Equality Analysis Report: Final
BAMER Mental health service provision review

Start Date:	4/1/19	
Equality and Inclusion Service Signature and Date:	Andy Woods	28/7/20
CCG Officer Signature and Date:		
Finish Date:	21/7/20-28/7/2020	
Senior Manager Sign Off Signature and Date		
Committee Date:		

1. Details of service / function:

Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.

Across Britain, people from ethnic minorities are generally considered to be at increased risk of poor mental health (EHRC, 2016). Some evidence suggests that mental health conditions go unreported and untreated because people in some ethnic minorities are reluctant to engage with mainstream health services (Mental Health Foundation, 2017).

As well as poorer access to services, there are large disparities in the way some ethnic minority groups experience mental health services and treatment (EHRC, 2016). For example, in England, Black Caribbean patients were more likely to be admitted to hospital than White patients once they had been seen by a Crisis Resolution and Home Treatment team (EHRC, 2016) and Black adults in the general population were the least likely to report being in receipt of any treatment (medication, counselling or therapy) (Cabinet Office, 2018). Having been referred to psychological therapies, both men and women in England were most likely to attain recovery if they were White (British, Irish or Other White) and least likely if they were Bangladeshi, Pakistani, or identified as Other Asian or the Other ethnic group (Cabinet Office, 2018)

Quality and satisfaction:

In England and Wales, the only detailed measure of people's experience of mental health care is through the CQC survey of community mental health services (NHS England, 2016a). This was found to be inadequate following the CQC's 2015 special inquiry into crisis care which showed that people's experiences of mental health care across other settings were very mixed and should be tracked on a regular basis (CQC, 2015). There is also no measurement of people's experience of inpatient mental health care, including secure care, despite the nature of compulsory treatment and the potential for those who are detained to be considered 'at risk'.[1]

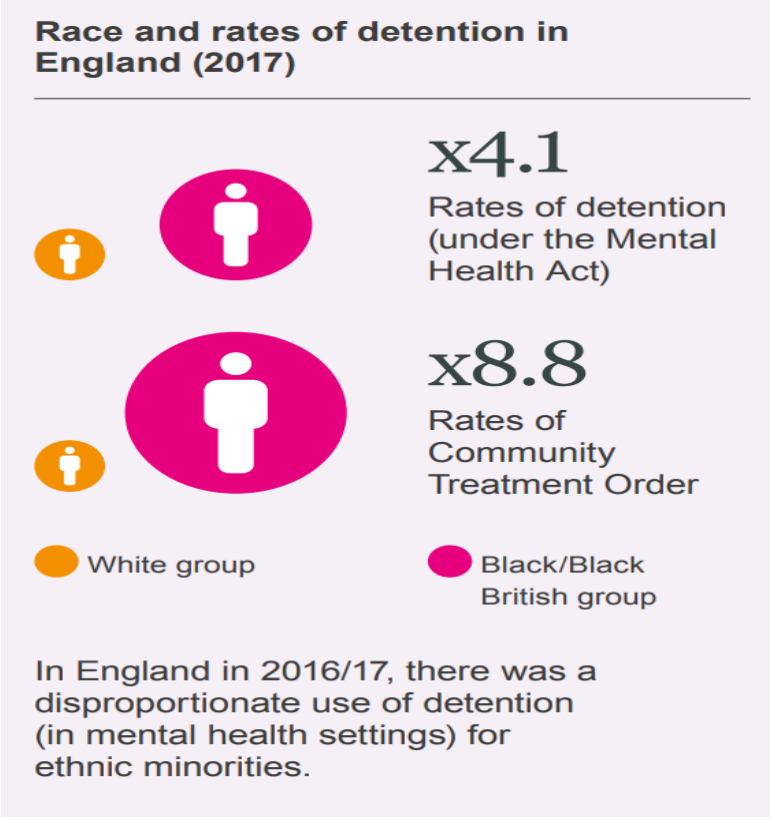
[1] Is Britain fairer? 2018 EHRC

Equality of access to psychological therapies remains an issue across Britain. There has been a significant expansion in access to psychological therapies in England, following the introduction of the national IAPT programme in 2008 (Improving Access to Psychological Therapies).97 However, 10 years on, NHS England acknowledges older people and ethnic minorities are under-represented among people who access IAPT therapies (NHS England, 2017).

Restraints & detention:

The mental health charity Mind has reported on huge variations in the use of physical restraint in hospitals in England from 38 to 3,000 incidents (Mind, 2013). UK Government policy papers in England have set out the need for a reduction in the use of restraint and an end to face-down restraint. Some guidance related to face-down restraint has been changed to reflect this (Mind, 2015a).

In England in 2016/17, there was a disproportionate use of restrictive interventions for ethnic minorities. The rate of restrictive interventions is over three times higher for Black or Black British groups compared with White British in 2016/17 (NHS Digital, 2017a). Among people in contact with NHS funded secondary mental health, learning disabilities, and autism services, 9,771 were subject to a restrictive intervention.101 The standardised rate of people subject to restrictive intervention per 100,000 was highest in the Black or Black British group (52.1), followed by Mixed (39.5), Other ethnic groups (24.7), White (15.8), and Asian (13.0) (NHS Digital, 2017a).



In 2016/17, known rates of detention in the Black or Black British group were over four times those in the White group (272.1 per 100,000 compared with 67.0 per 100,000). Rates for other ethnic groups (179.6), Mixed (157.0), and Asian or Asian British (82.1) were also higher. Detention rates for 'any other Black background', which includes Black European or Black American, were over 10 times the rate of White group (NHS Digital, 2017b). The independent review of the Mental Health Act interim report (2018) findings confirmed this trend and reported that Black Caribbean people were also more likely to come into contact with mental health services through the police, be given Community Treatment Orders (CTOs)103 (NHS Digital, 2017b), be admitted to secure hospital, and to have poorer health outcomes over time (Cabinet Office, 2018)

The proposal:

NHS Liverpool CCG currently commissions a Community Development Service (LCDS) to address inequalities in mental health experienced by BAMER communities and reduce barriers faced by members of BAMER communities who need to access support for mental health issues. LCDS is aimed predominately at people from BAMER communities with mental health issues, as well as the organisations, professionals and services who work with them and can provide support. People can self-refer to the service. They can also be referred by other agencies.

Representation & Advocacy

Signposting and Publicising

Community Development

Training and Education

The LCDS contract is delivered as a partnership between Mersey Care, PSS and Mary Seacole House. The service was commissioned from August 2015 following a competitive procurement exercise. A 3 year contract was awarded with a planned finish date of July 31st 2018 which has been extended until 31st March 2019.

A review of the service specification, outcomes and monitoring framework is proposed. It is also proposed that from 1st April 2019 the service will be built in to LCCGs overarching contract with Mersey Care, rather than exist as a separate contract. Consideration will need to be given to the independence of the service.

Regarding the specification the proposal is to link the service specifically into the following areas of One Liverpool Strategy development –

- Meeting new targets for Improving Access to Psychological Therapies (IAPT) and for Early Intervention in Phychosis for BAMER communities.

- Linking Voluntary Community and Social Enterprise (VCSE) services to GP neighbourhood planning.

- Expanding the reach so that barriers face by BAMER communities are addressed at community/primary care level.

- Linking effectively with LCC developments.

The aim of the service has been to reduce barriers faced by members of BME communities when seeking support with mental distress.

It is intended that BAMER community members will experience improvements in access to effective mental health interventions and mental health professionals will have increased knowledge and skills for effectively supporting people from BAMER communities and addressing mental health issues appropriately to patient need.

It is absolutely vital that performance around BAMER mental health services is fully

understood and clear and strong monitoring of BAMER services is a fundamental requisite.

Any future service has to have clear SMART monitoring protocols and meet the need of BAMER community

Future service has clear protocols in terms of reporting concerns , issues and discrimination to LCCG

COVID-19

COVID-19 has exposed pre-existing health inequalities.

- Health inequalities have widened across the North West – 'Due North Report' PHE-2014
- 'Health Equity in England Marmot Review 10 Years on' - February 2020.

Evidence continues to emerge in relation to BAMER communities being disproportionately affected by COVID-19.

- 'Disparities in the risk and outcomes of COVID-19' – June 2020
- COVID-19 Equality Brief

People living in poverty and people who experience health inequalities (BAMER) are experiencing disproportionate impact Direct and indirect impacts of COVID-19 on health and wellbeing –

- Rapid evidence briefing by the Health & Equity in Recovery Plans Working Group-June 2020 (Version 1).

What is the **legitimate aim** of the service change / redesign

- To increase choice of patients
- Value for Money-more efficient service
- Public feedback/ Consultation shows need for a service
- COVID-19 has exposed pre-existing heath inequalities experienced by BAME communities

2. Change to service

The consultation programme is to establish evidence for a possible redesign of service provision. Based on the results of the consultation and analysis of current service provision the following factors will be taken in to account.

- What current services offer
- What BAMER community need and want
- What professional need and want (including the police who arrest people on mental health grounds)
- Best way of providing value and efficiency of service provision
- Best way of monitoring performance

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

BAMER community has a long history of having of poor or unequal treatment compared to white counter parts.

BAME community -

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health

Protected Characteristic	**Issue**	**Remedy/Mitigation**
Age	10% of children in society suffer from mental health issues, when it comes to 'looked after children' this increases to 45% Key service issues for children are: • Helping children and young people stay mentally well (building resilience) tackling problems early to prevent them getting worse and taking action quickly if they do. • Making it easier to get support that works. • Care for the neediest young people. • Services doing things openly and honestly. • Having the right people in the right place at the right time in the workforce.	Ensure service meets young people's needs Ensure there is capacity in then team to meet this area.
Disability	Eight out of 10 people with a disability weren't born with it. The vast majority become disabled through an injury, accident, heart attack, stroke, cancer or conditions like MS and motor neurone disease Government statistics show 47 per cent of people who were formerly receiving Disability Living Allowance (DLA) saw their support fall or stop altogether when they	

(physical) (Mental health)	were reassessed for Personal Independent Payment (PIP). Of a total of 947,000 claimants who were reassessed in the year to October 2017, 22 per cent saw their support reduced, while a quarter were disallowed or withdrawn altogether — meaning 443,000 people will have had their claims reduced or removed. Physical disabilities: having a physical disability (and in particular where there is constant pain) can affect mental well being in addition to the frustration of society/environment not being designed to support/facilitate physical disabilities. A large number of people with physical disabilities have also had great difficult in accessing or keeping disability focused benefits. This has resulted in depression and even suicide. There will be BAME service users of current mental health service provision	Ensure that BAME with disabilities are included in service design and consider their needs as part of service delivery. Ensure there is capacity within the team to meet this need.
Gender reassignment	Gender dysphoria, confusion/denial about gender, fears around transitioning, gender reassignment treatment delays and refusals, and social stigma increased suicide risk There is a high rate of suicidal ideation (84 per cent lifetime prevalence) and attempted suicide (48 per cent lifetime prevalence) within this group. A supportive environment for social transition and timely access to gender reassignment, for those who required it, emerged as key protective factors. Whilst this group remain a small percentage of society, Being BME and transgender is an even smaller percentage yet will have a double impact of being 'trans' and being 'black'.	Link with Trans groups to identify mental health needs (and issues) and what BAME Trans needs would look like.

Marriage and Civil Partnership	N/A	
Pregnancy and maternity	King's College London found that one in four pregnant women (27%) were diagnosed with a mental health disorder when interviewed. Other studies have found that up to one in five women have a mental health disorder during or just after pregnancy[2]	Ensure pregnancy and post natal depression is part of the service plan and to link BAME parents in to mental health support networks. Service to link in with 'Improving Me' hosted in LCCG
Race	African- Caribbean African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. However, most of the research in this area has been based on service use statistics. Some research suggests that the actual numbers of African-Caribbean people with schizophrenia is much lower than originally thought. African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication, rather than be offered talking treatments such as psychotherapy, and are over-represented in high and medium secure units and prisons. This may be because they are reluctant to engage with services, and so are much more ill when they do. It may also be that services use more coercive approaches to treatment.	Ensure BAME staff are part of the work force. Ensure there is capacity within team to meet needs of BAME community. Ensure there is capacity in the team to provide cultural competence training, advice and guidance and support across key NHS Providers, Primary Care and other key services across partner organisations. Ensure service engages with BAME networks and is able to feedback on concern to commissioners Work with incumbent provider to develop processes were intelligence, concerns and barriers can be addressed Ensure service

[2] https://fullfact.org/health/mental-health-during-pregnancy/

	Asian The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group. Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support. Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems. Research has suggested that Western approaches to mental health treatment are often unsuitable and culturally inappropriate to the needs of Asian communities. Asian people tend to view the individual in a holistic way, as a physical, emotional, mental wellbeing Irish Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups. In particular they have higher rates of depression and alcohol problems and are at greater risk of suicide. These higher rates may, in part, be caused by social disadvantage among Irish people in the UK, including poor housing and social isolation. Despite these high rates, the particular needs of Irish people are rarely taken into account in planning and delivering mental health services Latin American /Portuguese Eastern European BAME - Homeless Refugees (asylum seekers)	continues to work closely with LCCG Equality team via Merseyside BAME CDW Group. Ensure service links in with LCCG engagement team. Ensure service links with new and emerging equality forum structures, including LCCG Equality Forum and NHSE&I BAME strategic Advisory Board.
Religion and belief	• Cultural beliefs compounded stigma and that services needed to be more aware of that. • There's some belief that people from	Ensure service is sensitive to cultural needs and can understand mental ill health linked to cultural

	some ethnic backgrounds have a stronger resistance to drugs, therefore may feel they're more likely to be prescribed higher doses of medication, • Some services aren't equipped for certain communities and the taboos they face. You need to understand where people come from to understand what they're facing[3]. Women and young girls from South Asian communities often carry a great sense of shame and the need to preserve their family's honour "The difficulty is that people, especially young [Asian] girls, can find it difficult to talk to their parents and family about their mental health problems."[4]	practices such as limited role for women in some cultures.
Sex (M/F)	The 2014 Adult Psychiatric Morbidity Survey (APMS) found the prevalence of common mental health problems to vary significantly by ethnic group for women, but not for men. Non-British white women were the least likely to have a common mental health problem (15.6%), followed by white British women (20.9%) and black and black British women (29.3%). Black adults were also found to have the lowest treatment rate of any ethnic group, at 6.2% (compared to 13.3% in the white British group).3 In contrast, a 2015 study by Stewart-Brown and colleagues found that those of African-Caribbean, Indian and Pakistani origin showed higher levels of mental wellbeing than other groups; this was found to be largely attributed to higher levels of wellbeing found among men. A review published in 2015, exploring the association between ethnicity, mental health problems and socioeconomic status found people from black ethnic minority backgrounds to have a higher prevalence	Ensure that needs of different sexes are part of any BAME mental health services

[3] Heather Nelson, chief executive of the Black Health Initiative

[4] Marjorie Wallace, chief executive of SANE

	of psychosis compared with the white majority population. This effect was still observed after controlling for socioeconomic status. Studies show that PTSD is higher in women of black ethnic origin and this association is related to the higher levels of sexual assaults that they experience; however, women of black ethnic origin are less likely to report or seek help for assaults or trauma. Disproportionate rates of people from BAME populations have been detained under the Mental Health Act 1983. A 2016 UK study examining the Mental Health Act 2007 assessments found this to be disproportionality associated with higher rates of mental health conditions and poorer levels of social support, but not due to ethnicity. In Northern Ireland, the suicide rate among male Irish Travellers is 6.6 times that of men in the general population. This group also continues to experience discrimination, with 65% of people reporting that they would not accept an Irish Traveller as a close friend[5] Women and young girls from South Asian communities often carry a great sense of shame and the need to preserve their family's honour "The difficulty is that people, especially young girls, can find it difficult to talk to their parents and family about their mental health problems."[6]	
Sexual orientation	There is also evidence that sexual minorities suffer from anxiety disorders at higher rates and are more likely to abuse alcohol and drugs compared to heterosexual people. Challenges such as the stigma associated with sexual minorities, discrimination, family disapproval, social rejection, and violence	Include LGBQ+ groups in design of services and ensure that there are LGB staff to help support LGB patients.

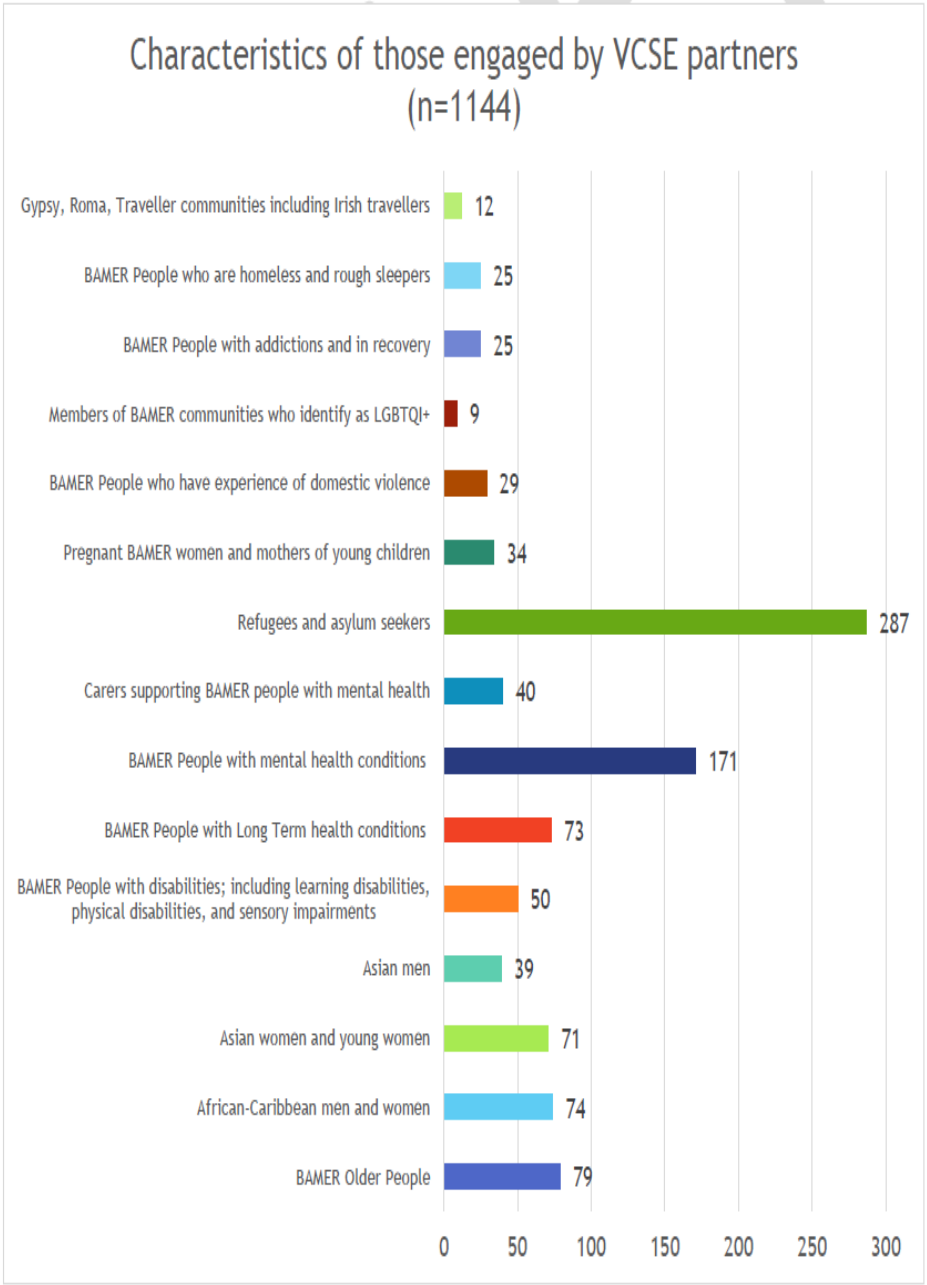
[5] https://www.mentalhealth.org.uk/statistics/mental-health-statistics-black-asian-and-minority-ethnic-groups

[6] Marjorie Wallace, chief executive of SANE

	are among the factors that can lead to mental health problems[7] Being Gay and being BAME adds to the cultural stigmatisation as often BAME cultures are not accepting of LGB+ lifestyles.	
Health Inequalities	BAMER communities are significantly more likely to experience poorer health and inequalities, which impacts on their mental health and wellbeing. BAMER communities are significantly more likely to live in poverty, which impact on their mental health and well-being Broader partners such as Police, Home Office, CPS and other key stakeholders are not engaged with.	Ensure eservice has clear protocol's to raise issue and barriers to LCCG and other key groups and partners including (BAME strategic Advisory Board) and wider partners including Police, CPS, LA,, Social Care etc.

4. Does this service go the heart of enabling a protected characteristic to access health and wellbeing services?
Yes
5. Consultation
Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
Consultation took place and a full report of the findings is contained in: '*Review of black asian, ethnic minority and refugee community experience of Liverpool's mental health service and Liverpool's community development service'* available from LCCG.

[7] https://www.psychologytoday.com/gb/blog/evidence-based-living/201702/mental-health-and-sexual-orientation-what-the-evidence-says


Characteristics of those engaged by VCSE partners (n=1144)
Gypsy, Roma, Traveller communities including Irish travellers
12
BAMER People who are homeless and rough sleepers
25
BAMER People with addictions and in recovery
25
Members of BAMER communities who identify as LGBTQI+
9
BAMER People who have experience of domestic violence
29
Pregnant BAMER women and mothers of young children
34
Refugees and asylum seekers
287
Carers supporting BAMER people with mental health
40
BAMER People with mental health conditions
171
BAMER People with Long Term health conditions
73
BAMER People with disabilities; including learning disabilities, physical disabilities, and sensory impairments
50
Asian men
39
Asian women and young women
71
African-Caribbean men and women
74
BAMER Older People
79
0
50
100
150
200
250
300

The gender and age of survey respondents were distributed as follows:

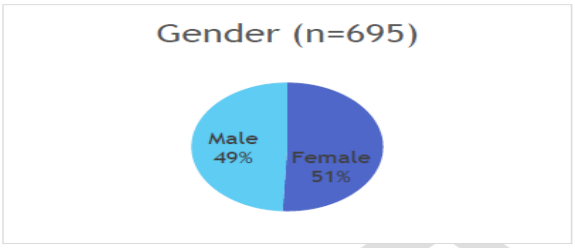


Figure 1

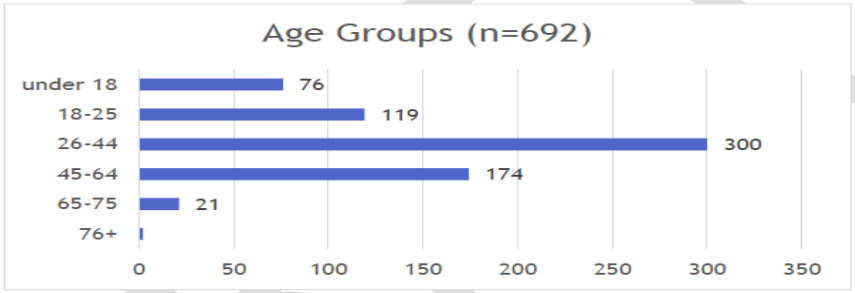
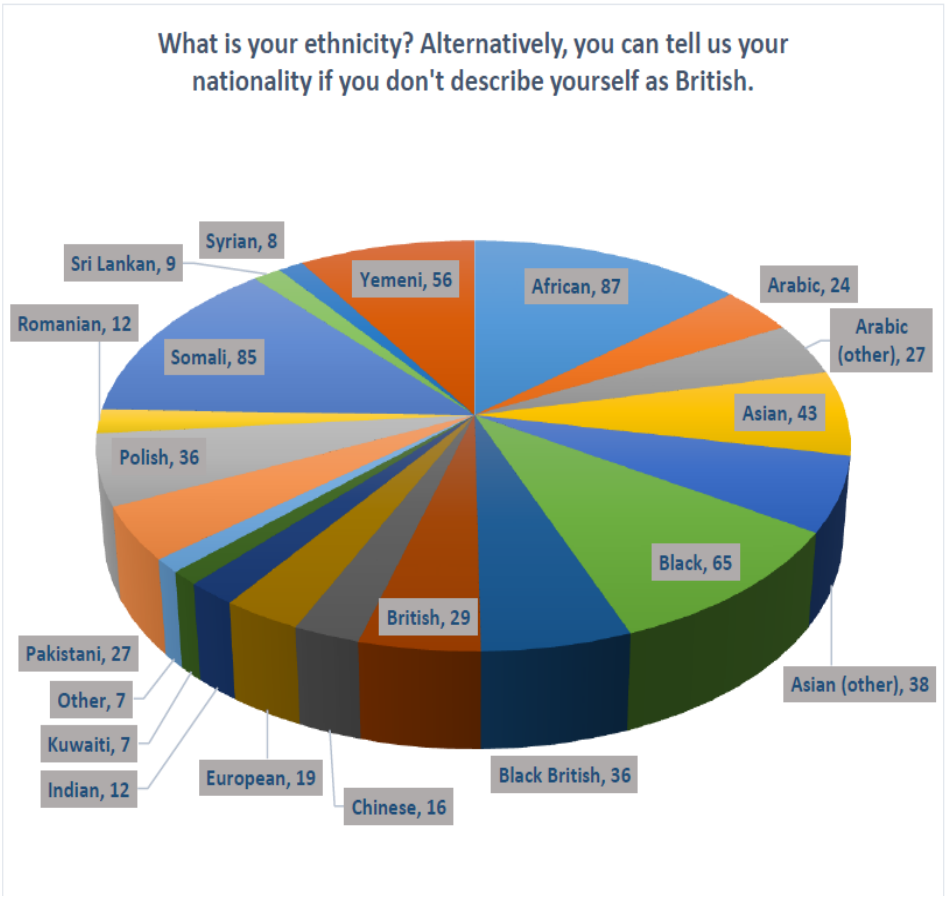
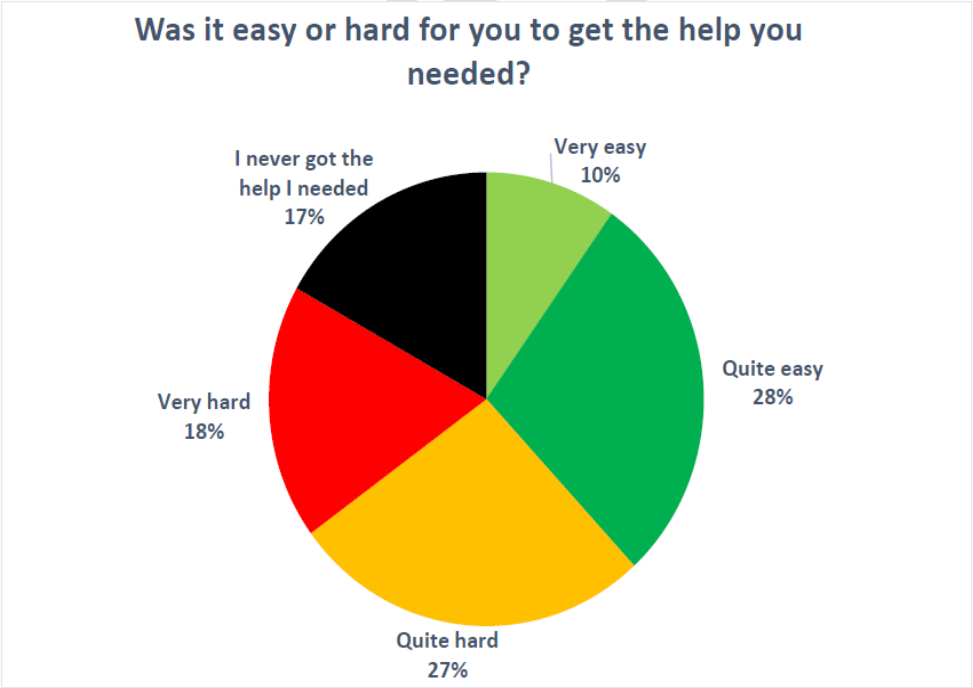
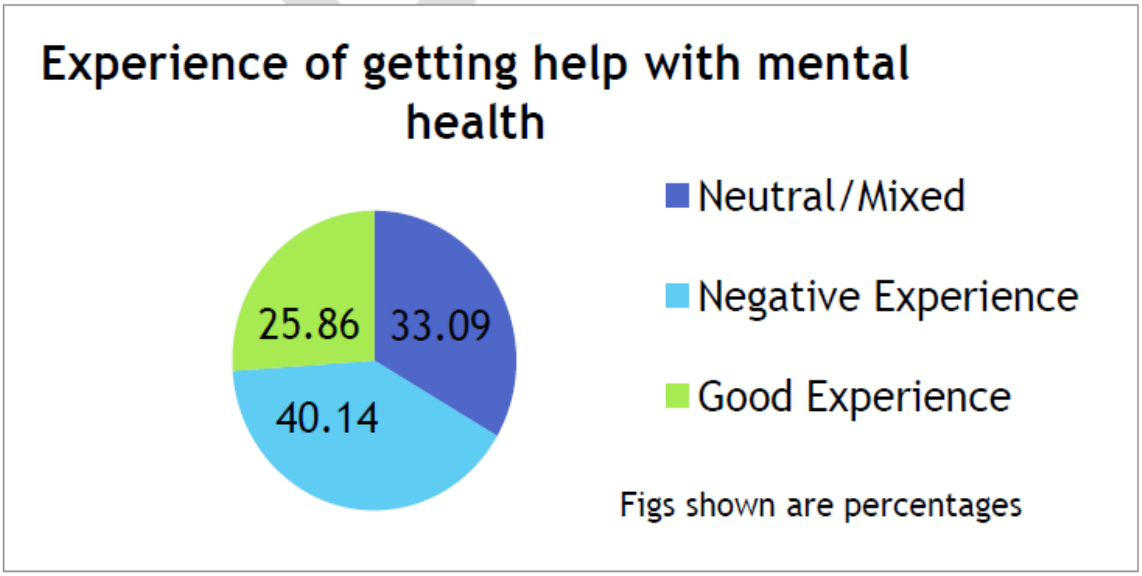


Figure 2







6. Have you identified any key gaps in service or potential risks that need to be mitigated

The main issues coming out of the consultation were in relation to accessing the service and the quality of the service as perceived by recipients.

Risk	Required Action	By Who/ When
Barriers to accessing services	Review access of service and monitor waiting lists/ dropout rate. Design services that are inclusive (see section 7 PSED below)	Service providers under instruction of commissioners
Less than good experience of using services	Develop service user feedback and design service will the help of service users. Monitor and assess quality of service being offered and how it meets need. Check if service users feels as though they have been discriminated against.	Commissioners/ Service providers
Under resourced Team During the term of the last contract the mission of the service has drifted	BAME service users have particular needs which are different support needs from the wider community. Resources have to be specifically allocated to help support BAME community with mental health needs. The service needs the capacity to deliver	Commissioners/NHS Mersey Care FT

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
The consultation shows that many BAME people have negative experiences of mental health services/provision.

It is vital that BAME have a dedicated mental health provision. Monitoring must take place (and be regularly reported back to commissioners) to assess usage, demand and quality and effect of targeted services to BAME community.

Providers must demonstrate how they monitor their performance and manage waiting times with a cross comparison of non BAME service users.

PSED Objective 2: Advance Equality of opportunity.

PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.

The consultation has shown that there is a clear need for a BAME badged service, targeting the needs of BAME community

BAME have particular support need so mental health service must take this in to account and provide a specialised provision.

Providers must demonstrate that they understand specific needs inked to BAME community and their programmes of support represent this knowledge and leaning.

PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it

The term BAME is generic and contained within this will be different layers of need linked to different ethnic groups and cultural relationships. The providers need to demonstrate how they can support a wide range of differing needs .

In addition, providers need to show how they will support:
Young people
Older and isolated people
Disabled users
LGBQ+ users
Trans users

PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.

The consultation has shown that there are perceived and real barriers to accessing mental health support.

Concerted efforts need to be made by providers to acknowldege these barriers and to over come them. Mental health can be a difficult disease to self-manage and support is often needed. People that may be worried about asking for help (for various reasons) need to be 'invited in' and reassured that asking for help is OK.

Providers need to demonstrate their methods of PR and inclusivity.

PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
The consultation has shown that there are still 'taboos' around asking for mental health support. Having a dedicated service for BAME is a good communication of understanding and fostering good relation between different groups, especially groups that are feeling the effect of racism within society. As part of fostering good relations, the providers need to ensure that work in the community is on going in order to a) tackle prejudice about mental health and b) promote understanding about mental health and services that support people with mental health difficulties.
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Ensure providers can demonstrate evidence and understanding of all the points raised above as part of the contract award process.
8. Recommendation to Board
Guidance Note: will PSED be met?
Providers that meet and deliver on the above criteria will meet PSED