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Less Talk, More Action:

Partnering with community leaders to reduce race inequalities

SACMHA

Proud to care in Sheffield

Presenters

Salli Midgley

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Learning Objectives

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1. Understand how we can turn talk into visible action for improving race equity in healthcare

2. Learn how various QI tools can help improve race equity

3. Have better confidence for initiating uncomfortable talks about race equity.

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Background

A look at the city of Sheffield…

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Photo by
Pete Quinn/Flickr

- Greenest city in Europe [1]
- It is 160 miles North of London
- Population of 556,500 [2]
- One of England's 8 "core cities"
- Famous for its "Steel Industry"
- Steel and engineering industries have created jobs for migrant workers from all over the world

[1] Eurocities, [2] Office for National Statistics,

Inequality in Sheffield

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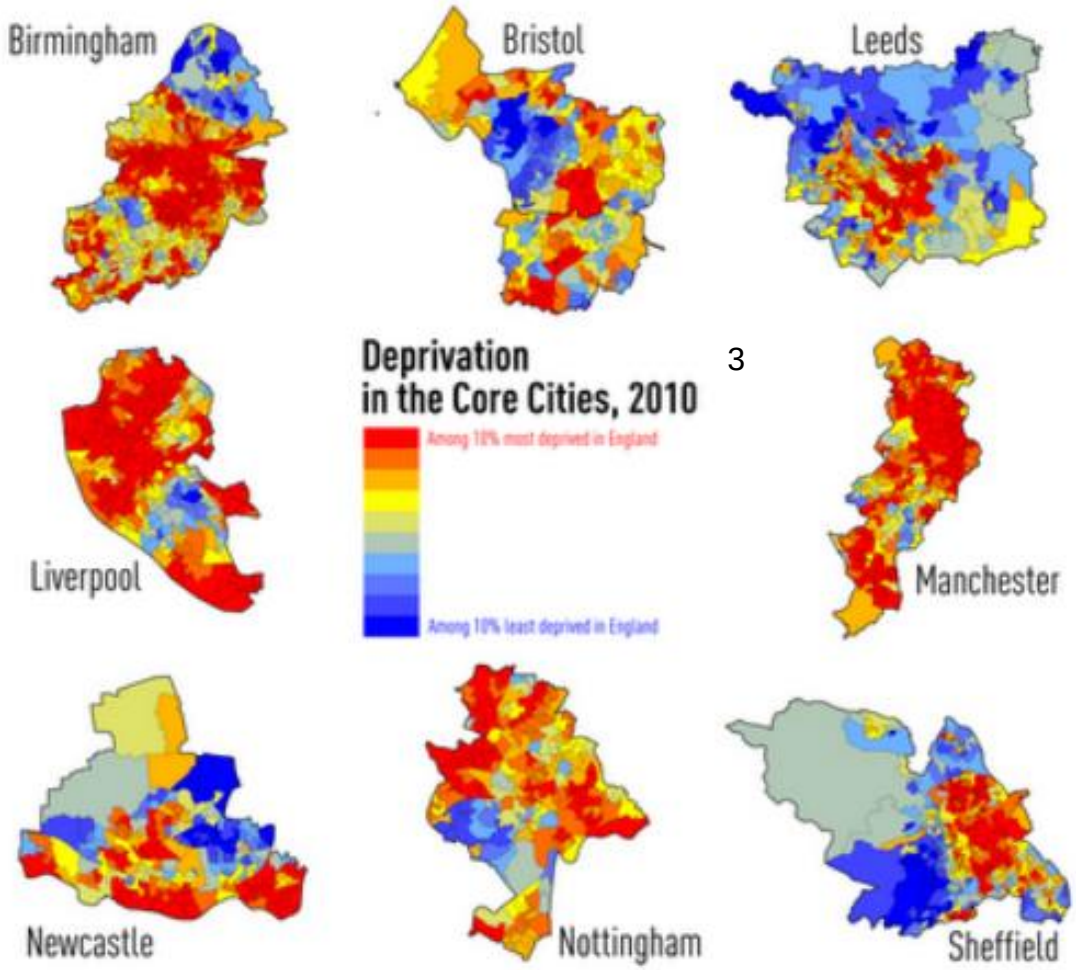

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- Sheffield is the 2nd least deprived core city in England
- Yet, ~1/4 of Sheffield's areas are in the most deprived 10% nationally
- Five areas are within the 1% most deprived in England [2]

[2] Office for National Statistics, 3 Alasdair Rae

A historically diverse city

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- The city has Black, Asian and minority ethic population of 31.9%[4]
- The Black Caribbean population in Sheffield is one of the largest in England
- Over 9,100 Sheffield people claim Black Caribbean ancestry
- Over 11,543 Sheffield people are Black African
- Census records show Black community members as far back as 1725 [5]

4 https://www.sheffield.ac.uk/research/features/elevating-underrepresented-voices-sheffield 5 Sheffield City Archives Black African and Caribbean Research Guide

Demographic spread[6]

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- Unclear how race and demographics interact in Sheffield as poor data
- Two Fifths of the Black African Population live in areas that are amongst the 10% most deprived in the country
- There are black communities dispersed across every area
- Therefore, the challenges are very different for different groups

6 Black African Community.pdf (sheffield.gov.uk) , https://nowthenmagazine.com/articles/we-still-dont-know-how-race-and-poverty-interact-in-sheffield

Black communities at higher risk of mental health issues

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- In the UK, Black people are more likely than white people to be diagnosed with mental health problems
- Despite this, they have the lowest mental health treatment rate of any ethnic group, at 6% (compared to 13% in the White British). [7]
- Black people are underrepresented on primary (ambulatory) care treatment lists, but overrepresented on secondary (acute) care lists
- In 2022, Black people were almost 5 times as likely as white people to be detained under the Mental Health Act – 342 detentions for every 100,000 people, compared with 72 for every 100,000 people[8]
- Most black people in UK face discrimination from healthcare staff

7 [ARCHIVED CONTENT] Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014 - NHS Digital (nationalarchives.gov.uk) 8- Detentions under the Mental Health Act - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk)

We know we have a problem

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“Mental health in the Black community is such a taboo subject, even in 2023. It is something that we still push under the carpet, we don’t talk about, we say it is a ‘White man’s problem’, it doesn’t exist for us in the Black community….and yet we still we over-represent in every single psychiatric ward.” **– Founder and CEO of Adira (organsiation supporting black people with mental health issues) and expert by experience**

"There’s a presumption that because you are Black, you live on a rough estate or come from a single-parent family, you are being aggressive when you’re actually in pain. You’re almost judged before a support session begins, simply based on the colour of your skin.” - **Black Female Service User**

"Wards are meant to be places of healing, where people who are unwell or are struggling are looked after, a place of safety, a place of treatment and kindness often become places that are further traumatising.” **– Clinical Psychologist and advocate for Black Service User rights**

Our aim

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- To improve mental health outcomes for the Black community of Sheffield using innovative approaches co-produced with those who understand the issues best:
    - People with lived experience
    - Bottom-up approach
    - Asking communities - “How do we do this?”

- Our top 5 recommendations to do this are outlined…

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1. Create partnerships & build trust

Building trust and partnership PRIOR to an aim

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- Healthcare organisations must **hold up a mirror** and look at what they are actually doing
- Start partnerships with **an honest, professionally vulnerable and transparent** conversation
- **Admit "We have a problem"**
- Co-production is about ***actually*** **listening**
- Necessary to **relinquish power**

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2. Build knowledge

Building knowledge of mental health in the community and reducing Stigma

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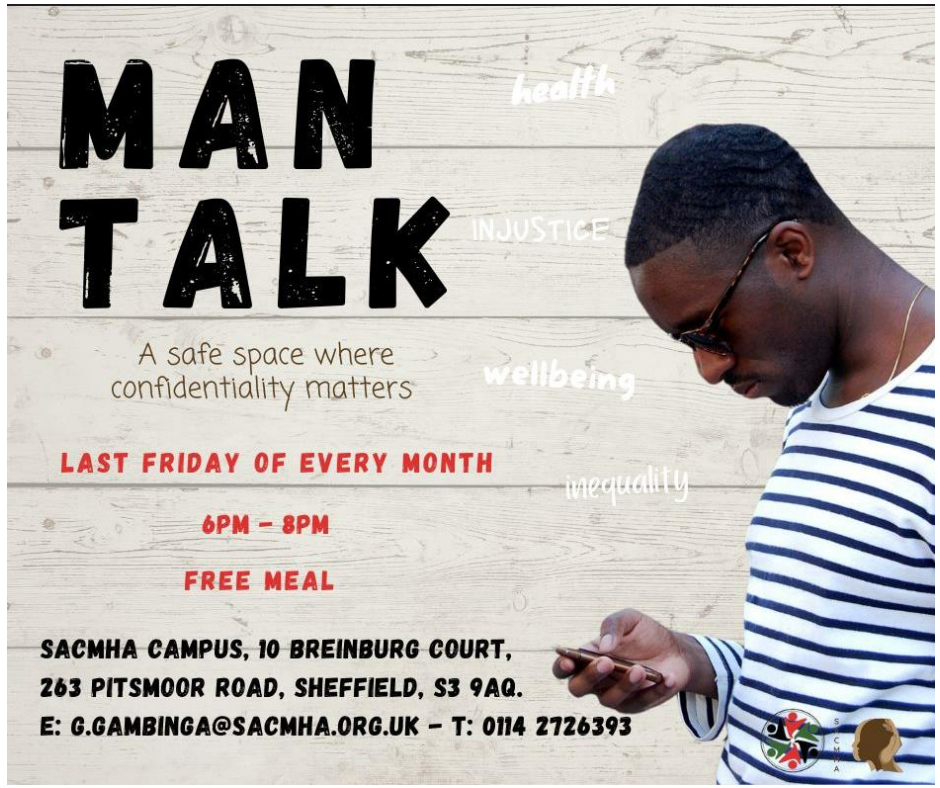
- DIRECT engagement/ contract
- Trusted Community Leaders
- Visible partnership
- Improving information about services [9]
- Ward presence
- Safe spaces in the community
- Strong engagement e.g., Man Talk[10]



9 Memon et al. (2019),[10] Man Talk (sacmha.org.uk)

Building knowledge within healthcare organisations improving cultural knowledge

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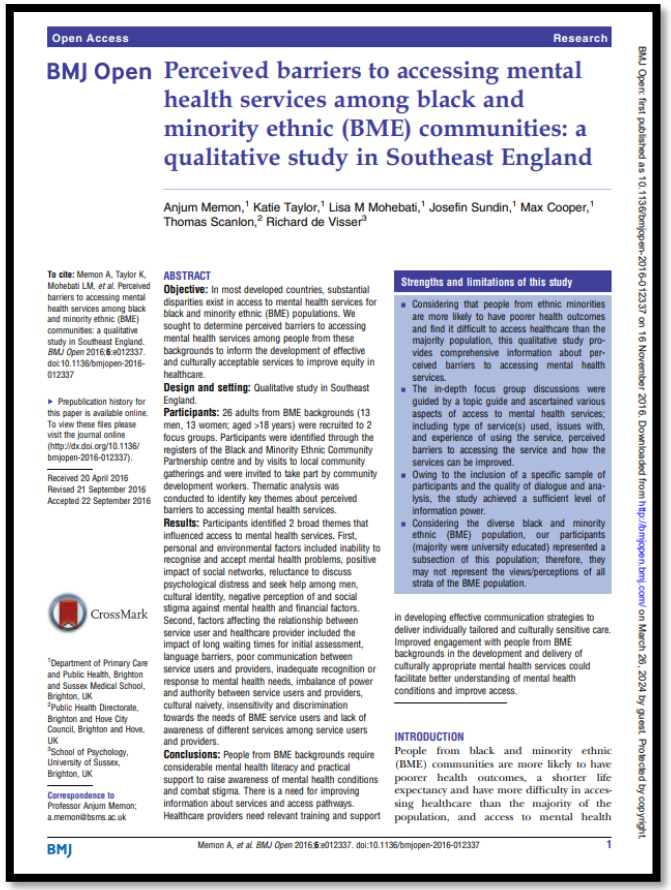

Open Access Research

BMJ Open

Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England

Anjum Memon,[1] Katie Taylor,[1] Lisa M Mohebati,[1] Josefin Sundin,[1] Max Cooper,[1] Thomas Scanlon,[2] Richard de Visser[3]

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ABSTRACT

Objective: In most developed countries, substantial disparities exist in access to mental health services for black and minority ethnic (BME) populations. We sought to determine perceived barriers to accessing mental health services among people from these backgrounds to inform the development of effective and culturally acceptable services to improve equity in healthcare.

Design and setting: Qualitative study in Southeast England.

Participants: 26 adults from BME backgrounds (13 men, 13 women; aged >18 years) were recruited to 2 focus groups. Participants were identified through the registers of the Black and Minority Ethnic Community Partnership centre and by visits to local community gatherings and were invited to take part by community development workers. Thematic analysis was conducted to identify key themes about perceived barriers to accessing mental health services.

Results: Participants identified 2 broad themes that influenced access to mental health services. First, personal and environmental factors included inability to recognise and accept mental health problems, positive impact of social networks, reluctance to discuss psychological distress and seek help among men, cultural identity, negative perception of and social stigma against mental health and financial factors. Second, factors affecting the relationship between service user and healthcare provider included the impact of long waiting times for initial assessment, language barriers, poor communication between service users and providers, inadequate recognition or response to mental health needs, imbalance of power and authority between service users and providers, cultural naivety, insensitivity and discrimination towards the needs of BME service users and lack of awareness of different services among service users and providers.

Conclusions: People from BME backgrounds require considerable mental health literacy and practical support to raise awareness of mental health conditions and combat stigma. There is a need for improving information about services and access pathways. Healthcare providers need relevant training and support in developing effective communication strategies to deliver individually tailored and culturally sensitive care. Improved engagement with people from BME backgrounds in the development and delivery of culturally appropriate mental health services could facilitate better understanding of mental health conditions and improve access.

Strengths and limitations of this study

- Considering that people from ethnic minorities are more likely to have poorer health outcomes and find it difficult to access healthcare than the majority population, this qualitative study provides comprehensive information about perceived barriers to accessing mental health services.
- The in-depth focus group discussions were guided by a topic guide and ascertained various aspects of access to mental health services; including type of service(s) used, issues with, and experience of using the service, perceived barriers to accessing the service and how the services can be improved.
- Owing to the inclusion of a specific sample of participants and the quality of dialogue and analysis, the study achieved a sufficient level of information power.
- Considering the diverse black and minority ethnic (BME) population, our participants (majority were university educated) represented a subsection of this population; therefore, they may not represent the views/perceptions of all strata of the BME population.

INTRODUCTION

People from black and minority ethnic (BME) communities are more likely to have poorer health outcomes, a shorter life expectancy and have more difficulty in accessing healthcare than the majority of the population, and access to mental health

- Many cultural misunderstandings
- White Staff sometimes report that they find Black Service Users facial expressions and shouting “more scary” than when a white service user does the same
- This is well-documented in research too: e.g. A study by Memon et al. (2016) highlighted that communities feel that *if staff “widened their cultural knowledge of what was normal” , it would allow them to consider a greater range of therapies and supportive techniques.*

[9] Memon et al. Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England - PubMed (nih.gov)








Building knowledge across partners

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- Innovation: Communities are very rarely approached & asked for solutions
- Meaningful partnerships - TRUST
- Open & transparent conversations
- Springboard for wider work e.g., Cultural awareness
- Influence
- Race Equity Events – bringing ALL together

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3. Measure and monitor impact

Quantitative data

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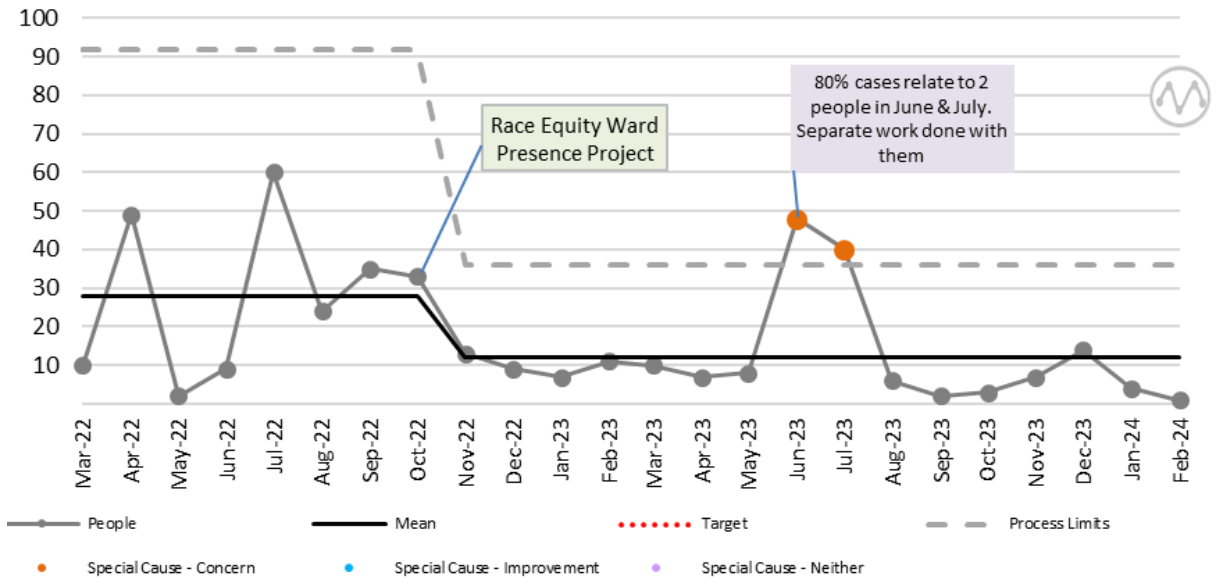
- Evidence of impact
- Respecting basic human rights
- Alignment with National Policies [11,12]
- Respecting basic human rights
- Mean number of people subjected to RP went from 10 to 6 people
- Mean number of instances of RP being used went from 29 to 11

Physical Restraint Incidents involving Black, African or Caribbean Service Users between March 2022– February 2024



[11]https://committees.parliament.uk/publications/3376/documents/32359/default/

Qualitative data (e.g. from events)

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“Opportunities for discussion” “Challenged but in a good way” “~Very informative but still a relaxed and open event” “ Very powerful and emotive event & echo the sentiment of how to get more people through the door – it’s not job for those already engaged1” “Thought provoking context” “Outstanding” “Very much needed, very informative” “ (liked most) The focus on lived experience, connecting and explaining new things i.e PCREF” “ I thought it was excellent in terms of speakers, turnout, diverse engagement” “ Grateful to work for a Trust committed to coproduce with service users and people from marginalised background” “Honesty about the work that needs doing and the reality of people’s experience” “ Motivated to do more!”	“It was great 😊 ” “ variety, engaging informal, warm atmosphere” “Great Event -I thought it was brilliant to bring everyone together in one room” “ variety of speakers, knowledgeable speakers, had a very positive environment and comfortable space for a difficult subject to discuss” “ #i found it very interesting and eye opening, also emotional and highlighting need for driving change” “The diversity of speakers in terms of background but from different organisations, communities and trusts” “ more events like this would need to happened top openly showcase the work that is happening but also to bring different professionals together to work proactively on the same issue” “I loved the honesty and range of speakers we had at the event” “Quite emotional, angry at injustices, thought the poetry was powerful beautiful and full of meaning and passion”

Incorporate into dashboards and systems

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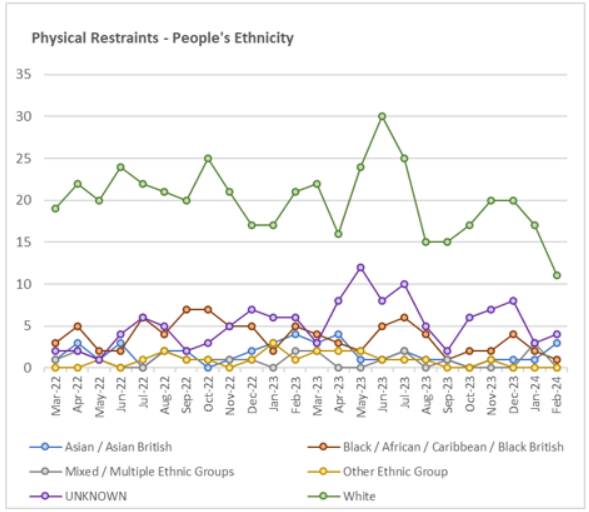
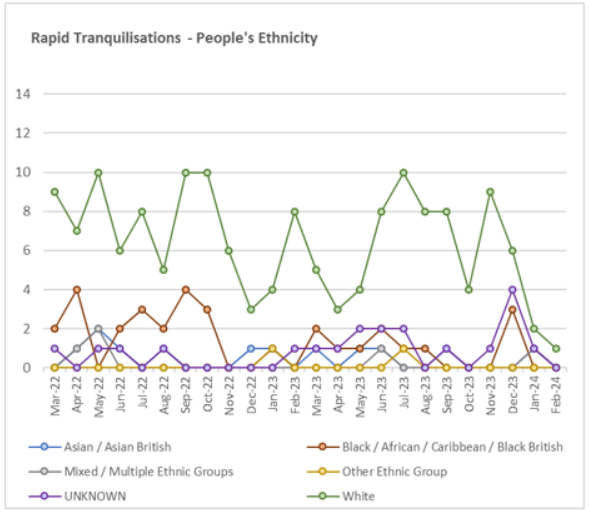
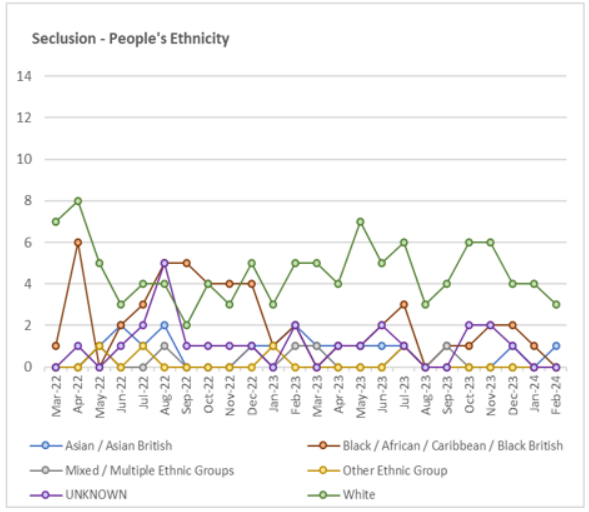
Race Equity Focus | Restrictive Practice





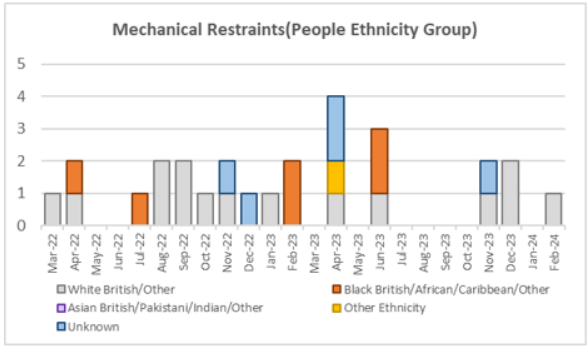


Seclusion
25% (1) of the individuals secluded in January were Asian British/Pakistani/Indian/Other.
Over 2 year people we are seeing a reduction in episodes for Black British/African/Caribbean/Other

Rapid Tranquilisation
Only 1 Rapid Tranquilisation has been reported in February for a white British person.

Physical Restraints
57.9% of individuals who were physically restrained were White British, 21% did not have an ethnicity recorded and 21% were from racialised communities.

Mechanical Restraints
This month there was 1 report of Police (Mechanical) restraint for a White British person



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4. Lived Experience is key

5. Lived experience is absolutely key

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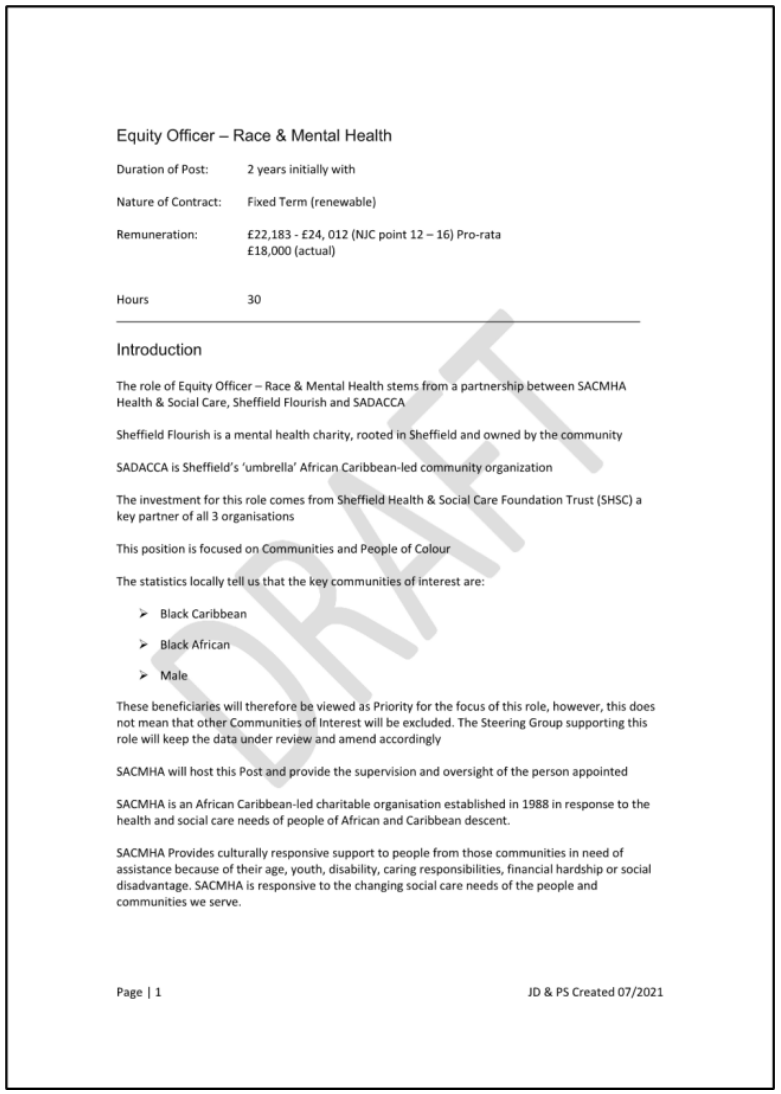

Equity Officer – Race & Mental Health

Duration of Post: 2 years initially with

Nature of Contract: Fixed Term (renewable)

Remuneration: £22,183 - £24, 012 (NJC point 12 – 16) Pro-rata
£18,000 (actual)

Hours 30

Introduction

The role of Equity Officer – Race & Mental Health stems from a partnership between SACMHA Health & Social Care, Sheffield Flourish and SADACCA

Sheffield Flourish is a mental health charity, rooted in Sheffield and owned by the community

SADACCA is Sheffield's 'umbrella' African Caribbean-led community organization

The investment for this role comes from Sheffield Health & Social Care Foundation Trust (SHSC) a key partner of all 3 organisations

This position is focused on Communities and People of Colour

The statistics locally tell us that the key communities of interest are:

- Black Caribbean
- Black African
- Male

These beneficiaries will therefore be viewed as Priority for the focus of this role, however, this does not mean that other Communities of Interest will be excluded. The Steering Group supporting this role will keep the data under review and amend accordingly

SACMHA will host this Post and provide the supervision and oversight of the person appointed

SACMHA is an African Caribbean-led charitable organisation established in 1988 in response to the health and social care needs of people of African and Caribbean descent.

SACMHA Provides culturally responsive support to people from those communities in need of assistance because of their age, youth, disability, caring responsibilities, financial hardship or social disadvantage. SACMHA is responsive to the changing social care needs of the people and communities we serve.

DRAFT

Page | 1 JD & PS Created 07/2021

- Investment in working with those who understand the issues most
- Not just expecting them to help out of good will
- Must be seen equal to staff to ensure equal partnership
- Clearly defined roles and responsibilities
- Once again, **must be co-produced**

Different priorities with different teams

Driver Diagram for Endcliffe Ward

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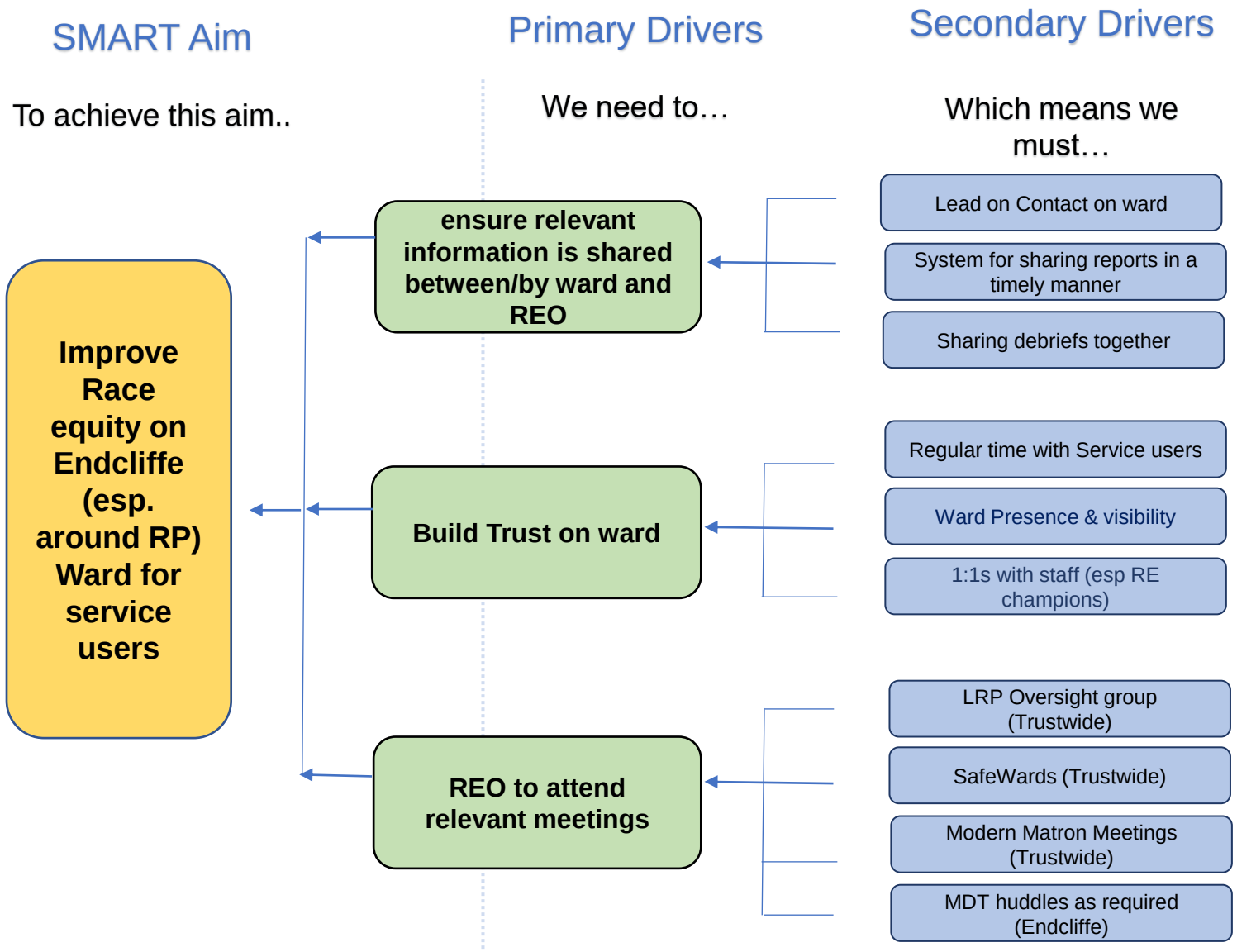

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5. Learn from every incident

Processes for learning

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- Trust to be built with each ward and team
- This involves being visible and approachable
- Race Equity Officer supports both staff and service users
- Learning and reviews link to relevant governance
- Post-incident debriefs
- Lessons learnt shared within teams
- Case studies collected and shared wider

Case Study 1

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YY is an African Caribbean man in his mid-50's has been in Forest Lodge for more than eighteen months. YY has been in the mental health system for over 15 years . YY is due to be discharged from the setting via Tribunal.

In October last year YY began having regular conversations with a friend of a patient who visited the hospital. This continued over a few weeks at which point YY asked her telephone number. The woman in question then put in a complaint about YY stating that she was afraid of him and that he had tried to stop her car from leaving the facility one night.

YY. who has daily unescorted leave came in to SACMHA to speak to the Equity Officer to inform her about the complaint stating that he was very worried that it would impede his unsecured daily leave and him being able to leave hospital permanently.

The Equity Officer then visited the hospital to enquire what had happened and was informed by staff there about the incident and that the woman in question was thinking of taking it further.
As Equity Officer, a meeting was arranged with the Ward manager for YY to air his side of the story.

YY stated that he had been talking to this lady for over a month and that the incident in
question had been because she was coming down the drive with only one headlight and he had flagged the car just to tell the driver that the car was faulty.

YY stated that he had no idea who was in the car and just done it as an act of kindness.
The Equity Officer requested access he CCTV footage and that of at least two weeks prior to get a clearer picture of what YY was saying. The ward manager agreed. An MDT was set up for YY with all his care team and the MOJ.

The Equity Office attended the meeting on and shared the views of YY who was also in attendance. In the meeting colleagues were advised that the complainant stated that YY was 'harassing her'. The outcome of this allegation was that the team had decided that YY's leave would now be supervised.

In line with the role of Equity Officer the meeting was challenged and advised that YY had rights and further, it appeared that no one had considered his side of the story nor viewed the CCTV before they sanctioned YY. The CCTV footage was viewed and bore out completely the events as YY had shared them with ward staff. YY had his leave reinstated and is now on the path to leaving the hospital and moving into Supported Living with no issues to report.

Case Study 2

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WW is a young man of mixed race – African Caribbean and White British. WW is in his early 20's and has been known to the mental health system since his teenage years. A call came in from the hospital advising that WW had to be put in seclusion because he had attacked staff and clients in the unit. WW had specifically asked for the Equity Officer to come up so that he could talk to her.

Once there all the staff surrounded the seclusion unit as WW had been abusive and physically attacking them. It was also stated that KF was refusing his medication and was not talking. The Equity Officer asked for some time to be alone with WW at which point she entered the unit and WW immediately began to speak.

WW stated that he was on the ward for breakfast and told the staff that he was still hungry. WW said that others had said the same thing and were given food but he was denied. WW freely admitted that he became angry and started to bang on the hatch at which point he was restrained and placed in seclusion. The Equity Officer allowed WW the space to share his perspective then advised WW that going about things in the way he had would not help him and shared with WW some alternative strategies he could employ when the need arose for him to challenge staff. The Equity Officer agreed with WW that she would speak with staff to see how he could have some more food and even food from his culture that would prove more filling.

The Equity Officer then reminded WW that staff wanted to give him his medication but he would need to eat first.

WW agreed and the Equity Officer sat with WW in the seclusion room while he ate.

Staff were informed that WW was ready for his Meds which he took with no issues.

WW was released from seclusion that same evening and placed back on the ward with a new plan for his dietary needs and plans for SACMHA to support the hospital with regular sessions that included culturally appropriate activities and food and that WW would attend SACMHA events in the community more regularly as this was clearly an issue for him

The VM Inequity Waste wheel

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Activity

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On your tables:

- Please review the case study you have been given
- Using the Inequity waste wheel
- Which elements of inequity can you identify?


Feedback from activity

Summary

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1. Create partnerships and build trust
2. Build knowledge
3. Measure and monitor impact
4. Lived experience is key
5. Learn from every incident

JUST TAKE ACTION!

Thank you

Q&A

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SACMHA

SHEFFIELD FLOURISH

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