *How should the charity interpret this?*	This chart is like the one above but with trend lines added and grouping all BAME communities under one single category rather than being split by ethnicity clusters. The data is also compared against the median proportion of MHP in Hammersmith and Fulham (Black line) and the median proportion of MHP in London (Red Line). Hammersmith and Fulham have a lower proportion of Mental Health providers than all of London.
X-axis/predictor variable(s)	BAME and White % for Hammersmith and Fulham
Y-axis/dependent variable(s)	Mental health providers per population
Model/Technique (if applicable) *What sort of model did you use?*	Scatter plots
Limitations *Any caveats? How confident are you in the results?*	The trend lines for BAME and White communities were obtained by filtering the data and including only those below MHP per pop = 0.00075 in order to avoid outliers (2 pairs above 0.00075)

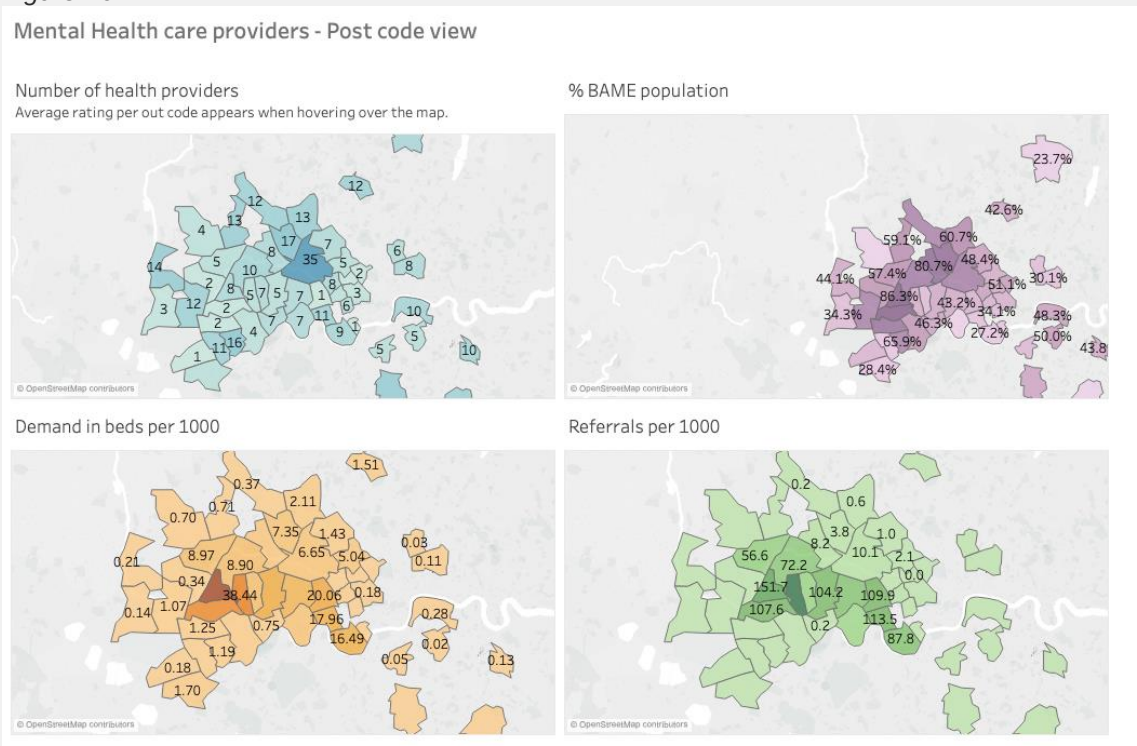
Finding 13: There may be a mismatch in demand and supply for mental health providers

Lastly, we made a Tableau dashboard comparing

- Number of health providers
- % of population that is BAME (taken from Public Health England)
- Demand in beds per 1000 people (using West London Trust admissions data and Census data)
- Referrals per 1000 people (using West London Trust referrals data and Census data).

One limitation: the population stats come from 2011 while the beds data come from the past three years and beds and referral data do not capture the real demand. The number of providers are health providers from the Charity Commission dataset rather than only mental health providers)

Figure 16

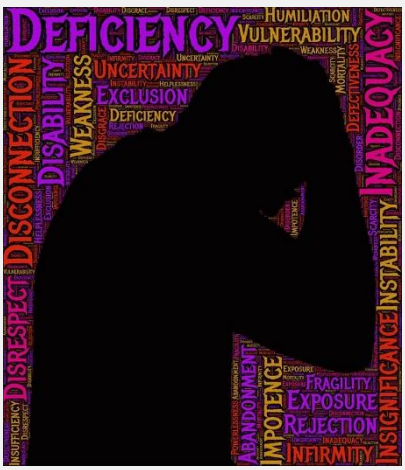


A tableau dashboard showing the mismatch between demand and supply. Referrals and Demand per 1000 people show how many referrals (or admissions) there were per 1000 residents, based on the 2011 census data for that Ward. The number of health providers is the number of *charities* from the Charity Commission data that provide health related services. These numbers don't include NHS/clinical services.

Section 3: Limitations

The main limitations are addressed in the findings, but it's worth highlighting a few here:

1. **Different datasets reflect different times**. The West London Trust data includes data from 2017-2020. The census data, which was used for some of the estimates of ethnicity, is from 2011, which is the most recent demographic data available. Sometimes we were able to instead use the population projections for 2019. However, in all cases, data from a 3 year period (2017-2020) was only compared to a single year. If there were substantial changes in the population during that time, the results may vary slightly.
2. **The public health data comes from different years**. Similarly, the data obtained from Public Health England came from different years depending on the metric used. Please reference the Data Dictionary to look up the relevant year.
3. For the CQC data we defined 'mental health provider' based on the provider's inspection category or specialism. We want to note that this is a categorisation provided by the CQC.
4. The ethnicity categories were aggregated due to small numbers in some of the groups. A more detailed analysis would be useful, but comes with the caveat that the number of individuals is small.
5. Correlation is not causation: We found some correlations between the % of population that is BAME and metrics of deprivation. A limitation of this sort of analysis in general is that it doesn't, for example, prove that increasing the proportion of BAME people in an area makes the area more deprived (due to withdrawal of services for example). It just says that as one metric goes up (or down) the other goes up (or down).



Community and Voluntary Sector Survey

As part of this research, Sobus undertook interviews with 17 local VCS organisations about local mental health services, needs and issues. Those surveyed delivered a range of services for youth, children and families, women, community, general welfare to mental health support. All of them operated in Hammersmith & Fulham and some in other west London boroughs.

The VCS organisations interviewed included:

1. 3 specialist mental health VCS services: collectively supporting around 330 clients per month, of which around 35% are from BAME communities
2. 11 small or micro BAME VCS organisations: collectively supporting around 953 BAME clients per month, of which around 37% present with possible mental health needs.
3. 1 generalist VCS service supporting all age ranges, predominantly in the north of the borough. This service supports around 2,684 clients per month, of which 80% are from BAME communities. Of this client group, the service reports that the majority of clients present with possible mental health needs.
4. 1 generalist VCS older people's service supporting 120 older people, of which 51-75% are from BAME communities. The service reports that on average 1 client per month presents with possible mental health needs.
5. 1 generalist VCS service supporting 45 young people, of which 76-99% are from BAME communities. The service reports that on average 1 client per month presents with possible mental health needs

Organisations were asked, when faced with a client with possible mental health needs which they were unable to support, which organisations or services they referred these clients to:

i. GP: the majority of organisations surveyed reported that clients were often advised to contact their GP regarding any mental health concerns. A high number of BAME organisations reported that clients often needed their support to make this initial contact, with language and cultural barriers and a high level of anxiety being the predominant reasons for this.

ii. Adult social care services were also high on the list of organisations that clients are referred to.

iii. Specialist mental health providers: Maytree, Back on Track, Alzheimer's Association, Dementia UK, H&F MIND and Richmond Fellowship were the most cited specialist mental health providers referred to.

iv. Family: organisations reported that often, a client may not have disclosed their mental health needs or concerns with family members or friends. Often this is

due to the fear of stigmatisation but mainly a desire to not be a burden to family/relatives. Most organisations reported that if they think the client in question has very low level mental health difficulties, they would encourage clients to reach out to family and friends for support in the first instance.

v. Where faith or religion is a key part of the individual or their family's life, many reach out to Imams, church leaders or other faith groups for help and assistance with mental health concerns. Recent feedback from Faith leaders has included a request for further information and training, to enable them to better support individuals presenting with possible mental health issues.

VCS organisations reported that for many clients, a friendly and non-judgemental listening ear is often all that is needed, alongside information, advice and guidance on where to get specialist support should it be needed.

For the most part, organisations interviewed appropriately identify the most suitable service or organisation to refer to, but report that some services can be harder to access, cannot meet the specific needs of the individual, or do not have the capacity to support additional or new clients. Many report difficulties in successfully making initial contact with mental health services, which are widely considered to be difficult to access and complex to navigate, even for those not facing additional challenges of language and cultural barriers. Navigating through the system can be extremely difficult – even for those experienced in engaging with statutory services.

"I haven't yet figured out what the password is to open the gates to these services, but I certainly haven't said the magic words yet! I asked for help 18 months ago, and I'm still waiting."

VCS representative with recent lived experience of trying to access mental health services

Differentiations between professions and statutory organisations and knowledge of the correct terminology is irrelevant to service users and the organisations that support them, who are just trying to get the help that is needed. There is a common perception that services are intentionally designed to be difficult to access, in order to avoid an increase in demand that cannot be met. Organisations report that they, and their clients, often simply give up trying to get the support they are seeking – whether due to extremely long waiting lists, lack of a response or reply from services, or being repeatedly advised that they need to approach a different organsiation or service.

At a time when people are in urgent need for support, the existing systems appear to be unhelpful at best.

Key perceptions and themes:

There is a lack of support to address the needs of BAME communities. This included the lack of cultural, holistic and community based approaches	There is a lack of diversity in professionals and support workers to understand and address the needs of specific communities.	Mental health services not well promoted in BAME communities therefore the assumption for most is that that service is not available, suitable or appropriate for them
The mental health needs of young people are not being met	Language and communication issues result in a lack of engagement	Communities turn to faith and cultural based practices to deal with mental health issues
There remains a significant stigma attached to people living with mental health difficulties		**Communities are not engaging with mental health services until it's too late (acute or crisis point is reached)**

Mental Health provision gaps

over 94% of those surveyed felt that there was a gap in service provision.

"There is a lack of holistic services based on cultural values and faith" *BAME organisation*

"Lack of MH awareness in some communities needing different approach" *Mental Health organisation"*

"Services are not promoted well, especially to people where English is the second language" *BAME organisation*

"Service users in most instances have to rely on self-referral for rehabilitation for those on drugs" *BAME organisation*

"There is a lack of adequate follow up in all sectors" *Older People's Organisation*

"There are a lot of young people with mental health issues"

"Social issues have not been addressed at all nor fully" *BAME organisation*

""GPs tend not to explore the issue, or issues as insufficient time available in a consultation appointment" *BAME Organisation*

"Stigmatization of people living with mental health and mental ill health prevents the conditions being incorporated in daily life discussion to be viewed as normal" *Children and Family Centre*

"MH services are not well promoted in the BAME communities and they assume that they will not receive appropriate support". *BAME Organisation*

"Professionals that have cultural background knowledge and experiences are needed. Fear of involvement with statutory services –"being marked within their community". We require more professionals and organisations with cultural knowledge and experience from the specific cultural groups" *Children and Family Centre*

"There do not appear to be many dedicated BAME mental health services available" *Community Centre*

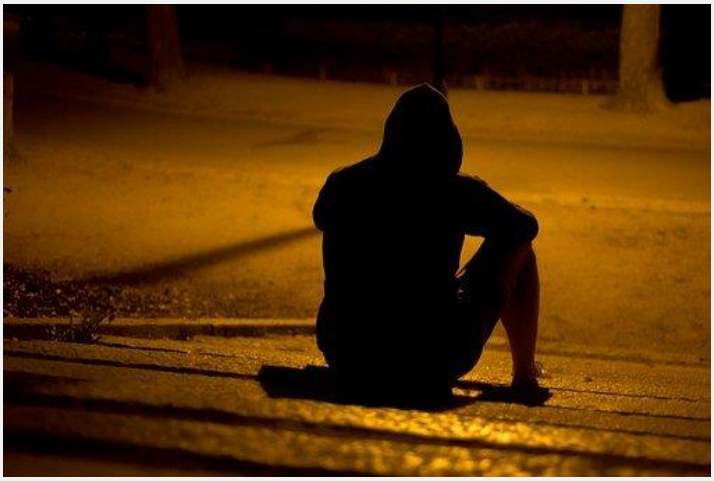
" Young girls from about the age of 14 tend to disappear unless I keep in touch with them" *Church based youth service*

"Young people report that their parents are disengaged as English tends to be their second language, which restricts their engagement with statutory services – Parents then rely on Imams, prayer and non-statutory community offerings" ***BAME organisation***

Young Hammersmith & Fulham Foundation study

In association with this project YHFF undertook a survey and analysis of community mental health provision of young people of the African diaspora. This included focus groups with young people.

The work identified stigma, lack of awareness, lack of collaboration, lack of diversity, lack of resources and difficulty in engaging as barriers for children and young people of the African Diaspora in accessing mental health services.



Young people participating in the study reported:

"I would google it…I wouldn't know who to go to, like a doctor or anyone, they're more for physical things"

"When I was going through school, there was nothing that could be done about (my mental health), and if there was, it was someone who was not my skin colour, not my religion, not having people understand."

"The culture of mental health in Somali communities is very difficult, similar to other communities, but we still haven't got to a process where it's being acknowledged"

YHFF Report**:** ***"****An analysis of community provision to support the mental health of children and young people (0-25 years) of the Africa Diaspora"*

https://yhff.org.uk/images/downloads/ypfWebsite/An-analysis-of-community-provision-to-support-the-mental-health-of-Children-Young-People-0-25-years-from-the-African-Diaspora.pdf

Conclusions and recommendations

Sobus and the BAME Mental Health Group has considered the findings from the research, and drawn together a range of conclusions and recommendations which they believe are needed to redress the imbalance and inequalities experienced by isolated communities facing mental health issues.

1. **Increased provision**: It has been generally acknowledged that support for marginalized and excluded communities experiencing poor mental health needs to be increased.

Recommendation 1: Health and social care bodies, including the CCG, local authority, Integrated Care System and Partnerships and acute health trusts should increase investment in and give higher priority to identifying, preventing and supporting mental health needs, particularly for residents from excluded and marginalized communities.

2. **A broader impact**: The cost impact of mental health is much broader than directly on mental health, adult social care and primary care services. It has an impact on broader issues, including the wider economy and employment; the physical home environment, housing security and stable tenancies; physical health and wellbeing, including self-management of long term health conditions, poverty and food security, children and young people's education, attainment and development, community cohesion and the quality and feel of our neighborhoods, as well as on the general family and household wellbeing and dynamics. VCS organisations are consistently supporting residents to deal with a myriad of these issues – some the *direct result* of mental health problems, and others, the *cause* of mental health decline.

Recommendation 2: Mental health should be given higher priority and focus in broader work of statutory and community services. The impact of Mental health should be considered in the development of generic services including housing, education (including mental health of the parents/carers of students), family support, adult learning, skills and employment, environment and culture, as well as broader policy and community development initiatives

3. **An equalities focus**: Whilst mental health is considered under the protected characteristic of Disability as part of Equalities Impact Assessments, the perception is that only significant or substantial mental health needs are routinely considered. The Equality Act 2010 states that a mental health condition is considered a disability if it has a long-term effect on an individual's normal day-to-day activity, or if it is likely to last for 12 months or more. However, the interpretation of this often

appears to be subject to individual service policy and individuals' approaches, beliefs, level of compassion, experience and understanding.

<u>Recommendation 3</u>: Equalities Impact Assessments should be undertaken by all statutory bodies for all service development and decision making, and should be undertaken collaboratively with communities to ensure they are thorough, meaningful and effective. EIAs should consider lower level mental health needs as part of the protected characteristic of Disability, and in the consideration of the protected characteristics of Race, Religion or Belief and Sex. EIA reports should be made public to promote transparency and openness.

4. **Cultural sensitivity**: Many services lack cultural sensitivity or flexibility. Services do not appear to accommodate cultural differences, or even appear to acknowledge or understand these. The result is that services are perceived as unwelcoming, inaccessible, inappropriate and inflexible, particularly to marginalized and excluded BAME communities who are often at higher risk of poor mental health, and who are furthest from the care and support that should be equally accessible to all. Some organisations reported that lack of cultural awareness and practices has resulted in the misdiagnosis of individuals. It would appear to some as if diagnostic tools do not take account of an individual's background. This particular issue relates closely to point 8, where people's fear of mental health stems from the poor experiences of treatment received by others from their community.

"It feels as though this service is inherently racist – they choose not to provide me with the service that I need, because they will not provide a service that meets my cultural needs."

<u>Recommendation 4</u>: Service providers should invest in supporting and developing institutional cultural competency and sensitivity in service delivery and community support. This could be enhanced through better engagement with local BAME and VCS organisations, who could be well positioned to inform, shape and deliver training in this area, in order for services to better meet the needs of all local communities.

5. **Collaboration and coproduction**: Community organisations, with real and current experiences of supporting people with mental health issues, are not given sufficient opportunities to inform and shape local mental health services. Commissioning activities tend to be undertaken in isolation by statutory bodies, with little or no meaningful engagement with the community to ensure a more in-depth understanding of local needs can be established. Statutory bodies appear to base commissioning intentions on clinical statistics and data – but all too often, the issues dealt with in the community are sought and are not seemingly valued.

<u>Recommendation 5</u>: Statutory services should embed systematic coproduction and collaboration of the BAME, Faith and broader VCS community in a comprehensive range of activities, including service design, development and review; monitoring and evaluation; commissioning, and decision making processes. The VCS and local residents should have the opportunity to elect services or service areas they would like engagement opportunities to be provided, and statutory bodies should give full consideration and publicly report on when and how this can be supported, at what level, or why engagement is not able to be facilitated.

6. **Accountable decision making**: Decisions about local services do not always follow meaningful engagement with residents and the organisations which support them. Whilst many services routinely gather feedback from service users and their carers, those not involved in those services don't always have the opportunity to contribute their views, or they are so unfamiliar with the concepts and services being discussed, that their contributions are at times dismissed as lacking relevancy and "off topic". Both the CCG and LBHF promote consultation and engagement opportunities, and a number of these activities have been highly successful at creating genuine opportunities to shape and inform local services, such as the LBHF Disability Commission.

   Whilst consultation activities are widely publicised through digital channels, there is often a lack of response, particularly from excluded and marginalised communities. The use of social media to promote engagement opportunities is undoubtedly effective at reaching large swathes of residents, but BAME residents, who are more likely to face multiple barriers, including culture, language, deprivation, digital exclusion and awareness of statutory services and their concepts and language, are subsequently less likely to participate. Decision's taken by health bodies are not well publicised or reported, and although the local authority offers residents good access to Policy & Accountability Committee and Decision Reports, these are usually lengthy, jargon-heavy and therefore not easy to digest. The other issue is of course, that by the time a decision report has been published, the opportunity to influence or contribute to the final recommendations has long since passed. Anyone interested in exploring future engagement opportunities, often needs to expressly search through statutory body websites and reports to identify opportunities themselves.

<u>Recommendation 6</u>: A schedule of engagement opportunities across all statutory bodies should be developed and published, which are systematically planned and appropriately resourced, to enable residents and VCS organisations to be able to participate. A statement on engagement activities and the degree of community input on the final recommendations should form part of every statutory sector decision report.

7. **Mental Health awareness**: There is a lack of awareness within local organisations about the range of mental health issues that can be experienced, how they present, and when and where to seek specialist support. Information and advice is too often taken at face value from unreliable or outdated sources, with the prevalence of misinformation all too readily available, particularly through social media and digital platforms. This results in a high risk that organisations could provide inappropriate or potentially harmful advice.

Recommendation 7a: Statutory and specialist mental health providers should develop and offer information sessions to local VCS networks and organisations on mental health conditions, how they most commonly present and how and when to refer clients to specialist services. This information should be centrally held and readily available to local VCS organisations who may be supporting clients with mental health needs.

Recommendation 7b: Mental Health training (including Mental Health First Aid) should be made freely available to local VCS organisations.

8. **Tackle misconceptions:** Despite efforts to destigmatise mental health, there remains in many communities a deep-rooted resistance to acknowledge they may need help and support. Many continue to regard poor mental health as something to be feared, as there remains a lingering misconception that families will be separated, children taken into care, elders placed in institutional homes or otherwise tragic outcomes. For others, the fear of mental health is around how it may be perceived as an inherent weakness in the individual, their family values, and standing in the community. Individuals and families may go to great lengths to hide or conceal mental health difficulties, often resulting in more rapid and significant deterioration than may have been the case, had appropriate support have been accessed.

   Whilst information about mental health issues, services and support is widely available, and is often available in community languages, the information itself does not take into consideration the culture, beliefs and practices of the communities they are trying to reach. This issue relates closely with recommendations 4, 5, 9 and 10, and through better cultural awareness and engagement with community organisations, more effective communication, information products and approaches may contribute to improved understanding and perceptions of mental health.

Recommendation 8: statutory bodies should work with VCS organisations to develop culturally relevant information products.

9. **Support for young people:** It is well established that young people are at particular risk of experiencing mental health difficulties. However, mental health services are often not perceived as accessible by young people, and there appears to be a disconnect between adult practitioners, whom young people perceive as patronizing and lacking any real understanding of the issues facing young people. Young people tend to seek support through their peers, which, as already stated, is often misguided, incorrect or outdated. Young people in general felt that mental health services "are not for me", and that even it was, support is not available at critical times when it is most needed.

Recommendation 9: Statutory and community mental health services should work with organisations and community leaders who effectively engage with and are well regarded by young people, in order to develop more effective early intervention and support for young people.

10. **Updated information**: Organisations, and indeed local residents are too often reliant on outdated and incorrect information, as changes in service names, providers, staff, structures and the latest policy, government directive, branding or terminology, can often result in contacts and information quickly and frequently becoming out of date. Whilst many services do send out updates about their service, it remains the case that a multitude of services, providers and organisations produce individual information products, but there is no single source of information that clearly sets out which body is responsible for which part of the service pathway, the support and services that are available, and how to contact and access them.

Recommendation 10: A single, comprehensive package of information should be produced by both statutory and specialist community health providers. This information should include:

- **An overview of mental health service pathways for both low level, moderate and acute services**
- **What interventions or support are available as part of those pathways**
- **Which organisations and services provide those interventions**
- **Contact and access details of each service**
- **Information on the accessibility of those services for excluded and marginalised residents**
- **Information on the service standards of mental health services – including target response times**
- **A jargon buster section, which sets out commonly used terminology**

This information should be widely and publicly available, updated annually, with clear accountability for updating the information by all statutory and commissioned community mental health services.

11. **Prevention**: It has long been recognized that preventative services can avoid or delay costlier interventions. However, whilst it is readily acknowledged that the availability of mental health services, self-help resources and information for those experiencing level mental health needs was greatly increased during the 2020 Covid-19 crisis, it remains the case that pressures of work, home, family life, physical health, finances, isolation and loneliness often lead to mental health difficulties, yet there remains little recognition of the longer term preventative impact of non-clinical services on mental health.

    Whilst significant levels of funding are pumped into statutory mental health services, little of this is being channeled into local VCS services. Funding, combined with in-kind support, better engagement with mental health services, and improved communication and information could make a significant difference to improving the health and wellbeing of the whole community and in particular, those who are disproportionately affected by mental health issues. VCS organisations are experienced in delivering projects at lower cost, and are best placed to engage and support residents at the earliest possible stage, to tackle triggers and issues that could potentially result in mental health problems in the future.

Recommendation 11: Statutory sector organsiation should explore with the VCS community, how they can support and invest in non-clinical community led projects to develop early intervention and a community focused approach

12. **A representative workforce**: There is evidence[5] of, and a persistent perception that statutory and specialist mental health services do not reflect the communities they support – therefore, are not as sensitive to cultural and community differences as they could be. Diversity, inclusion and equalities should be clearly embedded both in services and in all levels of the organsiation, to ensure diversity across the organsiation, its workforce and its leadership is evident.

Recommendation 12: Mental Health service providers should develop a more diverse and representative workforce at all levels to reflect the communities they serve, in order to deliver a more engaged and effective service.

13. **Service Location:** the local availability of services is one of the key issues which present a barrier to residents accessing mental health services. Many struggle to travel outside their immediate area and community, particularly those with busy home or work lives, or who live in an area in which their everyday needs are well met, or those who would struggle to afford either the time or cost to travel to unfamiliar areas or services – particularly at a time in their lives when they are emotionally vulnerable.

    First point of contact with mental health services could be more effective if locally based and accessed through trusted community organisations and would help

[5] https://www.kingsfund.org.uk/publications/workforce-race-inequalities-inclusion-nhs http://raceequalityfoundation.org.uk/wp-content/uploads/2018/03/health-brief3.pdf https://www.kingsfund.org.uk/publications/articles/unconscious-bias-and-its-effect-health-care-leadership

address negative perceptions of mental health and related support services. Closer proximity to the first point of contact may also enable residents to seek support locally, which would not impact their work, home and family commitments and demands.

Recommendation 13: mental health services should consider delivering first point of contact services in community settings to make them more accessible.

14. **Client data**: One of the more challenging aspects of this research was extracting the true profile of service users, as generic categories are used to describe ethnicity. It was evident during the data dive that at times this information was not captured systematically or routinely. Better data would enable a clearer understanding of the specific gaps in service provision and take up, and only by knowing this can we ensure that services are effectively targeted and delivered.

Recommendation 14: Service providers are encouraged to:

i) develop, maintain data systems that provide more granularity and accurately record the current profile of their client group including ethnicity, gender, age, sexual orientation and location.

ii) Make this data more accessible to communities and others supporting mental health work to identify needs and development of appropriate services.

15. **Tackle institutional racism and unconscious bias**: It is apparent at present because of broader news about Government, from Windrush to policing and justice, that institutional racism does exist[6]. We feel it right therefore, to raise this in the context of this report's findings and that services should consider looking at their provision and what changes they need to make to ensure greater equality.

Racism adds to the inequalities and is one of the main drivers of the disproportionate prevalence of mental health issues within BAME communities in our society. Sometimes it is difficult to call it out for what it is, even within the sector, for the reaction it elicits.

Whilst significant steps have been taken locally, notably the LBHF appointment of a Cabinet Member for Social Inclusion, we think it valid to state that service providers need to address this issue in the context of their organisations. Meaningful change can only happen if institutional systems and culture are looked at as well. Explicit training to understand unconscious bias and how it might manifest in the workplace and in the provision of services, developed and delivered with BAME led organisations would likely generate positive outcomes for all.

Recommendation 15: Statutory services should review their equalities and diversity training to ensure unconscious bias is explicitly incorporated, and coproduce this training with BAME communities and the organisations that support them.

[6] https://www.crimeandjustice.org.uk/publications/cjm/article/implicit-racial-bias-and-anatomy-institutional-racism

Acknowledgements

Our sincere thanks are given to all those who contributed to this project, including:

Contributors

Sobus:
Shad Haibatan
Sharon Tomlin
Sue Spiller

Data Ambassadors
Jordan Freedman
Zara Sari
Billy Zhao
Troubleshooter: Tom Wagstaff

Project partners
Jazz Browne, Nubian Life Resource Centre
Vanessa McCain, People Arise Now
Annie Rockson, Young Hammersmith & Fulham Foundation

Project support:

Superhighways Project
Alice Linell
Kate White

DataKind UK
Dulcie Vouden
Nicole Holgate
Giselle Cory

Data contributors
West London Mental Health Trust
London Borough of Hammersmith & Fulham
Hammersmith & Fulham GP Federation

BAME Mental Health Group members

Age UK Hammersmith & Fulham
Health Watch Central West London
Community Education Forum
Young Hammersmith and Fulham Foundation
Historical Me
Nubian Life Resource Centre
Quiq Inspire
People Arise Now
WILDE Foundation
Write – London

Sobus VCS Survey participants:

- Banooda Aid Foundation
- Community Education Forum Youth
- Community Education Forum: Women
- H&F Mind
- Feel At Home
- For Brian
- Hodan Somali Community
- I Am With You
- Imaan Care
- Kulan Foundation
- Nubian Life Resource Centre
- People Arise Now
- Richmond Fellowship
- St Andrew's Youth Club
- Urban Partnership Group: Addison Community Champions
- Urban Partnership Group: Masbro Elders
- WILDE Foundation

Our thanks also go to the DataKind volunteers who donated their time and skills over a long and busy DataDive weekend in September 2020.

Dawes Road Hub
20 Dawes Road
London SW6 7EN
https://sobus.org.uk
@sobus_H_F
info@sobus.org.uk

Pivotal, The Bower
211 Old Street
London, EC1V 9NR
datakind.org/chapters/datakind-uk
@DataKindUK
contact@datakind.org.uk