



Centre for
Mental Health
Commission for Equality



Commission for Equality in Mental Health

BRIEFING 2: Access to mental health support

Centre for Mental Health, July 2020

CONTENTS

Summary	1
Inequalities in access to mental health services	3
What makes support difficult to access?	5
Policies designed to increase access to mental health care	12
Ideas to improve access for people who experience inequalities	13
Conclusion	16
About the Commission	17
References	19

SUMMARY

Problems with access to mental health support are well known, with waiting times and eligibility criteria now widely debated and a major focus of national policy. Yet access issues run deeper. Too many people and communities have been left behind. Groups facing particularly high levels of poor mental health also, paradoxically, often experience the greatest difficulty in accessing services: an inverse care law.

In understanding the reasons some groups of people do not seek help as readily as others, it is important to look beyond the statistics and to see help-seeking as a two-way street. Sometimes, inequalities in access arise because people don't trust the support on offer or judge that it is not for them. Some communities have lost trust in mental health services, either through fear of a coercive response or because they see them as irrelevant to their daily concerns of money, housing, isolation and safety.

Most policies focus on increasing supply of the type of services that already exist. While this is a necessary step to address the disparity between mental and physical health in the NHS, it is not sufficient to meet the needs of many people. And as a consequence, it is services, not the people they intend to serve, that need to change to make themselves more accessible, acceptable and appropriate to people's needs.

National policies and strategies to increase access to mental health support have successfully expanded what's on offer in many areas. But they have paid less attention to whether the existing offer is right for everyone. Despite the existence since 2011 of the Public Sector Equality Duty, inequalities in access to mental health support have remained under the radar, often unrecorded and unnoticed, and rarely prioritised.

A major gap in national strategies is a lack of focus on improving access to interventions to prevent poor mental health. Targeted ‘secondary prevention’ measures could have a particularly significant impact on mental health inequalities by reaching out to under-served or high-risk groups. Yet the provision of such interventions is largely left to chance at the national level.

Ideas for actions that could help to address inequalities in access to mental health support that have been shared with the Commission so far include:

Improve access to wider choice of flexible support:

Voluntary and community sector initiatives can offer well-informed, acceptable support that responds to the specific needs of communities through flexible help that aims to improve mental health and address the social determinants of poor wellbeing.

Prioritise links between statutory services and community organisations: Bridging between communities and mainstream mental health providers by offering a more acceptable gateway to services, built on trust and mutual understanding.

Invest in user-led and peer support groups:

Offering not just an alternative to professionally-led services but also a wider range of functions including training and consultancy for statutory bodies, advocacy and welfare rights, and research.

Commission and design services in partnership with the people who need them: This has benefits across public health, social care and NHS commissioning.

Adopt trauma-informed approaches: This means adopting principles that emphasise safety and that seek to avoid putting people at risk of experiencing or reliving traumatic events from their past.

Develop a workforce that more closely reflects the local population: As the NHS seeks to expand its workforce under the Long Term Plan, it has an opportunity to proactively reach communities and groups that are not well represented already.

Include equality measures in mental health service access standards: Including a range of equality dimensions in access and waiting time standards may help to identify groups that are not getting timely help and hold providers to account for addressing gaps.

Strengthen the Public Sector Equality Duty:

Establishing a stronger, rights-based approach to equality of access to health care may help to drive improvements more consistently across the country.

If the NHS Long Term Plan’s vision of a ‘whole population’ approach to mental health and the Government’s ambition to reduce health inequalities are to be realised, equal access cannot be left on the margins of mainstream policy or practice. It must be at the heart of efforts to improve health and care nationwide during the next decade.

INEQUALITIES IN ACCESS TO MENTAL HEALTH SERVICES

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006 set out a clear statement of the duty of states to:

“Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons” (Article 25, United Nations 2006)

Estimates for England suggest that only one in three people who experience mental health problems are able to access the support they need (NHS Digital, 2016). But, as with the determinants of mental health, access to mental health support is not equally distributed across the population. While there is no central repository of information which gives a breakdown of those who struggle to access services, published research and survey evidence highlights how certain groups of people face inequalities in accessing the right help at the right time. A small number of examples include:

- Black adults¹ are the least likely ethnic group to report being in receipt of medication for mental health, or counselling, or therapy (Cabinet Office, 2018)
- The National LGBT Survey (2018) found that 24% of respondents had accessed mental health services in the last year, but a further 8% had tried to get help and failed. The survey also found that a majority of those who sought help found it difficult, with long waiting lists and unsupportive responses from GPs cited as reasons for this
- Only just over a quarter (27.9%) of children and young people who experience both a learning disability and a mental health problem have had any contact with mental health services

- 85% of older people with depression receive no NHS support (Burns, 2015). Older adults account for only 6.5% of people who use IAPT services (PHE, 2019), although prevalence estimates suggest the proportion should be closer to 12% (Department of Health, 2011)
- People living in more deprived areas of England are more likely to be referred to an IAPT service by their GP but are substantially less likely to receive a complete course of treatment (Hodgson, 2019).

Inequalities in access are also experienced in terms of the type of support available, how it is accessed, and how people are treated.

For example, Black Caribbean men and women are more likely than other ethnic groups to be referred to specialist, acute, or compulsory parts of the system rather than being supported with their mental health in primary care (Bhui et al., 2018), and more likely to be admitted to hospital than white patients following a visit from a crisis resolution and home treatment team (EHRC, 2016). NHS figures demonstrate that there is a disproportionate use of restrictive interventions for ethnic minorities, particularly for Black or Black British groups who are four times more likely to be subject to the Mental Health Act than White British people, and eight times as likely to be given a community treatment order when they leave hospital (NHS Digital, 2019b).

There is also an important overlap, or intersection, between ethnicity and other social and economic factors in terms of mental health service access and experiences of coercion. Use of the Mental Health Act is notably higher in urban areas with increased deprivation and ‘ethnic density’, especially Black Caribbean, Black African, and Black British communities (Bhui et al., 2018). Among people from South

Asian backgrounds, meanwhile, rates of Mental Health Act use are far higher among Pakistani and Bangladeshi communities, who are amongst the lowest earners in the UK (Fernandez-Reino and Rienzo, 2019) than among Indian communities, whose earnings are on average significantly higher (Department of Health and Social Care, 2018).

Despite a general preference among older people for talking therapies, and recovery rates which suggest that IAPT is particularly effective for this group (NHS Digital, 2019a), older adults are six times more likely than younger people to be on medication for low level mental health symptoms, and some face further difficulties because of side effects and interactions with other medications (Frost et al., 2019; Dakin and Arian, 2013).

A major current gap in mental health support is the provision of services to people who are regarded as having needs that are too complex for IAPT but who don't meet local thresholds for secondary services. This affects not just a single

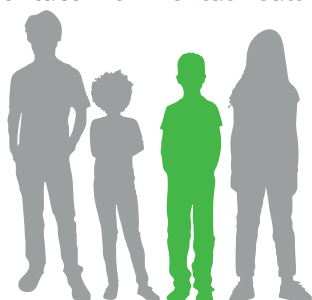
group but a mixed and varied range of people including those diagnosed with personality disorders or complex trauma symptoms, people with co-occurring drug or alcohol problems and people with persistent physical symptoms (Newbigging et al., 2018). There is anecdotal evidence that people who find themselves in this gap are more likely to be from economically disadvantaged or marginalised communities.

People using mental health services consistently say that they do not get access to the support they need – even once they have been accepted by a service. Surveys by the Care Quality Commission (2019), for example, note that a large proportion of people do not get help with physical health, money, housing and employment issues as part of their package of support. For example, 39% of those who wanted help for their physical health did not receive it and 46% of those who wanted help with money or benefits missed out. Young people making the transition from child to adult services can also find themselves excluded at this often difficult time in their lives.

85% of older people with depression receive no NHS support (Burns, 2015).



Only just **over a quarter (27.9%)** of **children and young people** who experience **both a learning disability and a mental health problem** have had any contact with **mental health** services.



People living in more deprived areas of England are **more likely to be referred to an IAPT** service by their GP but are substantially **less likely to receive a complete course of treatment** (Hodgson, 2019).

The Health Foundation: In deprived areas, patients referred for psychological therapy are less likely to receive treatment

Percentage of IAPT referrals that were treated, by deprivation decile (Index of Multiple Deprivation), 2018-2019

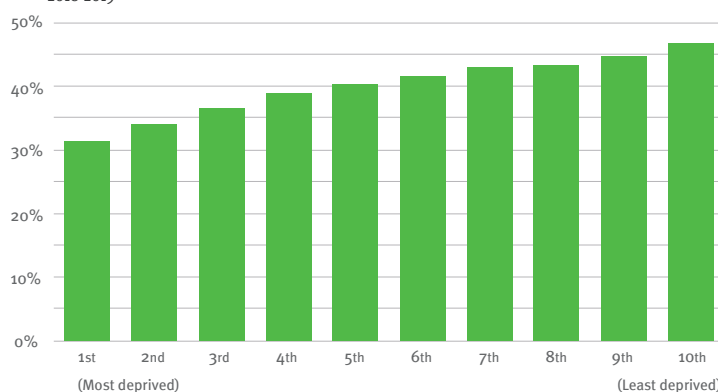


Chart adapted with permission from The Health Foundation

Source: NHS Digital <https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services>

WHAT MAKES SUPPORT DIFFICULT TO ACCESS?

System pressures

There can be no doubt that access to care is a challenge across the NHS and for social services nationwide. Poor initial access to health and care services has been identified as a major driver of poor quality care and poor outcomes (CQC, 2019b). As the Care Quality Commission observed:

“Too many people find it hard to even get appointments, but the lack of access is especially worrying when it affects people who are less able to speak up for themselves – such as children and young people with mental health problems or people with a learning disability. Too often, people must chase around different care services even to access basic support. In the worst cases, people end up in crisis or with the wrong kind of care.” (CQC, 2019b)

System pressures in health and care services are compounded by factors that are largely outside their control. When surveyed, more than two thirds of chief executives of NHS mental health trusts expressed concern about being able to maintain the quality of services. 92% said that demand for services addressing some of the most socially excluded groups was rising due to changes to the social security system, including the introduction of Universal Credit. Cuts to local authorities were seen to increase demand on the NHS by reducing the availability of preventative and early intervention services funded through the Public Health Grant, which has seen repeated cuts during the last decade (NHS Providers, 2019).

Grassroots organisations and initiatives, which are often well placed to support people in their communities, are suffering from a lack of direct funding and dwindling opportunities to work in partnership with local authorities due to austerity (McIntosh, 2019; Bell and Allwood, 2019).

User-led organisations have reported an especially dramatic fall in recent years (NSUN, 2019). While NHS funding has been protected relative to other areas of public spending during the last decade of austerity, concerns have been raised that this is distorting the whole system, creating a vicious cycle that is placing ever greater reliance on health services while others wither:

“Slowly but surely health care is eating other public services...Expenditure on health care in Britain has risen from 25% of public expenditure to 40% in two to three decades.” (Smith, 2019)

Overall demand for health services continues to grow year on year, with particularly noticeable increases in demand for mental health (and especially children’s mental health) care. This may be the result of both a steady rise in the prevalence of mental health difficulties, particularly among young people, and a growing readiness to seek help for mental health problems. As capacity in mental health services has not increased to accommodate growing demand, providers have sought ways of managing this trend, for example by increasing thresholds for care or reducing the intensity of contact people get from community teams.

Daily pressures on a stretched workforce operating at capacity, especially in primary care, can mean that GPs and their colleagues lack time in appointments to discuss potentially complex mental health issues.

“I have anxiety and depression, but it’s taken several visits to the GP to discover this.” (from Harper et al., 2019a).

Some GP surgeries explicitly limit appointments to single issues, making it less likely that mental health difficulties will come to the surface during consultations about physical health problems. Long waiting lists are cited as a major issue for some groups (e.g. National LGBT Survey, 2018; Embracing complexity, 2019) although these are of course also experienced by service users more widely and data on waiting times does not provide information about inequalities in access.

Gaps in support may result from unclear commissioning arrangements or from thresholds for services that ignore complexity of need. A Centre for Mental Health project supporting former prisoners into employment, for example, found that just nine out of 63 prisoners who were using specialist mental health inreach services in prison (for which high levels of need are commonplace) were later accepted onto the caseloads of community mental health services. Most of the remainder were receiving no help for their mental health needs after they were released. This may be a result of poor communication between prison and community mental health services, or assessment systems that excluded offenders or people whose needs are more complex, either directly or because they had nowhere to live (Durcan, 2018).

Lack of acceptable, appropriate services

Unequal access to mental health support is about more than services not being easy to reach by people from disadvantaged and marginalised groups. For many, it is also about the nature of the services that are provided. Accessibility requires not just geographical proximity and availability, it also requires those services to be acceptable and appropriate to people's needs. They need to speak people's language, to be relevant to people's lives, to be culturally and historically sensitive, and to be respectful and understanding of the experiences and struggles people have gone through.

There is growing recognition, for example, that a trauma-informed approach is vital to engaging and maintaining relationships to the large proportion of people with mental health difficulties who have experienced violence, abuse and other traumatic events in their lives. Where the care on offer does not feel safe, secure and respectful, it risks not just being inaccessible or ineffective, but also perpetuating a cycle of trauma (Wilton and Williams, 2019).

“Don’t they read my notes? It’s traumatising me every time I have to tell them about me.”
(Woman commenting on the experience of using a secondary mental health service, Wilton and Williams, 2019)

“...you can’t build up trust if the faces keep changing...and it’s risky to build up trust if you can’t be sure they will be there next time.”
(Wilton and Williams, 2019)

People from communities that have experienced major upheaval and crises are often under-served by mental health services. Services must respond to child and adult experiences of severe loss and disruption caused by war, civil unrest, persecution and natural disasters which are present in the lives of people from Eritrean, Nepalese, Syrian, Somali, Tamil and other communities (McIntosh et al., 2019; UNHCR, 2016). The Commission received evidence about the lack of support offered to refugee children, even where serious concerns about their wellbeing have been raised and experience of traumatic events overseas is recognised. Despite these circumstances, these children's needs are often considered below the threshold for NHS children and young people's mental health services (written submission from Migration Yorkshire, 2019).

While an awareness of trauma is important, so too are issues of faith, culture and language, and social factors such as loneliness, poverty, and stress around immigration status. Understanding and adjusting to these circumstances, and recognising people's strengths and abilities, is critical in supporting survivors of traumatic experiences to feel comfortable in communicating their distress and accessing support. 'Cultural competency' is not just about translating different languages – something not always possible for mainstream services in very diverse populations – but about training, building networks between services, community involvement and understanding where mental health interacts with other needs as part of a holistic approach:

Cultural competence is not a finite collation of testable knowledge, rather it is a skill set that takes time to master and requires developmental experiences that improve engagement with narratives of patients, sitting alongside evidence-based medicine and healthcare. (Bhui, 2018).

Young people have been found by the Care Quality Commission (2019b) to have particular difficulties getting early access to mental health help. Healthwatch England (2020) found that young people believed that if they asked for help with their mental health they would be dismissed as a 'hormonal teenager', that teachers were only concerned about their mental health if it affected their school grades, and they were worried that anything they told a mental health professional would not be treated in confidence.

Some of the most excluded and vulnerable young people report some of the most negative experiences of services that too often regard them as 'hard-to-reach', despite the fact that many have extensive but often unhelpful contact with a range of public services and

professionals. Experiences of help accessed through health, police, or school are often 'pathologizing, punitive, and temporary' (Stubbs et al., 2017), leading to an adversarial and damaged 'relationship to help' (Reder and Fredman, 1996).

"It breaks down trust, when people like teachers, like society, the media... tell you you're no good. It breaks down trust. And we've got to work on building that trust 'cos young black men believe it...they believe it. That's what they think they are – no good." (Young man, focus group, Khan et al., 2017)

The lack of an acceptable, trusted gateway to support, and a paucity of services offering the right support in the right way, are key barriers for marginalised young people, particularly those on the edges of the criminal justice system, to accessing services. A young person giving evidence to the Commission described how "services all look the same" from the perspectives of marginalised young people:

"Once you've been failed in one part of the system...forget about it... They don't care about me. If I don't feel safe, I'm not going there."

The absence of appropriate support also faces people with some types of mental health condition – most notably those diagnosed with personality disorder. A recent position statement from the Royal College of Psychiatrists (2020) stated that while the diagnosis of personality disorder is controversial, the absence of effective support for people experiencing distress was a major omission from mental health services in many areas. It concluded, for example, that primary and community services for people with a personality disorder were lacking in many local areas and very limited in capacity in others.

‘Complex needs’

People experiencing severe and multiple disadvantage can find it hard to access mental health support because their other needs act as barriers.

For example, rough sleepers with mental health needs can find it harder to access housing support due to their mental health problems, and harder to access mental health services while they are on the streets – one circumstance exacerbates the other when experienced simultaneously. The number of people with an identified mental health support need recorded as sleeping rough more than tripled between 2009 and 2015 (St Mungo’s, 2016). Although new models, such as Housing First, are being trialled to address this trend, provision of targeted support is patchy and the adoption of Housing First principles in mental health services has so far been slow (Allwood, forthcoming).

People with co-occurring alcohol or drug problems alongside poor mental health also find themselves turned away from support as a result of this complexity, despite its association with a wide range of adversities including physical illness, homelessness and domestic violence (Centre for Mental Health and Institute of Alcohol Studies, 2018). Whether this is due to discriminatory entry thresholds for services or a lack of confidence among practitioners, it creates a major barrier to help for people with high levels of distress and exclusion.

Poor access to mental health support for people with autism and learning disabilities has been highlighted by the Care Quality Commission (2019b) as being of especial concern, with a lack of community-based support leading to people reaching a crisis that leads to long-term hospitalisation. Research into mental health support and learning disabilities revealed that diagnostic overshadowing – where one condition is seen as a primary support need at the expense of others – leads to many young people with

learning disabilities not receiving the help they need for their mental health, despite having a much higher risk than the general population (Lavis et al., 2019). Elsewhere, people receiving diagnoses of autism have lost the support of mental health services and GPs due to being seen as ‘too complicated’ or ‘complex’ for treatment (Hallet and Crompton, 2018).

“My daughter went through CAMHS at around 14 with severe anxiety in at school. We were told there would be no treatment, because ‘autistic people ARE anxious’.” (Harper et al., 2019b)

A similar picture has been established in studies of neurodiversity more broadly. One study found that 40% of people with neurodevelopmental conditions could not access mental or physical health services because their additional support needs weren’t met to help them access help (Embracing Complexity, 2019).

Help-seeking behaviours?

Explanations for why some groups of people have less access to mental health support have often attempted to locate the problem in the help-seeking behaviours or other characteristics of the group itself.

Hence, men are believed to seek help less frequently than women, and there is evidence of a lower level of recognition of depression among men who may also present their distress in different ways to women (for example through aggression or substance use), leading to missed diagnoses and appropriate support not being provided at the right time (Fronimos and Brown, 2010; White et al., 2011; BPS, 2019). A survey of Polish adults living in the UK found that, while half were likely to have a diagnosable mental health problem, only 16% had sought mental health support, with men less likely to have sought help than women (Gondek, 2018).

In understanding the reasons some groups of people do not seek help as readily as others, it is important to look beyond the statistics and to see help-seeking as a two-way street. In other words, it is services, not the people they intend to serve, that need to change to make themselves more accessible, psychologically as well as geographically.

For example, a fear of psychiatry and associations of mental health services with institutionalisation may be a factor in why only a minority of older adults with depression discuss their symptoms with their GP (Strachan et al., 2015). This may combine with an observed fatalism among health professionals about a supposed inevitability of poor mental health in later life. For older adults who are LGBT+, historical experiences of oppression, discrimination and harassment (including the use of ‘conversion therapies’) may also feed into a distrust of services (Semlyen et al., 2016). And women experiencing poor mental health after the birth of their child have described a fear of being judged as an unfit mother and, at worst, of having their babies taken from them (Khan, 2015).

There is also longstanding evidence that in African and Caribbean communities, mistrust of mental health services comes from a fear (backed up by statistics) of being at greater risk of being sectioned and subject to coercive treatments – mirroring wider experiences of oppression from the state in this community (Keating et al., 2002).

“Once you talk to those types of people [mental health professionals], you don’t know how they’ll take it, they might deem you unwell and section you and then medicate you...” (Young person, Stubbs et al., 2017)

Both historical and contemporary experiences of the use of force and the tragic deaths of young men such as Olaseni Lewis following the use of restraint in police custody or in hospital have a profound impact on entire communities.

Cultural perspectives on mental illness can make it difficult for people to discuss mental health needs directly at a first appointment. ‘Somatisation’ – the presentation of mental distress as a physical symptom – is thought to be higher amongst refugees, asylum seekers, and some migrant communities. The effects on individuals as services seek to diagnose the causes of unexplained physical complaints can be detrimental: multiple referrals, scepticism, and over-investigation by unknown practitioners can be emotionally draining and increase the anxiety people experience around their own health and interaction with the health system (Fassil and Burnett, 2015; written submission from Migration Yorkshire).

Referral systems and processes

The ways people are engaged by services has a profound impact on whether they actually receive the support at all and what experiences they have of it. Referral systems in the NHS may, sometimes unintentionally, exclude some groups of people – for example where services have criteria or thresholds for acceptance that directly or indirectly discriminate (including because of co-occurring alcohol or drug use or lack of a home address). Referral processes can also be long and complex, making it more difficult for some to navigate the ‘maze’ and creating practical or psychological barriers to support. Services which operate open access or peer referral practices, and those that enable people easily to ‘come back’ without having to start from first base of referral, may overcome some of these obstacles. This can, however, be challenging to implement in a gatekept system such as the NHS or one that involves means-testing such as in social care.

Solutions may be found in the principles of the INTEGRATE approach, which was developed in London by MAC-UK:

- Putting engagement at the forefront of the service – requests for support are responded to but relationship-building is the priority;
- A peer referral system, which encourages young people to bring their wider peer group into contact with the service;
- Building mutual trust between young people and staff members, achieved in part by employing people from the peer group as peer supporters;
- A service delivered wherever young people are – i.e. in the streets or in safe community spaces – and support which isn't bound by formal appointment systems;
- A multi-disciplinary staff team offering flexible, holistic support (e.g. therapy, advocacy, and employment/benefits advice) that responds to multiple risk-factors; and
- Co-producing activities with young people, taking a strengths-led approach that focuses on what young people can do rather than what they can't. (Durcan et al., 2017)

Communication barriers

Communication barriers can have a significant impact on access to mental health support. Poor communication can prevent people from knowing about support in the first place or make it less likely that someone's needs will be identified and then met when they seek help.

People from communities whose first language is not English can face significant linguistic barriers to accessing treatment, and there is often no provision to enable them to access services:

“As I don't speak English well, I need an interpreter, but when asked I wasn't provided with one. There have been cuts to such services.

I have stopped asking for interpreters now and usually one of the family members come with me to appointments.” (Female user of the Tamil Community Centre, McIntosh et al., 2019)

The lack of skilled interpreters in GP surgeries and hospitals is a major obstacle to communicating symptoms and preferences around issues which may already be difficult to talk about. For migrant groups, this can be compounded by a lack of knowledge of the services on offer, a lack of community experience navigating complex care systems, and less awareness around having the right to access services (McIntosh, 2019). Those with irregular immigration status can also face a 'hostile environment' with fears around detention and deportation exacerbating existing difficulties in getting access to support (Refugee Council, 2017). Where GPs do not accept people without a home address, this can create an additional barrier.

Communication can be a barrier to access for other groups, too. For autistic people or people with learning disabilities, time-limited appointments and poor understanding among practitioners of their needs can make it more difficult to access the right support. Autistic adults require more time in appointments to process and respond to information, to manage the emotional impact of fear and stress, and to cope with sensory issues inherent in most health care facilities (Raymaker et al., 2017). Telephone based appointments or booking processes can also be challenging (Hallet and Crompton, 2018).

There are multiple barriers to accessing mental health support for deaf people. Without specialist interpretation services, or mental health practitioners who can use British Sign Language or know how to communicate with someone who lip-reads, deaf people may have to rely on family members to communicate with professionals (All Wales Deaf Mental Health and Well-Being Group, submission to the Commission for Equality in Mental Health).

Advocacy services have been noted to provide a bridge between mental health services and marginalised groups. Current statutory provision for Independent Mental Health Advocacy is limited to people already being treated under the Mental Health Act, but many voluntary and community advocacy services can go further in helping to overcome communication barriers earlier in people's contact with health and care services.

Data and monitoring

A lack of robust data and monitoring around access to services stymies efforts to address inequalities. A report by the Equality and Human Rights Commission concluded that:

There continue to be stark disparities in the way some protected characteristic groups experience healthcare...A lack of data and published evidence continues to limit the ability of health services across the three countries to respond to their needs. People with protected characteristics (other than age or sex) and at-risk groups remain excluded from a range of national local monitoring data. (EHRC, 2018)

Trying to understand the interconnection between different layers of identity can be especially difficult. For example, the Adult Psychiatric Morbidity Survey reports by age, gender or ethnic group but doesn't segment its analysis based on multiple factors and it packages many different ethnicities under group headings – this makes it challenging to understand what is happening nationally for groups (NHS Digital, 2016; Clark et al., 2018). Likewise Mental Health Act data provides some information about rates of detention by gender, age and ethnicity, but with little detail beyond the headline figures (NHS Digital, 2019b). This masks overlapping inequalities: for example

making it difficult to compare rates of detention among men and women of different ethnicities or in specific areas.

Some identities are excluded almost entirely from national datasets. The Irish community, for example, is aggregated into the 'white' category in some datasets, limiting the amount of relevant evidence available for service planning despite evidence of high levels of mental distress in this community (Ryan et al., 2006). (The same is likely to be the case for Gypsy, Roma and Traveller communities and people from Eastern European countries who are also invisible in most data sets.) Perhaps as a consequence, most local strategies don't make any mention of the mental health needs of Irish people (written submission from Irish in Britain, 2019; Walsh, 2014). There are similar gaps in relation to data about disability: both in terms of access to mental health support and access to wider services for people with different impairments, including mental health difficulties.

Data and monitoring can be lacking even in areas where a high prevalence of mental health problems is well evidenced. For instance, there have been no official figures for the number of people in prison in England and Wales who have a mental health condition since 1997, since which time the population has doubled (National Audit Office, 2017c; EHRC, 2018).

POLICIES DESIGNED TO INCREASE ACCESS TO MENTAL HEALTH CARE

Access to mental health care is now a major political issue. In the last decade, as mental health has become more of a political priority, the difficulties people have faced in getting help for their mental health have become a key policy concern.

National policies in relation to mental health have focused on both the availability of mental health services to meet growing demand and on the timeliness of mental health treatment. Recent policies that have sought to address shortcomings in access to mental health support in England include:

Improving Access to Psychological Therapies

(2008 onwards): the IAPT programme was designed to provide people with anxiety and depression access to psychological therapies close to home. IAPT now provides therapy nationwide to around a million people each year. Most people receive cognitive behavioural therapy (CBT) either individually or in groups, and in some local areas it can also be accessed online.

The Crisis Care Concordat (2013): this initiative aimed to improve responses to mental health emergencies. It was motivated particularly by concerns about the use of police stations as ‘places of safety’ in the Mental Health Act and the poor quality of care (and in some cases risk to life) many experienced. The Concordat required local health, social care and police services to work together to develop improved support in a crisis and spurred the development of more hospital-based places of safety and ‘street triage’ schemes.

Improving access to mental health services by 2020 (2014): the first specific access and waiting time standards for NHS mental health services in England were introduced in 2014. These aimed to bring about parity between mental and physical

health services, overcoming the ‘institutional bias’ that disadvantaged the former. The first standards applied to psychological therapies for adults and to treatment for a first episode of psychosis. The stated aim was to expand out to other areas of mental health care over time as clinically agreed standards were developed.

The Five Year Forward View for Mental Health

(2016): NHS England’s strategy for mental health services sought to increase the availability of mental health services, reduce waiting times for support and improve the quality of care they offered. Implementation of the strategy focused on areas where specific new or expanded services were required, for example specialist perinatal mental health provision, liaison psychiatry in general hospitals, early intervention in psychosis teams, and crisis resolution and home treatment.

Transforming Children and Young People’s Mental Health Services (2017 and 2018):

this green paper and subsequent consultation response focused on mental health support within schools and pledged to develop Mental Health Support Teams to help schools to manage children’s mental health more effectively and provide better links with local CAMHS. It also promised to test out a four-week waiting time target for CAMHS.

The NHS Long Term Plan (2019): the Long Term Plan pledged further investment in mental health services and for the first time since The NHS Plan in 2000 (which enabled the implementation of parts of the previous year’s National Service Framework for Mental Health) ringfenced funding for this. The Long Term Plan extended many of the initiatives in previous strategies, but its biggest ambition was to expand and improve community mental health services for people with a severe mental illness. It also pledged to set up some specific services, for example for people who are sleeping rough and for problem gambling.

All of these strategies sought to bring about more equal treatment for mental health (i.e. to be on a par with other health services) but there was much less of a focus on tackling inequalities in access between different groups of people.

Addressing unequal access to mental health support has largely relied on the retrospective use of data collection to encourage local service providers and commissioners to address gaps in access. The IAPT programme, for example, requires providers to collect data on the proportions of people they see who are from BAME communities or who are over 65. Local NHS commissioners are able to use incentive payments to nudge providers towards greater coverage of these poorly served groups. But this is not mandatory.

For the most part, national strategies and policies have assumed that the key task is to increase the

supply of what is already being provided; that we mostly need more of the same in order to close the very wide gap between need and provision. While this is an understandable response to the evident need to increase access to mental health support for the whole population, it leaves no room to question whether the existing offer is right for everyone's needs or if something different is required.

More recently, however, NHS England's Community Mental Health Framework (NHS England, 2019b) has signalled a greater focus on equality of access to services for some groups of people – for example those diagnosed with personality disorder or with co-occurring substance misuse. It is hoped that this will meet previously unmet needs and close the gap between primary and secondary care. This could perhaps trigger a more determined and sustained focus on equity of access in local areas.

IDEAS TO IMPROVE ACCESS FOR PEOPLE WHO EXPERIENCE INEQUALITIES

Community-led initiatives

Improve access to wider choice of flexible support:

Lack of trust, scepticism of the suitability of help on offer, and a perceived lack of understanding of community experiences can all influence whether people access statutory mental health support. Voluntary and community sector initiatives can offer well-informed, acceptable support that responds to the specific needs of communities through flexible help that aims to improve mental health and address the social determinants of poor wellbeing (Bell and Allwood, 2019). Peer support, help with employment or money problems, and skills development opportunities, often delivered in creative ways (for example in the Up My Street programme, Khan et al., 2017), can be more approachable and desirable than clinical or therapy-based interventions, and often work alongside them to provide a more holistic approach to people's needs.

Prioritise links between statutory services and community organisations:

there are several benefits to improving the ways in which statutory services and communities interact. Doing so brings significant value in bridging communities and mainstream mental health providers by offering a more acceptable gateway to services, built on trust and mutual understanding (Crawford et al., 2011). By working with community stakeholders and grassroots organisations, mainstream providers can also develop their staff teams' skills and awareness – learning, for example, how to avoid using terminology which might offend or alienate participants. One approach which has been evaluated positively is the training of Church pastors in Wandsworth in family therapy techniques, enabling them to combine their knowledge of faith and community with training in a psychological intervention that they could practise in a 'safe social space' (Burgess & Ali, 2016). This approach brought

together statutory services with community leaders and provided a ‘bridging’ function between the two on equal terms (ibid).

Invest in user-led and peer support groups: The importance of relating to people within their own frames of reference and understanding of their challenges – of speaking their language – cannot be over-estimated. Peer- and user-led organisations and services can do this in a distinctive way, offering not just an alternative to professionally-led services but also a wider range of functions including training and consultancy for statutory bodies, advocacy and welfare rights, and research. The National Survivor and User Network (NSUN, 2019) last year estimated that more than a quarter of its member organisations had closed in the previous two years, putting this important source of mutual support at risk.

Local and regional systems

Commission and design services in partnership with the people who need them: Involving communities and individuals in designing, planning and making decisions about the services they are offered as equal partners can help to reach groups who have previously found those services unhelpful, unfriendly or irrelevant to their needs. This should include reviewing and revising referral systems to prevent the exclusion of people who are deterred by existing processes. It has benefits across public health, social care and NHS commissioning, among others (Davie et al., 2018).

Adopt trauma-informed approaches: services that are trauma-informed have been found to meet people’s needs more effectively. Being trauma-informed means adopting principles that emphasise safety and that seek to avoid putting people at risk of experiencing or reliving traumatic events from their past. This is particularly important for women, who are more likely than men to have experienced violence and abuse and for whom it has a bigger impact on mental health (Wilton and Williams, 2019).

Trauma-informed principles can apply across a range of public services, for example in schools and Women’s Centres, not just health and care (Bear et al., 2019).

Ensure people with ‘personality disorder’ are not excluded from mental health services: As the NHS Long Term Plan is implemented, community mental health services need to ensure that they are reaching people who have previously found themselves excluded because of a personality disorder diagnosis (NHS England, 2019b). Recent guidance from the Royal College of Psychiatrists (2020) may help to support this process in local systems.

Communicate effectively and proactively: services need to be proactive in ensuring that they are available to the communities they aim to serve, including adaptations to reach out to groups that might otherwise not know about them and working closely with universal services such as general practices and schools that can help to facilitate access to more specialised support. This can be challenging for services that are already working at or above their capacity under intense pressure. But without a proactive approach, they are likely to be exacerbating inequalities by creating barriers to all but the most determined and articulate help-seekers. Independent advocacy services that go beyond the statutory role set out in the Mental Health Act may help to facilitate this more proactive approach.

Adapt mental health support for disabled people: including people who are deaf, those with learning difficulties and disabilities and autistic people, of all ages. For deaf people, for example, this may mean training staff in the use of British Sign Language and how to communicate with someone who lip-reads, or providing specialist interpreting or counselling services. As with other groups, solutions should be coproduced with disabled people locally according to their needs and wishes.

Develop a workforce that more closely reflects the local population: the mental health workforce is diverse and complex, but it is not always reflective of the communities it serves, particularly at higher levels in clinical services or in management. As the NHS seeks to expand its workforce under the Long Term Plan, it has an opportunity to proactively reach communities and groups that are not well represented already. Growing use of peer support and mentoring roles allow mental health service providers to draw directly from the people they serve and challenge the longstanding power imbalance between professionals and people using services. Reaching out to schools and colleges locally to young people to train in a range of mental health roles and professions may also help to bring about a longer term shift in the workforce (Durcan et al., 2017). This requires cultures that are truly inclusive, recognising the value of diverse contributions to achieving better outcomes and creating workplaces that support the wellbeing of their staff. The Workplace Disability Equality Standard could provide a framework for organisations to reach out to people with mental health difficulties and other impairments and make their workforce more representative of the communities they seek to serve.

Transform the skillsets of the workforce: The workforce, collectively, also needs skills that focus not just on treatment, but on engaging people on their own terms and supporting them to pursue their own goals in life, navigating systems as needed – to form relationships, seek employment, and get involved in communities. This suggests a need for workforce transformation. IAPT and CMHTs do not routinely enable people to achieve their life goals; if they did, they would by definition be more personalised to diverse people's aspirations and would thereby build greater trust.

Use the Public Sector Equality Duty as a framework to re-think commissioning and build local systems for equality: Primary Care Networks and Integrated Care Systems are developing now and influencing the shape of local health and care services. Drawing on the Public Sector Equality Duty could help them to foster collective action and shared determination to address inequalities in access

that have become entrenched and unresolved through previous generations of NHS reform and reorganisation.

National policies

Include equality measures in mental health service access standards: access and waiting time standards are relatively new to NHS mental health services in England but they are being extended under the NHS Long Term Plan. Including a range of equality dimensions in such measures may help to identify groups that are not getting timely access to help and hold providers to account for addressing gaps.

Set out clear expectations about support for people with 'complex needs': support for people with co-occurring conditions continues to lag behind. People whose combined needs are significant but who do not fit easily into a single service silo experience some of the poorest care and support despite facing major challenges in their lives. National leadership is essential to set a clear expectation for local services and to hold them to account.

Strengthen the Public Sector Equality Duty, including core objectives in health and social care services to improve equality of access: Establishing a stronger, rights-based approach to equality of access to health care may help to drive improvements more consistently across the country. This could include placing a greater requirement on health and care service commissioners and providers to take proactive, strategic steps to bring about equality of access, rather than simply requiring them to give 'due regard' to the duty.

Improve access to mental health support in prison and probation services: The Government should ensure that funding for prison mental health services is sufficient to meet levels of need and that all prisons become trauma-informed environments. Released prisoners and people on community sentences also need access to mental health support.

Develop a comprehensive new alcohol strategy including access to mental health support: People with alcohol problems have very high rates of poor mental health but frequently are excluded from mental health services (Centre Mental Health and Institute of Alcohol Studies, 2018). The Government should create a new alcohol strategy which would include clear expectations about the provision of integrated help and support.

Review equality data in mental health and related services: the independent Mental Health Act Review (Wessely et al., 2018) said the Government should ensure that data about ethnicity be collected and recorded more robustly and that it be used to inform improvement in services. This would be helpful across all dimensions of inequality, including socio-economic status, disability and gender, to help providers to know how far they are meeting people's needs and which groups are getting less access to support than would be expected.

CONCLUSION

Inequalities in access to support were the most common topic of responses to the Commission's call for evidence. Getting to grips with the question of why groups of people with the highest risks and the poorest mental health often get the least access to help is crucial to understanding how to reduce mental health inequality.

The evidence we have reviewed points to the conclusion that national mental health policies to date have failed to address inequalities in access to support, and in some cases have not even tried. Despite clear and compelling evidence of deeply entrenched inequalities, little action has been taken to tackle them. The evidence instead points to serious gaps – where distinctions between 'deserving' and 'undeserving' block access to mental health support, where complexity is used as a reason to exclude rather than include, and where the services on offer are simply not relevant or safe for those who most need them. However, we have also found examples of community-based initiatives – and partnerships between communities and statutory services – that show that a different approach is possible. Such approaches need to become the norm rather than the exception, even if they look very different from one place to another.

If the NHS Long Term Plan's vision of a 'whole population' approach to mental health is to be realised, this cannot be left on the margins of mainstream policy or practice. Without a much more explicit and concerted focus on inequalities, we will have missed an important window of opportunity to change the way public services support people's mental health at a time of growing investment (in the NHS at least) in the next decade.

To do this, we need policies and practices that put fair access to mental health support first, not last, on the agenda. We need to see services being developed that will meet the needs of groups and communities that have been left behind and are currently poorly served in terms of mental health support. These may be very different to what has been offered before: they may need to look very different, feel very different and be coproduced with the people they seek to serve with a workforce that understands and addresses inequalities. And we need to ensure that service commissioners and providers are both sufficiently funded and fully held to account for reducing inequalities as part of their overall mission to increase access to high quality mental health support.

Equality should not be incidental to the NHS's ambitions; it must be at their heart as one of its founding and most important values.

ABOUT THE COMMISSION

The Commission for Equality in Mental Health was set up by Centre for Mental Health in 2018 with an 18-month mission to investigate inequalities in mental health in the UK and produce policy and practice proposals to tackle them.

The Commission is chaired by Liz Sayce and includes members with personal and professional knowledge and expertise about mental health inequalities. It issued a call for evidence at the start of 2019 and has received about 100 responses from across the country. The Commission sought evidence from as wide a range of people and places as possible, from published academic papers to narratives from groups and individuals. We particularly welcomed evidence from people and communities that experienced mental health inequalities first hand.

The Commission is seeking to understand why and how inequalities in mental health happen, the ways they manifest, and most importantly what can be done to prevent or mitigate them. Our call for evidence sought evidence about inequalities in the determinants of mental health (the factors that have an influence on how good or poor our mental health is during our lives), in access to help (of all kinds) for our mental health, and in the outcomes that people get when they receive support.

The Commission has particularly sought solutions to mental health inequalities. It is interested in solutions at every level: from community-led initiatives that seek to challenge power or resource imbalances locally to national policies that could help to make mental health more equitable.

The Commission's ultimate aim is to bring about a significant and sustained reduction in mental health inequalities. This is the second of three briefing papers from the Commission. The third will focus on inequalities in experience and outcomes from mental health support. We will publish a final report later this year that will set out our recommendations for what a system designed for equality should look like.

The Commission was generously funded by the Elliott Simmons Memorial Trust. We are grateful for their support in enabling us to carry out this important piece of work.

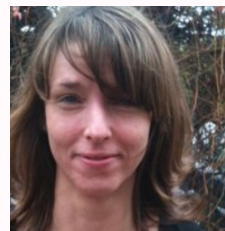
Members of the Commission



Liz Sayce - Chair



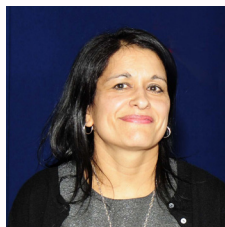
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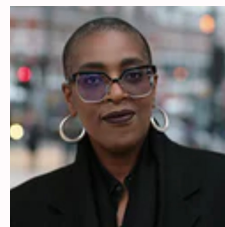
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Commission for Equality in Mental health

Briefing 2: Access to mental health support

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