

MIND THE GAP

A REPORT ON
BME MENTAL
HEALTH SERVICES
PROVISION IN
CROYDON



CROYDON BME FORUM

TALK TO US

OFF THE RECORD

This report is the product of a new partnership established between **Hear Us** (Croydon's Mental Health Service User Group) and Croydon's Black and Minority Ethnic (BME) Mental Health **Community Development Workers** (CDWs) based within two key organisations:

- **Croydon BME Forum** - The recognised umbrella and Local Infrastructure Organisation for Croydon's Black and Minority Ethnic voluntary and community sector organisations
- **Off The Record Croydon** - A Croydon-based support service providing free support to children and young people going through tough times

On behalf of all the project partners, we would like to express our sincere gratitude to everyone who has contributed to this report, including Comic Relief who have generously funded this strand of work.

Many thanks to the Hear Us Linkworkers, who have worked alongside the project team to facilitate discussions and support service users to begin a dialogue with us about their experiences.

We would also like to express our gratitude to mental health services who have opened their doors and taken part in this project, supporting us to hear the voices of their service users, staff and carers so that recommendations for improvement can be made. Our specific thanks to:

- Gresham 1 Women's Acute Ward
- Gresham 2 Men's Acute Ward

- Foxley Lane Women's Residential Service
- Tamworth Road Resource Centre

This report provides an insight into the experience of Black and Minority Ethnic (BME) mental health service users navigating their way through the mental health system. Without the openness and honesty of both the service users, carers and staff we interviewed, this report would lack the human element of their experiences. We hope that we have done justice to their words and are humbled by their honesty and insight into the BME service user experience.

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This report aims to provide an insight into the experience of Black and Minority Ethnic (BME) service users accessing mental health services within the Borough of Croydon.

Project Aims

Through discussion with service users, carers and members of staff, the project sought to explore the following questions:

1. What do BME service users experience as they navigate their way through acute and community mental health services in Croydon?
2. What challenges are faced by BME service users, their carers and service staff within mental health services, in particular reference to the service users' ethnicity?
3. What recommendations can be made so mental health services can better meet the needs of service users from BME backgrounds, as identified through this partnership project?

This report presents and summarises the voice and experience of the participants in their own words.

Project Background

Croydon's population comprises of 363,400 residents, with 44.9% of these residents coming from BME communities. Croydon has the twelfth-largest proportion of Black and Minority Ethnic (BME) residents in London, making its demographic comparable to inner London boroughs such as Hackney, Lewisham, Lambeth, Barking and Dagenham.

In terms of the health and wellbeing of

Croydon's BME population, mental health is a core component and is as important as physical health. Good mental health is a key factor in successful psychological and social functioning and poor mental health is associated with poor socio-economic status, poor education and poor opportunities for employment, and a host of inequalities, some of which fall under the umbrella term 'social exclusion'.

According to the London Health Observatory's mental health scorecard, last conducted in 2011, Croydon does well on some aspects of primary care mental health services but less well on others:

"Croydon has met its target for employing community development workers, but there are inequalities in admissions to adult psychiatric inpatient services by ethnic group"

"There are ethnic inequalities in admissions to adult psychiatric inpatient services in Croydon... The admission rate for White ethnic groups in Croydon is 32% higher than the England average for all ethnic groups, whilst the admission rate for Black ethnic groups in Croydon is almost double the England average"

This report aims to explore some of the inequalities previously identified, giving participants an opportunity to share their experiences and express their voice, highlighting the often overlooked aspects of BME mental health service provision.

The Need for Partnership

Since 2007, Hear Us has managed a user focussed monitoring (UFM) project within mental health services in Croydon. This

project, called the Linkworking Project, recruits current or ex local service users (Linkworkers) to visit mental health services and conduct consultation sessions with service users. Through these sessions, Hear Us provides an opportunity for service users to raise their concerns, issues and needs as they arise, which can then be fed back to the service providers (via the Linkworkers).

By providing a Linkworking service within mental health settings, Hear Us' objectives are to:

- Improve service users' experiences of accessing services, enabling greater involvement of people with mental health problems in the delivery and provision of services.
- Encourage Linkworkers to engage positively with services, providing an opportunity for Linkworkers to engage in meaningful work and develop attitudes towards mental health.
- Enable service providers to develop more inclusive and accessible mental health services and organisations, in particular for BME communities.

The remit of the CDWs is to support mental health services and community organisations to engage Black and Minority Ethnic (BME) communities in their work by:

- Empowering BME communities to play a key role in the development of services.
- Identifying barriers to accessing mental health services.
- Raising awareness of mental health issues and challenging mental health stigma within BME communities.
- Acting as a supportive link between

BME communities and mental health services.

- Helping organisations to build capacity.
- Bridging the gap between community organisations and statutory services, providing information and advice on how to engage with BME groups.

Using the Linkworking Project, the project partners had an existing mechanism to enable them to reach service users from BME backgrounds within mental health services. The partnership has enabled the team of Linkworkers to work alongside the CDWs, using the model of peer-to-peer support and user focussed monitoring to encourage service users to share their experiences. Through these discussions, the project began to investigate and collect the experiences of BME service users, carers and members of staff within the mental health system, which are presented in more detail in the following report.

This report aims to explore BME Mental Health provision in Croydon and establish the inclusivity and accessibility of local mental health services.

The Strategy

A new partnership was established to conduct this report between three key partners: **Hear Us** (Croydon's Mental Health Service User Group) and Croydon's Black and Minority Ethnic (BME) MentalHealth

Community Development Workers (CDWs) based at **Croydon BME Forum** and **Off The Record Croydon**.

The project partners' main aims were to engage service users, carers and members of staff in discussions around the following questions:

1. What do BME service users experience as they navigate their way through acute and community mental health services in Croydon?
2. What challenges are faced by BME service users, their carers and service staff within mental health services, in particular reference to the service users' ethnicity?
3. What recommendations can be made so mental health services can better meet the needs of service users from BME backgrounds, as identified through this partnership project?

Using the Hear Us Linkworking Project, which recruits current or ex local service users (Linkworkers) to visit mental health services and conduct consultation sessions with service users, the project partners have been able to reach both service users

from BME backgrounds and members of staff within mental health services. Carers have also contributed to the report, which attempts to summarise the voice and experience of all the participants in their own words.

Having identified a target sample, a qualitative approach was adopted, including semi-structured interviews and focus groups. A grounded approach to the data analysis was then undertaken, whereby a complex range of themes emerged.

The Findings

1. **Dignity in Care:** Concerns were raised about the level of dignity in care provided by mental health services and how responsive staff members were to service users' requests
2. **Medication Issues:** There is a lack of information regarding medication and side-effects, with participants feeling that there is an over-reliance on medication and a need for a more holistic approach towards treatment
3. **Cultural Competency and Sensitivity within Services:** There is a lack of understanding towards cultural difference and cultural requirements, ranging from the provision of food, overcoming language barriers and awareness of cultural issues
4. **Shortage of Staff and Resources:** The shortage of staff across community and acute settings clearly affects the quality of support being provided to service users, resulting in long waiting times and delays to service users'

- recovery.
5. **Care Pathways Communication:** Participants felt that the communication channels faltered at the point of admission, discharge and referral, which in turn left service users feeling anxious and unclear about what support is available.
 6. **Care Planning and Care Coordination:** Service users provided mixed feedback about the care planning process and their care coordination, highlighting the need for more active involvement from service users and more regular reviewing from staff.
 7. **Stigma and BME Communities:** The stigma of mental health illness amongst BME communities creates a barrier to BME service users accessing and receiving support. Lack of knowledge and understanding of cultural beliefs has an influence on how service users and their families perceive mental health illness and treatment.
 8. **Poor Provision for Refugees and Asylum Seekers:** Refugees and asylum seekers approach mental health services with complex needs, however services are not equipped to respond to these needs. Refugees and asylum seekers are reluctant to be referred onwards, resulting in significant challenges in accessing necessary and vital support for these service users.
 9. **Challenging Experiences for Carers:** Carers feel a sense of guilt, tiredness and frustration, particularly in reference to the information flow between mental health services and carers.
 10. **The Need for Talking Therapies:** There is a need for increased access to talking therapies for service users, which needs to be offered as part of an integrated, ongoing support. The challenges in delivering talking services to BME service users also need to be recognised and addressed.

The Recommendations

The report presents eleven recommendations to Croydon's mental health community, including commissioners, service providers and local community organisations. The recommendations to improve BME Mental Health service provision are as follows:

1. Provide services which offer patient-centred care, which accounts for individual needs and involves service users in all decisions about treatment and medication
2. Provide cultural competency training to staff, professionals and families
3. Recruit more staff, including personnel from a BME background
4. Reduce the burden of bureaucracy to improve services. In particular, it is important to:
 - a. Review the format of the data system
 - b. Simplify the procedure to access services
 - c. Improve inter-agency work and communication

5. Provide better information to overcome language barriers:
 - a. Develop information leaflets in different languages
 - b. Provide language prompts and props
 - c. Enable easier access to interpreters
6. Improve awareness and provision of support services as follows:
 - a. Services should offer more practical help in building life skills and supporting recovery
 - b. Improve information on available support services
 - c. Commission more community support groups
7. Improve the support provision for refugees and asylum seekers as follows:
 - a. Provide age appropriate support services for refugees
 - b. Provide services that regularly engage with and have access to local refugees' voluntary services for peer support and cultural reference
 - c. Ensure service staff have the necessary tools for effective communication
8. Improve support for carers as follows:
 - a. Fund more support groups
 - b. Resolve confidentiality issues
 - c. Provide more information and training for the family to combat stigma
 - d. Offer respite and psychological support
9. Improve access to talking therapies
10. Provide access to mental health advocacy
11. The gap in service provision for BME young adults (18-24 years old) should be closed

The findings and recommendations for improvement are detailed within the following report, presenting vital actions which need to be implemented by the local mental health community in order to close the gap in BME mental health inequalities.

This research commenced in April 2012 and the final report was completed in February 2013. The London Borough of Croydon provided the demography for the research.

The research focused on the perspectives of BME mental health service users, carers, community organisations and mental health staff who currently access or have accessed, provide support or work within acute and community mental health services operated by South London and Maudsley (SLaM).

The research set out principally to give all participants an opportunity to share their experiences and express their voice.

Research Design

The questions went through considerable re-write and rearrangement thought necessary to capture participants' experiences. Letters were also constructed and agreed to by the authors and sent to all of the prospective services, informing them of the desire to conduct research at their location.

The research collected information from different participants where perceptions and values which cannot be quantified, were judged. As a result a qualitative approach was identified as the most suitable for understanding and exploring the impact of all experiences.

The target sample included BME mental health service users, staff, carers and other community based stakeholders. Participants were recruited from four mental health services within SLaM and BME community organisations in Croydon, either via the Hear Us Linkworkers or directly through the BME mental health community development

workers contacts.

Data Collection

A total of twenty-eight sessions were conducted over the data collection period. Through these sessions a total of thirty-eight service users, twenty-six members of staff and seven carers were consulted. In total, seventy-one participants contributed to the report.

The method for data collection included the use of two tools:

1. Face-to-Face semi-structured interviews

Interviews were conducted with service users in all four services. Additionally, internal interviews with service staff, external interviews with both service user's carers and members from BME community organisations took place. Each interview was based on a semi-structured topic guide, which allowed participants to talk in depth about specific issues if they wanted to. The interviews were carried out by the BME mental health community development workers, with additional support from the Linkworkers.

2. Focus Groups

External of the services, two focus groups with ex-service users took place. There were also four internal focus groups with staff. The focus groups, similar to the interviews, were conducted using a semi-structured topic guide. However, they also incorporated participatory appraisal techniques which encouraged participants to engage with discussions. The focus groups were facilitated by the BME mental health community development workers.

Data Analysis

A grounded approach to the analysis was adopted which allowed themes from the collected data to emerge through a systematic process.

This systematic process involved reading all the data and labelling quotations and sections according to their content. This process continued until no new themes were identified. A second stage of analysis grouped the material into broader topics and identified overarching themes.

Due to the volume of data captured, not all supporting statements have been included in this report. Whilst the project partners recognise that all comments made were of equal value, some quotes have been omitted for editorial reasons.

Limitations of the Report

Although access was granted to engage with participants on services at four acute and community settings, the project encountered difficulties in obtaining access into other services. The project partners experienced “gate-keeping” at one service that refused all access. On the services accessed, fear of talking and what the repercussions might be, appeared to be a strong sentiment echoed by service users and some staff. Service users seemed reluctant to criticise some services, particularly those that they were currently accessing, while staff wondered who would read the report and whether their jobs could be jeopardized by saying too much.

Engaging service users at times proved difficult, although this could possibly be as a result of whatever condition had caused them to be admitted.

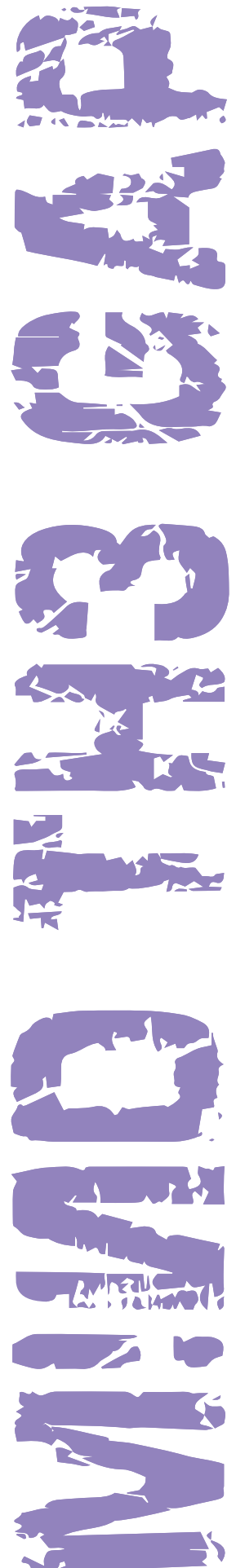
Insufficient time also proved to be a major hindrance, with constraints often occurring when meeting both staff and service users, outside of the researchers’ control.

Using the Hear Us Linkworking Project to provide a ‘route in’ to services resulted in the research being restricted to working within those services where Hear Us currently visits. As Hear Us work exclusively within ‘adult working age’ services, the research was not able to include as much information from children and young adults, or adult elders services as it would have liked too. Furthermore, whilst the intention had been to expand the Linkworking project into these services as a result of this partnership project, staffing challenges faced as a result of external issues meant that Hear Us were limited to sustaining the project within existing services rather than expanding into new services.

Through the analysis of the data gathered during interviews with service users, staff and carers, it was evident that the data contained a complex range of themes and issues. As a result of initiating dialogue with a range of participants across a range of services, the data was multi-faceted and presented a substantial number of rich themes. The following findings are a presentation of these themes:

1. Dignity in Care
2. Medication Issues
3. Cultural Competency and Sensitivity within Services
4. Shortage of Staff and Resources
5. Care Pathways Communication
6. Care Planning and Care Coordination
7. Stigma and BME Communities
8. Poor Provision for Refugees and Asylum Seekers
9. Challenging Experiences for Carers
10. The Need for Talking Therapies

The findings offer an insight into the issues and challenges facing BME Mental Health provision in Croydon and inform the recommendations presented in this report.



The most frequent issue raised by BME service users related to the dignity and respect they received from service staff. Serious concerns were raised about the lack of kindness received from staff addressing service users and their lack of responsiveness in attending to their needs.

Treatment from Staff

When discussing service users' experiences within an acute setting, some service users mentioned frequent rows taking place. At times it was reported that there were altercations between staff and service users, with staff shouting at service users and treating them with aggression:

"The (Staff) are always arguing..."
(Service User)

"I have experience of being aggressively handled by staff at other wards. When you are treated this way it stays with you and creates a lot of internal fear"
(Service User)

However, service users also seemed to report a significant difference in the kindness and respect they received from staff across different services:

"Some staff are excellent at understanding personal space"
(Service User)

Staff agreed that service users should be treated with respect, given choice about aspects of their care and be involved through the process:

"Service users should be treated with respect at all times and be kept safe"
(Member of Staff)

Responding to Requests

One particular issue raised in regards to staff treatment of service users, was regarding their availability and how they responded to requests:

"If you ask them (staff) for a favour it's always... 'I don't know' or 'you can't do that'. You don't react but you feel frustrated" (Service User)

"It was supposed to be recreational time....I asked to play pool and got no response from the member of staff. I asked a different staff member and got exactly the same response... I was completely ignored"
(Service User)

"Staff should show more respect and empathy for service users. If you need something, you need to press the emergency button (in the kitchen) because staff lock themselves in the office"
(Service User)

In a similar vein, service users also experienced some staff within some services as unavailable or responsive to requests for access to Occupational Health Activities taking place on the ward.

"I don't understand. At first I was told that I could see the OT at 11.20am.... it's now 2.20pm and I still haven't been seen. When I asked why, I was made to feel like a little kid asking for sweets"
(Service User)

Finally, service users also made several comments about the physical environment within services, highlighting issues of cleanliness, availability of basic hygiene items (tissues, toilet roll etc) and complaints about the heating.

Medication seemed to often be a point of tension for service users and was frequently discussed within all the services involved in the project. Many service users expressed a need for better information regarding medication and side effects; whilst others expressed fear of becoming a 'zombie' with the inability to communicate with others.

"I have expressed concerns about experiencing...side effects. The doctor has not been taking this seriously and has made me feel stupid for complaining about what I have been experiencing... The doctor kept using comments like 'it happens to everyone and other people find solutions to it'. I found this very dismissive and not very listened to"
(Service User)

"My son's medication has been changed. He has gained weight, he is 'drugged up', feeling like a zombie. His medication is not really monitored"
(Carer)

Several participants expressed a desire to be able to manage their own medication. However they experienced feeling disempowered and not listened to when discussing their medication:

"I don't want to be in a sedated state. I want to be able to manage my medication. I said this to the doctor but he did not listen..."
(Service User)

It was suggested by service users that there was a tendency to be over medicated by health professionals, rather than be given a minimum dose and offered additional therapeutic support to manage their condition.

"I was allowed to leave the ward to attend a pre-arranged hospital appointment and so missed taking my scheduled medication. When I returned they (staff) wanted me to take a double dose to make up for it and I refused"
(Service User)

Participants expressed the importance of taking a holistic view of service users. Acquiring good understanding of service users' social living environment including relationships with family members is imperative to recovery and wellbeing.

"When you deal with mental health, you need to see the person as a whole and include the family, you can't just prescribe the medication but need to look at the client's environment to help the recovery. Family members need to know about the condition and how to relate to the client with the right language"
(Member of Staff)

"Why do they give papers to sign to people when they are unwell? I was not told anything about [my daughter's] condition or the medication she was prescribed. To date, I don't know what the diagnosis is...I only know about medication by going through the bin! I think it is bipolar or psychosis... Carers need to have the information!"
(Carer)

Some service users highlighted the importance of medication in their journey to recovery; and the need to understand not only the side effects of medication but also the overall outcome upon mental wellbeing:

*“Medication makes you numb but service users should be explained that this is just a stage that can bring a change and helps to go onto a new life”
(Service User)*

Some of the service users interviewed expressed concerns about the mental health services’ responsiveness to physical health issues:

*“My diabetes has got worse since I’m here...there is little physical activity and sometimes there is no food in the kitchen. I can only walk up and down [in the ward]. What do they do? They just give you more insulin”
(Service User)*

Another service user recalled being admitted and telling the ward he had a long standing hospital appointment, which it was agreed he could attend with a member of staff. However on the day of the appointment, no transport had been arranged and no staff were available to attend the appointment. The service user recalled feeling vulnerable and unsupported as a result, losing confidence in the service.

The findings suggest that mental health services need to be more vigilant in supporting their service users with their physical health as well as their mental health and that this needs to be considered as an important aspect of their treatment and care.



Cultural competency, when applied effectively, can close the disparities in mental health care. Service users recalled cultural challenges that they had faced within mental health services, particularly around a lack of staff understanding towards cultural difference and cultural requirements:

"I'm not keen on the food so I hardly eat. I have specific needs that are clearly not catered for. I'm not asking for preferential treatment..... just a bit more consideration"
(Service User)

"The diet of people from some African background is different. They have some types of food which are not available in our hospital" (Member of Staff)

"If they are vegetarian, sometimes they can't get the food straight away. It's a long process to authorise. The vegetarian food is in the menu but it's not always there. You need to order it two or three days in advance. The menu comes to the ward; it's filled in and sent off two or three days in advance. So when a person comes to the ward there's a two or three days' gap"
(Member of Staff)

The lack of access to interpreters was also raised as a concern by service users.

"There is a big lack of interpreters for BME service users who do not speak English. There has been a Polish patient and an Asian patient who speaks Tamil, but no interpreters have been provided. Because the Asian patient was unable to communicate with everyone else, she was eventually admitted because she had an episode. There is a big lack of understanding and support for people of other languages. You

would expect some of the nurses to be able to speak other languages"
(Member of Staff)

Participants expressed the need for more diversity within services among the staff team:

"There should be more staff who speaks community languages. Also, it would be good to employ more black men"
(Member of Staff)

"A junior doctor, who was not able to speak fluent Tamil, requested an interpreter. The interpreter was not aware that the doctor could understand little Tamil. The interpreter did not translate accurately what the service user said...maybe she was struggling to translate so she was just using her own words" (Member of Staff)

"There are also clients who don't necessary want interpreters from their own culture to appear in the session e.g. a Persian client from Iran may want someone who speaks Persian from Afghanistan to feel more comfortable but that person may not speak the same dialect to pass on the information"
(Member of Staff)

"BME clients also find it difficult to talk in the presence of a translator because they don't know the person. That translator is someone they meet at the Mosque or at the Temple and knows all about the mental troubles... whereas a CPN or social worker is someone who can build the relationship over time and can reassure clients about confidentiality"
(Member of Staff)

In some cases, BME service users regard extended families as one unit,

all living together in the same dwelling. Unfortunately, the current system is not flexible enough to accommodate those differences and service users feel unsupported.

“When they need accommodation from the Council, some BME clients do not understand why we must make one housing application for the couple and child and a separate one for their grandparents. They ask ‘why can’t grandparents live with us? They have been helping us so we must live together!’ The culture here is different because we cannot apply for two generations to live in one place. As a result, those clients see us as unsupportive and discriminatory”
(Member of Staff)

Similar problems were experienced in relation to confidentiality and carers. When service users people are given this form, some do not understand the meaning of the consent form as it is perceived as inflexible and very unhelpful as it seems to exclude some members of the service users’ family.

“When you ask some BME carers how their loved ones are doing, it is a given fact that they want to speak on their behalf. They don’t want to wait for consent because it’s their culture”
(Member of Staff)

Mental health inequalities are particularly difficult to overcome for people who are from ethnic minorities are even more difficult to overcome for people from ethnic minorities, who often gain access to help at a very late stage. A great gap has widened as the sector has not adequately addressed the inequality of access to psychological therapy in particular the case of those from the

BME communities.

“There are still many inequalities that exist in mental health, some of which are particularly pertinent for people with schizophrenia, such as not getting access to effective and evidence based psychological and pharmacological treatments”
(Member of Staff)

An assessment at the first sign of crisis:

Staff mentioned the importance of service users getting a comprehensive assessment as soon as the condition worsens as this may help the person to avoid further escalation towards a crisis point.

“I know the signs that she’s getting worse so, why can’t we get an assessment at this point? Who do we call? Why do we have to wait for a full crisis and hospital admission? I know I can’t cope with another crisis” (Carer)

“Once a person has been discharged from the acute services to the GP, they can’t be reassessed. You have to go to the GP and the GP has to refer the person to a consultant again and go on the waiting list!”
(Carer)

The overarching impression from service users is that health professionals should receive more training on cultural competency to understand different cultural aspects and the role of spirituality in mental health. Service users should be part of the training so that staff can have a better understanding of patients’ experience. Services should also be regularly monitored to make sure that they are more culturally sensitive and responsive.

The shortage of staff across community and acute settings clearly affects the quality of support provided to service users in both community and acute settings. Our interviewees described the pressure resulting from their heavy workload

“There are too many expectations of the Care Coordinator, too high caseload. The team is great and so is management but all colleagues are also feeling the pressure because of their workload and, as a result patients’ needs are not really met. I am a nurse but I do everything... welfare benefits, placements reviews, housing issues... anything!” (Member of Staff)

“As a Care Coordinator, you can’t be an expert in everything! I feel like a rubber band...pulled in all directions. They say that the Care Coordinator should delegate to others but, who are ‘the others’? There is no other! I am mainly dealing with responding to crisis situations instead of planning the work that helps clients recover. I feel that I am really not giving the support that the client sitting in front of me really needs” (Member of Staff)

The shortage of staff results in long waiting lists which delays service users’ recovery

“The basic problem is that we don’t have enough therapists for the size of the population in Croydon. The commissioners know that this is the reason for the waiting list” (Member of Staff)

There is also an insufficient number of CPNs, social workers, consultants and psychologists able to speak community languages such as Gujarati, Punjabi, Urdu and Tamil.

“We haven’t got a Tamil or Indian therapist. The Tamil service is done through a translator. We are lucky to have many Care Coordinators who speak several languages but they are not therapists” (Member of Staff)

Staff can only dedicate a short amount of time to service users, making it extremely hard to perform a thorough patient assessment and capture different aspects affecting the person. This has an impact on the relationship between staff and BME service users, particularly when language and cultural background is pivotal in building trust.

“We find it difficult to assess people, especially the cultural side of it. We just look at what we see and what we can provide e.g. we give medication to calm the person down. If you had the time you might sit down with that person, have a one-to-one with them and find out that maybe is not psychosis...maybe is the culture...maybe is something else and find a better way of providing the care that’s needed. We do try but it’s very difficult” (Member of Staff)

“The shift work sometimes makes it very challenging when supporting patients. There is never enough time to complete everything” (Member of Staff)

Not having enough staff to help with risky situations on the ward was also a real concern.

“Sometimes we have to work with limited staff numbers which always puts us at risk. It is a cause for concern” (Member of Staff)

In investigating service users' issues with care planning and care coordination, an overarching theme emerged highlighting the need for clearer communication. Service users, carers and members of staff all commented on communication issues across the different services involved, raising concerns about the care planning approach and care pathways, including the admission, discharge and referrals processes.

Admission

All the participants that took part in the project reported the need for a responsive assessment and admission process. For example, carers who were interviewed highlighted that the period before admission was an anxious time and services needed to provide assessments as soon as someone's condition worsened, in order to avoid the situation escalating to a crisis point:

"I know the signs that she's getting worse so, why can't we get an assessment at this point? ... Why do we have to wait for a full crisis and hospital admission?" (Carer)

"I was told that if my mum didn't improve in a few days she would be sectioned, this sounded very extreme and unsupportive – especially when I know that going back to one of those mental health wards would be the worst thing which could happen. It's very hard to watch ... and feel that there is nothing that you could do about in" (Carer)

At the point of admission, service users felt the need for more regular and clear communication about the process:

"Although I've had mental health problems in the past, it's my first time in an adult ward and really I'm not sure why I am here. No one has explained anything to me about how long I'm here for or why I'm here. I'm just in a daze" (Service User)

Service users highlighted the need for an induction into services and a daily orientation to the ward as many service users were unclear why they had been admitted. Although this may have been explained upon the point of admission, it needed to be re-emphasised and reiterated on a regular basis.

Furthermore, some service users recalled that the admission process felt intrusive with service users imparting a lot of information to the staff, but not receiving basic information they felt they needed, creating a sense of imbalance. For example, service users would like an explanation as to why certain items were confiscated, a tour of the ward indicating where things are and how they work, what activities were available and so forth. This was highlighted as a particular issue for people experiencing their first admission into a particular service, who felt they needed a daily explanation for their admission on to the ward.

Discharge

The process of discharge seemed to bring about significant fear and anxiety for service users who were interviewed. Indeed, service users expressed concerns around discharge planning across all of the services involved in the project:

"I should be looking forward to going home but I'm not. At least here I get my medicine and meals on time and don't have to rely on myself" (Service User)

Participants also highlighted a lack of information and communication between the service, the service users and their carers:

“I have not been given any discharge information, neither have I seen a doctor. I am not sure what is happening” (Service User)

“[My daughter] was discharged on the Friday evening before Christmas. A taxi took her to the flat. There was no bed linen, no food. I was not told anything” (Carer)

All service users highlighted their concerns about not being sufficiently supported following their discharge as well as feeling uninformed about what on-going support would be available to them once discharged.

Referral Processes

In some cases, when referred on to another service (both internal and external to the mental health services), service users were not clear about why they were referred. Staff members reiterated this, highlighting a poor flow of communication between staff within services:

“It is about communication. Sometimes we, as professionals, don’t liaise with each other properly. We should check that a colleague is happy to take over the complete care of a service user” (Member of Staff)

In particular, communication between external agencies and mental health services was reported to be inconsistent. For example:

“We are alerted that a person may be discharged from prison by the Court two weeks prior to the court case. So, we request information, contacting

the prison to get a report that comes to us with a clear pathway into us... and none of that happens because the communication wasn’t coming back even though it had been requested” (Member of Staff)

Findings: Care Planning and Care Coordination

Feedback from the service users regarding their care coordinators and their care plans was decidedly mixed, with some reporting positive experiences whilst others expressed issues with this aspect of their treatment and care:

“I get on very well with my care coordinator and see him every week” (Service User)

Other service users reported that their care coordinators changed frequently and that this had a significant impact on their mental health, creating uncertainty and low mood.

Service users reported generally that their care plans were useful but not updated as often as needed:

“I have had a care plan, which have given me some focus, but this has not been updated for about eighteen months or so” (Service User)

Feedback on the process of creating a care plan was also at times negative for the service users:

“I have a care plan – it seems as though when it’s given to you, it is a very rushed process. The plan is very dictatorial – I wasn’t given a chance to say anything about it” (Service User)

Negative perceptions of mental health illness within many BME communities have created fear and anxiety in relation to mental health illness diagnosis. The stigma associated with being labelled as “mad” or “possessed” has created a barrier for many BME individuals who find it challenging to engage with mental health services. Building trust between staff and service users and developing knowledge and understanding of their culture, can help to build the necessary rapport with service users and their families.

“I’ve noticed that there is growing stigma in the Caribbean community about mental health problems being related to Obea (witchcraft); before I mainly encountered this within African communities, this is very concerning, obviously there is a need for stigma to be challenged” (Member of Staff)

“A lot of work is needed to try and breakdown mental health stigma within BME communities. I know that there is a lot of stigma in relation to dementia and sometimes a patient’s cultural background can create a barrier in relation to accessing help and support” (Member of Staff)

“They don’t understand what we are trying to do. If [you believe] you are possessed, you do not treat that with medication. [They think] there is a different way, usually through praying or cleansing. A patient believed that she had to cleanse herself with urine so she kept her urine and at the end of the week she would have a bath in it... that’s what she believes she needs to get better. We can’t understand that... for us it’s medication...because there’s a chemical imbalance... but they don’t see it like that” (Member of Staff)

Stigma of mental health illness can have a detrimental impact upon families. Lack of knowledge and understanding of an illness or how to cope can lead to isolation and fear, with family members feeling overwhelmed by the illness or uncertain how best to support their relative.

“Stigma around mental health is strong. An [Asian] mother of a daughter with a mental health problem doesn’t want to say anything because other brothers or sisters may not be able to marry because there is mental illness in the family. Another example is a mother who is loyal to the family and doesn’t want to say that her husband or a child is like that because it is a shame” (Member of Staff)

“The husband of a female client with schizophrenia used to say to her... ‘you do this because you are mad’... [In time] I was able to build trust with him and talk to him about the right words to use when talking to his wife. [I said] you don’t have to use the word ‘mad’. Now they can understand each other better” (Member of Staff)

“Everyone thinks I’m a perfect mother... if they knew about [my son’s] condition, they would be disappointed. I don’t want them to say bad things about him...I don’t want them to make fun of him. I lie to my family and this is a burden” (Carer)

Participants spoke about their concerns regarding BME service users being ‘institutionalised’ through spending extensive periods of time within the mental health system. Staff stressed the importance of service users not being

admitted on to wards for long periods of time, which they felt created a strong dependency upon the system whilst also exacerbating the stigma experienced.

“It can be hard trying to help BME patients not to become institutionalised as a result of being in the mental health system for long periods of time. The stigma that this carries can be hard to move on from” (Member of Staff)

“Some service users think that we are trying to rush them out of here before they are ready, but they don’t realise that the longer that they are in here the harder that it is for them to integrate back into the community and live a healthy life” (Member of Staff)

“When we work with service users who have been in patients for a long period of time, they come here and the next step is to help them to move on. The longer they stay within the system, the more likely they are to not leave” (Member of Staff)

Findings: Poor Provision for Refugees and Asylum Seekers

Staff highlighted the plight of asylum seekers referred to the services. They are destitute and generally with no support from family or friends. Their life circumstances deepen their depression.

“There are a number of asylum seekers who are pregnant or have young children and it is hard to get Social Services to take on their cases because of the difficulty in providing financial support, subsistence or accommodation. The current financial situation makes it even more difficult for them” (Member of Staff)

The referral process to the Adult in Need Team (Croydon Council) is long and bureaucratic. In addition, every referral needs to be communicated to the Home Office for relevant checks so service users do not want to be referred for fear of being deported. It is challenging to access support for BME asylum seekers without creating additional trauma through the involvement of the Home Office.

“When you refer an asylum seeker to the [Adult in Need] Team you are told that they have to check up their position with the Home Office. So clients are scared and don’t want to see you any longer. They go into hiding and this could be the case of a young mother with a baby” (Member of Staff)

Our interviewees clearly outlined how hard life is for refugees and asylum seekers in Croydon:

“Many refugees and asylum seekers live in hostels or in shared accommodation where they do not feel safe. Because of their trauma and symptoms of PTSD they are hyper vigilant, anxious and aware of threat. Quite often they talk about having neighbours who are drug dealers or people who are threatening them where they live. So they can’t really relax because of what happens around them. Sometimes they are lucky because they are moved to a quieter area where the general population is older” (Member of Staff)

The carers we interviewed clearly explained the challenges they face in looking after a family member with a mental health condition. A sense of guilt was common.

“Why is my child like this...why my family?”
(Carer)

Carers mentioned several reasons for their tiredness and frustration: the issue of confidentiality affecting their relationship with healthcare professionals, the lack of understanding of mental health conditions and medication, the challenge of dealing with emergencies and the difficulty in communication.

“It can be extremely difficult trying to communicate with doctors and nurses in relation to my relative. They are not always clear on the information which they give you and this makes it harder when trying to give support. It can feel very lonely and isolating”
(Carer)

“Caring for [my son] is challenging because he does not open up easily. Occasionally he shares his feelings of grieving for the career and life he never had, like not having a family or not being an architect”
(Carer)

The stigma attached to mental health problems prevented them from discussing their son's or daughter's condition within the family. This deepens their feelings of isolation and concern about the future.

“What do [families] understand about mental health? What do they do if they have a case in the family?”
(Carer)

“I worry for her [my daughter's] future and my future. She is not getting better and I'm getting older. I want her to be helped to develop day to day living skills and support in finding a job”
(Carer)

Mind in Croydon's (2011) previous research 'The First Step' identifies that "BME clients were just as likely as White British clients to access...counselling service(s)". Participants agreed, speaking about the need for increased access to talking therapies so that BME service users can explore thoughts and feelings whilst working through issues.

"[My son] enjoys and needs to talk. Talking through his emotions, his issues would be good"
(Carer)

"[My son] only had one session with a psychologist but that was clearly not enough!"
(Carer)

"The physiologist asked him some questions and was happy with the answers. He told him that he was capable of looking after himself and did not need any more sessions. He should have at least given him a few more sessions to see how my son would cope [in case] he was feeling stressed and paranoid"
(Carer)

Commenting on the scale of provision of talking therapies in Croydon, participants acknowledged that whilst there is existing provision within mental health and community services, the existing services are struggling to meet the demand for support. This sits alongside the view that access to psychological therapies could help to maximise the effectiveness of medical treatment.

The participants said that talking therapies should be part of the overall treatment and is needed on an ongoing basis:

"I feel that it is the condition that is being treated and not [my son]. He is coping through medication but, how is he coping with life? Nobody really cares"
(Carer)

Whilst the need for talking therapies was clearly identified, challenges in providing this type of intervention were also discussed.

"By default we have to work with a guideline that doesn't fit BME people, for example; NICE guideline on schizophrenia. Having therapy is part of the guidelines but we know that most BME people don't do therapy for several reasons. It is not explained adequately why they need to speak to a stranger (Health Professional) about their problems so when the guideline talks about medication and therapy as part of the combination some BME people are kind of forced into therapy... something they are not familiar with, not comfortable with, it's something new to them, totally alien to them to some cultures."
(Member of Staff)

The findings indicate that the service users, carers and staff we interviewed are seeking a clear improvement in the quality of BME mental health services provision in Croydon. Services that are appropriately staffed, offer patient-centred care and are culturally sensitive would result in better outcomes for BME service users.

Our research has shown that the stigma attached to mental health problems in BME communities is a real barrier to engaging with mental health services.

All BME service users have told us about their need for better communication on their admission, discharge and referral pathways. Serious concerns have also been raised by BME service users on the wards about the poor level of respect received by staff. The impression of being overmedicated and feeling like a “zombie” is an experience shared by many of our service users who want to work, to be fully independent but just need practical support in building life skills.

Carers’ challenges in looking after a family member with a mental health problem have been described in a heartfelt manner. Their need for support groups, mental health training and better communication with healthcare professionals are all essential aspects in making them feel more like partners in care.

Staff are looking for more personnel to be employed in key roles to ensure that sufficient time is dedicated to the care of individual service users. They have also expressed a great interest in receiving more cultural competency training in order to bridge the gap in cultural knowledge. All our participants have emphasised the importance of employing staff from a BME background as a fundamental step towards

building trust with BME users and their families, working together in the journey to recovery. The difficulty in providing a good service to refugees and asylum seekers has been clearly outlined.

It can be concluded that, in order to improve health outcomes for BME mental health service users, a series of steps should be taken by commissioners and senior management within SLAM. Those steps are summarised in the list of recommendations below and are based on suggestions for improvement from service users, carers and staff who have taken part in our project.

**MIND
THE GAP**

Taking into account the above findings, the project team identified eleven recommendations for the Croydon's mental health community. Both Hear Us and the team of Community Involvement Workers (CDWs) recognise their role in improving BME Mental Health service provision in Croydon and encourage the wider community to take up the following recommendations:

1. Provide services which offer patient-centred care, which accounts for individual needs and involves service users in all decisions about treatment and medication
2. Provide cultural competency training to staff, professionals and families
3. Recruit more staff, including personnel from a BME background
4. Reduce the burden of bureaucracy to improve services. In particular, it is important to:
 - a. Review the format of the data system
 - b. Simplify the procedure to access services
 - c. Improve inter-agency work and communication
5. Provide better information to overcome language barriers:
 - a. Develop information leaflets in different languages
 - b. Provide language prompts and props
 - c. Enable easier access to interpreters
6. Improve awareness and provision of support services as follows:
 - a. Services should offer more practical help in building life skills and supporting recovery
 - b. Improve information on available support services
 - c. Commission more community support groups
7. Improve the support provision for refugees and asylum seekers as follows:
 - a. Provide age appropriate support services for refugees
 - b. Provide services that regularly engage with and have access to local refugees' voluntary services for peer support and cultural reference
7. Ensure service staff have the necessary tools for effective communication
8. Improve support for carers as follows:
 - a. Fund more support groups
 - b. Resolve confidentiality issues
 - c. Provide more information and training for the family to combat stigma
 - d. Offer respite and psychological support
9. Improve access to talking therapies
10. Provide access to mental health advocacy
11. The gap in service provision for BME young adults (18-24 years old) should be closed

1. Provide services which offer patient-centred care, which accounts for individual needs and involves service users in all decisions about treatment and medication

Some service users told us that they should be treated like a real person with their own individual needs and hope, and not seen or labelled as a 'condition to treat':

"You are put into a box with a label based on ideologies that everyone who has a mental illness is the same and that the mental health model does not cater for your own individuality and autonomy"

(Service User)

"When you tell your care team anything, the response is based on four years of educational theories that has no relevance to what you are dealing with and so you become more confused and withdrawn because you are not treated like a normal person"

(Service User)

Services should also offer more flexibility in terms of care pathways, so that they can be accessed quickly when needed and offer services which are tailored to the needs of the service user, rather than what is available from the service.



2. Provide cultural competency training to staff, professionals and families

All participants recommended that staff, GPs, police officers and families receive training on issues related to cultural competency, religious beliefs, spirituality and mental health illness. They felt that this would help them to challenge attitudinal barriers which can lead to stigma and discrimination amongst service users. Staff also recommended that patients be offered therapeutic support through professional therapists rather than ward staff that may not be appropriately trained.

*“More training is needed in relation to supporting BME service users, training is needed on mental health barriers, stigma, culture, religion and so forth”
(Member of Staff)*

*“I think that the patients should be offered therapy through a psychologist or a counsellor. This would be more worthwhile than doing it through the nurses. Not everyone is fully equipped or trained to provide therapeutic support to patients. Some of the nurses give patients their own perceptions and views instead of listening, this makes it harder for some of the patient’s to open up and feel comfortable”
(Member of Staff)*

3. Recruit more staff, including personnel from a BME background

It is recommended to employ more staff from a BME background. There are insufficient CPNs, social workers, consultants and psychologists able to speak community languages such as Gujarati, Punjabi, Urdu and Tamil. Our participants strongly recommended mounting an information campaign to encourage BME community members to train in mental health. This would overcome the communication problem as some service users do not feel comfortable in the presence of an interpreter.

*“[BME staff able to speak community languages] would help BME clients express their needs and how they feel. This is especially important because in certain languages there is not an equivalent translation for the word depression”
(Member of Staff)*

It is essential to resolve the issue of shortage of personnel in both community and acute mental health settings. The staff we interviewed lamented the challenge of dealing with a heavy workload due to insufficient staff. As a result, a shorter time is dedicated to a thorough patient’s assessment and capturing the cultural background of a service becomes a real challenge. This creates pressure and frustration as it is very hard to meet patients’ needs with the little time available. Not having enough staff to deal with crisis situations was also a real concern.

In particular, it is important to

- a. Review the format of the data system

The data system in community services should be reviewed. Staff have reported that the name that BME service users want to be known as is often different from what is recorded on the system. Records should be located quickly and accurately, regardless of the service user's cultural background. The system in place needs to be functional so that staff can effectively work with people from different ethnic backgrounds.

- b. Simplify the procedure to access services

It is recommended to devise a simpler system to access services. Staff in community services have complained about the excessive volume of paperwork required to be completed to get services such as COS and SDS. They clearly indicated that the demand for support services is real but the long and bureaucratic procedures create a barrier to accessing those services and slows down service users' recovery.

"There are so many barriers to getting services such as COS or SDS or getting somebody to do voluntary work... everything is so difficult due to the bureaucracy and the amount of paperwork we have to do! 'So when you say to people I have to fill in this form or do this SDS package'...the patient can't be bothered any more...so people don't access services and the funding will be cut!"
(Member of Staff)

- c. Improve inter-agency work and communication

It is recommended to improve the flow of communication between Prisons, Courts, Mental Health Services and Probation services. A national standardised communication procedure needs to be in place. Currently, poor communication delays the provision of support. Those BME service users (but this applies to any user) discharged in probation by the Courts may "go off the radar" because of lack of communication.



5. Provide better information to overcome language barriers

BME service users assessing health care services face many obstacles such as lack of communication or understanding.

In order to provide better information to BME service users, the following is recommended:

- a. Develop information leaflets in different languages

Participants suggested translating information leaflets about mental health services (including talking therapies) into languages such as Farsi, Dari, Spanish and Russian. The contents of these leaflets should explain what kind of services are offered, how they can be used, how people can benefit from them and how to know when people are ready for it. Leaflets should also indicate that it is within people's rights to choose a different interpreter.

"Often people come to therapy because another member of staff is involved or a relative has persuaded them that this is a good thing for them. If they can't understand what therapy is, it is difficult for them to say if it is the right thing for them or not... there is nothing written in their language that they can take away...having that information before they are referred to us would be very helpful"
(Member of Staff)

This information should be available from all services, including GPs, community services, acute services, voluntary sector services and psychological therapy services, so that clients can be informed when they are being referred or admitted to service.

- b. Provide language prompts and props

To help better communication between services and BME service users, staff should be provided with a 'language folder'. The folder should contain small cards with some basic words and expressions printed in the most common languages e.g. 'it's meal time' or 'time for your medication', 'it will calm you' or 'feeling anxious'? Participants mentioned Cantonese, Vietnamese, Gujarati and Polish as the most useful languages.

- c. Enable easier access to interpreters

The staff interviewed were keen on communicating well with service users and wanted to have a quick and easy way of accessing an interpreter whenever needed:

"We have patients who speak English but when they are unwell they don't speak in English. It's important that language is not a barrier"
(Member of Staff)

"Once an interpreter has been cleared we should be able to use him/her as often as we need rather than going through the process again and again"
(Member of Staff)

6. Improve awareness and provision of support services as follows

- a. Services should offer more practical help in building life skills and supporting recovery

All the service users that were interviewed were keen to go back to work and wanted to live independently, but needed support to achieve this. Service users expressed a desire for services to provide activities and free sessions to help them improve their self-confidence, prepare for employment and enhance their social skills.

- b. Improve information on available support services

Some service users told us how they wanted more information on community groups to support them following their discharge from a service. Members of staff also highlighted the need for on-going support:

*“Many of the patients have anxieties about being discharged back into the community as they do not feel ready. Therefore it is important that we are given adequate support to enable us to best support the patients
(Member of Staff)*

Whilst there are a number of community support services available, knowledge of these services amongst both staff and service users was fairly mixed. Whilst services such as the Community Development Workers and Hear Us, amongst other community organisations, work to raise awareness of these services, additional training and communication is needed to ensure that the wide range of organisations are known about by service staff and services users. Indeed, service users who were interviewed were often unaware of the range of support available:

*“I need help with my benefits, that support should be provided here”
(Service User)*

- c. Commission more community support groups

Service users spoke very positively about small community groups, which provided a more personalised approach. These provided the opportunity to feel listened to as well as socialise with other service users:

*“Smaller groups and charities should be acknowledged and funded to provide the support needed when the person has been discharged. They help build the trust and give the encouragement that helps service users move on and learn a new way of life. They could also train service users to be fully independent again and make less use of services, saving them (services) money”
(Service User)*

7. Improve the support provision for refugees and asylum seekers

- a. Provide age appropriate support service for refugees

At present refugees and asylum seekers who need support are primarily signposted to other services, however at times these services are unable to meet service users' mental health needs:

“One of the obstacles that refugees (service users) tell me about is that it is overwhelming. It’s a big hall, with a lot of people there. Because some have PTSD they are often irritable so they can easily flip or become angered in those situations and get into a fight so they don’t want to go back there because they don’t want to get into trouble. Smaller groups would be more accessible for the people that I see. If they had that kind of support in the community it would help with the treatment and the work we do together”
(Member of Staff)

A service is needed which enables refugees and asylum seekers to socialise and connect with other people their own age. Participants highlighted the need for more small community groups and arts projects. For example, Compass, a specialist support service for refugees, asylum seekers and forced migrants, provides a group for boys and young men, as well as counselling interventions. There is also the ‘Vauxhall City Farm’ project where refugees and asylum seekers can socialise and learn more about PTSD, depression, anxiety and enjoy working in the farm’s gardens to grow vegetables and fruits.

More services such as those mentioned above are clearly needed to provide age

appropriate support services, however there is also a need for training to enable better awareness amongst service staff about what is currently being provided.

- b. Provide services that regularly engage with and have access to local refugees’ voluntary services for peer support and cultural reference

Participants spoke about the need for additional staff, good team work, and better communication between staff and service users. They also highlighted the need for support from management, a good working environment and the importance of treating all service users in the same way.

- c. Ensure service staff have the necessary tools for effective communication

Where possible, provide a counsellor who speaks or has an understanding of the service user’s language or culture.

“It would help with the communication of what we are saying...these are the options for you... and to help them understand a bit more and help accept some help”
(Member of Staff)

8. Improve support for carers as follows

a. Fund more support groups

It is recommended to fund a group for carers as this was identified as the most important form of support that carers requested. Joining a group is a way of sharing experiences as well as accessing peer support and training.

“I joined a support group... It was like having a family”
(Carer)

“It is good to share ideas, sorrow and happy times with a lot of non-judgemental people. When you feel weak, others lift you up”
(Carer)

b. Resolve confidentiality issues

The barrier of confidentiality and poor communication between healthcare professionals should be addressed. Carers need to know about the diagnosis of the people they care, as well as the side effects of medication and any other information that enable them to feel involved as partners in care.

“I don’t need to know everything but just a few things to help me care for him”
(Carer)

A quick assessment should be available as soon as the condition of a service user deteriorates, in order to avoid this escalating into a crisis. Regular reviews of medication should be arranged to monitor side effects of medication, such as high blood pressure and weight gain.

c. Provide more information and training to the family to combat stigma

The poor understanding of mental health problems within families fuels prejudice so mental health training should target family members. Crisis services information should be more widely circulated as carers were not aware of it.

“We need to know what to do, should something happen. We need to know who to talk to about what to do. We don’t want an automated service as it’s frustrating not to be able to get through to someone”
(Carer)

d. Offer respite and psychological support

It is recommended that a more holistic approach is required when considering the respite needs of carers. This should include range respite, talking therapies and mediation to work through issues and feelings

9. Improve access to talking therapies

BME service users recommended that access to talking therapies be improved. They felt that this was paramount to their recovery, believing that it would be helpful to discuss feelings and issues that need resolving, in order to navigate their way out of the mental health system.

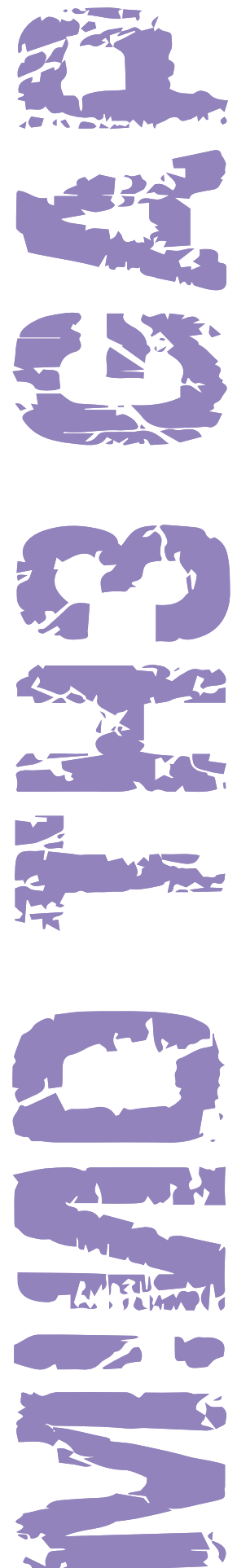
*“(Through talking therapies it is possible to) find a new way of living and seeing a new person in yourself”
(Service User)*

At the time of writing, the Improving Access to Psychological Therapies (IAPT) service had been introduced in Croydon to increase the provision of talking therapies. However, participants highlighted that talking therapies services as a whole were struggling to meet the demand for their services.

Lack of funding in community services and the subsequent shortage of staff, resulted in a long waiting time for BME service users needing psychological therapy sessions.

*“There is not enough funding and, depending on which therapy people are referred to, the waiting time is between 6 months and over a year”
(Member of Staff)*

In order to improve access and meet demands, commissioners need to sustain existing provision and consider increasing investment in this area



10. Provide access to mental health advocacy

Staff recommended that BME service users should be offered ongoing advocacy support when they come into contact with the mental health system, and particularly during admission on to a ward. They felt that advocacy support would enable the presentation of the views and opinions of service users whilst helping them to prioritise their mental health needs. Service users would also be provided with information on mental health services, treatments options available and medication.

*“There should be advocates on wards for BME service users, who provide ongoing information and support on different issues, including their choices. This could help to break down barriers”
(Member of Staff)*

11. The gap in service provision for BME young adults should be closed

Staff in community services emphasised the importance of providing services able to cater specifically for young BME service users (18-24 years old) who do not feel comfortable in attending group sessions with older service users.

*“Most of those BME young people are British but the service cater more for those who are older than them. If you have a voice hearing group for instance, it would be challenging for a 20 year old black man to attend where there are men of 45-50 year old...it’s not cool!”
(Member of Staff)*

**MIND
THE GAP**

Closing Remarks

Historically numerous reports have been produced outlining the gaps in mental health service provision for BME communities. Reports such as *Inside Outside* (2003), *Count Me In* (2005; 2011), *Breaking the Circles of Fear* (2002), *Delivering Race Inequality in Mental Health Care* (2005) and the *Independent Inquiry into the Death of David Bennett* (2004) all make strong recommendations for the improvement in BME mental health service provision. The authors recognise the valuable contribution these reports have made towards improving awareness of mental health inequalities.

This report sits within this context, at a time when the economic climate is resulting in tough times for all. Services are weathering significant change, facing increasing demand for their services alongside decreases in funds and cuts to local services.

On the backdrop of this challenging landscape, Croydon's mental health community services needs to take responsibility for ensuring that the gap in BME mental health service provision stays in focus.

Organisations such as Hear Us and the BME Mental Health Community Development Workers (CDWs) recognise their own role in supporting the uptake of the recommendations and raising awareness of BME service users' needs. However, this report also urges the wider community, including practitioners, service providers and commissioners, to implement the recommendations for the improvement of BME mental health service provision in Croydon.

Without immediate action and improvement, the gap in mental health service provision for BME communities is at risk of becoming impossible to close.

What will you do to Mind The Gap?

A&E LIAISON

Accident and emergency liaison is a service within A&E departments for mental health assessments and referral to special mental health services.

ACUTE MENTAL HEALTH WARD/SERVICE

Offers inpatient care to someone who has an acute mental illness and require 24 hour hospital care. Acute illnesses start quickly and have distressing symptoms.

ADMISSION

Where a person may begin a period of care.

ADVANCE STATEMENTS/DIRECTIVES

Can include individual's wishes in certain circumstances, to refuse or request for certain treatments.

ADVOCATE

Is someone, who supports a service user or carer during his or her contact with mental health services.

AFTERCARE

The support a person receives once discharged from inpatient care.

ALTERNATIVE THERAPIES

These are therapies that are not part of standard medical practice (example aromatherapy).

ANTIDEPRESSANTS

Antidepressants aim to treat the symptoms of depression by helping those who suffer feel more motivated and energetic.

APPROVED SOCIAL WORKER (ASW)

Employed by social services, usually working in hospitals and the community as part of community mental health teams.

ASSERTIVE OUTREACH

Aims to offer outreach support services to people in the community who have

difficulty in maintaining contact with mental health services.

ASSESSMENT

This is the process to identify a person's needs and treatment at first contact.

BLACK AND MINORITY ETHNIC (BME)

A term used to describe people from minority groups because of their skin colour and/or ethnicity.

CARE PLAN

A care plan is an agreement between a patient and the health professional to help the patient manage their day-to-day health.

CLINICAL ACADEMIC GROUPS (CAGS)

Set up to help SLaM to organise and manage their services, research and education and training, for the benefit of patients.

COMMUNITY MENTAL HEALTH SERVICE

Community mental health services are aimed at patients who are mentally unwell, with significant mental health needs, and need support in the community to continue on the road to recovery. Service users will be treated in a community based setting and/or in their homes, depending on individual needs.

COMMUNITY DEVELOPMENT WORKER (CDW)

A community development worker works collectively with a particular community or communities to bring about social change and improve quality of life. They work with individuals, families or whole communities to empower them to take appropriate action.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

They are a multidisciplinary team that

provides mental health services for children and adolescents.

COGNITIVE-BEHAVIOURAL THERAPY (CBT)

Is a method of treating psychiatric disorders based on the idea that the way we think about the world and ourselves (our cognitions) affects our emotions and behaviour.

COGNITIVE THERAPY

A method of treating psychiatric disorders that focuses on revising a person's thinking, perceptions, attitudes and beliefs.

COMMISSIONER

Refers to the person within the PCT (see pct) who is responsible for allocating money to chosen service providers.

COMMUNITY MENTAL HEALTH TEAM (CMHT)

A multidisciplinary team that offer specialist community care services.

COMMUNITY SUPPORT SERVICES

Enable individuals to live independently and access opportunities for social involvement locally.

COMMUNITY PSYCHIATRIC NURSE (CPN)

These are registered nurses who work with people in the community.

COMPLEMENTARY THERAPIES

These are therapeutic practices or techniques that are not currently considered part of conventional medical practice.

COMMUNITY OPPORTUNITIES SERVICE (COS)

Provide a range of day and employment related opportunities to help people who have severe and ongoing mental health problems lead a more active life in their communities. They work closely

with patients, their carers and care co-ordinators to set goals that reflect personal needs and aspirations.

COUNSELLING

Refers to a talking therapy that attempts to deal with an upsetting event(s).

DIAGNOSIS

The determination by a health care professional of the cause of a person's problems, usually by identifying both the disease process and the agent responsible.

DUAL DIAGNOSIS

Refers to two or more disorders affecting one person.

EARLY INTERVENTION SERVICE

Provide support and treatment for young people with psychosis and their families.

HOME TREATMENT TEAM

The home treatment is a multidisciplinary team made up of consultant psychiatrist, associate specialist, qualified nurses, social workers and support time and recovery workers. Home treatment teams help avoid admission to a mental health inpatient ward by supporting people in acute mental crisis in their homes. The teams also help people who have been discharged from hospital as they make the transition back into the community.

INPATIENT

Inpatient care is the care of patients whose condition requires admission to a hospital.

LINKWORKER

Linkworkers are ex or current service users that visit mental health sites across the borough of Croydon to meet with service users to listen to issues, problems, worries or needs. Through these meetings, the Linkworkers provide an opportunity for service users to raise their concerns, issues

and needs as they arise, which can then be fed back to the service providers.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE)

Is a specialist health authority of National Health Service (NHS) that publishes guidelines in the following three areas:

- (1) The use of health technologies within the NHS (such as the use of new and existing medicines, treatments and procedures)
- (2) Clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions)
- (3) Guidance for public sector workers on Health promotion and ill-health avoidance.

OCCUPATIONAL THERAPIST (OT)

Occupational therapists work in hospital and various community settings, providing both assessments and treatments in order to develop, recover, or maintain the daily living and work skills of patients with a physical, mental or developmental condition.

PATIENT-CENTERED CARE

Is the active involvement of patients and their families, in the design of decision-making regarding the patient's options for treatment.

POST-TRAUMATIC STRESS DISORDER (PTSD)

A debilitating condition that is related to a past terrifying physical or emotional experience causing the person who survived the event to have persistent, frightening thoughts and memories or flashbacks, of the ordeal. People with PTSD often feel chronically emotionally numb.

PRIMARY CARE

The care you receive when you first come into contact with health services.

PRIMARY CARE TRUST (PCT)

This is the organisation that looks after primary care.

PROGNOSIS

The patient's chances for recovery; a medical assessment of the probable course and outcome of a disease, based on the recorded history of the disease, the physician's own experience of treating the disease, and the patient's general condition and age.

PSYCHIATRIC NURSE

Is a nurse with special training in the treatment in patients with psychiatric disorders.

PSYCHIATRIST

Is the medical doctor who specializes in the treatment of mental, emotional or behavioural problems.

PSYCHOLOGIST

Is the specialist in the diagnosis and treatment of mental and emotional problems. Because psychologists are not physicians, they cannot prescribe drugs. Their role with patients usually involves testing, counselling and psychotherapy.

PSYCHOTHERAPY

Is the treatment of mental and emotional disorders using psychological methods, such as talk therapy.

SECTIONED

This is used to describe someone detained under the mental health act.

SEDATIVES

A group of drugs used to produce sedation (calmness). Sedatives include sleeping pills and anti-anxiety drugs.

SELF DIRECTED SUPPORT (SDS)

Previously known as Direct Payments, Self-

directed support is designed to help people to manage their own social care support and choose the services that suit them best.

SERVICE USER

This is someone who uses health services.

SOUTH LONDON AND MAUDSLEY (SLaM)

Provide the widest range of NHS mental health services in the UK.

TALKING THERAPIES

Talking therapies can help a patient work out how to deal with negative thoughts and feelings and make positive changes. This usually involves talking to someone

who is trained to help you deal with these feelings.

USER FOCUSED MONITORING (UFM)

Interaction with service users, conducted within mental health settings, providing them with an opportunity to raise any issues and express their concerns regarding their service experience.

USER INVOLVEMENT

Refers to a variety of ways in which people who use health services can be involved in its development and improvement.

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