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Access and engagement for people from minority ethnic communities for mental healthcare

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NIHR ARC National Priorities Programme: Mental Health Implementation Network (MHIN)

Rationale

For people with psychosis and other severe mental health conditions

- Black Caribbean, Black African and Black British people are more likely to experience coercive pathways into care. Other minority ethnic groups are also impacted [2018 MHA review]

- Mental health inequities are “longstanding” and “rooted in….structural, institutional and interpersonal racism…” [race & health observatory]

- “Inability to provide culturally competent/ adapted healthcare leads to disparities…(and) poor access to available services…” [Rathod]

Wide ranging inequities:

- Ethnic minority groups less likely to be referred to psychological therapies (IAPT) or self-refer
- Less likely to receive cognitive behavioural therapy & less likely to complete sessions/ attend as many sessions as White British people
- Involuntary admissions also more likely in Black adolescents/ young people [Walker et al, 2021]
- “rooted in a distrust of primary care and mental health care providers”

*“…we’re sometimes met with a challenge; that we already know what the problem is, that more reports and research won’t help, and that what we need now is **action**…”*

Dr Habib Naqvi, Director NHS Race and Health Observatory

Healthy Minds Initiative

What is the solution

The Healthy Minds' initiative developed a culturally sensitive group-based psychological intervention where South Asian service users could feel that their ethnic, cultural and spiritual beliefs were understood, and where specific barriers to access for these communities were addressed.

Who provides the solution

Birmingham and Solihull Mental Health NHS Foundation Trust – Birmingham Healthy Minds

How is the Solution provided?

1. Developed a culturally sensitive psychoeducational group-based therapy
2. Language barriers or literacy issues are addressed to improve uptake
3. Psychological Wellbeing Practitioners (PWP) supported to deliver interventions in languages other than English.
4. Cognitive behavioural therapy (CBT) approaches adapted with the South Asian community in mind, specifically for women

Where has this been delivered?

Birmingham and Solihull Mental Health NHS Foundation Trust

Ethnicity & Mental Health Improvement Project (EMHIP)

What is the solution

EMHIP has identified a set of key interventions to reduce ethnic inequalities in mental health care.

The outcomes of these interventions and the process of change will be evaluated through a series of ethnicity audits.

Who provides the solution

Community embedded workers and healthcare professionals

How is the Solution provided?

Consists of 5 domains with linked interventions

- Mental health and wellbeing hubs in the community
- Increasing choice and service options, e.g. bespoke community-based service for people repeatedly admitted under the Mental Health Act
- Reduce coercion, e.g. through shared decision-making
- Enhance inpatient care- ‘cultural mediation’ in inpatient settings
- Develop a more culturally capable workforce

To maximise impact and ensure whole system change, these interventions should be considered as one integrated programme.

Where has this been delivered?

South West London and St George’s Mental Health NHS Trust in Wandsworth

Tackling Inequalities and Discrimination Experiences in health Services (TIDES) study

What is the solution

The '**walking in the shoes of'** Virtual Reality (VR) study uses innovative methods to examine how bias influences behaviours and decision making in the NHS.

Who provides the solution

TIDES is led by a team of researchers and academics at King's College London and City, University of London.

How is the Solution provided?

- Virtual reality (VR) scenarios form a key part of immersive training and education for NHS staff, managers and policy makers from all minority ethnic backgrounds, and will be integrated into a Race Equality Assessment toolkit
- Will enable managers and staff to ‘walk in the shoes of’ ethnic minoritised staff in occupational roles most affected by racism, discrimination and other adversity which aims to be engaging, empathic and experiential

Where has this been delivered?

These training simulations are being piloted with collaborators who hold senior management positions in the NHS.

Discussion

- Are there other promising and innovative solutions which we need to consider in this topic area?

- How can we ensure that impacted communities are equitably involved in this process?

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Improving Access to Psychological Therapies for children and adolescents, especially in schools

Facilitated by Dr Sarah Robinson

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Rationale for focus on CYP

- Rates of probable mental disorder in 6-16-year-olds increased between 2017 and 2021 from one in nine to one in six .
- Children and young people with a probable mental disorder were more likely to say that lockdown had made their life worse than those who were psychologically well.
- When it came to receiving help for mental health problems during the pandemic, almost 1 in 5 of 5- to 16-year-olds (or their guardians) with a probable mental disorder who tried to seek help for mental health problems reported that they didn’t receive the help they needed.

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Interventions identified

1) brief Behavioural Activation in schools
2) parent delivered CBT
3) i-THRIVE

Brief Behavioural Activation in schools

What is the solution

Brief BA is based on the behavioural theory of depression with a focus on Reinforcement.

It focuses on increasing positive reinforcement for non-depressed behaviours.

Who provides the solution

- Trained Clinical Psychologists
- Children's wellbeing practitioners (CWP)
- Educational mental health practitioners (EMHPs)

How is the Solution provided?

It includes six to eight face to face sessions delivered twice or once a week.

The therapist and young person work collaboratively to identify the young person's personal values, then identify, plan and engage in activities in line with these values

- Sessions 1 and 2: Engagement and Treatment Rationale
- Session 3: Risk Management
- Sessions 4 to 6: Identifying Values and Activities Across Life Areas

Spread and impact to date?

Introduced into five secondary schools

Feasibility data was collected impact/effect for n=19 significant

Parent-delivered CBT

What is the solution

Evidence-based guided parent-delivered CBT based intervention for childhood anxiety

Consistent with a self-help approach

Who provides the solution

Parents/carers, guided by therapists.

How is the Solution provided?

Parents are given a self-help book and received one of two forms of therapist support:

- full guidance, which consisted of weekly therapist contact over 8 weeks, involving four 1-hour face-to-face sessions and four 20-minute telephone sessions (i.e. about 5 hours and 20 minutes of therapist guidance).
- brief guidance, which consisted of fortnightly therapist contact over 8 weeks involving two 1-hour face-to-face sessions and two 20-minute telephone sessions (i.e. about 2 hours and 40 minutes of therapist guidance).

Spread and impact to date?

- Parent Guided CBT for childhood anxiety has been evaluated in NIHR funded randomised controlled trials across various settings with significant effects
- Not currently implemented at any real-world setting

i-THRIVE

What is the solution

i-THRIVE refers to the implementation of the principles of the THRIVE Framework. It is the mechanism to deliver a population/whole-system approach to promote “Thriving, and seeks to improve outcomes in relation to children and young people’s mental health and wellbeing.

Who provides the solution

Training is led by the i-THRIVE Team

Solution is a system led model of care

How is the Solution provided?

- No ‘wrong door’, anyone, would be able to provide CYP with support or signpost them.
- Knowledge of the best ways to ask for CYP views about what was important to them and what they wanted to be different.
- Signposting to things the CYP, their family and friends, could do to support their mental health needs
- Specialized mental health help would support the CYP to evaluate their progress
- To be supportive but transparent conversations about what different treatments

Spread and impact to date?

Over 75 sites across England, Northern Ireland and Scotland.

System based intervention that suggests accessibility and experience are improved

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Group discussion
- are there innovative evidence-promising solutions we have missed?
- initial thoughts about the three projects identified?

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Integrated physical and mental health care for people with severe mental illness

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Background

- *"No health, without mental health"*

- **People with severe mental illness**
  increased risk of physical disease
  reduced access to adequate health care
  reduced life expectancy

- **Interventions**
  physical health
  mental health

National Clinical Audit of Psychosis (NCAP)
Audit Core Standards

What is the solution

NCAP was set up to improve the quality of care for people with psychosis.

It assesses the services that England and Wales provide for people with psychosis.

NCAP then states what can be improved.

Who provides the solution

Early Intervention in Psychosis (EIP) Teams

How is the Solution provided?

- Every year EIP services are assessed against eight standards, including:
  - ✓receiving an annual physical health screening, includes smoking status, alcohol intake, substance use, BMI, blood pressure, blood glucose levels and cholesterol levels
  - ✓receiving support for any physical health problems
- Services will be offered if the screening indicates any need for intervention.

Where has this been delivered?

EIP teams from each NHS Trust in England.

PRIMROSE

What is the solution

Programme of research to improve the assessment and management of cardiovascular risk in people with severe mental illnesses.

Who provides the solution

Practice nurse/health-care assistant

How is the Solution provided?

The manualised intervention consisted of 8–12 appointments with a practice nurse/health-care assistant over 6 months

Involving collaborative behavioural approaches to CVD risk factors.

The intervention was compared with routine practice with a general practitioner (GP).

Where has this been delivered?

Study was carried out in general practices across England.

Diabetes and SMI and self management approaches

What is the solution

Develop and evaluate a diabetes self-management intervention for people with severe mental illness and type 2 diabetes.

Explore the generalisability of this approach to other comorbid long-term physical health conditions.

Who provides the solution

Service Users

How is the Solution provided?

A platform of digital tools that:

- ✓provide core data in standard format for multiple disciplinary diabetes teams,
- ✓giving access to real-time information improving patient care.

Where has this been delivered?

Aiming to deliver to all NHS patients.

Virtual Physical Health Clinic (VPHC) and Consultant Connect (CC) services

What is the solution

VPHC and CC supports staff to manage the medical needs of their inpatients.

They provide different routes for clinicians to access advice on the management of physical health conditions, both chronic and acute.

Who provides the solution

Virtual Physical Health Clinic (VPHC) and Consultant Connect (CC) services

How is the Solution provided?

- Two sessions per week of consultant physician time and one session per week of ANP time
- A referral system via the SLaM electronic patient journey system (ePJS) with triage of referrals
- Virtual clinic appointments offered throughout the week via MS Teams
- Telephone support for ad hoc queries
- Email response to queries
- Provide virtual education and training sessions
- Telephone and photo advice service for doctors providing specialist medical advice

Where has this been delivered?

In general practice in Southwark and Lambeth and SLaM inpatient services

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Group discussion

- initial thoughts about the interventions identified?
- are there other innovative evidence-promising solutions you would like to recommend?

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Prof. Simon Hackett
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Integrated care protocols for co-occurring mental illness and substance use

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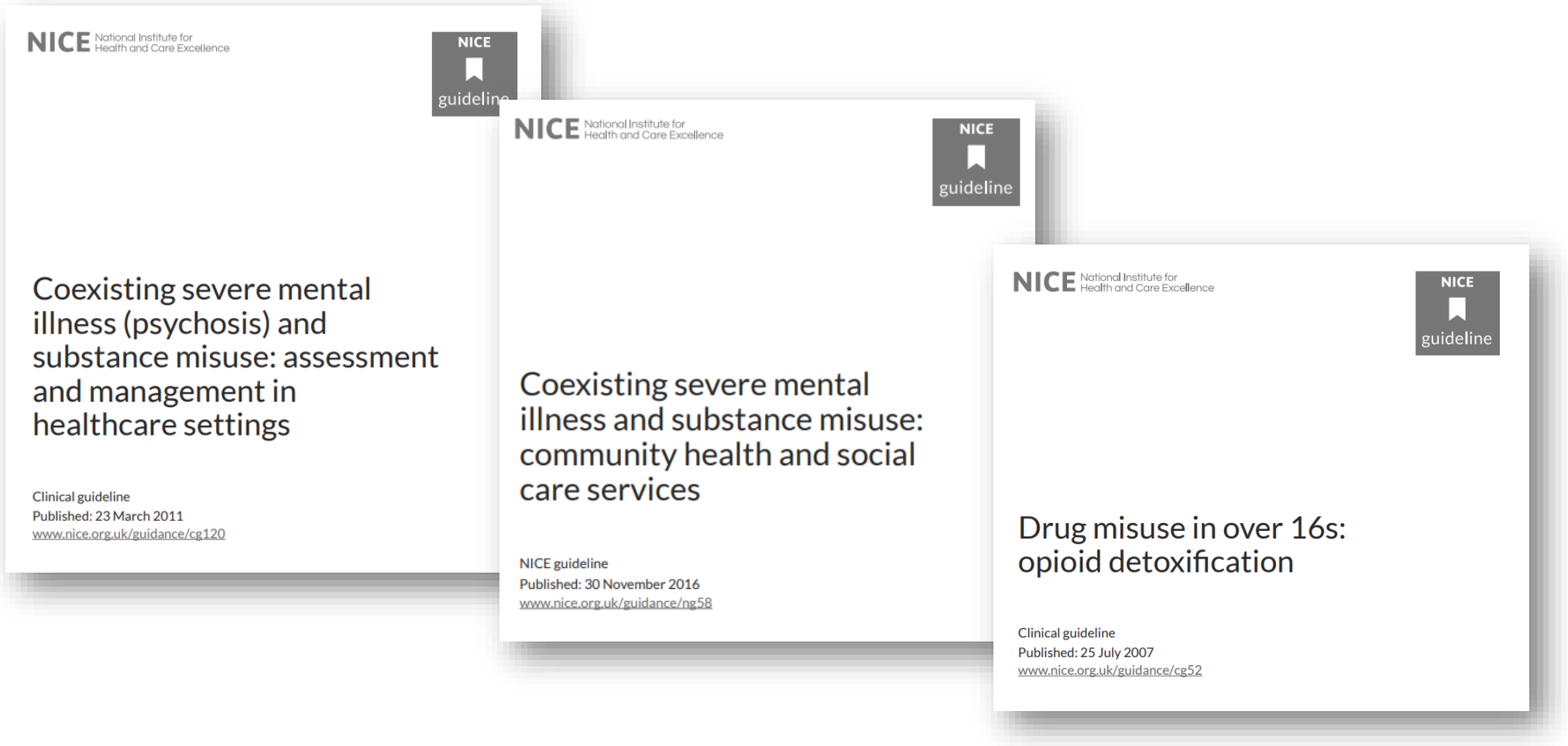
Background

- Substance use and mental illness frequently co-occur:
  - Particularly strong association between anxiety/major depression and alcohol use disorder.
  - Elevated rates of psychiatric disorders also seen in people with cannabis, cocaine and opioid dependence.
- Various reasons proposed to explain high rates of comorbidity:
  - One condition may directly influence another, e.g. heavy alcohol use may lead to depression.
  - Comorbidity may also be indirectly produced, e.g. substance use to self-medicate/relieve mental distress may lead to dependence.
  - Common shared causes, e.g. genetic predisposition, socioeconomic factors, trauma.
- Adverse impacts for these individuals are tangible:
  - People with co-occurring substance use and mental illness experience worse health, social and economic outcomes than those with single diagnosis conditions

Current guidelines for practice in the UK…



…the reality for many individuals seeking help

"I went to [the hospital] and said to them, 'I am having intrusive suicidal thoughts. I don't know why. I'm frightened.' And their response was, 'Unless you reduce your alcohol to 13 units a week, you will receive no treatment from the NHS or from private practice.' And I came out and thought, "Well, that's it then. That's it. Nothing is going to change, I'm not going to get any help." Three weeks later, I had planned and organised my suicide." (ADEPT Study Participant)

They're not the same service, that's the thing. The community mental health team are different to the alcohol – whatever you call it – team. If you said anything about your drinking to the community mental health team, they would say, "That's not my area of expertise, you need to talk to people at [Addiction service] for that sort of thing." (ADEPT Study Participant)

"I'm facing this maze full of doors and every time I open a door, there's another door, sets of doors. There's no coherent structure within the system that says 'Can we please pull this together so we can actually provide the help this person needs?'" (Expert by Experience)

Assertive Outreach Service

What is the solution

Assertive Outreach Treatment (AOT) is a model of care where health professionals support clients at home or in their local neighbourhood, rather than asking them to come to a clinic or hospital. It is an established model of care for severe mental health illness.

Who provides the solution

For alcohol and mental health comorbidity it is provided by a specialist multi-disciplinary assertive outreach team and often includes peer-to-peer support

How is the Solution provided?

- Emphasis on care provided in the clients home or local neighbourhood
- Small caseloads (10-15 per keyworker)
- Frequent and flexible contact (at least once per week)
- Assertive engagement and follow up
- Comprehensive health and social care
- Treatment individualised, with a client led agenda
- Close multidisciplinary working (medical, nursing, social care, counsellors, peer support)
- Extended contact (12 months or longer)
- Much more intensive and extensive than standard care

Where has this been delivered?

Originally developed and implemented in the 1970s in USA for people with severe mental illness and addictions comorbidity. Specifically for alcohol dependence this has been implemented in several NHS trusts across England, and evaluated in South London and Salford, usually closely linked to in-hospital Alcohol Care Teams.

What do you think? Tell us via the chat function

- Thinking about promising interventions:
  - Is there anything else we need to know about the intervention already identified?
  - Are there other innovative evidence-promising solutions we have missed?

- Thinking about the ‘bigger’ picture:
  - Do we need specialist combined services? ***or***
  - Do we need to skill-up existing single focus services?

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