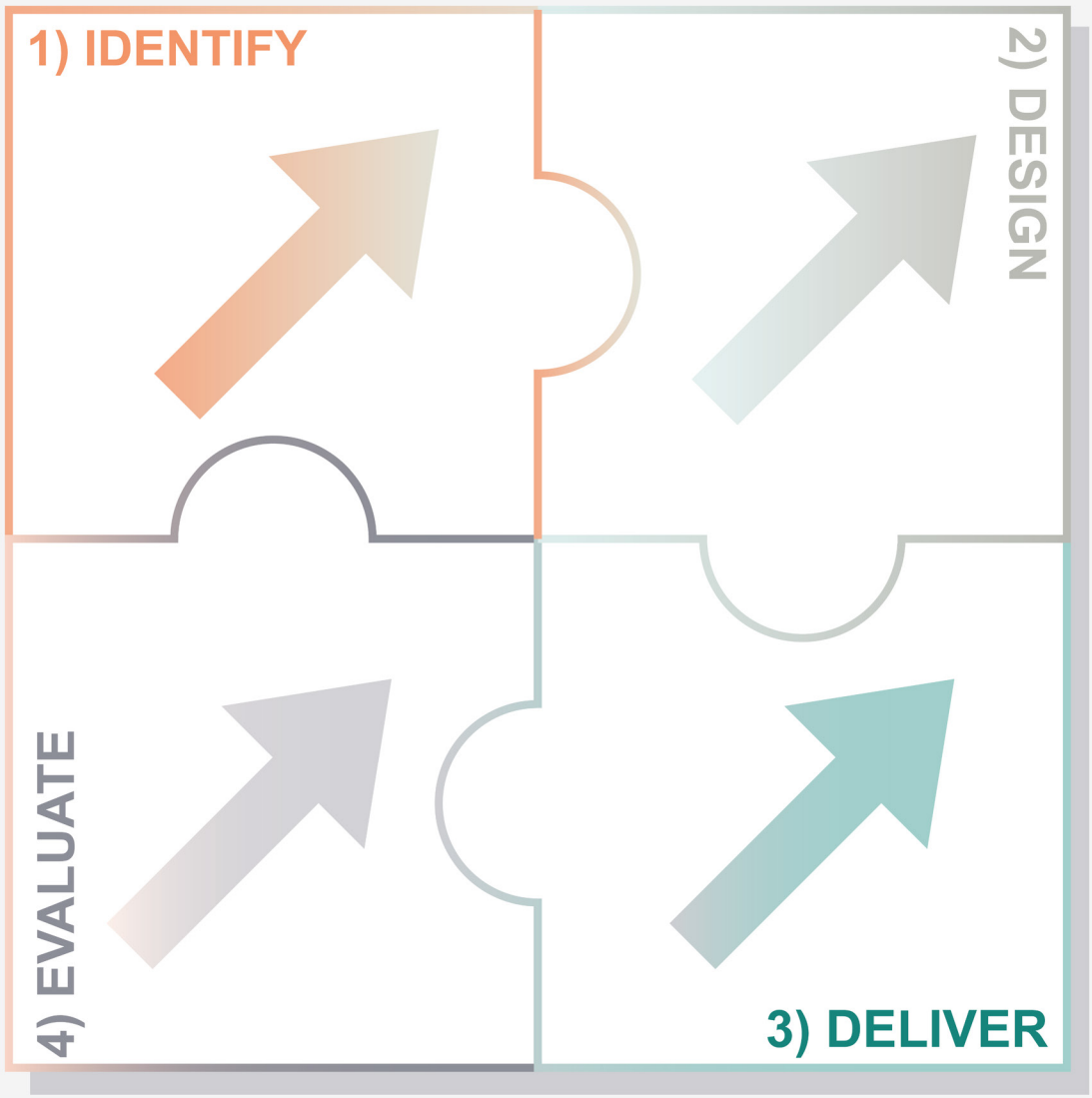
Advancing Mental Health Equality



Appendices and helpful resources

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Online PDF version

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Appendix 1: The case for change

The arguments for advancing equality in mental health

People with mental health problems are at a higher risk of disadvantageous experiences across many areas of life, because of the impact some mental health problems can have on social functioning. This disadvantage feeds on itself, in that intersectional discrimination, systemic inequalities and social factors also contribute to and perpetuate mental health problems. Additionally, many people will face an additional level of disadvantage due to the inequalities present within mental health care and treatment. For example, the specialisms of mental health services vary considerably around the country, leading to something of a 'postcode lottery' when it comes to availability of services in local areas and communities. Both the Five Year Forward View for Mental Health (5YFVMH)[1] and the NHS Long Term Plan[2] seek to address this issue.

Wherever it is provided care should be appropriate to people of all ages. Older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age-appropriate care.

Source: The 5YFVMH, NHS England

There are three crucial cases for addressing inequalities and advancing equality: economic, legal and moral.

The economic case

In general, improving mental wellbeing has the potential to benefit the economy.[3,4] Prevention and early intervention can improve clinical outcomes, avoiding or reducing mental healthcare costs and enhancing an individual's ability to contribute to the economy through employment. For example, the Centre for Mental Health and the London School of Economics demonstrated that every £1 invested in evidence-based early intervention in psychosis (EIP) results in approximately £15 in avoided costs over a 10-year period; similar savings are shown for other conditions such as conduct disorder.[3] If a sector of the population is excluded from these benefits because of inequalities in mental health care, this translates to a real economic deficit.

Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

Source: Fair Society, Healthy Lives: The Marmot Review (2010)

Improving an individual's mental health can also indirectly improve their physical health, further reducing costs for the healthcare system. In fact, additional healthcare costs associated with inequalities are over £5.5 billion per year.[5] Beyond the healthcare sector, the annual cost of health inequalities is estimated to be £31–33 billion in lost productivity, with a further £20–32 billion in lost taxes and avoidable welfare payments.[5]

The legal case

Health and social care service providers are bound by various legislative acts to proactively work towards eradicating unequal access, treatment and experiences of care.

Table 1: Key legislation for advancing equality in health and care service provision

Legislation	Key articles
Equality Act (2010)[6]	13. Duty to not discriminate 20. Duty to make adjustments 149. Public Sector Equality Duty
Health and Social Care Act (2012)[8]	Section 4 (Secretary of State): *1C – Duty as to reducing inequalities* Section 23 (the Board): *13G – Duty as to reducing inequalities* *13N – Duty as to promoting integration* Section 26 (Commissioning Groups): *14T – Duties as to reducing inequalities* *14Z1 – Duty as to promoting integration* Section 62 (Monitor): *4b, 4c, 5b, 5c* Section 175 (NHS trusts): *3a, 3b, 4b*
Mental Health Act 1983 (amended 2007)[9]	8. 2B (b) *'respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006).'* 64J. 1) *'In assessing for the purposes of this Part whether he has reason to believe that a patient objects to treatment, a person shall consider all the circumstances so far as they are reasonably ascertainable, including the patient's behaviour, wishes, feelings, views, beliefs and values'.*
Mental Capacity Act (2005)[10] including Deprivation of Liberty Safeguards	4) Best interests: *'(1) In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of –* *(a) the person's age or appearance, or* *(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests'.*

Legislation	Key articles
Human Rights Act (1998) (revised version)[7]	Article 2: Right to life *'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law'.* Article 3: Prohibition of torture *'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'.* Article 5: Right to liberty and security *'Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law'.* Article 7: No punishment without law *'No one shall be held guilty of any criminal offence on account of any act or omission which did not constitute a criminal offence under national or international law at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the criminal offence was committed'.* Article 8: Right to respect for private and family life *'Everyone has the right to respect for his private and family life, his home and his correspondence. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others'.* Article 9: Freedom of thought, conscience and religion *'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance'.* Article 14: Prohibition of discrimination *'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status'.*

NHS commissioners are bound by the duties of the Health and Social Care Act (2012)[8] to reduce health inequalities in access, experience and health outcomes.

All services will be monitored against their adherence to the principles set out in the Equalities Impact Assessment and each caregiver must comply with the Equality Act (2010).[6]

The moral case

The life expectancy of people with a serious mental illness is 10–20 years less than it is for people without a mental health problem.[11] This statistic suggests that having a mental health problem in itself can lead to unequal health care, including a lack of support to access physical health care. Moreover, this estimate does not account for intersectional determinants of health such as protected or NICE-identified characteristics, so life expectancy may be even further reduced for some groups. This clear inequity establishes a moral imperative and a call to action.

The Equality and Human Rights Commission have recently called for the Public Sector Equality Duty (Equality Act, 2010)[6] to be strengthened and for public bodies to take firm action to address challenges in reaching equality.

Existing resources, policy and guidance

While there have been various proactive or reactive initiatives, programmes, policy and guidance aimed at tackling inequalities over the years, these issues continue to penetrate many parts of the mental health care system. Some efforts to reduce inequality have produced good results or have helped services to identify problems. For example, the 5-year Delivering Race Equality programme[12] revealed persistent inequalities in early intervention and crisis care, rates of detention and lengths of stay in secure services for people from Black, Asian and Minority Ethnic (BAME) communities, driving some of the recommendations in the 5YFVMH.[1] Efforts to address these persistent inequalities remain a necessity.

Appendix 2: Summary of the AMHE mapping review

A systematic mapping review was conducted to establish an evidence base for the AMHE resource. A systematic mapping review aims to consolidate studies to address a broad area, in this case: mental health inequalities. The process aims to synthesise evidence about a topic area and develop an understanding of evidence available and potential gaps in the evidence base. Research questions for mapping reviews are commonly broader than in other types of reviews and data are presented in a tabular or visual format.

Together with stakeholders and methodologists, the AMHE research team co-produced three central research questions:

1. What evidence is there on **interventions** to address or reduce mental health inequalities?
2. What is the evidence from **economic** evaluations for interventions to address or reduce inequalities in mental health care?
3. What are the **barriers** and **facilitators** to interventions to address or reduce mental health inequalities?

Relevant studies and inclusion criteria for the mapping exercise were identified through an informal review of the evidence base. A qualified information scientist then conducted a systematic search of the selected databases. Screening and filtering of search results was followed by extraction and tabulation of data from included studies.

As this was a mapping review, it does not include an assessment of study quality nor a determination of effectiveness of the interventions described within them. However, the findings provide a starting point for commissioners and providers looking for existing interventions aimed at advancing equality, along with information about the target populations and outcomes. The findings also reveal potential gaps in the evidence, which can be used to inform future research. The tables below represent the findings.[a]

[a] The AMHE Mapping Review Protocol is, at the time of writing, under peer review and consideration for publication.

It is important to note that, in the interest of conciseness, the population categories used in this mapping exercise may conflate several sub-communities, and do not reflect the nuances between, for example, the sub-communities that make up the lesbian, gay, bisexual, transgender, queer and 'other' (LGBTQ+) category. This should not be interpreted as negating the unique needs and perspectives of each individual community. How populations are categorised is another area to be mindful of when referring to the existing literature and drawing conclusions about different populations. Further research into mental health inequalities could involve improving the granularity and specificity of population data.

Table 2: Types and number of interventions*

Intervention type	Abbreviation	Number of included studies
Delivering education and training	DET	23
Providing psychological support	PPS	35
Re-structuring the care team	RSCT	13
Engaging the community	EC	3
Providing financial incentives/provisions	PFIP	12
Improving access to testing and screening	IATS	4
Improving access to psychological therapies (IAPT)	IAPT	5
Enhancing language and literacy services (and communication)	ELLS	3
Other	O	2
Other – home-based case	oHBC	2
Other – culturally adapted	oCA	10
Other – technology	oT	10
Providing reminders and feedback	PRF	0

**This table is based on an existing taxonomy[13] – some studies may be applicable to multiple intervention types.*

Table 3: Populations identified during the mapping review

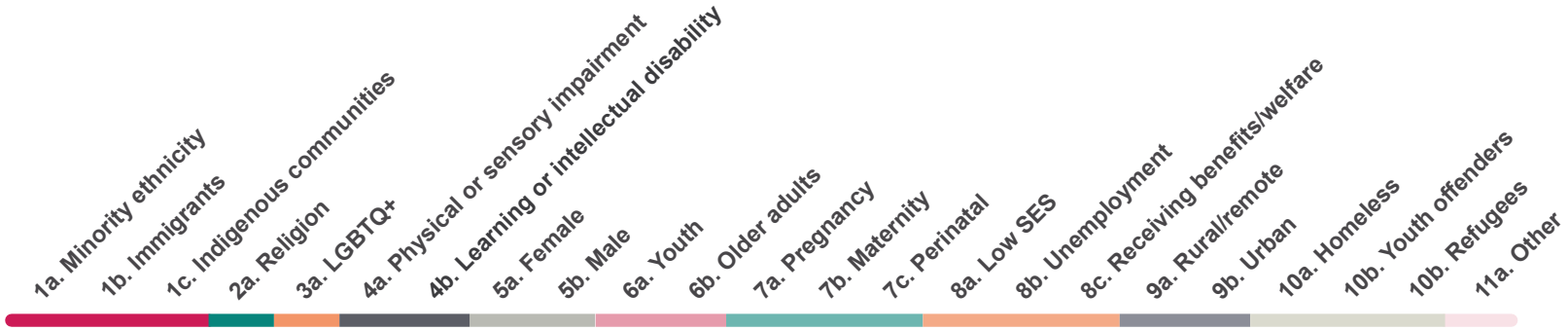
Characteristic	Characteristic subtype	Number of included studies	
		by characteristic subtype	by characteristic
1. Race	a) Minority ethnicity b) Immigrants c) Indigenous communities	27 5 4	36
2. Religion	a) Religion	3	2
3. Sexual orientation and gender reassignment	a) LGBTQ+	3	3
4. Disability	a) Physical or sensory impairment b) Learning or intellectual disability	1 4	5
5. Sex	a) Female b) Male	5 2	7
6. Age	a) Youth b) Older adults	23 7	30
7. Pregnancy or maternity	a) Pregnancy b) Maternity c) Perinatal	3 6 3	12
8. Socioeconomic status (SES)	a) Low SES b) Unemployment c) Receiving benefits/welfare	61 1 3	65
9. Location	a) Rural/remote b) Urban	8 4	12
10. Specific groups	a) Homeless b) Youth offenders c) Refugees	1 1 3	5
11. Other	a) Any other	10	10

Table 4: Frequency of countries in which primary studies were conducted

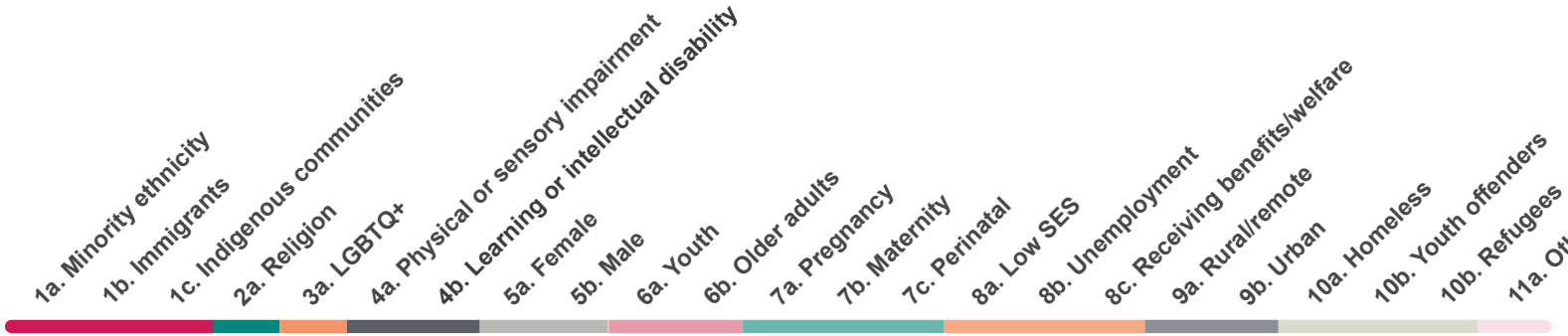
Country	Number of studies
Research Question 1 – *Interventions to address inequalities in mental health care*	
USA	35
UK	16
Australia	7
Ireland	6
Netherlands	4
Iran	3
India	2
Austria & Russia	1
Belgium	1
Canada	1
China	1
Colombia	1
Germany	1
Israel	1
Norway	1
Pakistan	1
Portugal	1
Spain	1
Unclear	2
Research Question 2 – *Economic evaluations of interventions to address mental health inequalities*	
Ireland	2
USA	2
UK	1
Research Question 3 – *Barriers and facilitators to interventions to address mental health inequalities*	
UK	10
USA	8
Australia	7
Canada	2
Chile & Colombia	1
Ethiopia	1
Ireland	1
Kenya	1
Sweden	1

Table 5: Intervention types aimed at populations possessing specific characteristics

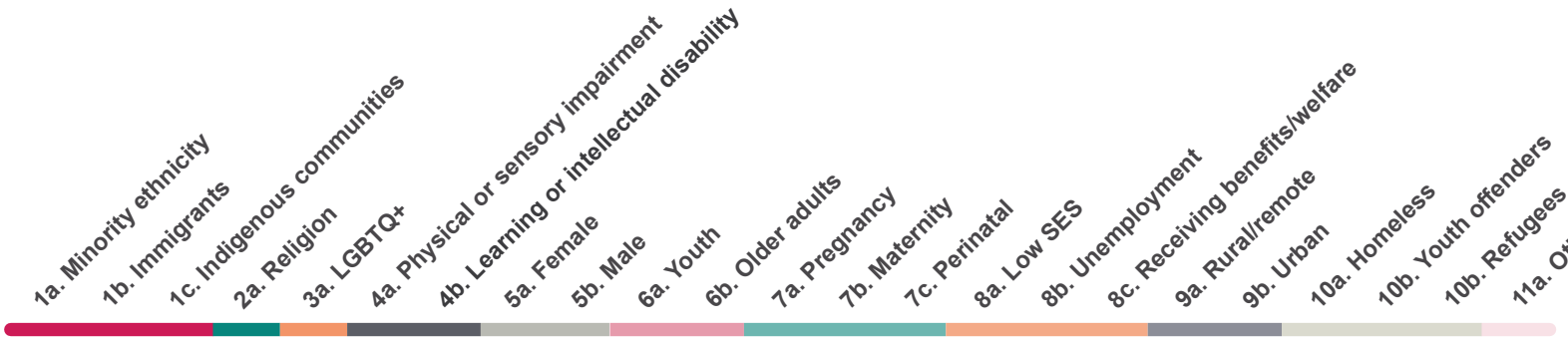
		1a. Minority ethnicity	1b. Immigrants	1c. Indigenous communities	2a. Religion	3a. LGBTQ+	4a. Physical or sensory impairment	4b. Learning or intellectual disability	5a. Female	5b. Male	6a. Youth	6b. Older adults	7a. Pregnancy	7b. Maternity	7c. Perinatal	8a. Low SES	8b. Unemployment	8c. Receiving benefits/welfare	9a. Rural/remote	9b. Urban	10a. Homeless	10b. Youth offenders	10b. Refugees	11a. Other
Family check-up intervention[14]	DET										1				1									
Incredible Years Parenting Programs[15–21]	DET										1				1									
Incredible Years Teacher Programs[22,23]	DET										1				1									
Child-teacher relationship training (CTRT)[24]	DET										1				1									
Multiple Family Group Therapy[25]	DET	1									1				1									
7-week exercise training programme[26]	DET								1						1									
15-module mental health and resilience curriculum[27]	DET								1						1									1
'Living With Teenagers'[28]	DET	1									1				1									
12-week physical exercise programme[29]	DET										1							1						1
Emotional intelligence training programme for deaf students[30]	DET, PPS						1				1													
Aussie Optimism Program – Social life skills and optimistic thinking skills[31]	DET														1									
Pro-Kind programme[32]	DET													1	1									
SHAPE Program[33]	DET, PPS	1													1									



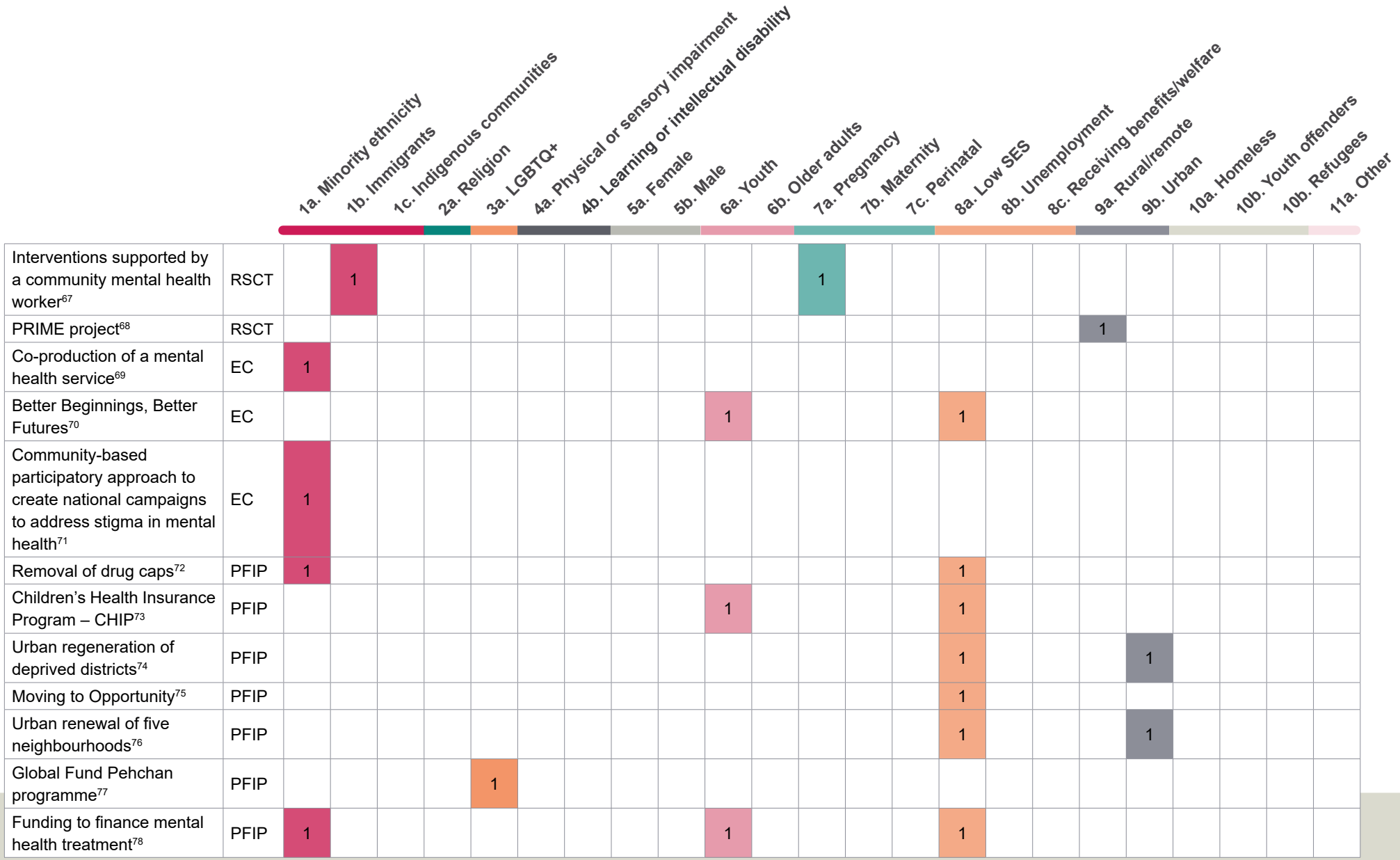
Yoga training in schools[34]	DET										1					1							
Attribution retraining programme[35]	DET							1															
Non-violence communication training[36]	DET										1					1							
Refugee Wellbeing Project[37]	DET																					1	
Cultural Consultation Service[38]	DET	1																					1
Peer-mentoring programme[39]	DET, RSCT														1	1							
Manualised parenting programme led by trained peer facilitators[40]	DET, RSCT										1					1							
Interpersonal therapy with parenting enhancement[41]	PPS													1		1							
'Zippy's Friends'[42]	PPS										1					1							
Modified FRIENDS Program[43]	PPS	1									1					1				1			
Universal, school-based interventions targeting resilience and protective factors[44]	PPS										1					1							
Mindfulness-based wellbeing for parents programme[45]	PPS															1							
Enhanced brief, interpersonal therapy[46]	PPS													1		1							
Interpersonal therapy[47]	PPS	1														1							1



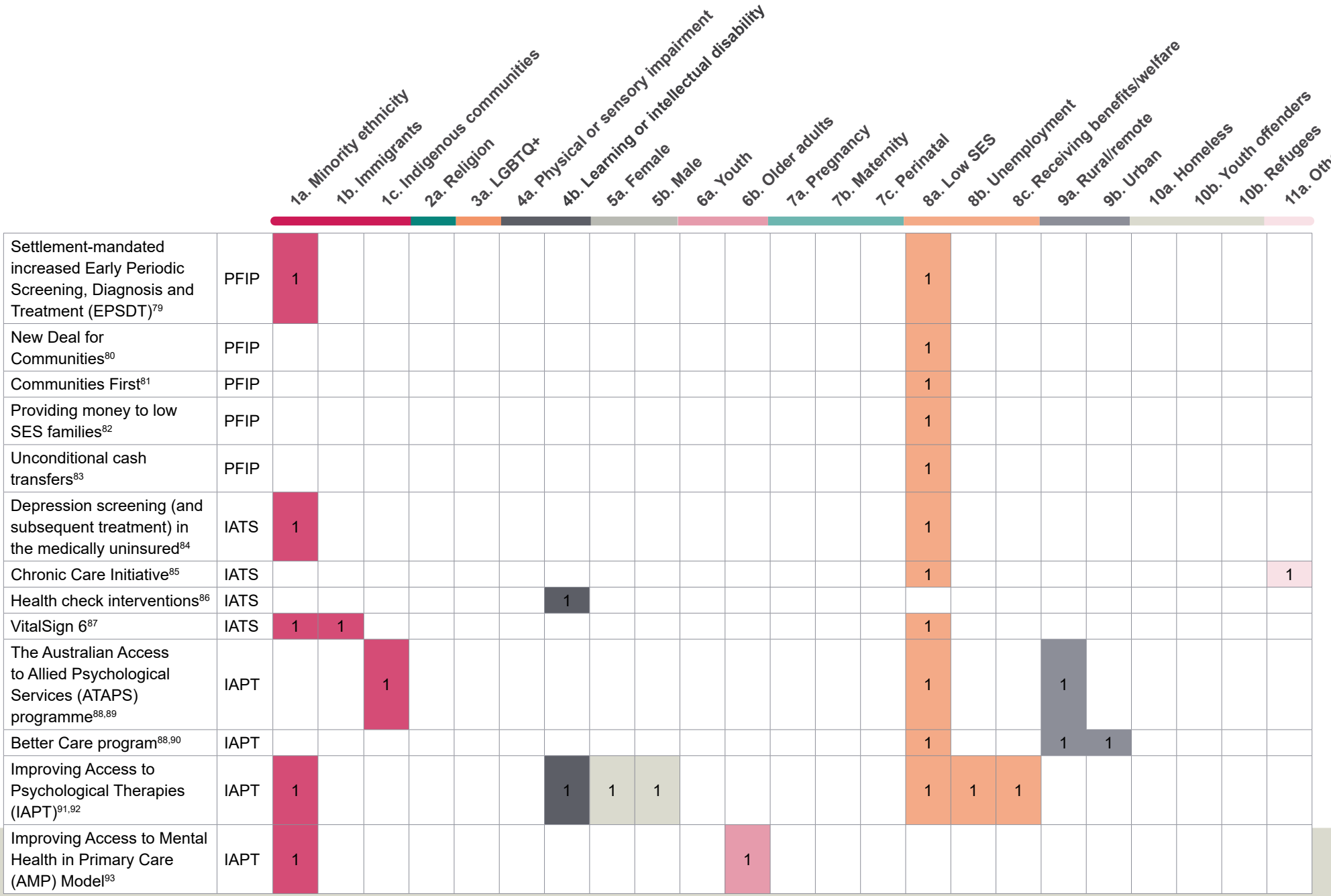
Self-compassion training or stress inoculation[48]	PPS																			1		
Functional Family Therapy for offending or antisocial behaviour[49]	PPS																				1	
Problem-solving therapy for primary care[50]	PPS	1									1											
School-based, trauma-informed group intervention using cognitive behavioural therapy (CBT) and mindfulness[51]	PPS										1				1							
ESTEEM: Effective Skills to Empower Men[52]	PPS					1				1												
Mindfulness-based stress reduction and mindfulness-based CBT[53]	PPS														1		1					
Exercise Without Worries[54]	PPS														1							
Specialised group program to enhance children's self-efficacy and mental health[55]	PPS		1							1												
Psychoeducative interventions for depression[56,57]	PPS, DET														1							1
Combined model of primary care with culturally sensitive wellbeing intervention with interactive training packages[58]	RSCT OCA PPS DET	1									1				1							



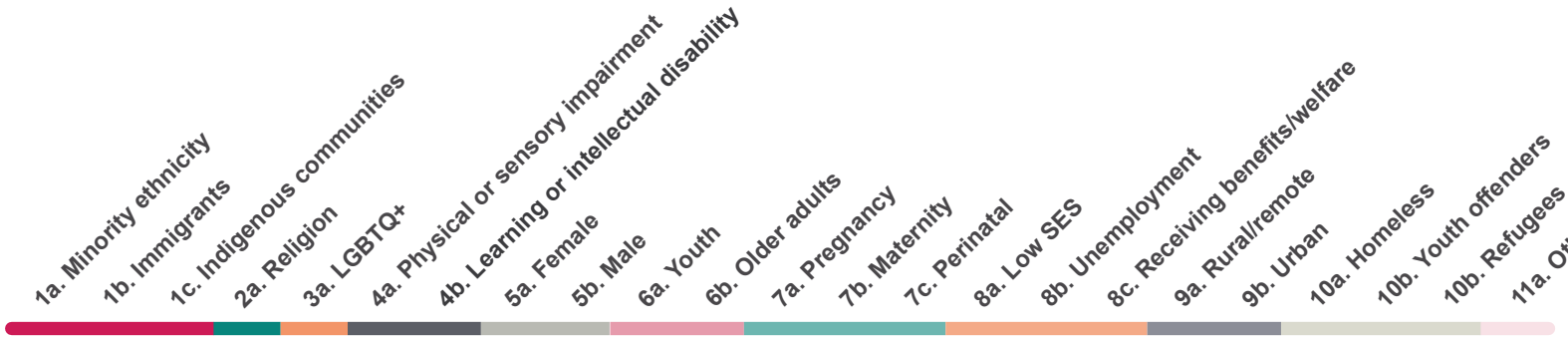
PROSPECT – Prevention of Suicide in Primary Care, Elderly: Collaborative Trial[59]	RSCT											1				1						
Introducing a psychologist and social worker into Aboriginal primary care services[60]	RSCT			1																		
Collaborative depression care within obstetrics-gynaecology[61]	RSCT								1							1		1				
Lay support pregnancy outreach workers[62]	RSCT												1			1						
Comprehensive community mental health services for children and their families[63]	RSCT	1									1					1						
Coordinated anxiety learning and management[64]	RSCT															1						
Collaborative Care model for people with limited English proficiency[65]	RSCT																					1
Collaborative care model for trans-identified people[66]	RSCT					1																



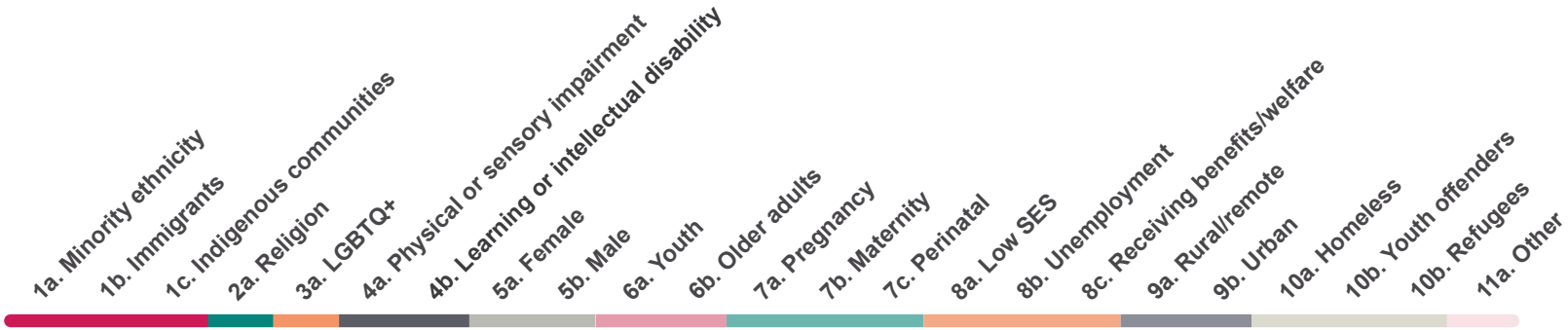
Interventions supported by a community mental health worker[67]	RSCT		1									1											
PRIME project[68]	RSCT																	1					
Co-production of a mental health service[69]	EC	1																					
Better Beginnings, Better Futures[70]	EC									1					1								
Community-based participatory approach to create national campaigns to address stigma in mental health[71]	EC	1																					
Removal of drug caps[72]	PFIP	1													1								
Children's Health Insurance Program – CHIP[73]	PFIP									1					1								
Urban regeneration of deprived districts[74]	PFIP														1				1				
Moving to Opportunity[75]	PFIP														1								
Urban renewal of five neighbourhoods[76]	PFIP														1				1				
Global Fund Pehchan programme[77]	PFIP					1																	
Funding to finance mental health treatment[78]	PFIP	1								1					1								



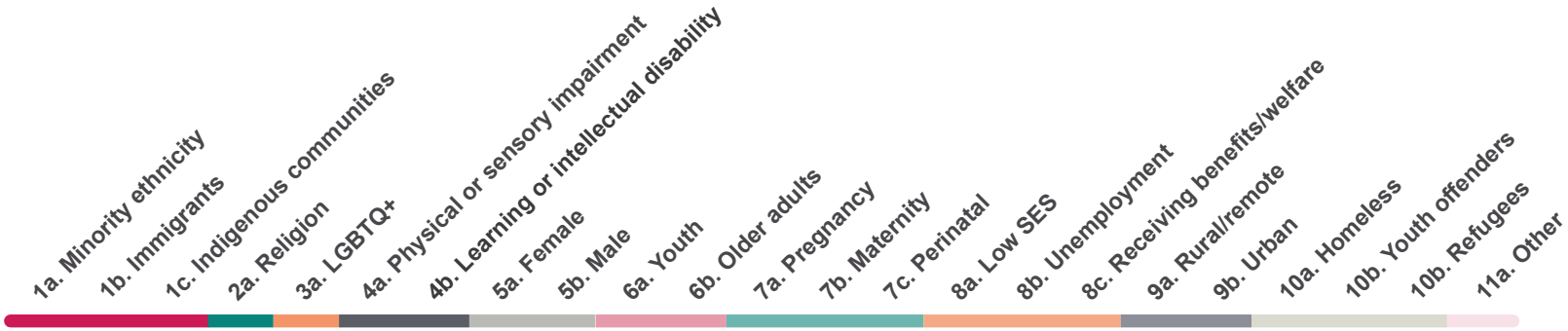
		1a	1b	1c	2a	3a	4a	4b	5a	5b	6a	6b	7a	7b	7c	8a	8b	8c	9a	9b	10a	10b	10b	11a
Settlement-mandated increased Early Periodic Screening, Diagnosis and Treatment (EPSDT)[79]	PFIP	1														1								
New Deal for Communities[80]	PFIP															1								
Communities First[81]	PFIP															1								
Providing money to low SES families[82]	PFIP															1								
Unconditional cash transfers[83]	PFIP															1								
Depression screening (and subsequent treatment) in the medically uninsured[84]	IATS	1														1								
Chronic Care Initiative[85]	IATS															1								1
Health check interventions[86]	IATS							1																
VitalSign 6[87]	IATS	1	1													1								
The Australian Access to Allied Psychological Services (ATAPS) programme[88,89]	IAPT			1												1			1					
Better Care program[88,90]	IAPT															1			1	1				
Improving Access to Psychological Therapies (IAPT)[91,92]	IAPT	1						1	1	1						1	1	1						
Improving Access to Mental Health in Primary Care (AMP) Model[93]	IAPT	1									1													



Eis Ledader initiative[94]	IAPT	1			1																	
Spanish language adaptation of the MOM's Empowerment Program[95]	ELLS	1	1						1							1						1
CBT presented in Norwegian with an inductive hearing loop system[96]	ELLS, PPS							1														
Interventions to improve therapeutic communications between BAME patients and professionals[97]	ELLS	1																				
World Health Organisation's 'Healthy Schools' model[98]	O										1					1						
Eye Movement Desensitisation and Reprocessing[99]	O																				1	
Structured, volunteer home-support[100]	OHBC														1	1						
Australian Nurse-Family Partnership Program[101]	OHBC		1								1			1								
MOM-Care[102–104]	OCA, PPS													1		1						



Culturally adapted CBT for psychosis in Pakistan[105]	OCA, PPS														1							
Culturally sensitive wellbeing intervention[106]	OCA, PPS	1									1				1							
Culturally adapted one-session treatment (OST-CA) for phobic Asian Americans[107]	OCA, PPS	1																				
Religious CBT for depression[108]	OCA, PPS				1																	
Culture-Sensitive and Resource Oriented Peer (CROP) Groups[109]	OCA																				1	
Coordinated perinatal mental health care model developed based on intersectionality theory[110]	OCA	1												1								
Culturally informed, family-focused treatment for schizophrenia[111]	OCA, PPS	1																				
Aboriginal medical services as a culturally appropriate alternative to mainstream care[112]	OCA			1																		
BRIGHTEN Program[113]	OT, PPS	1									1											



Computerised CBT gaming intervention (SPARX-R)[114]	OT, PPS										1					1								
MOM-Net[115,116]	OT, PPS													1		1								
Trauma-focused CBT delivered via telehealth technology[117]	OT, PPS	1									1					1			1					1
iBobbly App[118]	OT, PPS			1															1					
Computerised CBT[119]	OT, PPS																		1					
Health-e Babies App[120]	OT, DET												1			1								
Telehealth[121]	OT, PPS																		1					
Interventions delivered through a mobile device[122]	OT, PPS															1								
Internet-based interventions[123]	OT, PPS																							1
Total by characteristic subtype		**27**	**5**	**4**	**2**	**3**	**1**	**4**	**5**	**2**	**23**	**7**	**3**	**6**	**3**	**61**	**1**	**3**	**8**	**4**	**1**	**1**	**3**	**10**
Total by characteristic type		**36**			**2**	**3**	**5**		**7**		**30**		**12**			**65**			**12**		**5**			**10**

Appendix 3: Positive practice examples

This appendix provides examples of positive practice that have been identified and recommended by people with lived experience and other stakeholders involved in the development of the AMHE resource. The examples included here were chosen based on their alignment with the co-produced AMHE Key Principles.[b]

Rainbow Alliance

Advances mental health equality for people from the LGBTQ+ community

Population: *LGBTQ+*

Demonstrates positive practice in:

- *community connection*
- *multi-agency collaboration*

Awards:

- *Trust award for Staff Health and Wellbeing*
- *Shortlisted for the Health Equality award by Positive Practice in Mental Health*

Provided by: *Leeds and York Partnership NHS Foundation Trust*

Location: *Leeds*

For more information, please see here and here.

The Rainbow Alliance creates a social movement in which Trust staff, service users and carers collaborate to enhance the quality of care for the LGBTQ+ community, across the organisation. They are accountable to the trust's Equality and Inclusion Group, and provide an opportunity for members of the Rainbow Alliance to lead on LGBTQ+ service improvement projects in their areas.

The Rainbow Alliance achieves these functions by establishing effective working partnerships with other NHS Trusts across Leeds, with the local authority and with voluntary, community and social enterprise (VCSE) support services. They also ensure that the Rainbow Alliance has a visible presence around the trust by inviting members to attend quarterly meetings to share good practice and progress. The Rainbow Alliance also promotes, supports and represents the Trust during key events involving the LGBTQ+ community.

Contributions from all Rainbow Alliance members are equally valued and encouraged when considering the ongoing work of the alliance, and members are provided with regular updates via social media, quarterly meetings, emails from alliance leads and trust-wide communications. The impact of the Rainbow Alliance will be regularly measured and shared across the organisation and reported to the Equality and Inclusion Group.

Membership to the Rainbow Alliance is open to all trust staff, the LGBTQ+ communities of Yorkshire, anyone who has accessed trust services and their carers. Formal Rainbow Alliance meetings are also held regularly. The dates, times and venues of these meetings are advertised on the trust's website at www.leedsandyorkpft.nhs.uk.

[b] Not all services included in this appendix have been visited by the NCCMH. We invite any comments or queries and will review the decision to include these examples should any concerns be raised.

Black Thrive

Addresses the disproportionality in mental health outcomes experienced by Black, African and Caribbean residents by catalysing change across a diverse range of service provision to promote wellbeing, improve access and provide excellence in care

***Population:** Black residents of African or Caribbean descent*

Demonstrates positive practice in:

- *co-production*
- *community connection*
- *improved user experience*
- *good links with services*

***Location:** Lambeth, London*

For more information, please see here

Black Thrive in Lambeth is a partnership between several organisations including NHS Lambeth Clinical Commissioning Group (CCG), the Metropolitan Police, Healthwatch Lambeth, Lambeth Council, and South London and Maudsley NHS Foundation Trust. The partnership was formed to address the inequities faced by Black communities when it comes to mental health and mental illness.

Black Thrive adopts a holistic approach to mental ill health and believes that social determinants, such as housing, education and employment must be considered in order to achieve better outcomes. Co-production sits at the heart of their approach by equally drawing upon the knowledge and expertise of service users, their families and professionals. This person-centred approach strives for equality of voice.

Members of the local community share decision-making authority with statutory organisations, including strategic leadership and governance of the programme. Black Thrive also has a small staff team that works with services to support and enable better collaboration with the community to improve mental health and related outcomes.

Black Thrive is committed to openness and transparency, exercised through its shared measurement system, which collects and disseminates information across the community of Lambeth.

Working groups have been set up to support transformation in services and outcomes, focused on four key areas: improvement in service user experience, access to appropriate services, prevention of mental ill health, and mental health of children and young people from the Black community. The working groups aim to embed change within existing services as well as identify opportunities to innovate with new projects. The working groups are supported by the Black Thrive staff team who provide facilitation and project management.

Dial House @ Touchstone

Addresses the inequalities faced by people from BAME communities by offering an accessible, out-of-hours crisis service, which provides compassionate, culturally sensitive and survivor-led care and advice

***Population:** Residents from BAME groups*

Demonstrates positive practice in:

- *co-production*
- *community connection*
- *survivor-led service*
- *culturally sensitive care*

***Provided by:** Leeds Survivor-Led Crisis Service (LSLCS)*

***Location:** Leeds*

For more information, please see here

Dial House @ Touchstone is a specialised service provided by LSLCS, with the primary aim of improving access to, and experience of, mental health services for people from BAME communities by offering a culturally sensitive and accessible service. In particular, the team aims to disrupt the consistent over-representation of Black men in psychiatric units and the criminal justice system. The service is grounded in a non-medical and non-diagnostic model as a response to the reluctance often observed among BAME communities to engage with community-based mental health services.

All the staff at Dial House @ Touchstone are themselves members of the BAME community and have lived experience of mental health problems. The team have an excellent history of delivering an effective and compassionate service to marginalised communities, and people who are often facing multiple disadvantage as a result of intersectional characteristics. Visitors to the service are highly involved in service development and take an active role in interviewing staff for posts, speaking at public events, and monitoring and evaluating the service.

Dial House @ Touchstone also places great importance on community connection and often hold events to publicise their activities and improve engagement with the local community. Currently, they are also involved in the development of externally delivered training to improve awareness of the impact of racism and discrimination on mental health crises.

A recent Social Return on Investment analysis of LSLCS reported that for every £1 invested in the service, society gets £7.50–£12.50 back. This highlights the positive impact of the care offered at this service and, more generally, the wide-reaching effects of improving health outcomes for marginalised communities.

King's Health Partners – Pathway Homeless Team

Addresses the major inequalities faced by people who are experiencing homelessness by providing both housing assistance and engagement with community mental health services

***Population:** Individuals experiencing homelessness*

Demonstrates positive practice in:

- *multi-agency collaboration*
- *advocacy*
- *improved housing outcomes*

***Awards:** Winner of the 2018 Psychiatric team of the year – working age adults, awarded by the Royal College of Psychiatrists*

***Provided by:** Guy's and St Thomas' NHS Foundation Trust and South London and Maudsley NHS Foundation Trust*

***Location:** Lambeth and Southwark, London*

For more information, please see here

The 'Pathway Homeless Team' at King's Health Partners is a specialist service that primarily aims to improve the health and housing outcomes for homeless people admitted to hospital. The team are committed to improving the quality of care for homeless people, while reducing delayed or premature discharge from hospital and supporting access to community health and social care services through assertive advocacy.

Furthermore, the team have established excellent links with local GPs, community health services, social services, housing departments, hostels, outreach teams and a range of voluntary sector services; this allows the service to provide a more holistic approach to care and improve housing and care outcomes. In particular, the team provide expert assistance around housing issues by supporting the completion applications for housing, accommodation maintenance and benefits payments.

The service has developed a collaborative forum with other homeless services at the trust including Psychology in Hostels and the START team (a rough sleepers' mental health outreach service) and works collaboratively with the Health Inclusion Team – a community nurse-led homeless service based in Lambeth, Southwark and Lewisham.

The team are also proactive in identifying frequent hospital attenders in order to improve subsequent engagement with the community mental health teams. This proactive approach aims to provide earlier intervention and improve outcomes. The service also engages with the community and publicise their activities through academic teaching, training, conferences and publications. The team also co-produce events and teaching activities.

An evaluation of the service identified a reduced length of stay with improved housing outcomes in more than 70% of referrals, as well as reduced unscheduled care after intervention and increased mental health scheduled care.

South Staffordshire Wellbeing Teams

The Wellbeing Teams cover three services that aim to improve access to psychological therapies for all and reduce inequalities

Population: *16+*

Demonstrates positive practice in:

- *community connection*
- *identifying inequalities*
- *British Sign-Language trained staff*
- *materials produced in Braille*

Provided by: *Midlands Partnership NHS Foundation Trust*

Location: *Staffordshire*

For more information, please see here

The South Staffordshire Wellbeing Teams are jointly commissioned by the Midlands Partnership Foundation Trust and Mental Health Matters (MHM), a VCSE provider of psychological therapies, employment services and social care. The partnership serves a diverse region of rural and urban communities with a variety of individual needs. Thus, the easy referral system (over-the-phone or at community events) ensures accessibility for a wide population. The services offer psychological therapies in accordance with NICE guidance, with a particular focus on those with comorbid long-term physical health conditions, in an effort to improve integrated care for this population.

The Wellbeing Teams place co-production at the centre of their work, recognising the valuable contribution of people who use their services in developing and delivering mental health care and support. People with lived experience now sit on the interview panel for job posts within the service and many previous users of the service volunteer within the team. The teams also arranged a fully-booked, co-produced Wellbeing Workshop, led a webinar on 'Co-Production and Social Media' for NHS England, and entirely co-produced their last annual IAPT conference.

The Wellbeing Teams closely monitor the protected characteristics of the people who use their services. The staff receive training in British Sign Language to improve access for people with hearing impairments. A dedicated, HSJ award-winning staff member has also adapted materials into Braille to increase access for people with visual impairments.

Furthermore, the services have recently started offering programmes in local gyms, businesses, supermarkets and libraries to provide information and promote the service. As a result, the teams have been able to identify several key communities who are currently subject to inequalities including older adults, young people aged 16–19 and LGBTQ+ communities. They are now proactively engaging with local partners and services to minimise these inequalities.

Parenting and Child Service

A national service that offers mental health support and expert witness accounts to children and young people who have faced early adversity and trauma

Population: *children and young people age 0 to 17 years old*

Demonstrates positive practice in:

- *multidisciplinary approach*
- *offer comprehensive assessments*
- *consultation resource for local services*
- *expert witness assessments*

Provided by: *Great Ormond Street NHS Foundation Trust*

Location: *London*

For more information, please see here

The Parenting and Child Service, based in the Great Ormond Street Hospital, comprises the Child Care Consultation Team and the Attachment and Trauma Team. The Attachment and Trauma Team typically receive referrals for children and young people experiencing complex psychological trauma resulting from early adversity, such as familial abuse or neglect. The Child Care Consultation Team offer multidisciplinary expert witness assessments for courts in complex child protection cases.

This national service offers care to a diverse range of children and young people from a variety of ethnicities and socioeconomic backgrounds, particularly looked-after children. Referrals are accepted from social workers, mental health workers, paediatricians, and child and adolescent mental health services (CAMHS) across the country.

The team offer expertise in a range of disciplines, such as psychiatry, psychology, psychoanalytics, psychotherapy and systemic family therapy. The team are also able to offer comprehensive mental health assessments, including an assessment of cognitive ability. Due to the complex social background typically seen in the referrals, this is often the first time these children and young people have had such an assessment. This offers a crucial opportunity for them to access the correct care.

The service also places importance on community engagement. The team maintain positive relationships with local services and charities in order to signpost inappropriate referrals and recommend alternative treatment or support. They also raise awareness of prominent issues through teaching, training and publishing. For example, the team are involved in the training of local CAMHS teams and provide a consultation resource for local professionals seeking advice for complex cases. This collaborative approach promotes access to suitable care and support for young people who may otherwise not have had their voices heard.

Steps2Change

Aims to improve access to high-quality, timely, evidence-based therapies for individuals experiencing mild to moderate mental health problems

Population: *16+*

Demonstrates positive practice in:

- *identifying inequalities*
- *community engagement*
- *improved integration of physical and mental health care*

Provided by: *Lincolnshire Partnership NHS Trust*

Location: *Lincolnshire*

For more information, please see here

Steps2Change, offered by Lincolnshire Partnership NHS Trust, primarily aims to improve access to high quality, evidence-based talking therapies for Lincolnshire residents experiencing anxiety, depression or stress. They also aim to ensure that no individual receives less favourable treatment on the grounds of protected characteristics and are responsive to the unique needs of each individual. Referrals are accepted from healthcare professionals or the individual themselves, ensuring accessibility.

The Steps2Change team place particular emphasis on the integration of physical health and mental health support. Based on a steering group with both commissioners and service providers, the team agreed to run three pilot schemes targeting comorbid mental health problems in diabetes, cardiac rehabilitation and chronic obstructive pulmonary disease (COPD). This expansion has offered further training opportunities to the team and improved access to talking therapies for people with comorbid physical health problems. For example, housebound individuals with diabetes or COPD can now be seen at home and older adults with a recent cancer diagnosis have been able to engage in therapy after previous restrictions on age and diagnosis.

The service also maintains links with local universities and colleges to improve access for the student population and use their own social media pages to establish and maintain connections with the community. Voice2Change, a unique forum run by those who have used the service, has been highlighted in an NHS blog as an example of positive practice. The forum provides an opportunity for meaningful feedback and ensures the team remain responsive to the needs of the community.

Steps2Change is proactive about identifying and tackling inequalities in services access; they routinely monitor access for underserved patient groups and subsequently target engagement and communication activities to these groups. For example, the team identified migrant factory workers as an underserved population. One of the ways the service is improving access is by offering on-site appointments at local factories. Ultimately, monitoring this information and formulating effective responses to identified inequalities has helped Steps2Change deliver greater mental health equality in their local area.

Leeds Assertive Outreach Team

Adopts the Assertive Outreach model to facilitate improved engagement with those experiencing serious mental illness and complex issues

Population: *18+*

Demonstrates positive practice in:

- *multi-agency collaboration*
- *development of a bespoke, co-produced PREM*
- *an almost 80% reduction in the number of annual inpatient days in the year following referral to the Assertive Outreach team*

Provided by: *Leeds and York Partnership NHS Foundation Trust*

Location: *Leeds*

The Leeds Assertive Outreach team uses the evidence-based 'assertive outreach' model. It aims to engage those who experience psychosis and who lack awareness of their illness and the need for treatment. People referred to this service typically present with complex needs, which may include comorbid diagnoses, risk of self-neglect, unstable accommodation or homelessness, a history of offending, and repeated relapses and psychiatric admissions. Those who utilise this service have not typically had their needs met by the statutory or VCSE sector, highlighting the importance of the assertive outreach approach.

Within the Leeds Assertive Outreach team, there is an over-representation of individuals from the BAME community, reflecting the lack of engagement with this community in alternative care pathways. Further, in the interest of promoting inclusivity, the service does not operate an upper age limit. The team are also involved in multi-agency work and have partnered with the local authority and a range of charitable organisations to further mental health equality.

The team are responsive to the unique needs of the BAME population and recognise that the use of formal assessments can be challenging. Thus, the team are currently developing a fit-for-purpose, bespoke patient-reported experience measure (PREM) which will be co-produced with users of the service. This innovative approach ensures that outcome measures are sensitive to the needs of the community and upholds the principle of person-centred care.

The Leeds Assertive Outreach team has demonstrated a range of positive outcomes as a result of engaging with marginalised communities. For example, a recent internal review demonstrated a reduction of almost 80% in the number of annual inpatient days for the year following referral to the Assertive Outreach team, compared with the previous year.

Foundation for People with Learning Disabilities

A national information service for people with learning disabilities, their families and professionals who work with them

Population: *People with learning disabilities and their families*

Demonstrates positive practice in:

- *co-production*
- *support and training of peer support workers*
- *delivery of national and international consultancy and training*

Provided by: *Mental Health Foundation*

Location: *National (based in London)*

For more information, please see here

The Foundation for People with Learning Disabilities is a national service that provides information and resources, free of charge, to people with learning disabilities and their families. The foundation's primary aim is to increase awareness and knowledge surrounding learning disabilities. It aims to attain greater awareness and knowledge through the completion of high-quality projects and the production of reports in six key areas: education and employment; family, friends and community; rights and equality; health and wellbeing; getting the right support; and changing service delivery.

The foundation offers training, typically co-facilitated by people with learning disabilities, to professionals to help build their confidence and understanding of working with this population. It has also recently run two projects in partnership with people with learning disabilities and their families, involving them at all levels and stages, including design, development, delivery, recruitment, monitoring and evaluation.

The 'Feeling Down' project co-produced a guide and self-management tools to support people with learning disabilities independently plan for their wellbeing. They also produced a report aimed at raising awareness among policy makers, commissioners, health and social care services and anyone supporting or working with people with learning disabilities.

The 'Pass It On' project aims to develop a sustainable mental health programme for people with learning disabilities. It hopes to train 72 people with learning disabilities to run peer support groups and self-management groups for 300 people with learning disabilities in the community.

Alongside these projects, the foundation works closely with academic institutions to ensure their work is independently and robustly evaluated. They also partner with other organisations to combat stigma and discrimination, highlighting the Equalities Act wherever people with learning disabilities are denied access to mainstream support and services.

Nafsiyat Intercultural Therapy Centre

A multidisciplinary and multi-lingual service that aims to address inequalities in the treatment of mental health among people from BAME groups and refugees, through the delivery of short-term, culturally sensitive therapies

Population: *Adults (18+) from an ethnic minority community*

Demonstrates positive practice in:

- *community connection*
- *intercultural approach*
- *delivery of cultural competency training*
- *delivery of therapy in 20 languages*

Provided by: *Camden and Islington NHS Foundation Trust*

Location: *London*

For more information, please see here

Established in 1983, Nafsiyat primarily aims to improve access to psychotherapy and counselling services for people from diverse religious, cultural and ethnic communities in London. The Nafsiyat Centre was the first in the UK to recognise the importance of the patient's and therapist's cultural backgrounds in therapeutic effectiveness. Nafsiyat believe in the power of psychotherapy but understand that, for many people with complex backgrounds, therapy must be delivered to them by a person who understands and empathises with their experiences.

Today, Nafsiyat offers community-based support and short-term, culturally sensitive therapy in over 20 different languages, delivered by volunteer counsellors who also come from diverse cultural backgrounds – of which 35% are themselves refugees. The centre also emphasises community connection and employs a Community Link Worker to support people with practical problems that may prevent them from fully engaging with therapy – typically issues surrounding immigration, housing and benefits. However, the centre has also delivered community-based projects to tackle the social issues and stigma surrounding mental health. For example, in 2013, Nafsiyat ran a 1-year project in the London Borough of Haringey to tackle stigma within the local Turkish, Kurdish and Turkish-Cypriot communities.

Nafsiyat also share their work through research dissemination, publications, case studies, an annual report, presentations at various events, their own events, maintaining a strong online and social media presence, and through specialist training. In particular, Nafsiyat deliver a one-day cultural competency workshop for counsellors and psychotherapists. The workshop draws on clinical examples as well as intercultural experience. The training is offered in bespoke packages to specific groups, as well as to the public on a quarterly basis.

The centre collects the same weekly Minimum Data Set as NHS IAPT services, but they also collect and analyse weekly data from an outcome measurement tool developed by the service itself. Evaluation demonstrates that around 60% of people show reliable improvement on standardised measures of anxious and depressive symptoms; this is impressive considering individuals typically demonstrate much higher baseline scores than those using typical IAPT services.

Stockport Healthy Young Minds, Learning Disability Team

Addresses the mental health needs of young people with moderate–severe learning disabilities

Population: *Young people with moderate–severe learning disabilities and complex needs*

Demonstrates positive practice in:

- *co-production*
- *positive behaviour support*
- *team members are trained in alternative communication strategies, such as Talking Mats*

Provided by: *Pennine Care NHS Foundation Trust*

Location: *Stockport*

For more information, please see here

The Learning Disability team, based in the Stockport Healthy Young Minds service, addresses the mental health needs of young people in the local populations who have moderate–severe learning disabilities and complex needs. Crucially, the team employ a School Consultation model to ensure they are able to access the local population, identify mental health needs and refer or signpost accordingly. Following referral, interventions offered are typically geared around early intervention and family support.

The service advocates for the use of positive behaviour support and highlights the use of proactive rather than reactive strategies. Throughout their work, the team also place importance on the promotion of self-esteem and skills development within a least restrictive framework to foster personal growth of the young people who use the service. Due to these increased provisions of behavioural support strategies, the consultant child and adolescent psychiatrist within the team has been able to significantly reduce prescribing of antipsychotic medication for young people displaying challenging behaviour since 2010.

The team is also passionate about improving access to support for people who present with communicative barriers. Skilled interpreters are used to support those who struggle to understand or express themselves in English. Team members are also trained in Talking Mats – a tool to help people with a learning disability to communicate their needs, wishes and preferences to allow more effective communication. The team also recognise the importance of supporting the family of the young person. The team hold drop-in workshops for parents to meet other parents with similar difficulties and to build an important social network for parents and carers. The team have also previously run a group for siblings of children with a learning disability to identify any mental health problems within the family setting.

Finally, community engagement is also a valued asset within the service. The team previously co-developed a ‘Challenging Behaviour’ pathway with the local children’s community learning disability team and parents of young people with additional needs. The service has held conferences to promote the Positive Behaviour Support approach and has run workshops to raise awareness of mental health difficulties and to reduce the stigma associated with mental ill health.

Appendix 4: Barriers and solutions to advancing equality: co-produced examples

A variety of cultural, economic, geographical, social and political barriers may impede access to, and experience and outcomes of, mental health provision. It is crucial for commissioners and care providers to recognise the barriers relevant to their services and implement effective solutions. Table 6 outlines some of the key barriers raised by people with lived experience, and commissioning and service provision experts during a workshop, along with some examples of solutions for tackling them.

Table 6: Barriers and solutions to advancing equality

Potential barriers	Possible solutions
Engagement of targeted group(s)	• Conduct local mapping of available local services • Build in external visits to community groups to facilitate informal networking and the formation of local connections
Access to mental health services and care	• Co-locate mental health professionals in primary care and community outreach settings
Mental health requires a different level of care	• Adopt a person-centred approach, tailored to the needs of the individual
Transport to access care	• Tap into the community resource to arrange a lift or car sharing. • Use of, and signposting to, community-based services, outreach clinics or drop-in centres • Offer technology-based care, e.g. digital methods of delivery
Resources at GP practices – lack of capacity to meet patient needs	• Co-locate mental health support workers with GP services
Access to GPs	• Support GPs by co-locating occupational therapists in primary care settings to organise activities and spread awareness about mental health
Access to peer support	• Make more peer support positions available, including for older people
Lack of interface between social care and health care	• Integrated care systems to manage both social care and health care
Diagnostic overshadowing with comorbidities e.g. learning disabilities or physical health problems	• Review current exclusion criteria and outcome measures for services • Use of specialised mental health measures during care appointments for learning disabilities • Implement frequent mental health measures during physical check-ups • GP presence in mental health care settings

Potential barriers	Possible solutions
Culture	• Peer care model delivered in local community settings to provide a gateway
Religion, faith	• Peer care model delivered in local community settings to provide a gateway and encourage access (e.g. mosques, churches, community centres etc.) • Engage in open, non-stigmatising discussions around the use of religious support methods alongside formal mental health care, if the individual expresses the desire to use such methods
Language	• Ensure access to interpreters and translated materials • Provide basic mental health training to interpreters
Issues around male/female wards when considering gender identity	• Encourage people and staff to be more actively inclusive and provide appropriate spaces for people who are transgender and others whose gender does not conform to their gender at birth • Ensure staff awareness of people who identify as non-binary and acknowledge this within the service design and operating procedures
Older people's mental health tends to focus on dementia	• Improve awareness among older people by ensuring that mental health campaigns also feature the voices of older people with experience of functional mental health problems • Use appropriate language
Transitions from children and young people's mental health services to adult services is not always seamless	• Implementation and achievement of the Commissioning for Quality and Innovation (CQUIN) transition goal • Use of a mental health 'passport'
Transitions from adult to older adult services is not always seamless	• Collaborative care between services and tailoring care to individual needs
Some services might not be of good quality (increasing reluctance to use them)	• Address quality of care first
Delivering leaflets – not always clear if these are received or read	• Use community groups and other avenues to deliver the message, and to deliver leaflets where this is appropriate • Consider spreading awareness of local services through community radio, television and social media accounts
One's own attitudes to mental health/ self-stigma	• Awareness, campaigning and education • More conversations around mental health in primary care and GP services
Mistrust of mental health services	• Community outreach efforts • Build external community visits into care delivery
Institutional racism and discrimination	• Appropriate, mandatory training for all staff • A diverse and representative workforce • Awareness, campaigning and education

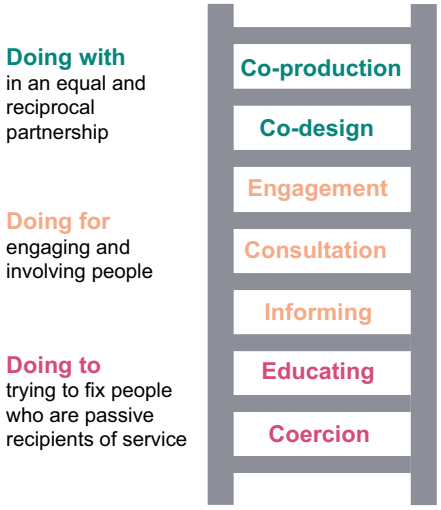
Although many services have already done work to identify and tackle inequalities, barriers still remain. The Kings Fund Review of the NHS Long Term Plan[124] helpfully highlights some of the challenges associated with improving care, especially for people with multi-morbidities closely linked to health inequalities.

Appendix 5: Co-production at every stage

The AMHE resource should be used alongside Working Well Together: Evidence and tools to enable co-production in commissioning,[125] which supports commissioners in end-to-end production, provides guidance and tools for co-produced commissioning and practical recommendations for each step of the process.

Co-production is essential for advancing equality in care. When engaging the community of interest, remember that this may include service avoiders as well as people who currently use services or have used them in the past. While co-production is a valuable process for both service providers and the community of interest, there is also an accumulation of evidence that it offers economic savings, particularly in the management of individuals with long-term health conditions.[126]

The Ladder of Co-Production (Figure 1) shows a hierarchy of engagement, where *'doing with'* is the ideal.



Co-production ladder by Think Local Act Personal

Figure 1: The Ladder of Co-production.
Source: www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool

It is common for practitioners and commissioners to mistake 'doing for' and 'doing to' as co-production, when it is not. There is no singular, gold-standard model of co-production; each process should be tailored to the content and goals of the project, the people involved and the community of interest.[127] Co-production should not be perceived as a one-off, isolated event, but as an ongoing journey with a central aim of establishing lasting relationships and connections. To truly bring about a cultural and attitudinal shift, co-production should be embedded at every stage of the commissioning cycle and service development process. Commissioners and service providers should be able to demonstrate co-production throughout the strategy and design stages, through to service development and delivery (including collaborating with community-led groups on co-delivery), and finally, service evaluation and improvement.

A co-produced definition of co-production

Co-production is an ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them.

NCCMH: Working Well Together guidance

Table 7: Incorporating co-production at all stages

Identifying inequalities	Generating ideas and problem solving
• Bring people together as a working group to share ideas and discuss strategies. It is most helpful to have people with a range of experiences e.g. people with first or second-hand lived experience (such as parents of children with mental health problems), professionals, providers and system leaders • Ensure the working group accurately reflects the community of interest, in terms of diversity and protected characteristics • Start with a blank page and populate it with ideas • Minimise barriers to engagement and involvement • Refer to The Ladder of Co-production[128] • Discuss and agree preferred language and terminology to ensure activities are accessible to all and handled respectfully.	• Consult the community of interest when thinking about ways to identify inequalities • Consider a variety of methods, e.g. expert steering groups, focus groups, conducting surveys in the community, talking to people, or a combination of all of these • Collectively examine current methods of data collection and check who the data does or does not include or represent • Think about inequalities that may be exacerbated by data collection methods, e.g. the heterogeneity within ethnicity labels such as 'White Other' or 'Black Other' • Think about how to engage unserved or 'hidden' groups
Evaluating and improving services	**Tackling inequalities; implementing change**
• Meaningfully involve people who have used services; get their views, thoughts, experience and opinions • Involve people with lived experience in assessing and reviewing the equality and human rights impact of service policies and practices • Consult people with lived experience on the suitability of current outcome measures for service evaluation; involve this community in the development of bespoke, fit-for-purpose outcome measures • Remain reflective throughout; the co-production activities should be evaluated at each stage by all members to ascertain which elements worked well and which elements require improvement for future iterations.	• Involve people with lived experience in implementation, roll-out and piloting • Make sensible use of existing resources, including the VCSE sector • Consult people with lived experience on methods and delivery of community outreach to tackle inequalities in access • Co-develop the strategy with meaningful input from stakeholders, including people with lived experience. They can offer unique contributions regarding what does or does not work. Treat all consultants as equal, valued members of the team.

Appendix 6: Barriers and facilitators to co-production: co-produced examples

Everyone has a right to be involved in co-production and each person brings their own unique insight and value to the process. Therefore, it is important to acknowledge the barriers to inclusion that may face those with lived experience of mental health problems[129] and those who possess protected or intersectional characteristics. Ultimately, we must acknowledge that co-production will not always run smoothly and there are likely to be many challenges. However, these challenges and difficulties are equally important in informing future co-production activities. Table 8 outlines some key barriers that may hinder an individual's ability to contribute during co-production, along with some suggested solutions.

As an ex-service user and carer for my mum, most times I feel I have lost my own identity and this [AMHE] project built my confidence, gave me a sense of identity and enabled me to make a positive contribution! It is a great sense of belonging to be part of a focus group and research project where you are equally important as mental health professionals and academics. The focus is not on your only identity as service user or carer but as an individual who brings knowledge, skills and competence to contribute effectively and make a positive contribution to the project.

Source: Person with lived experience, reflecting on working with the NCCMH to develop the AMHE resource

Table 8: Barriers and facilitators to engaging in genuine co-production

Barriers to co-production	Solutions
Financial barriers	• Ensure fair payment for contributors • Consider how payment may affect people who receive welfare benefits
Transport to co-production activities	• Hold co-production activities in the community • Involve charitable organisations to contribute to costs of transportation • Facilitate remote contributions e.g. by phone or email
Complex or lengthy application forms	• Offer video format applications as well as written or computerised application forms • Provide support with the completion of application forms • Offer more casual contracts or partnerships
Service users may have dependent children, parents etc.	• Offer support with finding alternative care arrangements • Allow remote contributions in co-production e.g. by phone or email or provide on-site childcare
Service users constrained by working hours	• Hold activities outside of typical working hours
Service avoiders are hard to reach	• Implement more community outreach tactics • Use social media to spread the message • Hold activities in non-stigmatising and non-restrictive settings
Communication abilities/ skills	• Avoid medical or specialist terms • Use lay language throughout the process • Use interpreters
Acute mental illness	• Encourage a greater role for advocates
Power imbalance between service users and practitioners	• Hold activities outside of service grounds/away from service premises • Avoid specialist or medical terminology
Awareness of co-production	• Use informative advertising or public health campaigns • Liaise with local community centres • Involve voluntary sector organisations
Limits on time and resources	• Involve or outsource to VCSE organisations

Appendix 7: Co-developed examples of poor experiences due to inequality

These examples were co-developed with two consultants on the AMHE resource who were also people with lived experience. The following examples of how access to, and experiences and outcomes of, care could be improved by taking meaningful action on inequalities.

An experience where help was needed	What was the inequality issue here?	What could have been done better?
Benny visited his GP for a routine health check-up. Benny's GP carried out a series of standard physical health checks. When the GP asked Benny about his level of daily exercise, Benny mentioned he had not been going on his daily walk lately. Benny had been feeling particularly low in mood lately and had been avoiding going out because he sometimes didn't feel like seeing people and preferred to stay indoors. Benny decided not to tell his GP about his mood. After all, he thought there was nothing a GP could do about it. Benny had seen posters about depression in the GP's waiting room, but these all had pictures of younger people. Benny reminded himself that all older people feel very low in mood – that it's normal. He decided not to make a fuss and therefore said nothing.	Benny didn't ask for help because he did not know that support was available from his GP. He viewed the depression service posters in the GP waiting room as irrelevant for someone of his age. He continued to suffer in silence, believing that no one could help him. In fact, had Benny mentioned his experiences to his GP, the GP could have assessed his needs and provided an appropriate referral or follow-up (for example, to IAPT care).	Had the service shown more inclusive advertisements or posters for its mental health support services, depicting a variety of age ranges, Benny might have felt able to tell his GP about his low mood and how this had been affecting his daily routine. Benny may have been reassured that the GP would be able to help him and may have opened up about his feelings.

An experience where help was needed	What was the inequality issue here?	What could have been done better?
Lia is a 40-year-old South Asian woman who always sees the same GP. She has experienced several hospitalisations under the Mental Health Act. She can manage some conversation in English but there are often a number of misunderstandings that go unnoticed. She is struggling as a single parent and goes to see her GP, feeling her head will explode from emotional distress, which she describes in English as very bad 'head aching'. When the doctor asks how her children are, she says they 'give me a headache', the doctor thinks this is a light-hearted comment and shares a laugh with her. The doctor offers advice about painkillers and rest. Lia assumes this is the only thing she can do to help herself. She struggles on, and without support finds herself detained again after a few months.	Not being fluent in English means that, although not obvious, there is a communication gap. As a result, the consultation is less helpful and Lia does not get the support she needs.	The service could have sought the help of a language interpreter to help the GP understand Lia's concerns, symptoms and experiences. It might have allowed the GP to proactively offer the needed support from mental health and social care services or community groups. This could have ensured that both Lia and her children were better supported, minimising the likelihood of further crises and subsequent hospitalisation.
Danny has a diagnosis of emotionally unstable personality disorder (EUPD). She goes to A&E because she is feeling very unwell, but the triage nurse notes her diagnosis and recent visits to A&E seeking support in crisis. The triage nurse thinks she is seeking emotional support and asks whether she has hurt herself in any way. When she says she hasn't, the nurse tries to reassure her that there is nothing wrong with her and advises her to call the mental health crisis team for better support. However, Danny is in fact experiencing some serious physical symptoms, which go untreated. Danny does not trust that anyone will take her physical symptoms seriously and so does not request a consultation for symptoms that may need investigation in future.	Danny's physical health needs have not been met because of the stigma and misunderstanding surrounding people who repeatedly experience severe distress and crisis, specifically those associated with an EUPD diagnosis.	Had the triage nurse been better trained to recognise, manage and support people who present frequently to A&E, and those with a diagnosis of EUPD, she may have been better able to help Danny get appropriate help for her physical and mental health needs. Training co-produced by people who have struggled with repeated mental health crises could help combat stigmatised attitudes towards people with an EUPD diagnosis.
Joshua visits a community mental health service for support after 8 p.m. but finds the service is closing for the evening. He manages to catch a receptionist before she leaves and she advises Joshua to attend A&E if things get worse. Joshua is handed a leaflet with a lot of information on it. Joshua has mild learning difficulties and sometimes struggles to comprehend documents like this. Joshua explains this but there is no alternative leaflet to provide him.	No reasonable adjustment was made regarding Josh's comprehension and communication abilities. Because of this, Joshua is unable to read the leaflet and understand it.	The service could have provided an Easy-read version of the leaflets for people with learning disabilities. By not doing so, Joshua was left unable to understand how to seek help outside of office hours. If Easy-read had been provided, Joshua might have been better able to access the help he needed.

An experience where help was needed	What was the inequality issue here?	What could have been done better?
Jerome is a 50-year old man with complex needs. He manages his day-to-day activities with the help of his benefits, which are under review. Jerome visits his psychiatrist for ongoing support. After an appointment, he receives a copy of his clinic letter which includes a short update on medication changes and information about his therapy, but it does not include enough evidence of Jerome's specific difficulties with day-to-day activities. As a result, his benefits are withdrawn after months of uncertainty and a stressful assessment. While appealing this decision, Jerome feels incredibly stressed and his mental state worsens. He begins to need more and more support from crisis services. Without benefits, he can no longer afford to engage in therapy or other activities that were helping him.	Jerome is unable to access the therapy or support he needs because of the financial instability caused by changes to his benefits. This has a significant effect on his quality of life and his symptoms.	Had there been better benefits advice and support available in the area, or via the mental health service, Jerome may have been able to seek help. Training designed and delivered in partnership with people who have been affected by similar issues would help clinicians understand how the benefits system is designed to work and how it can support and make a difference in recovery or maintaining mental health.
Claudia calls and makes an official complaint about the mental health service not honouring her request to be called Claudia (rather than her given name, David) when communicating with her. Claudia is in transition. Some staff also refer to 'him' and ask questions about the types of care 'he' would like. Claudia feels that the service's inability to recognise her transition is detrimental to her recovery and wellbeing. For example, Claudia knows that she needs inpatient services. However, she hides the fact the she is so unwell as she believes she will be put in a male ward.	Claudia's needs are not being met and the way staff address her is adding to her distress and affecting her mental health. As a result of the service being unresponsive to her requests, she is prevented from getting the care she needs.	Better staff training on providing high-quality care to patients undergoing transition could ensure that patients like Claudia are treated with respect and dignity. It could help staff provide better and more tailored care. The service could develop a protocol about how people in transition are treated (for example, there could be a liaison member of staff who has specific responsibilities and expertise working with patients in transition).
John is feeling extremely low in mood and so attends the GP surgery to try and make an appointment. There are no appointments available for the next couple of weeks. John is told by the reception staff that he can make an appointment from 9am the next day, when the next set of appointment slots are released online. John is embarrassed; he is having financial difficulties and hasn't been able to pay his Internet bill and he is no longer able to access the Internet. He leaves and doesn't make an appointment.	Directing patients to services on the Internet without checking that they have access can cause a problem for many older people and people with low incomes. John was not able to access the online appointment system and went without an appointment as a result.	The service could have put alternatives in place to ensure that staff and systems are still accessible to those without access to the Internet. Briefing or training could mandate that staff ask if a patient has access to the Internet, and offer alternatives if they don't.

Appendix 8: NCCMH Sharing and Learning event

In developing the AMHE resource, the National Collaborating Centre for Mental Health (NCCMH) held a Sharing and Learning event with several organisations working to advance equality in different areas of health care. The aim was to identify good practice, share intelligence and align work as much as possible. This section provides a list of some of the organisations involved and the work they have planned, in development or underway.

Organisation/Title of initiative	Information
Alzheimer's Society: Bring Dementia Out	An innovation aimed at meeting the needs of LGBTQ+ people affected by dementia, to ensure that LGBTQ+ people affected by dementia feel more comfortable to access the help and information they need. The work has been developed in partnership with people affected by dementia, LGBTQ+ communities and organisations. The 'Bring Dementia Out' prototype has been tested in Greater Manchester and Brighton and Hove in January and February 2019, and will include an evaluation.
Black Thrive	An initiative seeking to enable change across the London Borough of Lambeth so that Black communities can thrive and improve their mental health and wellbeing. It was set up following the identification of gross inequalities experienced by the Black community in Lambeth, across many areas of mental health support, care and treatment.
Care Quality Commission (CQC): Human Rights Approach, Equally Outstanding, CQC Race Equality Network	CQC embeds equality and human rights into regulation through their Human Rights Approach to regulation. CQC has published 'Equally Outstanding', a good practice resource, e-learning module and case studies which show how a focus on equality and human rights can lead to outstanding care. CQC has set Equality Objectives for 2019-2021: 1. Confident with difference – person-centred care and equality 2. Accessible information and communication 3. Equality and the well-led provider 4. Equal access to care and equity of outcomes in local areas – this includes a specific focus on access to mental health care for people from BAME communities 5. Continue to develop a diverse CQC workforce with equal opportunities for everyone and a culture of inclusion.
Ministry for Housing, Communities and Local Government	• Easel: a charity providing mental health support for people who are homeless • Homelessness prevention trailblazer: working with health and social care to help identify and work with those who are at risk • Housing first: big pilots for people with complex needs. There is evidence suggesting that this model improves mental health. It is person-centred and does not require people to meet various requirements before they get support.

Organisation/Title of initiative	Information
Cabinet Office: Race Disparity Unit	The Race Disparity Audit was published in October 2017 with the Ethnicity Facts and Figures website. It covers 130 topics across health, housing, criminal justice, employment, education and culture. Where possible, the data can be arranged by time series, geography, and key controls like age, gender and socioeconomic status. The unit published specific mental health-related findings including disparities in the prevalence of mental health problems, treatment received and outcomes of care.
Race Equality Foundation: Race Disparities in Mental Health project	An 8-month project funded by the Health and Wellbeing Alliance. Project partners include: • Race Equality Foundation (lead partner) • Friends, Families and Travellers • Association of Mental Health Providers • Nacro • Faith Action • LGBTQ+ Partnership • Maternity Action • Men's Health Forum Literature reviews and seminars highlighted themes related to race disparities in the experiences of BAME groups, as well as good practice examples. They are in the process of developing online resources to inform and influence policy and practice.
Rethink	Rethink aims to ensure the government follows through on its commitments to deliver parity of esteem and address inequalities, which currently see those who are most ill waiting the longest for treatment. Their past and present work includes: • Fair Funding for Mental Health: putting parity into practice – a report identifying how much funding is needed to achieve parity of esteem • Progress on the Five Year Forward View for Mental Health: On the road to parity – a report highlighting gaps in core services • Right treatment, right time – a report highlighting how long people with severe mental illness are waiting for treatment • Ongoing work with NHS England and Public Health England.

Appendix 9: NCCMH Mental Health Safety Improvement programme: Reducing Restrictive Practice

Operational definitions

One of the key aims of the Mental Health Safety Improvement programme is to reduce the use of restraint in mental health services. This is an important objective of advancing equality given the disproportionate number of BAME people and young women who may be subject to restraint and other restrictive practices, such as seclusion and rapid tranquilisation.

Physical restraint – Any direct physical contact where the intention of the person intervening is to prevent, restrict or subdue movement of the body, or part of the body, of another person.

Seclusion – The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.

Rapid tranquilisation – Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

Appendix 10: NICE guidelines and quality standards

Highly relevant	
Community engagement: improving health and wellbeing and reducing health inequalities	NG44
Guidance targeting populations with protected characteristics or identified as being at risk of experiencing mental health inequalities	
Alcohol: school-based interventions	PH7
Antisocial behaviour and conduct disorders in children and young people: recognition and management	CG158
Child abuse and neglect	NG76
Child maltreatment: when to suspect maltreatment in under 18s	CG89
Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care	NG26
Depression in children and young people: identification and management	CG28
End of life care for infants, children and young people with life-limiting conditions: planning and management	NG61
Harmful sexual behaviour among children and young people	NG55
Looked-after children and young people	PH28
Psychosis and schizophrenia in children and young people: recognition and management	CG155
Social and emotional wellbeing: early years	PH40
Social and emotional wellbeing in primary education	PH12
Social and emotional wellbeing in secondary education	PH20
Transition from children's to adults' services for young people using health or social care services	NG43
Pregnancy and maternity	
Antenatal and postnatal mental health: clinical management and service guidance	CG192
Postnatal care up to 8 weeks after birth	CG37
Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors	CG110
Disability	
Autism spectrum disorder in adults: diagnosis and management	CG142
Autism spectrum disorder in under 19s: recognition, referral and diagnosis (also children and young people)	CG128
Autism spectrum disorder in under 19s: support and management (also children and young people)	CG170
Care and support of older people with learning disabilities	NG96
Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges	NG11
Learning disabilities and behaviour that challenges: service design and delivery	NG93
Mental health problems in people with learning disabilities: prevention, assessment and management	NG54

Personality disorders	
Antisocial personality disorder: prevention and management	CG77
Borderline personality disorder: recognition and management	CG78
Older adults	
Dementia – assessment, management and support for people living with dementia and their carers	NG97
Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset	NG16
Home care: delivering personal care and practical support to older people living in their own homes	NG21
Older people with social care needs and multiple long-term conditions	NG22
Older people: independence and mental wellbeing	NG32

Appendix 11: AMHE resource contributors

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Helpful resources

Race inequalities

Dementia and Black, Asian and Minority Ethnic Communities: Report of a Health and Wellbeing Alliance Project (VCSE Health and Wellbeing Alliance)

Guidance for Commissioners of Mental Health Services for People from Black and Minority Ethnic Communities (Joint Commissioning Panel for Mental Health)

The End of Delivering Race Equality? Perspectives of Frontline Workers and Service-users from Racialised Groups? (RAWOrg)

Tackling inequalities in LGBTQ+ groups

A Whole Systems Approach to Tackling Inequalities in Health for Lesbian, Gay, Bisexual and Trans (LGBT) People: A Toolkit (The National LGB&T Partnership)

LGBTQ Mental Health: Exploring Advocacy Approaches to Health Inequalities (Mental Health Foundation)

Older people

Guidance for Commissioners of Older People's Mental Health Services (Joint Commissioning Panel for Mental Health)

Hidden in Plain Sight: The Unmet Mental Health Needs of Older People (Age UK)

Mental Health in Older People: A Practice Primer (NHS England and NHS Improvement)

Children and young people

Life Central: Young People

Guidance for Commissioners of Child and Adolescent Mental Health Services (Joint Commissioning Panel for Mental Health)

Gypsy and traveller communities

Research on Learning Disabilities in Gypsy and Traveller Communities

Learning disabilities

Guidance for Commissioners of Mental Health Services for People with Learning Disabilities (Joint Commissioning Panel for Mental Health)

Improving Access to Psychological Therapies (IAPT) for People with Learning Disabilities (Foundation for People with Learning Disabilities)

Improving Access to Psychological Therapies (IAPT) Learning Disabilities Positive Practice Guide (Foundation for People with Learning Disabilities)

Co-production

4Pi: National Involvement Standards

Changing Our Lives – The Mental Health People's Parliament, Sandwell

Guidance on so-producing a research project (INVOLVE)

Integrated commissioning for better outcomes: A commissioning framework (Local Government Association and NHS Clinical Commissioners)

People not Process – Co-production in Commissioning (Think Local, Act Personal)

Housing difficulties

Developing the long term plan for the NHS: joint response from Homeless Link and St Mungo's

Homeless and Inclusion Health standards for commissioners and service providers (Pathway and the Faculty for Homeless and Inclusion Health)

Reducing health inequalities

CQC's Equality Objectives for 2019–2021

Reducing Health Inequalities through New Models of Care: A Resource for New Care Models (UCL Institute of Health Equity)

Self-harm and suicide prevention

Self-harm and Suicide Prevention Competence Framework: Children and Young People (NCCMH, UCL and Health Education England)

Self-harm and Suicide Prevention Competence Framework: Adults and Older Adults (NCCMH, UCL and Health Education England)

Self-harm and Suicide Prevention Competence Framework for Work with the Public (NCCMH, UCL and Health Education England)

Women

Mapping the Maze: Services for Women Experiencing Multiple Disadvantage in England and Wales (AVA and Agenda)

Other useful online resources

Londoners Said: An Analysis of the THRIVE LDN Community Conversations (Mental Health Foundation)

EAST: Four Simple Ways to Apply Behavioural Insights (Behavioural Insights Team)

Health Inequalities Manifesto (Mental Health Foundation)

Independent Review of the Mental Health Act 1983: supporting documents (GOV.UK)

Is Britain Fairer? (Equality and Human Rights Commission)

Measuring Patient Experience (The Health Foundation)

Mental health data and analysis: A guide for health professionals (GOV.UK)

Modernising the Mental Health Act: Independent Review of the Mental Health Act (GOV.UK)

The Positive Practice in Mental Health Collaborative

Care Opinion

NHS resources

A Refreshed Equality Delivery System for the NHS (EDS2)

Adult Psychiatric Morbidity Survey (NHS Digital)

Adult Social Care Outcomes Framework (ASCOF)

Mental Health of Children and Young People in England survey (NHS Digital)

Keep Your Head

Health Survey for England (NHS Digital)

MindWell Leeds

Patient and public participation in commissioning health and care (NHS England)

Patient and Public Engagement Project: Patient and Public Dialogue Workshops (NHS Health Research Authority and Ipsos MORI)

Abbreviations

Term	Definitions
5YFVMH	The Five Year Forward View for Mental Health
AMHE	Advancing Mental Health Equality
ATAPS	Access to Allied Psychological Services
BAME	Black, Asian and Minority Ethnic
CAMHS	Child and adolescent mental health services
CBT	Cognitive behavioural therapy
CCG	Clinical Commissioning Group
COPD	Chronic obstructive pulmonary disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
EIP	Early intervention in psychosis
EUPD	Emotionally unstable personality disorder
IAPT	Improving Access to Psychological Therapies
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and 'other'
LSLCS	Leeds Survivor-Led Crisis Service
NCCMH	National Collaborating Centre for Mental Health
NICE	National Institute for Health and Care Excellence
PREM	Patient-reported experience measure
UCL	University College London
VCSE	Voluntary, community and social enterprise

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