Learnings from a project to engage with Black people detained under the Mental Health Act, Black communities & mental healthcare staff about health inequalities in Berkshire

Executive Summary

Black people are 3-4 times more likely than white people to be detained under the Mental Health Act (MHA) in Berkshire, which is comparable to the UK more broadly. This is a striking health inequality impacting on those detained, their families and their communities.

Berkshire Healthcare Foundation Trust (BHFT) commissioned Mind in Berkshire (MiB) to engage with Black communities, Trust and other mental healthcare staff to try to gain an in-depth insight in to the lived experience of Black communities with a view of better understanding how this effects them and what can be done to improve their experiences.
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This engagement generated some detailed and considered views generously shared by members of Black communities, other community groups, and staff working for and with BHFT. These views concerned possible reasons for the differential detention rate, and wider issues which the Black communities feel encapsulates their experience of services and which need to be explored and addressed thoroughly with their voices laying the foundation for the search for solutions to these systemic issues.

This paper sets out the feedback gathered following thematic analysis. Where individual quotes are included, or stories summarised, participants are identified either as 'community' or 'staff' members, and as coming from Black, White or Asian backgrounds, or their ethnicity being unrecorded. These very broad categories have been used to offer some context but also to protect anonymity. It should be noted that 'staff' members are predominantly but not exclusively people working for BHFT. Staff are also members of communities too, but identified as staff if they offered feedback primarily from that perspective such or were approached via staff channels or networks. The majority of community voices came from Black people.

Responses were grouped into 7 themes:

- A perception of systemic racial bias at both national and local levels

- Direct or reported experiences of poor experiences of health services by Black people, nationally and locally
- Stigma around help seeking for mental health problems in some Black communities
- Need for better cultural understanding & training for NHS staff
- The impact of intergenerational trauma experienced by Black people
- The potential of early education and proactive approaches to improve the mental health of Black people
- The need to build trust and respect between cultures and to develop / deliver culturally responsive services (not just 'communicate better'.)

These themes lend some support to three of the seven hypotheses generated by BHFT through a literature review of research into the differential detention rates experienced by Black people (set out in appendix A):

- Societal racism and stigma
- Internal stigma and beliefs
- Lack of social support and poverty
- Structural inequalities in the criminal justice system

Our recommendations for the Trust in taking forward its health inequalities work are summarised below. These have a read-across in several areas to the requirements of the *Patient and Carer Race Equality Framework* (PCREF), launched since the inception of this project.

- Be aware and respectful of a deep-seated mistrust of public services

Community members and staff (who form a community in their own right, and are part of wider communities outside of the workplace, including being of Black ethnicity and hence part of Black families and communities) described the deep-seated mistrust Black communities have of public services, including healthcare systems and mental health services, and the reasons for this. This needs to be borne in mind as BHFT moves forwards in its efforts to co-develop, implement and review plans with Black communities and Black staff members. Acknowledging that trust needs to be earned lays a respectful foundation for engagement, alongside making an explicit commitment to working in a proactive and sustained way to address power imbalances. Feedback from Black community members was often stated to be a repeat of comments made previously, but repeated as there was a perceived need for assurances that this feedback had been heard.

- It is a necessity to improve cultural awareness and understanding within the workforce

Feedback indicates that both clinical and non-clinical staff groups could be better at engaging with Black communities effectively. This applies both to clinical and to quality improvement / community engagement work, both of which should be approached in ways which are deemed culturally considerate and, most importantly, safe. Formal training and improving representation of Black people among Patient Expert groups, would help here.

- Embed meaningful patient and carer feedback mechanisms

Qualitative data has been gathered here, which can supplement quantitative data to develop a richer understanding. Internally, this can be used to support improved awareness of the complex issues at stake. Externally, acknowledging the challenges could also start forging stronger community relationships as a supporting foundation for effective implementation of future plans, including the PCREF.

mind in Berkshire

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About Us

Mind in Berkshire is the shared working name of two Local Minds[1] with an established presence in Berkshire, and which work in partnership with communities and community organisations. As members of the Mind Federation, we have ready access to the experience and expertise of National Mind and over 100 Local Minds.

Mind has a successful track record both nationally and locally of effective community engagement in racialised communities and garnering the voices of people with Lived Experience of mental health challenges. In particular, National Mind has worked with Local Minds to produce the *Service Design in Mind* toolkit, setting out a structured approach to incorporating ideas and insights from people with lived experience, and the *300 Voices* report through the Time to Change campaign, which demonstrates the use of a toolkit to engage with young African and Caribbean men.

Locally, the Mind in Berkshire partners have led service design using the recognised Mind toolkits and applying Federation values to ensure Lived Experience is at the heart of developing service provision.

See:

https://www.oxfordshiremind.org.uk/support-us/involvement/

https://www.bucksmind.org.uk/service-user-involvement/

The Berkshire Mental Health Act Detentions Project

In 2023, Berkshire Healthcare Foundation Trust (BHFT) invited Mind in Berkshire (MiB) to submit a proposal on collating learnings from Community Engagement & the Lived Experience of people from Black communities who had been detained under the Mental Health Act (MHA) within Berkshire.

BHFT's data showed that, from 2021 to 2023, 11.1% of people detained under the MHA at BHFT were Black. By reference to Census data for Berkshire, this meant that Black individuals were 3.07 times as likely to be detained as white individuals. For the period 2016-20, the proportion of the population detained who were Black was 10.6%, indicating Black individuals were 3.50 times as likely to be detained as their white counterparts. This

[1] Buckinghamshire Mind and Oxfordshire Mind

disparity is similar to that found in other regions of the UK (with some areas showing a greater disparity and others showing less).

BHFT set up 4 workstreams to review this health inequalities issue:

I. Case Review of Section 2 detentions (supported by a literature review)
II. Mapping mental health offerings across localities to identify possible gaps
III. Community Engagement & Lived Experience
IV. Cross-workstream analysis to identify drivers of differential detention rates

MiB was commissioned to lead on workstream *III. Community Engagement and Lived Experience*.

MiB's work on this project has been led by its Engagement and Development Leads for Berkshire West and Berkshire East. They have drawn on existing expertise within their organisations, particularly from our Equity Diversity Inclusion and Equality Manager, Involvement Lead, and Outreach workers across the East and the West of Berkshire.

Approach, ethics, and goals

BHFT ("the Trust") asserted at the outset that it was keen for the Community Engagement and Lived Experience workstream to be led by an external organisation, to benefit from an independent gathering of this data, and be able to offer participants the option of contributing anonymously. MiB agreed that this was the right approach as previous experience has shown us that people feel more comfortable to speak freely when provided with anonymity.

An approach was agreed between MiB and the Trust using the principles set out in National Mind's *Influence and Participation*[2] and the *300 Voices*[3] toolkits:

300 Voices was designed to develop mutual empathy and understanding between young African and Caribbean men and professionals, with the aim of improving service quality, and the experiences and outcomes of people accessing compulsory mental health and other services. The focus is on giving people the opportunity to frame their own narrative and identify 'turning points' that can change outcomes and improve experiences. It is an explicitly non-judgmental approach that aims to improve community engagement and to address some of the drivers of mental health inequality. It draws on:

- **Storytelling** – giving individuals' perspective centre-stage
- **Appreciative inquiry** – a focus on change through positivity and finding solutions

[2] https://www.mind.org.uk/workplace/influence-and-participation-toolkit/how/methods/service-design/
[3] https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/young-black-men/

- **Restorative practice** – developing collective solutions to repair the experience of harm

The model also embraces Mind's general approach to influence and participation work:

- **Equality** – across all voices /contributions
- **Diversity** – respecting different preferences for how to engage
- **Accessibility** – of opportunity to participate
- **Reciprocity** – people should feel valued for their contribution

To engage with the Black community, we recognised that we would need an approach that was focused, flexible and sensitive to the issues being discussed. We approached a range of community groups and representatives, leading to individual and group conversations.

Engagement with staff was originally planned for after the initial engagement with people with Lived Experience (which could include family/carer experience). However, as the project progressed, MiB and the BHFT project team started to explore options around engaging staff as members of their own communities, with and connected to Lived Experience of the issues subject to the enquiry. Some of the community meetings we attended included individuals with professional experience – sometimes alongside personal experience – of supporting Black people around mental health issues. It was recognised that this avenue could be facilitated by the Trust supporting MiB to connect with staff groups, which it did.

In reporting on our findings, in order to give context, where individuals identified themselves as working around mental health in a professional capacity, their comments are referenced as coming from 'staff'. Other comments are referenced as coming from a 'community' source. It should be noted, however, that staff are also members of communities. In addition, whilst most of the 'staff' we spoke to worked for the Trust, not all were BHFT employees: some were people working alongside BHFT or from Trust premises but employed by other organisations. Details of individuals' employers or their job titles have not been included in order to preserve anonymity.

Throughout our engagement, MiB has outlined the purpose of BHFT's proposed Reference Group to oversee the continuation of its health inequalities work. MiB believe the idea to be refreshing, progressive and in line with the co-production values laid out in the *Service Design in Mind / 300 Voices* toolkits. The first step would be for BHFT to develop full Terms of Reference for the Reference Group with full and equal participation of all members.

Engagement approach

Community mapping and engagement

MiB's community engagement began with a mapping exercise to generate a list of potential contacts across Berkshire. This involved reviewing contacts generated through previous projects or ongoing collaborations, supplemented by online research and snowballing[4], to identify those likely to be a conduit to Black adults with experience of accessing statutory mental health services. Contacts were included if they had a remit or expressed personal interest in Black communities, mental health support or both. 138 relevant community groups or leaders across Berkshire were identified.

Where our mapping did not clearly identify community groups or leaders likely to facilitate access to Black people, we used a variety of alternative channels such as sports clubs; the Independent Mental Health Advocacy (IMHA) service; community engagement leads and wider community based leaders.

The MiB project leads then met or spoke with contacts to outline the project, offer a light briefing on the issues to be explored with project participants, and answer any questions. This was aimed at supporting people within community groups to decide on how they may want to engage themselves or encourage others within their own community or family groups to consider this. In addition to one-to-one conversations, reaching out to these contacts resulted in opportunities to raise awareness of the project at 10 community meetings. In total, just over 100 inputs were gathered from engagement with a community focus.

BHFT / staff engagement

Alongside the community engagement as originally conceived, we sought to bring forward elements of the BHFT staff engagement which had been scheduled to follow the gathering of Lived Experience stories. The reason for this was recognising BHFT – and other mental healthcare – staff as another possible avenue to Black individuals with experience of detention – via community and family connections. MiB prepared resources for the Trust to share internally inviting staff to contact us.

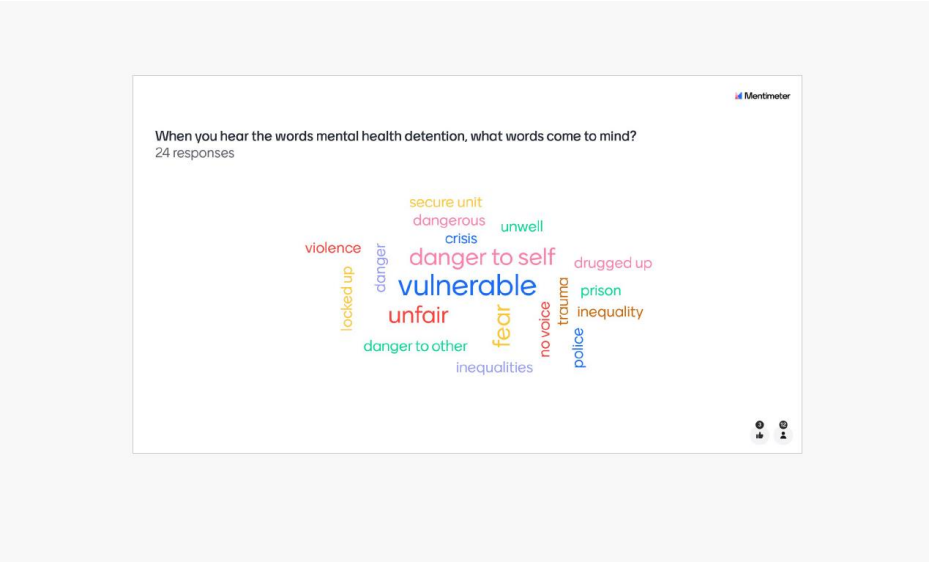
As part of the staff engagement we attended the CommUNITY Forum, an anti-racist assembly facilitated by BHFT, and focused on providing a safe and empowering space to platform voices, ideas and find solutions to support the diverse communities across Berkshire. The Forum is attended by a mix of staff, not just from BHFT, making it an

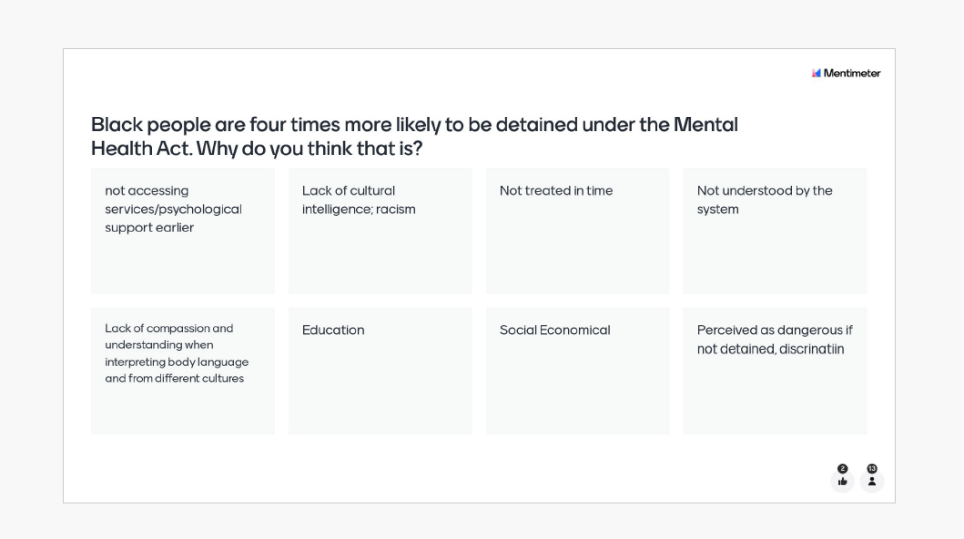
[4] a recruitment technique in which research participants are asked to assist researchers in identifying other potential subjects.

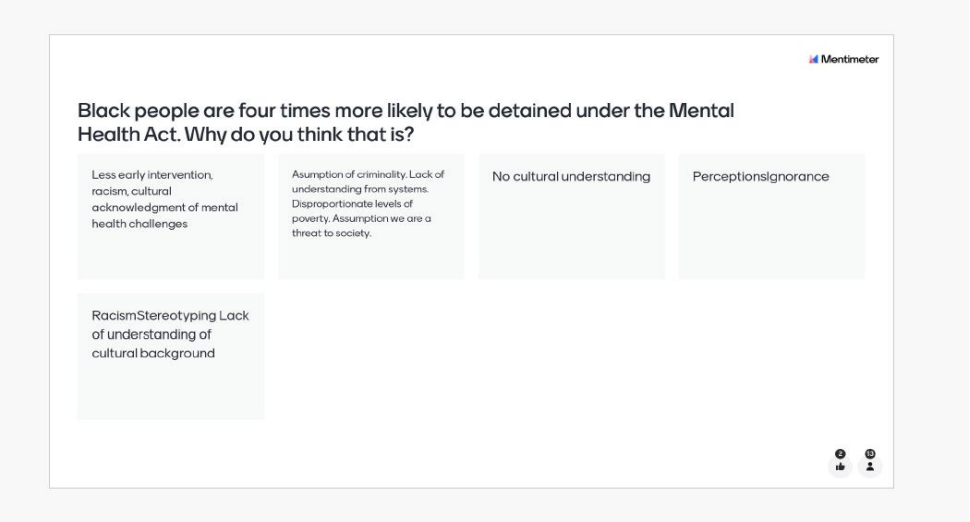
excellent initiative focusing on diversity. We invited attendees to share feedback via a Menti-meter poll using 3 key questions:

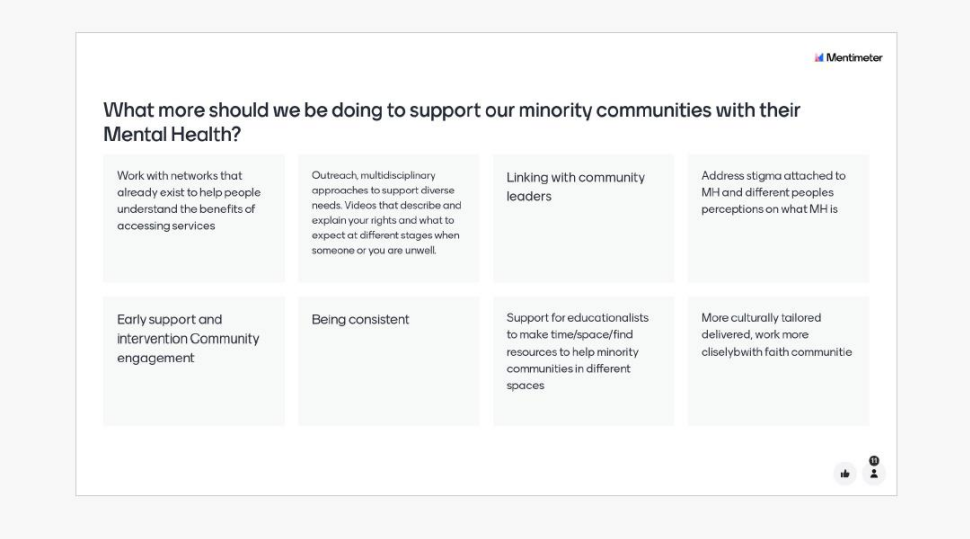
- When you hear the words 'Mental Health Detention', what words come to mind?
- Black people are four times more likely to be detained under the Mental Health Act. Why do you think that is?
- What more should we be doing to support our minority communities with their Mental Health?

Some of the responses from this Berkshire-wide event can be seen in the pictures below.









We also ran a pop-up event at Prospect Park Hospital on 16.04.2024 in collaboration with a senior BHFT Staff Member who was very passionate about staff having the opportunity to share their voices. The event was informal and allowed facilitators to connect with staff as they worked throughout the day. Informality was key to ensuring staff felt comfortable, as was having the opportunity to offer assurances that inputs and feedback would be reported in an anonymised way. From this event, we were able to gather approximately 80 inputs from staff in a range of roles and with varying lengths of service and experience, as well as distribute leaflets about the project. (NB: Comments gathered from the Prospect Park event are referred to below as simply 'staff' feedback. The majority of people we spoke with were BHFT employees. However, some were people working at the Prospect Park site, on that day, were employed by other organisations.)

Interestingly, several of the staff we spoke to found it difficult to recall having encountered any Black patients, whether detained or not and said they felt they believed they had seen more patients from other ethnic groups as in-patients. A couple of the staff even queried

if the health inequality subject of this project was accurate in its description, as they personally were not aware of the higher rates of detention faced by Black people locally or nationally.

Changing the focus of this work

At the outset, this community and staff engagement was primarily aimed at setting foundations and building a stronger rapport as we sought to gather more in-depth accounts of individual experiences of MHA detention. It became increasingly clear, however, that some of the seemingly wider issues which people were feeding back to us were very pertinent to the project's overall aims. MiB made the suggestion that we widen the parameters of the project to support capturing this feedback, which BHFT agreed would be informative. The feedback reported below therefore covers wider perspectives on the Black experience of mental health and support, i.e. the context in which the specific mental health inequalities are experienced by this population within Berkshire. We also heard from people as why they thought it was so challenging to recruit participants to the project as originally proposed, which offers learning for future direction by identifying barriers to involvement and community participation.

The themes emerging from our conversations are set out below. In order to protect anonymity, we have not reported in detail on the characteristics or backgrounds of those we spoke with. Where direct quotes are included, these are attributed either to a "community member" or "staff member". Those described as staff were people working at Prospect Park Hospital and most, but not all, were BHFT employees. Both descriptors cover a range of ages, gender identities and occupational status. In the case of "community member" this also includes people in and out of work, and in the former case working in various sectors. Where known, ethnic background is reported under the broad categories of White, Black and Asian.

Themes

Systemic Racial Bias in the UK

Many of the people we spoke to were keen to assert that the differences in MHA detention rates for Black people needs to be seen in the wider context of Black people's experiences in the UK. There was quite widespread general awareness of the differential detention rates amongst those we spoke to (not necessarily the detailed statistics), recognising these are largely people either working within the mental health system or approached because of a known interest in mental health and/or their knowledge of the issues Black communities are facing.

Many of those we spoke with pointed out that Black people's expectations of mental health services, and services' readiness to support Black people, are influenced by issues going beyond mental health services, beyond health services and sometimes back over many decades but are yet still relevant and experience defining.

> ***"I think as Black people our traumas can be a little different because of how the systems treat us. We're more likely to be arrested, more likely to be convicted, we're less likely to receive second chances in my experience so why would health be any different?" (Black community member)***

> ***"I've seen how [my mixed-race grandchildren] have been treated in comparison to their cousins (white) and it's disgusting. ... There is a difference in how Black people are treated across society as a whole, we have to do better. Struggles are different and we have to want to understand that." (White community member)***

Some people drew attention to the experiences of refugees and migrants, amongst whom community groups witnessed a lot of stress-induced suicidal ideation.

> ***"They tell us they feel mis-judged, even hated, and it's frustrating not to be seen for who they really are. They feel they're not coping, but they worry about being separated from their children if they admit this. They say how they feel is caused more by their hostile treatment here than the torture and abuse they have escaped from." (Community member, ethnicity unrecorded)***

It was suggested by several people that wider experience of racism is likely to be a factor meaning Black people come to mental health support later in their illness.

> ***"People don't trust us ... how people have been treated historically can play a huge role. I don't only refer to what we see in health, I think about the abuses carried out by the police on the Black community, another state***

service. We can't act like this doesn't break trust or effect any other relationship with services." (White staff member)

"Lack of early intervention is a huge issue in my experience. In school when you're white or the workplace when you have issues they are taken seriously very quickly. When you're Black there's less concern, it's put down to bad behaviour and just pushed aside." (Black community member)

Another analysis offered was that Black people are likely to perceive race-related danger when brought into contact with White-led systems. 'Fight or flight' is a standard biological response to perceptions of danger across a range of contexts. In the case of someone from a marginalised racial group being expected to seek support from a White-led service, previous negative experiences where race was the primary factor for their mistreatment can have a strong influence on why they may not meet those support-seeking expectations. The response from Black individuals may then be avoidance of or resistance to offers of mental health support. Resistance, in particular, is at risk of being mis-read in Black individuals, where there is already a pre-disposed racially-biased perception of threat.

"The reason I think we're seeing more Black people sectioned is because the way they are perceived when struggling with a mental health crisis and their Blackness can already be seen as an indicator of violence. This is racism to put it simply. Pre-disposed views play a huge role on the approach taken when someone is being sectioned." (Black community member)

Several community members shared that they had witnessed detentions which they thought could easily be understood to constitute a trauma sufficient to trigger PTSD.

Amongst those we spoke with, there was also widespread awareness that Black people experience worse health outcomes across a range of conditions and services, that 'Racism is a public health crisis.' It was pointed out that Black people do not park this knowledge when invited to engage with mental health services: it is their context.

"It's not only in MH services, look at the disparity in the how Black women experience childbirth under the care of the NHS. This is scary and affects all Black communities and how they view the support services say they want to offer." (Black community member)

This means that even in the absence of any direct negative experience of mental health services specifically, Black people may be reluctant to engage, especially if they can see an alternative. There is a need for services to acknowledge this and be much more proactive in reaching out to Black communities.

"I'm quite fortunate, I haven't had struggles with my mental health, but I've experienced being treated differently within systems that are meant to

protect me. Anytime I need support, I'm more likely to go private because I'll get the care I need. Maybe when I'm paying my skin colour isn't much of a factor..." (Black community member)

"I've seen how Black people have been treated in spaces 'for all' and let's just say they're not always as they're made out to be. I think health services have to do more to connect with Black people, work within the community." (Black community member)

"Black people would come to us earlier if they trusted our services and it's on us to think about how we build that trust back and prove we're here for them just as much as anyone else." (White staff member)

Some community members talked about the stories shared with them about Black people feeling unwelcome or unwanted, which in itself triggered anxiety or depression, and the resulting reluctance to engage with services which are seen as part of a hostile and anti-minority system. One person expressed the solution in very simple terms:

"...all I can think about is why not start treating us as equals - like we belong." (Black community member)

Poor Experience of Mental Health Services

It was less common for people to cite direct poor past patient experience of mental health services specifically as a factor likely to impact on differential detention rates, but this was raised by some who felt previous experience had led to a distrust and hyper awareness of how the health system has and could continue to treat Black people.

"Some of the stories we hear, the racism is clear and obvious. Dismissive of the cultural differences, patronising family members who highlight concerns and generally bad attitudes towards these young people and their loved one. What happens as a result is these young Black people become disillusioned with services and don't trust them because of this experience." (Black community member)

"I have used services previously and felt quite patronised and not taken seriously. That's definitely had an effect on me and my confidence in the staff." (Black community member)

This provides an insight into the importance of approach and how when working with patients/clients one negative experience can create or strengthen distrust of services which can perpetuate existing health issues as client/patients feel undermined or belittled by providers.

Some people talked about the factors Black people need to weigh up in deciding what are the relative risks of approaching or not approaching mental health services.

> ***"We know to some people we're seen as less, and that affects the care we receive, and instead of going through that, we would rather suffer in silence." (Black community member)***

We heard from staff who had profound concerns about the health services Black people have been offered, and the context in which these have been developed.

> ***"There is systemic and structural racism. It is built into policies, training and in academic literature. So then assumptions are made around stereotypes." (staff member, ethnicity unrecorded)***

> ***"There are HUGE racial disparities. I feel ashamed as a Black person working here, even though I know we're offering a much needed service." (Black staff member)***

Sadly, we also had feedback from some staff members indicating persisting views which blame Black people for their poorer experience of mental health services and the perpetuation of racism.

> ***"Black men are harder to support because they just won't engage." (White staff member)***

> ***"The differences are probably down to how much weed is smoked in Black communities." (Asian staff member)***

We also heard from staff members who were willing to share their poor experiences of NHS mental healthcare services as Black staff members. This is obviously a concerning issue in itself. It also led to the staff members we met drawing the conclusion that the differential detention rates were to be expected and often normalised.

> ***"I speak as a Black member of staff – I don't feel like I fit in. Racism comes from the top!" (Black staff member)***

> ***"I don't feel accepted and heard as a Black medical professional, so I am not surprised that the numbers of detention within my community is so high." (Black staff member)***

Stigma about mental health in some Black communities and for some Black men in particular

One of the most common themes that has come out of the engagement was the issue of stigma. The vast majority of people we spoke with gave at least one example of how stigma effectively contributes a brick towards a blockade between the individual and mental health support. This stigma of mental illness is universal but may not look the same for each community because of different collective and communal experiences.

> ***"It's very difficult as a man, let alone a Black man to share that you're struggling. I think race is a huge factor, there is so much bias against people of colour, especially if you're Black and that makes me feel as if it's hard to trust services." (Black community member)***

Many community members shared that throughout Black communities there is often an expectation that 'you just need to get on with' mental health, and there is a reluctance to share personal struggles about mental health where issues are seen to be much more abstract and less serious in comparison to physical ailments. According to many of our Black community participants, physical health will trump mental health the majority of the time when it comes to taking issues seriously.

However, whilst stigma is common, it is by no means a universal truth that Black people cannot discuss mental health issues within their communities / families, or are always discouraged from seeking external support. One community member described how their family took the view that there is very much a place for external support.

> ***"My family always said we cannot know everything and we should seek other support alongside family at times." (Black community member)***

What is very clear is that the Black communities we have engaged with are aware of the stigma that causes difficulty for many to express themselves. However, some members of those Black communities were also keen to point out that the issue is not confined to self- or community stigma. People talked about how the issue is exacerbated by the bias of those who work within services – further alienating Black service users. The combined effect is very damaging and is a cause for great concern.

> ***"I have seen staff take different approaches to service users and their only difference is the colour, accent, background. They are spoken down to, tones which people wouldn't use with their pets and then sent on their way – disillusioned, more confused and leaving with additional shame to accompany the heavy load they already came in with." (Black staff member)***

Encouragingly, though, within mental health services, there are some staff with a keen appreciation of the importance of acknowledging what impact stigma has within communities, and see their role as including actively challenging this stigma.

> ***"Stigma is massive. There has to be a solid investment of time by services to create better relationships with Black communities, reaching out and starting to break this down. We can't just wait for people to end up with us." (White staff member)***

Low levels of cultural understanding and training in mental health settings

Many people we spoke to felt more training was needed within mental healthcare systems to make them culturally safe. Staff often expressed this as a need for better understanding of communities and behavioural norms, particularly a misreading by White staff of how Black people express themselves either when feelings are running high or when they're feeling overwhelmed.

> ***"I see such a difference in the way we deal with patients. There have been times where I have been working with patients/families from African backgrounds and they have been deemed by colleagues to be aggressive when in fact they're not at all, they are just passionate when they speak. I learned this from a senior colleague while training to qualify. They explained how talking loudly isn't always a sign of aggression and in many cultures it's just the norm and people are passionate which they have the right to be. That was a real learning moment for me." (White staff member)***

Staff members did offer some suggestions as to how cultural understanding could be improved alongside formal training courses, such as ensuring Black representation on interview panels and within Lived Experience reference groups or similar. We were advised that there were no Black Lived Experience experts currently engaged in NHS work in the East of Berkshire and seemingly only one such expert in the West of Berkshire. The member of staff who shared this was unsure why this was and explained that maybe the cultural aspect may be at play, e.g. the stoicism of senior members of Black families.

Staff also drew attention for the need for better cultural awareness beyond secondary mental health care.

> ***"GPs and their staff need to be more culturally aware. They are the gate keepers." (staff member, ethnicity unrecorded)***

Community members recognised the need for improved cultural awareness in settings besides the NHS, which often play a supporting role in protecting mental wellbeing.

> ***"There is no doubt that many people aren't very culturally aware of other people's backgrounds. I also think because we focus on the majority (white***

population) we don't think about different populations." (White community member)

Several community members referred to the concept of person-centred care but noted how this was rarely applied in terms of recognising the Black experience as integral.

> ***"There is so much conversation about person centred care, but they're not interested in the person as a whole – only the symptoms/diagnosis. This is an awful way to treat people and to ask for trust when so little is done to resolve these injustices, and discrimination is another slap in the face." (Black community member)***

> ***"Professionals are not expected, nor are they trained, to consider cultural differences and needs which should be at the front of person-centred care and this has been going on for so long with such little change it can no longer be put down to ignorance but instead, it's just not important enough. We have seen how quickly action can be taken when things are deemed important enough." (Asian community member)***

One staff member we spoke with talked about another example of differential treatment of Black patients which they thought might be paralleled in differential detention rates. This staff member gave the example of a Black patient who the staff member felt was on the wrong ward and seen as posing a greater risk than was his reality. This staff member expressed frustration that they couldn't persuade colleagues to re-consider what was most appropriate for this patient.

> ***"It just didn't make sense why he was treated so differently. The only explanation I could see was that he was Black." (Staff member, ethnicity unrecorded)***

The need for cultural training was expressed by some community members as important to break down the myth of a homogenous Black community.

> ***"...black people aren't a monolith. We differ in so many ways, where we're from, our cultures. These are often overlooked by professionals." (Black community member)***

Intergenerational trauma

Community members talked about how beliefs and behaviours can be shaped not just by the traumas experienced by individuals directly but also by the traumas experienced by previous generations. An example given in the context of Black communities and mental health was how at least 411 Black people with chronic and mental illness were sent back

to the Caribbean between the 1950s and 1970s.[5] In some cases, families remaining in the UK were not even informed, so assumed they had been abandoned by a loved one, only to learn years later how the separation came about. This leaves many Black people today reluctant to seek mental health support. Experience is an aspect that doesn't have to be had firsthand for people to formulate opinions and views about the subject of focus. Once these views are solidified it is very difficult to change them.

We were told a parallel story by a Black NHS staff member, who remains deeply affected by a memory from childhood of a family member being detained. This individual advised quite candidly they would be unlikely to seek mental health support for themself today because of their family member's experience.

Another Black healthcare professional was clearly supportive of the project and happy to share their own views with us. However, they explained that intergenerational trauma was probably too great for them to be able to encourage family members to participate and in fact the degree of mistrust and fear was held so deeply they could not partake in the project at that point in time.

> ***"I have family that wouldn't speak to you because they are scared of the connection you have to the NHS with regard to this project. It really runs that deep and I have explained to them how I have met, spoken and am working with you and they still are very scared because of how they and their experiences have been treated before." (Black staff member)***

Need for early education and proactive approach to mental wellbeing

Both community members and staff expressed that they felt it critical for there to be more learning opportunities for the younger generation to focus on the maintenance of mental wellbeing, and being proactive in approach would bode well for future generations of Black people.

> ***"We need to do more work with schools and community groups to educate them on the importance of their mental wellbeing." (Black Staff member)***
>
> ***"... Preventative measures in schools so our children and young people grow up understanding how important their mental health is. That way it will become the norm." (Black Community member)***
>
> ***"It's important to highlight the earlier young people are educated about mental health and the importance of maintaining mental wellbeing, the***

[5] https://www.bbc.co.uk/news/uk-65926622

easier it is for conversations to be had and learning to take place as they get older." (White Community member)

Some expressed they felt having community training was important and would help cultivate better and more fruitful relationships

"There should be some open courses for the community to partake in, this would support us with more people able to recognise the signs" (Black staff member)

"Communities want more opportunities to help themselves, we're interested" (Black Community member)

"Why aren't we visiting and delivering more in local spaces to inform.?" (White NHS staff member)

The need to build trust and respect between Black communities and the NHS, and to act on what we are told

The lack of trust between Black communities and the NHS was a recurring theme. We spoke to some staff who saw this as an indication that better communication of offers to Black communities was the answer. However, amongst some community members and also some staff there was frustration and anger with this response, interpreted as dismissing Black mistrust as just Black people's ignorance. Those who shared and sought to provide insight into personal, communal and intergenerational experiences felt there was a lack of understanding, and in fact the act of listening wasn't taking place to understand what was being said so as to inform the response. The issue with this approach is that a lack of understanding makes it challenging to respond with action which positively impacts the issues raised. Messaging from services which is **not** informed by feedback from the target audience can then strengthen the barriers between both parties who are invested in solving these issues.

"Don't just rely on social media to get the message out. That doesn't build trust." (Staff member, ethnicity unrecorded)

Several community members talked about the need for the NHS to demonstrate a real commitment to ongoing collaboration with communities. Many had contributed to previous NHS-led projects described as aimed at improving Black's people's experiences. Unfortunately, however, this left them less rather than more willing to participate again.

"Services don't seem to understand that it is incumbent upon them to build trust. This takes time and services aren't known for giving their time to building long-term relationships. Quite the opposite unfortunately and what

they don't realise is they are the catalyst for the response they often receive when seeking to involve communities in projects, communities are not always receptive or welcoming to the engagement because the approach taken is often about ensuring boxes are ticked rather than change being made. They know this because they have experienced it before." (Black community member)

Examples were offered of how a Black experience is likely to be dismissed or disregarded if this illustrates a challenge to systems designed for a White majority. A common and legitimate response to this is weariness or cynicism when invited to use your voice as a Black person.

"People of colour get to the point where they are expected to just accept the treatment they receive and when they do challenge, their experiences are dismissed or even watered down to make others feel more comfortable. This is consistent and a reflection of a much larger and brutal interconnected system that Black people have to navigate every day." (Asian community member)

The community leaders we spoke with expressed consistently the necessity for Black communities to be able to have a greater input into projects focusing on their health and wellbeing. One elder went as far as to suggest the approach taken to community projects by health services was offensive, lacking consideration about how much it takes from them to let outside organisations in given the history of poor treatment.

"As a Black woman I feel tired and disillusioned. The constant sharing of my experience doesn't ever seem to lead to change. You have to be interested in people to build trust – it's earned not just given." (Black community member)

There was concern about the lack of sustained programmes to address these issues as a true partnership between the NHS and Black communities, and open scepticism about short-term projects and data-gathering without any visibility of how the data is then used and how those who take part are fed back to.

"The NHS uses ... consultation as a smokescreen to shelter the decision makers as they take away community's fundamental right to be involved in how they are treated/supported." (Black community member)

"It can't be stressed enough the importance of building a long term trusting relationship with the communities and taking into consideration community partners' agendas." (Black community member)

Community members also talked about the need to embed an appreciation within the NHS that Black communities hold knowledge which the NHS can benefit from if it seeks to

learn with due respect and humility. Too often, Black community members had witnessed NHS projects or outreach based on the premise that there would be better service take-up if only Black communities knew more about NHS offers, without any expectation that those offers may need to change to truly meet Black communities' needs.

> ***"There has to be a solid investment of time by services to create better relationships with Black communities. It has to be reciprocal relationship and the services must be open to learning and being taught alongside the communities they aim to support. There is no doubt there has been a need for this support for years." (Black community member)***

> ***"There is definitely work we can do ...as a community, but services have to work with us properly. We need to be respected; we are experts on our own spaces, but we don't know everything but nor do the NHS so why do they not work with us in a respectful way? It's very disappointing. We (Black people) are being overlooked and our experience and expertise dismissed. I know from working first hand to support community members that they don't trust services because of the attitude shown to them and they know it's because they're different in terms of race and religion. This is enough to ensure someone will never seek help again and when it's raised this is not taken seriously." (Black community member)***

Beyond service development projects such as this, people also talked about the need to deliver services in a different way so that family and community members were properly seen as assets and partners in care rather than assumed to be a barrier to people accessing support.

> ***"There is an assumption that because Black people aren't actively seeking out other offerings from services they're under they aren't interested but that's not always the case. I have seen many a time where they will be taking their medication, have a supportive family and are very well supported at home. Western culture is more individualistic but other cultures are more collectivist which can be seen as non-engagement in services but that's not always the case." (Asian staff member)***

There was interest from Black community members in developing community based mental health support. Ideas were offered around how greater use could be made of safe spaces and trusted relationships within a partnership approach. Statutory partners could offer training within this, but also develop their own knowledge and understanding, particularly around the strain which daily racism places on people.

> ***"We as people of colour are always having to think about how people view us, not because they know us but just because what we look like. It's exhausting." (Black community member)***

We spoke with community members who remain convinced that change is possible, but provided the NHS appreciates the level of effort required.

> ***"If you're serious about changing the outcomes and current statistic you have to recognise your own prejudice and racism in your practice because you can't move forward without accepting it exists.***
>
> ***Systems can change and it doesn't have to be difficult, but it is because the people that run this system have a vested interest to maintain the current status-quo. Their comfort and privilege is more important because it serves them and they can sleep well at night knowing that they did the best they could within the parameters available... the ones they would never seek to change.***
>
> ***Black people's problem is a system that doesn't recognise their issues or needs. It's not designed to, they are squeezed in. A round peg in a square hole and we are expected to do all we can to fit a mould that is never going to fit us." (Black community member)***

We spoke with Black community members who were certainly not closed off to the idea of working with BHFT to address the detention rate disparity. However, they were very clear that the approach needed to be different to what they had experienced in the past.

> ***"I have a lot of criticism for the NHS/local trust but alongside that I want to provide what I feel could be conducive to some sort of solution. Firstly, I think the NHS trust needs to be transparent and apologise, sincerely to Black communities for some of the mistreatment they have received (would suggest this for all poc/faith communities but focusing on the Black communities). Secondly, work co-productively with Black communities. Focus on the balance of power and ask 'what do you need from us to combat this issue?' VCSE Orgs have to be a part of this co-productive process. Third and final, listen and do. But do with not to – it should always be a collaborative. Do not rob the individuals you serve of their fundamental right to lead, and be guided in the process of change." (Black community member)***

Discussion and implications for future engagement work

Literature review

As part of the wider project, BHFT commissioned a literature review which generated a series of hypotheses to explain the greater rate of MHA detention experienced by Black individuals (see above).

The findings from MiB's engagement work have been presented in accordance with a thematic analysis of the records of conversations within the engagement. The report's structure is therefore driven by the data, rather than organised around the hypotheses falling out of the literature review. However, some links can be drawn as summarised in the table below.

Hypothesis	**Links to MiB engagement report themes**
1. Black individuals are at increased risk of psychosis	Inconclusive
2. Societal racism and stigma	The themes of 'systemic racial bias' and 'stigma' lend support to this hypothesis
3. Internal stigma and beliefs	The theme of 'stigma' lends support to this hypothesis but note that this covers internal and external sigma
4. Lack of social support and poverty	The theme of 'systemic racial bias' lends some support to this hypothesis
5. Structural inequalities in the criminal justice system	The theme of 'systemic racial bias' lends support to this hypothesis
6a. Talking Therapies not utilised	Inconclusive [6]
6b. Disparities in access to and outcomes of Early Interventions in Psychosis	Inconclusive [7] -

Patient and Carer Race Equality Framework

Since this project started, NHS England has published its 2024/25 priorities and Operational Planning Guidance setting out what Integrated Care Boards should prioritise

[6,7] The community / staff engagement contains various references to under utilisation of / late access to mental health services generally, but was not specific enough to either of the particular services named in the literature review to offer supporting evidence.

in the coming year. Mental health services are one of six priorities in the guidance, within which there are five specific objectives, including implementation of the Patient and Carer Race Equality Framework (PCREF).[8]

This framework is intended to support mental health trusts to improve experiences of care for racialised communities. As all mental health providers must implement the framework by March 2025, and as it will become part of the CQC inspection process. MIB feel it is relevant to consider the learnings from this Community and Staff Engagement project by reference to the 3 PCREF components, as outlined below.

Component 1: Leadership and governance

- ***Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation.***
- ***Co-develop, implement and review local PCREF plans with racialised communities and your workforce.***
- ***Identify priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans.***

Monitor core measures at Trust Board level on a regular basis and publish PCREF plans.

Our engagement has identified significant challenges that BHFT may face in co-developing, implementing and reviewing PCREF plans with Black communities and with Black members of the workforce. However, the feedback also offers potential solutions in that it elaborates on where Black communities are seeking assurances that their voices have been heard. Openly acknowledging this feedback is key, and would demonstrate respect for communities' perspectives.

BHFT will need to demonstrate commitment to change to earn the trust of Black communities and staff members. Making this a priority and committing sustained effort over a period of time will be needed to bring about the change the Trust wants to see.

Recommendations:

- Acknowledgement of feedback from this engagement piece with the communities who participated.
- Clear statement of commitment to earn the trust of Black Communities led from the Trust Board recognising the community experience, expertise and desire to work more closely with services.

Component 2: National organisational competencies

[8] https://www.england.nhs.uk/publication/patient-and-carer-race-equality-framework/

- ***Engage with racialised communities to identify and agree core organisational competencies.***
- ***Agree on measurable and practical actions to co- develop in local PCREF plans.***
- ***Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans.***

Feedback has been gathered from Black communities as part of this engagement project which can inform the development of local competencies in support of the PCREF. These relate particularly to the need for improved cultural awareness and understanding – both via formal training and in the form of improved representation of Black people as Patient Experts. This, in turn, will be able to support BHFT in creating a Trust wide understanding about the importance of learning and understanding different cultures to support person centred approaches to care.

Our engagement has also highlighted community concerns about previous NHS approaches to gathering and acting on perspectives from Black communities. This is not necessarily linked to previous initiatives run by BHFT, but BHFT is of course known to be a part of the NHS, and organisational boundaries within healthcare are not always understood by lay people. This indicates a need to develop competencies within the Trust to support effective and culturally safe community engagement. We would suggest the reference group that BHFT plans to develop be involved in identifying these competencies and support in the design and implementation of these learning opportunities developed for staff. A co-productive approach to this work will allow the Trust to recognise and utilise the community knowledge as an asset, developing and strengthening knowledge but most importantly building a bond formed on mutuality.

Recommendations:

- Cultural awareness training rolled out across all levels of the Trust.
- Improved representation of Black People as Patients Experts.
- Clear actions on community engagement feedback, “You said, We did” approach.
- Co-production involvement with the proposed reference group from the beginning to shape the creation of the group including wider organisations both statutory and VCSE based to support recruitment and facilitation.

Component 3: Patient and carer feedback mechanism

- ***Ensure patient experience data is used, monitored and flowed to national data-sets to enable bench- marking, lesson-sharing and service improvement.***
- ***Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services.***

- ***Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities.***

This engagement project was designed to gather broader patient experience data in the form of qualitative data, which can be much richer than quantitative data. Very few of the people we spoke to through this community and staff engagement identified as having direct personal experience of being detained as a Black person, or being the carer for someone with this direct experience. Some have identified as family members of people with this direct experience, however, and/or have alluded to a closer connection. e.g. speaking in more general terms about a traumatic family history with mental health services.

There has been a significant amount of commentary from community members concerning the lack of feedback following previous engagement with Black communities by the local NHS (not just BHFT), and the impact this has on trust and their experience of services. Acknowledging community feedback is a vital step in the engagement process, paving the way to start to build relationships with racialised communities. In connecting with communities (this includes staff, who are a community in themselves) outside of the realm of providing healthcare, demonstrating a commitment to sustained engagement becomes key. This needs to include a willingness to hear how communities define the context in which they experience health concerns. This will not only help build a better foundation of knowledge to work from for BHFT but also create a bridge for the community and Trust to approach issues of significant importance which may lead to unequal and unwelcome health outcomes.

Recommendations:

- Address the issues of communities feeling unheard and unresponded to in regards to any engagement done with them.
- Gain better understanding of the context in which the Black community experience health concerns.
- Recognise the "stories" the community share on their experiences and how that can shape engagement with services.
- Reconsider current avenues available for constructive dialogue and explore how they can be widened as well and made more culturally sensitive with Black community members.