

Addressing health inequalities:

Developing a better understanding of physical health checks for people with severe mental illness from Black African and Caribbean communities

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Executive Summary

This project aimed to address health inequalities by developing a better understanding around the awareness of and attendance to physical health checks (PHC) for people with severe mental illness (SMI) from Black African and Caribbean communities.

An initial scoping of the literature demonstrated a lack of detail around whether PHCs are accessible and appropriate for this population. It also demonstrated the need for direct engagement with this group to hear their experiences and views. Through partnering with three Black African and Caribbean-led voluntary organisations, engagement took place with 34 people they support and 12 members of staff.

The main points which arose from consultation with people with SMI included: a variation in awareness of PHCs, with significantly lower awareness in some locations; a lack of engagement from health professionals with regards to discussing PHCs and why they are important; and what measures could be implemented to support people to attend PHCs.

The focus groups with staff corroborated some of these findings, particularly the mixed levels of awareness of PHCs and the need for more information sharing around what PHCs are and why they are important for people with SMI. They revealed a number of challenges around take-up of PHCs, including accessing primary care due to stigma, difficulties making appointments and substance use. The role of the voluntary organisation was also discussed; with their specialist knowledge they are well-placed to bridge the gap between themselves, the people they support and statutory services. However, poor communication and lack of funding meant this avenue was not being explored effectively in all areas.

Lastly, a lack of cultural awareness and fears of being sectioned again meant people were apprehensive about using services. Throughout these engagements, several recommendations were suggested by people and staff, many of which focus on improving awareness and supporting attendance.

Introduction

Severe mental illness (SMI) is a term used to refer to people who have psychological problems, including schizophrenia and bipolar disorder, which can be so debilitating it can severely impair their ability to engage in functional and occupational activities (Public Health England (PHE), 2018). Evidence shows that Black Caribbeans in the UK have a particularly high level of schizophrenia and Black African and Caribbean communities have a higher occurrence of psychosis (Pinto et al., 2008; Qassem et al., 2015; Nazaroo et al., 2020). Factors such as deprivation, poor housing, unemployment, racism and discrimination, social class and social exclusion have been shown to increase risk of mental ill health, and are areas of inequality that are more pronounced among some Black, Asian and minority ethnic communities (Bignall et al., 2019; Pinto et al., 2008). Persisting levels of economic, social and geographical inequalities contribute considerably to ethnic inequalities in health outcomes, including SMI; economic and social disadvantage has been identified as a root cause of increased risk of psychotic illness among Black people (Nazaroo et al., 2020).

People with SMI experience health inequalities which have been exacerbated by Covid. It is well established that they have poorer physical health than the general population and can die up to 20 years prematurely (Chesney et al., 2014; Hayes et al., 2017). People with SMI are more likely to have diabetes, COPD, asthma, obesity, coronary heart disease and stroke, and are more likely to have comorbidities than the general population (PHE, 2018). Smoking rates are high among this group which is one of the more significant causes of poorer health (NHS, 2016). Over time, there has been an increase in the prescription of antipsychotic medications, which also increases the risk of certain health conditions such as obesity and diabetes (Correll et al., 2011; Holt, 2019; Reilly et al., 2015). Diagnostic overshadowing is reported as a potential barrier to physical health care, contributing to health inequalities for people with SMI. This is when symptoms of a physical illness are attributed

to the person's mental illness or side effects of medication leading to under or delayed diagnosis (Nash, 2013; Rodgers et al., 2018). Recent research shows people living with the co-morbidity SMI and diabetes, and staff supporting them are not always able to distinguish between the symptoms of SMI and diabetes, it recommends interventions to help with this (Bellass et al., 2021).

Physical Health Checks

In January of 2022 mental health leaders circulated a letter to integrated care system (ICS) leads, chairs and community mental health chief executives, to warn of the impact of Covid on widening health inequalities, and to urge primary care teams to prioritise physical health checks (Townsend, 2022). PHCs - an intervention by the NHS to detect early signs of physical ill-health - are for all people on the SMI register and are incentivised within the Quality Outcomes Framework (British Medical Association (BMA) and NHS, 2021).

Physical health check core components ([NHS England, 2019](#)):

- Blood pressure and pulse check
- Weight measurement - body mass index
- Assessment of smoking status
- Assessment of alcohol consumption
- Blood glucose test
- Blood lipid including cholesterol test

Additional elements of a comprehensive physical health check:

- Assessment of nutritional status, diet and level of physical activity
- Assessment of use of illicit substance/non prescribed drugs
- Medicines reconciliation or review

In addition to the above, PHCs, which may be delivered in primary or secondary care, should include relevant national screening and immunisation programmes (as recommended by PHE) (NHS England, 2018). There should be a follow-up to the PHC that involves the creation of a personalised care plan where necessary. This should address the full needs of the patient; for example, taking steps to combat loneliness, isolation, and provision of wider engagement in self-care, exercise, healthy eating, and lifestyle (NHS England, 2018). Follow-up should occur over the 12 months following the health check to ensure that patients are able to self-manage their conditions effectively.

There are several ‘how to’ toolkits and guides on PHCs and physical health for people with SMI published by CCGs and NHS Trusts. For example, the [NHS RightCare Toolkit](#) offers ‘expert advice and guidance to support system wide improvement to help improve physical health for people with severe mental illness (SMI) and reduce health inequalities’. However, very few go into detail about how they will work to address inequalities experienced by Black African and Caribbean people with SMI, or other minority ethnic groups.

An ambition of the Long Term Plan (NHS, 2019) is to see a total of 390,000 people with SMI receive a PHC by 2023/24. In 2022/23, 227,076 out of 522,000 people on GP SMI registers, nearly 45%, were in receipt of all six elements of the health check in the 12 months to the end of 2022/23 Q1 (NHS England, 2022a). Checks of smoking status, blood pressure and BMI weight were most commonly performed, with alcohol and blood lipids being less common. Although Clinical Commissioning Groups (CCGs) are required to collect data on the additional elements of a comprehensive health check listed above and report on the delivery of appropriate follow-up interventions and access to national screening, it is for monitoring purposes only and not made publicly available.

The NHS also offer a free general health check to all individuals aged between 40-74 without a specific health condition every five years. A study was recently completed (Patel et al., 2020) to

show evidence of uptake. In England, between 2012 and 2017 nearly one million people were offered a health check, of which just over 50% were completed. Those offered closely resembled the ethnic makeup of the general population, except an underrepresentation of White and Black Caribbean ethnicities. The study found that people attending the checks were more likely to be women and older, and ethnicity and deprivation were similar compared with non-attendees. However, without further breakdown to identify whether Black African and Caribbean people with SMI are attending, alongside limited available data on follow-up interventions, there remains insufficient evidence to be confident that PHCs as an early intervention to prevent physical ill health are reaching all communities. This is concerning as we know Black, Asian and minority ethnic communities already experience inequalities in accessing appropriate care and support, and have poorer outcomes (Bignall et al., 2019).

Delivering physical health checks

Several key factors have been identified as contributing to the successful delivery of physical healthcare for SMI patients. Importantly, there is a broad recognition for the value of integrated care across mental health services and the need for information sharing systems, colocation services, shared protocols which promote responsibility and accountability, multidisciplinary teams and joint funding and commissioning (Lamontagne-Godwin et al., 2018; Rodgers et al., 2018). However, issues with implementation persist and the fragmented coordination of care is seen as a contributing factor. Poor communication between primary and secondary care and inadequate clarity around who is responsible have previously been mentioned as challenges (Rodgers et al., 2018). In a more recent qualitative study focussing on the provision of physical health care, Community Mental Health Team (CMHT) clinicians identified barriers including the issue of uncertainty around whose responsibility it is, as well as differing clinician backgrounds and training, and practicalities and resource limitations (Butler et al., 2020).

Attending physical health checks

There is less information available on what works well and barriers to attending PHCs for people with SMI, and less still on people from Black African and Caribbean communities. Butler et al's (2020) study collected data on the attitudes towards physical healthcare from 14 patients. They found a mixed response to awareness of physical health, with most people stating they knew the importance of it but could not give any more detail. People were however motivated to engage with PHCs for differing reasons. Few expressed the connection between mental illness and physical health comorbidity and there was confusion around who provided physical healthcare which was evident through the varied responses. Some research shows that people with SMI are apprehensive about attending screening due to the anticipation of a negative experience, including the prospect of being traumatised or embarrassed (Clifton et al., 2016). Stigma has also been reported as a barrier by patients and field experts - it is said that some primary care staff and other non-mental health specialists perceive people with SMI to be difficult to deal with and may find it uncomfortable (Rodgers et al., 2018).

In 2021 HM Government (2021) published a Covid-19 mental health and wellbeing recovery action plan, which included investment from NHS England 'to work across primary and secondary care services with voluntary and community sector partners to deliver tailored outreach and engagement for people living with severe mental illness to increase their engagement with physical health-checks'. The plan states improvements in integrated working have already led to 'proactive outreach models to boost the number of people with serious mental illnesses accessing physical health checks'. This is encouraging and may have contributed to the increase in PHCs being completed from around 30% in quarter three in 2021/22 to nearly 45% in quarter one in 2022/23 (NHS England, 2022a,b). Although without a breakdown by ethnicity of completed PHCs, it is unknown whether outreach efforts worked and PHC completion increased among African and Caribbean people with SMI during this time.

More generally, we know a number of barriers exist which prevent Black African and Caribbean people from accessing mental health services. Stigma around mental health is present among all communities; however it appears commonly among Black African and Caribbean communities. This can be based on cultural and religious beliefs about mental illness, feeding into a sense of shame for families, believing it to affect their social identity, leading to denial of the issue and a lack of familial support (Mantovani et al., 2017). Participants of this study indicated that the interrelationship between internalised and community stigma was a contributing factor in delayed or non-engagement with mental health services. Memon et al., (2016) identified perceived barriers to accessing mental health services for Black, Asian and minority ethnic people, including the consequence of long waiting times, language barriers, poor communication and reluctance to discuss mental illness and seek help among men. A recent review highlighted a lack of trust in health professionals as a factor impacting help seeking. One reason given for this was the perceived lack of understanding by health professionals of what racism is and how it impacts people's individual experiences and their experiences of mental health services (Kapadia et al., 2022).

What we did in this project

This project aimed to find out more about whether Black African and Caribbean people with SMI are aware of and are accessing PHCs.

To do so, we partnered with three voluntary organisations who offer services specifically to Black African and Caribbean people affected by mental illness. From scoping the available literature, a set of questions were developed which were used by staff in a one-to-one consultation with people who use their services. These consultations were carried out in person and via the telephone. The aim was for ten people from each organisation to be consulted. This option was chosen as staff members have developed a trusted relationship with the people they support and we wanted people to feel as comfortable as possible answering questions. Upon completion, questionnaires were returned to the Foundation and analysed.

Following the consultation, Foundation staff held a focus group with staff from two of the organisations and a one-to-one interview with the other. These engagements were informed by the consultations, as well as their own experience of working in the field of mental ill-health, specifically supporting those from African and Caribbean communities. They were all held online and ranged between 60-90 minutes. Transcripts were produced and analysed together with the completed questionnaires. Key themes were developed, noting all the recommendations provided by people and staff.

Organisations

For this project, the Foundation partnered with [Sandwell African Caribbean Mental Health Foundation](#) (SACMHF) in West Bromwich, [African Caribbean Mental Health Services](#) (ACMHS) in Manchester and [Sheffield African Caribbean Mental Health Association](#) (SACMHA) in Sheffield. These organisations offer culturally appropriate services to support people affected by mental ill-health, including community mental health advocacy, peer support/befriending, community outreach, counselling and Improving Access to Psychological Therapies (IAPT).

Participants

Demographic details were collected for the people consulted and focus group participants. We received a total of 34 responses from the consultation phase, 28 of which were people living in the community and six were people living in a secure unit. Those six were analysed separately due to the different context: 12 from SACMHF, ten from ACMHS, and 12 from SACMHA. A total of 12 people participated in the focus groups and one one-to-one interview was completed.

The table below summarises the characteristics of the participants.

Table 1 Characteristics of participants

Demographic data		Number of respondents
Gender	Male	19
	Female	15
Age	18-24	5
	25-39	8
	40-59	15
	60+	6
Ethnicity	Black Caribbean	16
	Black African	4
	Black Other: 'Black British'	5
	Black Other: 'Black'	2
	White and Black Caribbean	4
	White and Black African	1

Two people consulted did not provide their ethnicity which explains the discrepancy in the total responses.

The table below provides details of the participants in the focus groups and interviews.

Table 2 Characteristics of focus group participants

Demographic data		Number of respondents
Gender	Male	2
	Female	11
Age	18-24	1
	25-39	2
	40-59	9
	60+	1
Ethnicity	White: English, Welsh, Scottish, Northern Irish or British	1
	Black Caribbean	9
	Black African: Angola	1
	Black African	1
	Black Other: 'Black British'	1
Disability	Yes	2
	No	11

All participants stated that the gender they identify with is the same as the sex they were registered at birth.

Findings from consultations

The results from the consultations are summarised below. They are discussed in three sections: awareness; attendance and follow-up; and support.

The first section looks at the awareness of PHCs, whether healthcare professionals are telling people about them and whether people have had the link between SMI and physical health explained to them. This is followed by results on attendance and follow-up, including how many people were offered a check and how many people attended one. The last section is on whether people know where to find support to attend a PHC if they need it and what people think can be done to help support them.

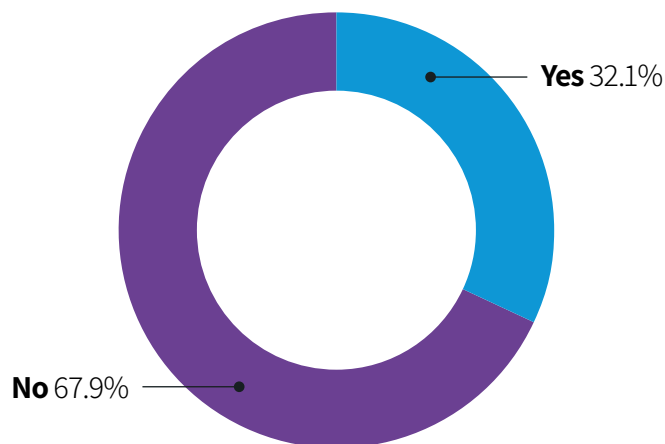
Awareness

One of the aims of the consultation was to gain a better understanding of the awareness among people with SMI from African and Caribbean backgrounds of PHCs. Of 28 respondents, 16 had heard of PHCs, and 12 had not. Broken down by organisation/location, two out of ten from ACMHS, nine out of 12 from SACMHF and five out of six from SACMHA were aware. Out of six respondents from the secure unit, five had heard of PHCs, although the sixth person went on to say they had been offered one.

The consultation also aimed to get an understanding of the communication surrounding PHCs. When asked whether their GP had spoken to them about PHCs, 19 responded 'No' (see Figure 1), when asked if any other mental health service provider had spoken to them about PHCs, 17 responded 'No'.

Figure 1: Communication from GP about physical health checks

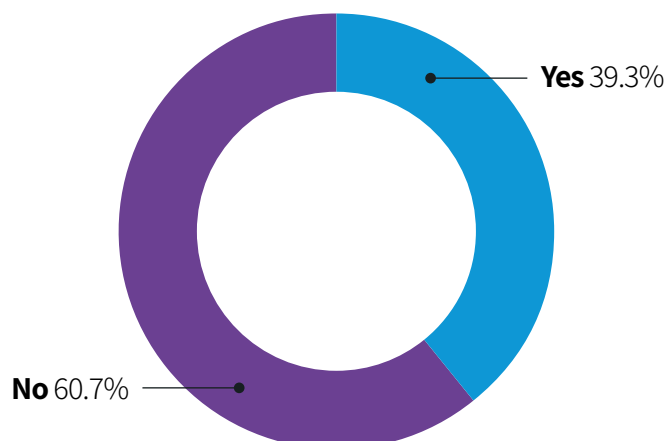
Has your GP spoken about the physical health check?



From those who responded yes (n=11) to having been told about PHCs by a mental health service provider, we asked them to specify who, answers included Early Intervention Team, voluntary organisations supporting them already, Community Psychiatrist Nurse, Social Worker and Forensic Low Secure Unit.

Figure 2: Communication from other mental health providers about physical health checks

Has any other mental health service provider spoken to you about PHCs?



Of the six from a secure unit, five had been spoken to about PHCs from other mental health providers - all of which specified their local NHS trust or the name of the unit they were residing in.

In order to gain an understanding of whether people with SMI knew why PHCs were important for them, we asked whether anyone had explained the link between SMI and physical health. There was a slight majority with 16 out of 28 responding ‘No’. This contrasted with people in the secure unit, where all six respondents answered ‘Yes’.

These findings suggest that awareness of PHCs varies and is low in some areas. Some comments from the consultations in Manchester included “People should be given more information, I’ve never heard of these checks” and “Should be given more information”, compared with comments from Sheffield such as “everyone keeps banging on about it” and “it’s everywhere” in relation to where they heard about PHCs.

These contrasting comments paint a complex picture. The majority of people had not been spoken to about PHCs by their GP or any other mental health service provider. Perhaps it is therefore not surprising that 16 out of 28 people had not had anyone explain why PHCs are important for people with SMI. Nevertheless, all six of the respondents living in the community and all six of the respondents living in a secure unit from Sheffield had had someone explain to them the importance.

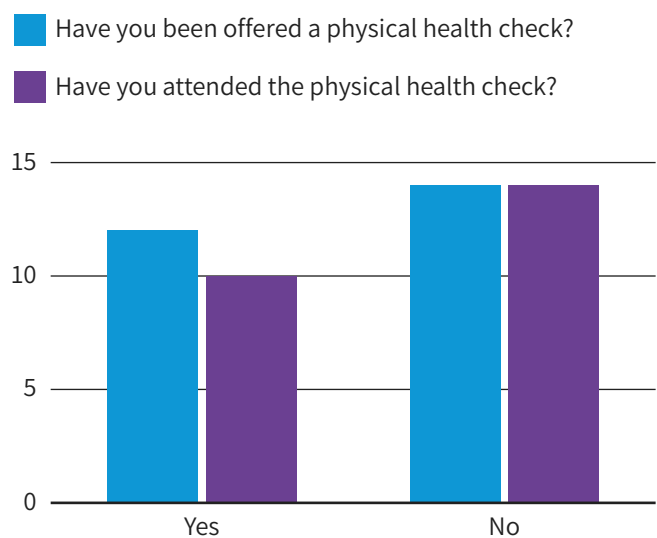
Attendance and follow-up

When asked whether they had been offered a PHC, 12 out of 28 respondents answered ‘Yes’. Ten of those offered did attend (Figure 3). Broken down by location, one out of ten from ACMHS, six out of 12 from SACMHF and three out of six from SACMHA attended a PHC. Out of the respondents who attended, the majority were contacted by their GP (seven), two were contacted by community mental health teams, one was told by

a family member, another was contacted by the Early Intervention Team, and another stated that they have regular checks for their diabetes.

Figure 3: Offered and attended a physical health check

Attendance to the physical health check

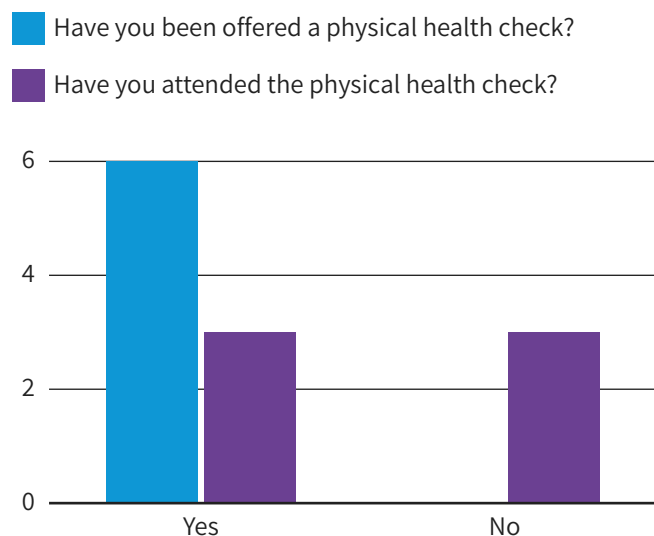


Of those who attended a PHC, we asked whether they received any follow-up interventions and whether these were appropriate. Three said they did not receive any interventions. Five stated that they did receive interventions, and some provided detail. One of these respondents regularly visits the GP in light of other medication they were taking, and therefore receives regular follow-ups in this way. One person was told to “eat a healthier diet”, and another was told to reduce their drinking habits. The remaining two respondents who attended a PHC did not have a response entered in the consultation form.

Six out of six of the secure unit respondents had been offered a PHC; three attended. One of the three who didn’t attend commented ‘all about the substance abuse team and that’; another said ‘I’ve never needed them’. The other who didn’t attend, answered ‘No’ to having heard of PHCs but also said staff on the ward had explained why they were important and had offered them one.

Figure 4: Offered and attended a physical health check, secure unit

Attendance to the physical health check, secure unit



From the secure unit of those who attended a PHC, when asked about follow-up interventions, two have diabetes and said they have ongoing blood tests, with one saying staff tell them ‘about diet and exercise’. The other person who attended said they had an intervention recommended which the nurse put in place but offered no detail about what it was.

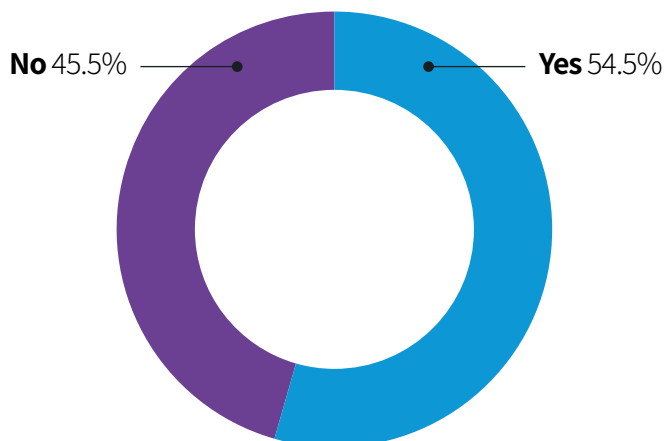
Given the above information, out of those who were offered a health check, many attended one which is promising. However, it seems there is still work to do to ensure people understand why it might be important for them to have one.

Support

We asked respondents whether they would know where to find support to attend a PHC if they needed it (Figure 5). Of the 28 participants, 18 said ‘Yes’.

Figure 5: Finding support

If you need support to attend a physical health check, do you know where to find it?



This was followed by a question about where respondents would seek the support, and the answers were as follows:

- Voluntary organisation
- Staff at accommodation
- Family and friends
- Outreach worker
- Doctor
- CPN
- Online
- Community team
- A&E and 999 services

Most of the secure unit responses said they would seek support from the nurses on the ward.

Lastly, we asked what people think could be done to support them to attend PHCs. The answers included providing more information about them and why they are important, regular reminders via telephone, text and letter, as well as a ring and ride service and detailed information about what to expect at a PHC and support to attend. Below are some of the comments people shared with us:

‘People should be given more information, I’ve never heard of these checks. This is not a good thing if they are important. I live close to my GP but would still need prompting to go.’

‘I would need somebody to follow (accompany) me there, I would be afraid to go first time. I would need them to talk to my support worker to help me understand.’

'Transport'

'GP's could make patients aware as well as mental health service and social services, any connecting person could raise awareness. Some awareness and publicity could be passed on to the relevant people or their family members.'

'More awareness and reassurance, make it less daunting'

'No morning appointments'

From the information provided, it is clear many people know where they can find support to attend a PHC if they need it, although some said emergency services which indicates they may wait until the problem is severe. A number of practical measures were suggested to help support people to attend.

Findings from the focus groups

From the interview and focus groups, there were clear themes which arose expressing commonalities between experiences. There were also areas where variations were visible. Both are discussed below.

Awareness

Awareness of PHCs, the work that is going on around them and the delivery of them varied between organisations. This was evident through the consultations, and was further demonstrated during the focus groups. In West Bromwich it was felt that Covid had had a big impact on things like PHCs and they weren't aware health services had started offering these services again. They said low awareness was in part due to people not being able to see their GP face-to-face, with little opportunities to be told about them and understand why they are important.

Low awareness was a theme which ran throughout the conversation in Manchester, staff and people using their services felt they didn't have enough information about them. One person commented 'In my experience, no, they don't get offered them, and they're not aware of them'.

The situation in Sheffield seemed entirely different, it was said 'every secure unit, every community team, be that forensic community team, or just sort of mental health community team, including the social workers, they have somebody that is specifically the lead for physical checks...I think it is sort of filtered down to everybody'. This invigorated approach was said to be, in part, a response to an inadequate rating from the Care Quality Commission (CQC) following an inspection of Sheffield Health and Social Care NHS Foundations Trusts' acute mental health wards and psychiatric intensive care unit for adults of

working age, mental health crisis services and health-based place of safety, forensic inpatient low secure wards, community-based mental health services for adults of working age and wards for older people with mental health problems (CQC, 2020).

Challenges around uptake / Accessing primary care

Participants listed a number of challenges that people with SMI face with regards to uptake of PHCs. These were said to lead to disengagement with services all together. This potentially leads to a situation where 'once you leave secure units, as far as physical goes...as they said, call 911/999'.

Stigma

One participant said a number of the people they support have said 'I already have all this nonsense that you're talking to me about my mental health, I don't want you adding all this sudden nonsense as well, physical health, that was another kind of common thread. Don't keep adding stuff to talk to me about, don't keep adding stuff to tell me off, they feel like you've been told'.

This was said to be related to stigma and not wanting to stand out in the group setting, which correlates with the literature on the stigma attached to mental illness, but also the anticipation of a negative experience, where embarrassment or trauma may be felt.

One voluntary organisation offers elements of health checks, including blood pressure, and are trying to figure out the best approach to reduce stigma. It was said 'they won't want to be checked at the table but almost hate being taken to a side room more than at the table. So we stand to think that maybe the group setting is not the best intervention for the younger guys.' They go on to say 'but I think to say to them, you don't seem right, would you like to come into the side room so we can have a chat and then they get up and everybody's looking? That doesn't seem to be working, it seems to be doing the opposite of what we wanted'.

Booking an appointment

For some people booking a GP appointment, which has been impacted due to Covid, was said to be a significant challenge to overcome. The very nature of SMI means that engaging with functional activities can be extremely difficult. The process of booking an appointment in some areas was said to require someone to call between a certain time in the morning, this was said to compound existing challenges around making and attending appointments. People said, 'it is really difficult to get a face-to-face with your GP', commenting on the system, saying 'you can only make an online appointment with the GP, so from 8-10 sometimes you can't get through, sometimes you don't know how to navigate online, and sometimes it malfunctions and you can't select. So then you've got to wait for the next day'. Someone else highlighted 'if you missed them in the first five minutes of the day, they all, the appointments have gone'.

The early time frame that people spoke of was said to be a specific challenge for people with SMI as it is not uncommon for them to have different sleep patterns or have problems with substance use. Someone commented 'because they self-medicate with other things, sometimes you know the appointment might not be relative to them or conducive to them because a lot of them sleep in late... So that would be put on the back burner for them'.

Underserved group

There were a number of points raised which indicate African and Caribbean people with SMI who aren't under the care of secondary care services, be that in a secure unit or CMHTs, are underserved. Some spoke of disengagement with health services which

resulted in people waiting until physical health conditions got really bad before they sought medical help - 'the option is either hope you get better, or go to A&E when it's gotten so bad... that's what seems to be the case'. This coincides with some of the answers given by people with SMI who said they would visit emergency departments if they needed support.

This was in contrast to those under secondary care where 'all of them have some level of heavy involvement with the community team or with the forensic social workers, so they tend to either be told when the appointment is and then somebody comes and picks him up, or sometimes the community team comes and does it, you know, with them.'

For some, the diagnosis of a mental health condition overshadowed their physical health: 'I've had some of the clients say they go to the doctors to try and explain something but it's kind of dismissed as you know, maybe their mental health'. Another said: 'I think the emphasis is on their mental health diagnosis and kind of treating that. There isn't very much discussion regarding any physical health. That's what I found with my clients anyway'. This ties into what was found in the literature about diagnostic overshadowing, which is reported as an issue when it comes to physical health care for people with SMI.

Others said the people they support do not feel listened to: 'oftentimes they feel as though they're not listened to. So you know it's pointless, they won't go on their own'. This was corroborated by someone saying 'a lot of people that I work say that they feel overwhelmed and they're not listened to, especially in our [African and Caribbean] communities'.

Substance use

Substance use was mentioned as a factor which meant booking and attending something like a PHC might not be a priority for people. It was said to be 'the biggest hurdle to people participating in the checks'. One participant commented: 'substance abuse is by far and widest the, well besides their diagnosis and their conditions themselves, substance abuse is by far the biggest hurdle to access to the physical health checks, either because somebody forgets, or they're too drunk, too high to go, or just too drunk or too high to even really recognize that they're going downhill'. Another person said: 'because they self-medicate with other things, sometimes you know

the appointment might not be relative to them or conducive to them because a lot of them sleep in late or, you know substance abuse, might have substance abuse, various other things. So that would be put on the back burner for them'

This not only leads to disengagement with health services, but can result in loss of contact with the voluntary organisation. One participant described the issue they have: 'then the other thing, which we don't, we don't really have a way around, but you can't come into the cafe if you drunk or high, because there are others. But then the moment we say that the ones that have the substance abuse issues, then go further and get further, further lost...there's a no win with that one because we can't let them in. But once we throw them out, then they're gone for good. Most times they don't, they don't they don't come back'. It was said that 'they are the group that really needs the most help'.

Fears over being sectioned again

One reason for not engaging with primary care services and PHCs more specifically was the fear of being sectioned again. 'That's the other reason that either people have had such a bad experience, they just opted out or some, especially as they deteriorate, they don't want to get anywhere near where they might get sectioned again, that includes the GP, so they end up getting worse, both mentally and physically'. This is of course not an unfounded fear, as it is known there are inequalities in compulsory admission which sees Black Caribbean patients nearly three and half times more likely to be admitted than White patients (Halvorsrud et al., 2018).

The role of voluntary organisations

The voluntary organisations we spoke to offer culturally specific services for people who need support with their mental ill-health and who often experience inequalities. They are in a good position to bridge the gap between health services and the people they support. Some felt that this was not happening well: 'I think there's a breakdown between charities or organisations that support people with mental health and the health sector because they don't liaise, there's no in between. So I think what I'm trying to say is you haven't got people in positions that have got the go-between. So you've got... obviously we represent the Black community but we're only allowed to go so far. We're not healthcare

professionals. So healthcare professionals are sometimes reluctant to share certain information.'

It was noted by another participant that statutory services are 'depending on the third sector to fill in the gaps without giving them resources... So we are doing more but without resources, and then people are just running on empty'. Other participants agreed that more funding was needed.

Some felt voluntary organisations were not respected as equals which is demonstrated in the following comments:

'Sometimes I feel that the system don't take certain charities serious. Because like I said, if they're going straight to somebody, we have to go left, right, centre, go back on ourselves before we can go forward and then it's a time thing, and in some cases, our clients, they haven't got the time. And it becomes very difficult where they get disheartened, to get them to talk again or come forward'

'As a charity we're made to feel like the poor relation. You know? When I first started four years in this role, I went around to all our community mental health teams, all the old contacts that I had, addressed their meetings and some of the comments were like, "oh we thought you'd lost the funding", "we didn't know you were still going". You know it's like we've disappeared. We're not visible. Why are we not visible? We've not closed, we've not lost our funding, we're still here. So I don't know'

It feels as though the opportunity to work collaboratively with voluntary organisations who hold specialist knowledge on working with African and Caribbean communities is not being utilised as well as it could.

Work currently being done by voluntary organisations on PHCs ties in with awareness of them. In Sheffield there is high awareness, which is reflected in the programme of work they have. They are in the process of developing a programme to train people to 'specifically to go out to service users that either have things like dementia, or people that have severe diagnosis mental illness, and do kind of higher level type of physical checks. So they'll either go to their homes, we've got a little room in the cafe that they will do it there, or we try and work out

how we can do it in the city centre because after the pandemic, there was quite an explosion of people from ethnic minorities that were homeless.' They go on to say 'So now we're trying to, because they're the hardest to reach, either because you can't find them or because they usually drunk by the time we get there and that's a whole other issue, but we're trying to work out how we can get the health champions to do it, I'm likely going to be trained as your champion, and then I can go into it because I've got connections with them already. But that's our specific thing that we're doing because we weren't doing it before and then we've got the funding, so we just setting it up'.

Another organisation, although it is not doing work directly focussing on PHCs, it is raising awareness of conditions such as diabetes and cancer.

In the 2021 the NHS allocated additional funds for primary and secondary care services to work in partnership with voluntary and community partners to deliver tailored outreach and engagement for people living with SMI. This will hopefully see greater engagement with specialised African and Caribbean mental health voluntary organisations.

Cultural awareness

There needs to be cultural competence training to overcome stereotypes to ensure these are not reproduced and impact how healthcare staff interact and communicate with those with SMI from African and Caribbean communities. This was said to be the case with regards to booking an appointment: 'some people would get annoyed and particularly if they're Black, ethnic minorities it's seen as that, well I guess you know this, a bit of aggression and the receptionist at the other end isn't going to tolerate that because they're seeing it as aggression, and they're not you know they're just anxious about wanting that follow up or that appointment'

It was also said that the way PHCs were communicated could sometimes be patronising for some: 'I think sometimes it's how they're told to do it. I think it's probably cultural, because the Africans, for example, really, really hated the fact that, you know, the community, when they spoke about the community team, or the, you know, when they said, when I said, so who's told you about these things [PHCs], the tone and the sort of emotion behind it was much friendlier with either Black British or

Caribbean, then it was with the Africans, because I think they felt like they were grown men being told what to do. So they almost didn't go just as a kind of up yours type thing'.

They went on to say 'that came across, I think very heavily with the guys that were saying people tell me about it, but it's probably the way that they tell them. And I don't think the staff mean any harm by it. I think just the way that they tell it and I think even our guys the way that they react probably works with aunty and within the community, but when you go beyond the community, then that, that either seems aggressive, disinterested, or any, any number of things'.

How and who communicates with people seems to play a role in how effective the interaction is. When talking about one of the people they had consulted, they said: 'He was saying stuff like its young White women that keep telling me to check my balls or to check, or to check my blood pressure. You know, I don't want, I don't want to have those discussions'. When the participant probed people further: 'I kind of brought up different types of physical checks. So blood pressure is kind of a weird one because of the body contact, but nobody seemed to mind, you know, the pinpricks for glucose. Not a single one would even entertain talks about prostate cancer and whatnot'. They went on to say 'I do think, though, that for this guy, it probably would be more accepted if it was coming from a guy.'

In the literature, a lack of trust in health services - primary and mental health - was mentioned as a factor impacting help-seeking behaviour. This point was raised by a participant; when asked whether they thought health professionals were talking to people with SMI about the link between their physical and mental health, they commented: 'I think that in general anyway, Black communities and hospitals and doctors and checks - we're very sceptical of that anyway. So for me, if there's nobody representing from those organisations coming and speaking to a community prior to that, then Covid has made that even worse because people with cancer and those illnesses aren't even getting checks and treatments, and so I think the answer overall is no, and especially for the Black community because they don't get the same treatment as somebody who is White in the healthcare system and I think Covid has probably made that go from zero to minus now.'

Conclusion

In conclusion, it is evident there are issues around awareness of PHCs which need to be addressed in order for more people and voluntary organisations to be actively involved in promoting and supporting attendance. It is promising to see that most people who were offered a PHC attended one. That being said, it is important that the significance of PHCs is communicated in the right way for people to see the relevance of attending. It is also encouraging to see that many people know where they would seek support if they needed it, although some said emergency services, which means there is work to do to ensure they seek help before this stage.

From the initial analysis of the one-to-one consultations, it seemed primary care services were not using every opportunity to talk about PHCs. However, upon further investigation following the focus groups, discussions revealed this may be because there is a lack of regular engagement with African and Caribbean people with SMI living in the community. A number of challenges were raised around accessing primary care services and the uptake of PHCs for these people; not least the GP booking system and substance use. There was reported to be limited collaborative working between statutory services and voluntary organisations in some areas - disappointingly - as, if appropriately funded and resourced, Black, Asian and minority ethnic-led voluntary organisations are often well placed to address some of the challenges. The findings reinforce the need to adopt innovative ways of working, which are co-produced with African and Caribbean people with SMI, and delivered in collaboration with voluntary organisations.

For example, outreach funding could be used to commission African and Caribbean-led voluntary organisations to do work engaging their communities and train statutory services on how to better reach and engage with them. This may help overcome some of the issues around communicating appropriately and would contribute to building trust, to which there are no shortcuts, as these are some of the most marginalised people in society. It is also

evident that substance misuse teams need to be better connected with voluntary organisations to ensure people are getting the support they need. Inevitably, this would need to be done hand-in-hand with addressing the enduring inequalities African and Caribbean people face which increase the likelihood of SMI, as well as the disproportionate rate of compulsory admittance.

It is difficult to shed any light on the appropriateness of interventions recommended as few people shared information on this. The majority of staff and people consulted were unaware of any interventions which had either been offered or taken up, aside from advice such as 'eat a healthier diet' and regular health checks due to existing conditions such as diabetes.

Our approach to this research has been received well, demonstrating the importance of speaking to those the services are for. This was expressed by a staff member 'I think also with the service users, just the asking...seemed as important as the vouchers, just being heard. You know, just saying, "Why are you asking this?" And then you said, well, we want to understand and then do better...just that seemed to feel just as important to them as the vouchers'. Additionally, the importance of working with voluntary organisations was highlighted in this comment, 'I don't think we would have ever thought to do it the way that you did it or even to think to say, let's ask people about physical checks, but it has been absolutely invaluable. So much so that it's going to change quite a lot of what we're planning on doing with the health champions. That's how we decided to start with service user focus group'.

It is also important to use this opportunity to highlight the need for improved data collection, including ethnicity, in order to have a more accurate picture of who is attending PHCs, what interventions are being recommended, and how frequently they are being taken up and completed.

Recommendations

There was consensus among people consulted and staff members of the voluntary organisations that awareness of PHCs must be addressed and appropriate support provided to help facilitate attendance. It was recommended that this take shape in multiple ways which are listed below.

More proactive promotion	<p>Where awareness of PHCs was low, with few people hearing about them from their contact with healthcare services, it was suggested that any opportunity to discuss them, what they entail and why they are important should be taken by all health professionals – making every contact count.</p> <p>It was suggested that there could be a better presence of visual methods to promote awareness - this included flyers, posters, billboards, and social media.</p>
Community engagement	<p>For some voluntary organisations it was noted that there is a lack of engagement with them and the people they support. They would welcome health professionals coming into the community to give informative talks. This was seen to address low awareness as well as provide more information about why PHCs are important.</p> <p>African and Caribbean-led voluntary organisations could be commissioned to do engagement work with the communities they represent to increase engagement and attendance to PHCs.</p>
Support attendance	<p>Where necessary people said support to attend would be beneficial. For example, a ring and ride service and avoiding early morning appointments. Reminders using different means of communication e.g. text, as well as letters and phone calls, were said to be useful. These measures could be supported using the additional NHS funding mentioned in the mental health recovery plan.</p> <p>People said it is important for them to know exactly what to expect during the appointment to reduce anxiety, therefore detailed information about what the appointment will include is useful.</p>
PHCs on the road	<p>Upskilling staff in voluntary organisations to carry out some elements of the checks in their organisations, people's homes or places they know to find people. This could be supported by NHSX investment in supporting care with remote monitoring.</p>

These findings suggest that there are approaches which can be taken to increase awareness of PHCs among Black African and Caribbean people with SMI which we think are important to take forward. With the right resourcing, Black, Asian and minority ethnic-led voluntary organisations supporting Black African and Caribbean people with SMI, who have expert knowledge and experience, are well placed to implement some of the above measures.

References

- Bellamy, S., Lister, J., Kitchen, C.E.W., Kramer, L., Alderson, S.L., Doran, T., Gilbody, S., Han, L., Hewitt, C., Holt, R.I.G. and Jacobs, R. (2021). Living with diabetes alongside a severe mental illness: a qualitative exploration with people with severe mental illness, family members and healthcare staff. *Diabetic Medicine*, 38(7), p.e14562.
- Bignall, T., Jeraj, S., Helsby, E. and Butt, J. (2019) *Racial disparities in mental health: Literature and evidence review*. London: Race Equality Foundation.
- Butler, J., de Cassan, S., Turner, P., Lennox, B., Hayward, G. and Glogowska, M. (2020). Attitudes to physical healthcare in severe mental illness; a patient and mental health clinician qualitative interview study. *BMC Family Practice*, 21(1), pp.1-8.
- Care Quality Commission (2020) *CQC publishes report on Sheffield Health and Social Care NHS Foundation Trust*. Available at: <https://www.cqc.org.uk/news/releases/cqc-publishes-report-sheffield-health-social-care-nhs-foundation-trust>
- Chesney, E., Goodwin, G.M. and Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World psychiatry*, 13(2), pp.153-160.
- Clifton, A., Burgess, C., Clement, S., Ohlsen, R., Ramluggun, P., Sturt, J., Walters, P. and Barley, E.A. (2016). Influences on uptake of cancer screening in mental health service users: a qualitative study. *BMC health services research*, 16(1), pp.1-12.
- Correll, C.U., Lencz, T. and Malhotra, A.K. (2011). Antipsychotic drugs and obesity. *Trends in molecular medicine*, 17(2), pp.97-107.
- Hayes, J.F., Marston, L., Walters, K., King, M.B. and Osborn, D.P. (2017). Mortality gap for people with bipolar disorder and schizophrenia: UK-based cohort study 2000–2014. *The British Journal of Psychiatry*, 211(3), pp.175-181.
- Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E. and Bhui, K. (2018). Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis. *BMC medicine*, 16(1), pp.1-17.
- HM Government (2021) COVID-19 mental health and wellbeing recovery plan. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973936/covid-19-mental-health-and-wellbeing-recovery-action-plan.pdf
- Holt, R.I. (2019). Association between antipsychotic medication use and diabetes. *Current diabetes reports*, 19(10), pp.1-10.
- Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarreal-Williams, N., Bécaries, L. and Esmail, A. (2022) *Ethnic inequalities in healthcare: A rapid evidence review*. NHS Race and Health Observatory.
- Lamontagne-Godwin, F., Burgess, C., Clement, S., Gasston-Hales, M., Greene, C., Manyande, A., Taylor, D., Walters, P. and Barley, E. (2018). Interventions to increase access to or uptake of physical health screening in people with severe mental illness: a realist review. *BMJ open*, 8(2), p.e019412.
- Mantovani, N., Pizzolati, M. and Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, 20(3), pp.373-384.
- Martin, J.L., McLean, G., Park, J., Martin, D.J., Connolly, M., Mercer, S.W. and Smith, D.J. (2014). Impact of socioeconomic deprivation on rate and cause of death in severe mental illness. *BMC psychiatry*, 14(1), pp.1-10.
- Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T. and de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open*, 6(11), p.e012337.
- Nash, M. (2013). Diagnostic overshadowing: a potential barrier to physical health care for mental health service users. *Mental Health Practice*, 17(4).
- Nazroo, J.Y., Bhui, K.S. and Rhodes, J. (2020). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociology of Health & Illness*, 42(2), pp.262-276.
- NHS England (2018) *Improving physical healthcare for people living with severe mental illness (SMI) in primary care*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-smi-in-primary-care.pdf>
- NHS England (2019) *Physical health check and follow-up interventions for people with severe mental illness. Technical guidance*. Available at: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/10/FINAL-Technical-definition-2019-20-physical-health-SMI-data-collection-26.09.2019-amendments.pdf>
- NHS England (2022a) *Physical Health Checks for People with Severe Mental Illness August 2022*. Available at: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/08/Physical-Health-Checks-SMI-Statistical-Press-Notice-2022-23-Q1.pdf>
- NHS England (2022b) *Physical Health Checks for People with Severe Mental Illness February 2022*. Available at: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/02/Physical-Health-Checks-SMI-Statistical-Press-Notice-2021-22-Q3.pdf>
- NHS England (2016) *The Five Year Forward View for Mental Health - report from mental health taskforce*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>
- NHS (2019) *The NHS Long Term Plan*. Available at: <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>
- Patel, R., Barnard, S., Thompson, K., Lagord, C., Clegg, E., Worrall, R., Evans, T., Carter, S., Flowers, J., Rovers, D., Nuttall, M., Samani, N. J., Robson, J., Kearney, M., Deanfield, J and Waterfall, J. (2020). Evaluation of the uptake and delivery of the NHS Health Check programme in England, using primary care data from 9.5 million people: a cross-sectional study. *BMJ Open*, 10:e042963. doi:10.1136/bmjopen-2020-042963
- Pinto, R., Ashworth, M. and Jones, R. (2008). Schizophrenia in black Caribbeans living in the UK: an exploration of underlying causes of the high incidence rate. *British Journal of General Practice*, 58(551), pp.429-434.
- Public Health England (2018) *Severe mental illness (SMI) and physical health inequalities briefing*. Available at: <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#fn:1>
- Qassem, T., Bebbington, P., Spiers, N., McManus, S., Jenkins, R. and Dein, S. (2015). Prevalence of psychosis in black ethnic minorities in Britain: analysis based on three national surveys. *Social psychiatry and psychiatric epidemiology*, 50(7), pp.1057-1064.
- Reilly, S., Olier, I., Planner, C., Doran, T., Reeves, D., Ashcroft, D.M., Gask, L. and Kontopantelis, E. (2015). Inequalities in physical comorbidity: a longitudinal comparative cohort study of people with severe mental illness in the UK. *BMJ open*, 5(12), p.e009010.
- Rodgers, M., Dalton, J., Harden, M., Street, A., Parker, G. and Eastwood, A. (2018). Integrated care to address the physical health needs of people with severe mental illness: a mapping review of the recent evidence on barriers, facilitators and evaluations. *International Journal of Integrated Care*, 18(1).
- Townsend, E. (2022). *Exclusive: NHSE orders health check blitz to stop mortality gap growing*. Available at: <https://www.hsj.co.uk/mental-health/exclusive-nhse-orders-health-check-blitz-to-stop-mortality-gap-growing/7031686.article>



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