healthwatch Croydon

Meet the changemakers… and get involved

Adult Mental Health services

GP and community services

Questions and answers

Wednesday 18 July 18.00-20.30

CVA Resource Centre, 82 London Road, Croydon

In association with

NHS Croydon Clinical Commissioning Group

NHS South London and Maudsley NHS Foundation Trust

Table 3- Session 1: (17.10 to 17.29)

Gordon Kay: Healthwatch Croydon Manager (GK)
Valentine Nweze, Service Lead for Mental Health Assessment and Liaison in Croydon, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4

Themes that came out of the discussions:

Services:

- GP surgeries and staff need to have a good understanding of mental health services locally. Individual GPs may not feel confident to diagnose.
- People not getting support as not considered ill enough – bouncing between services.
- Consider co-location of services.
- Avoiding having to wait three months to get a referral because it all has to go via GPs - meaning a delay in referral and treatment.
- Need for specialist mental health training in GP surgeries both at GP and health professional level.
- There is no funding for dedicated services for those on the Autism spectrum in Croydon unlike other boroughs. Residents have to apply to the panel for specific funding and usually do not succeed.

Knowledge and communications:

- Better knowledge and advice of services and what is out there is needed.
- A list of facilities that people have early access to.

Full Discussions

Gordon Kay: You have heard a lot in these hours. Which questions do you feel you should be asking? So, from what we've heard, this is specialism in GP and community service.

Resident 1: I think ensuring that general practice staff, so GPs and other clinical staff in practices, have a good understanding of mental health services locally and how they affect people generally. GP services can be difficult if you're mentally unwell. They need to find wider support. They need to have on hand advice and support on GPs. If it's like anywhere I work, GPs will refer, and they are bounced back. They struggle with people who are psychiatrists as they considered as not mentally ill enough. That bouncing in between services is difficult for the patient. You would expect them to be well equipped.

GK: Are the options available when you're considered as quite serious? It has to be something quite dramatic. Does something need to be done around communication?

Resident 1: I think it's really useful to co-locate the services and it helps with access. If someone is struggling without a diagnosis, that's a problem. A GP may not feel comfortable with diagnosing mental illnesses.

Resident 2: What we follow is a step to step guideline. We are thinking about people who bounce back we think about self-help in our community. Talking to GPs or people who work in clinical settings, that should be the first point. If there were supports from GPs and given sometimes. How do we get that information? I don't get the feeling that we know what's out there in the community. I've been to a lot of these and they talk a lot about mapping.

Valentine: I want to contribute to this. If you look at this diagram, you can see there are levels. In practice, in an inclusive model. At one point, there is a capacity issue. We are working with local authorities to explain why we need a list of facilities where people can have easy access to. For example, if you refer someone and they are here, it will take three months to see them. They don't need to be here. The other aspect is that we are going to GPs and they have the same view that referrals are being bounced back. We have an issue with the fact that people aren't getting to that point. In reality, we spend 45% referrals and some of the GPs referrals that should be here aren't here. It delays time, and treatment. We've tried to support GPs by separating our team into two teams, so each unit can focus on graphical network by GP hub. In addition to that, we have two teams handling referrals which mean that the GP can link better. Our GP services can be adapted to people in their area. The second thing is to help the GP because the referrals bounce back. We are creating a form for referrals which will help the GP. We've also designed signposting which links all people who have mental illnesses. They look at that list and they click on the signpost and it opens up information about those services. They can make that decision right there and then.

Gordon: It's almost reflecting what Paris was saying. It's doesn't have to be the GP being the middle man. It can be a community centre setting.

Valentine: That's the ideal position. We are trying to see if we can do anything different in the meantime.

Gordon: That's a great overview.

Resident 3: I was just wondering if there is specialist training in GP settings?

Valentine: It's something we're not ruling out. We have templates. We have people working with GPs and colleagues that support them.

Resident 2: List is the head of nursing is linking with us. One of the GPs set up a training and I think I'm going.

Resident 3: Refusing to go and see doctors and GPs, there is an overemphasis of needing to get GP trained.

GK: There is a GPSSI. It might be a thing to develop that in different communities.

Resident 4: My interests are quite specific. I've got some tough questions. In terms of topics of GPs, there is a lack of strategy. Neuro development services are falling between mental health and learning disabilities. GPs don't know what to do.

Resident 2: There have been conversations about that. It had to go to tertiary panels for funding.

Valentine: I think you're right. One of the conversations is that some of those conditions, like Asperger's syndrome, there are services for that. Even people who show traces are given support. In Croydon, there is no funding. This place is already locked out with numbers there is a delay for those people to get treatment. The pathway is convoluted. It's because of funding. It needs to be given to the CCG.

GK: The challenge is autism overlaps with mental health, learning disability, and education. Easily people are falling through because no one knows where to place it. The stress that is involved with normal services if you have autism causes mental health.

Resident 3: They also need to safeguard the children.

(Session ends)

healthwatch Croydon

Table 3 – Session 2 (17.33 to 17.53)

Gordon Kay: Healthwatch Croydon Manager (GK)
Valentine Nweze: Service Lead for Mental Health Assessment and Liaison in Croydon, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Difficult to access secondary care unless you have a mental health diagnosis, which means those with long-term non-mental health conditions find it difficult to access services.
- Reconsider inconsistent GP charges for essential letters that helps those with mental health conditions get on with their lives.
- Need for a focus on community services for those with severe mental health conditions. Neighbouring boroughs have funding, but Croydon does not.

Knowledge and Communications:

- Patients need to be better communicated to, not just through letters which might be ignored.

Support:

- Talking therapies for those with long-term conditions, whose mental health had been affected by their condition.

Resident 1: I was diagnosed as a diabetic and one of the things I noticed was the people there were deeply depressed. Later on, I went to Diabetics UK and I was the only one who was type 2 on the table of type 1. I didn't realise how fragile they were. I didn't know talking therapies were available for diabetics. I don't think I need it. The ones who are there really need to get referred very quickly.

GK: Are you aware of this?

Valentine: The last meeting we had it was mentioned that they provided talking therapies for long standing conditions. If it starts to manifest as emotional disturbances, they are the best for that. We do have managing emotions group. It can be depression or anxiety. We have a higher-level pf physiotherapies groups. Our problem is that unless your presentation is coming from a head condition, it's difficult to meet the criteria for the secondary level of mental health care.

Resident 1: Newly diagnosed diabetics are depressed to start with. You need to pick them up to start with and not 5 years later.

Valentine: You are right. It needs to be preventative. They need to have access. You don't have criteria excluding people from assistant services. In Croydon, we want to set up services to guide these people to the right services. I would recommend they self-refer themselves. Some of these meetings should be passed to people through their council letters. When they get council tax letters, it should be placed there. If you don't want to include your GP, it can get you into contact straight away. We are thinking about this with CCG.

Resident 2: The leaflets are amazing. It's happened so quickly.

GK: It's tailoring it to people who have had a dramatic change in their life. There's a mental health service as well.

Resident 3: Physical checks require GPs. Especially those under prescribed medication. A lot of people becoming well under secondary stations. Often, the way they communicate with patients is thorough letters. They might not even read them. A person I heard a talk from was a psychological nurse and she had managed to keep track of people who hadn't turned up, via letter invitation, and followed up. This lasted for a year.

GK: So, you're asking for GPs to be proactive in their roles. It's a case of proactive follow up. It may not be an assessment which needs to be done by a GP.

Resident 1: You've got a parallel with diabetics. They're not carried out by GPs.

Valentine: Those who are on benefits, and on assistance, have gone from being assessed by somebody to being referred. To get their independence, vulnerable people need letters and support. I know of 3 GP practices that don't charge. I've raised it with CCG. My GP charges £30. For other people who haven't got big income and need £30. I'm saying GPs should not charge for letters. They don't charge at secondary services. A lot of people with adult mental health are referred back to GPs.

GK: It's a challenge because GP services are private services on a public contract. It's a good point to raise. It'll roll on and cause problems later.

Resident 4: What community services were available to people with severe mental health?

Valentine: They can be here or here. Usually people who come through diagnosis get here. They can be managed by the GP. There are some risk issues and if this is the case, it will be passed to here where all the referrals are passed to. From here, it is decided where they are best allocated. The only problem is that we need funding for them.

GK: There is a potential for the services, but we need the money to fund it. Is it a general service? Can the GP refer them to the CCG? And request a specific service?

Valentine: No. The money has to come from somewhere. It has to come through us so that we can properly allocate them.

GK: How do you decide you budget?

Valentine: They're saying at the moment that. In Lewisham, Lambeth, and Sutton you can. In Croydon, they don't have the money to do that. They need to make a decision on whether they need to go to CCG. We see the patients and then we refer them.

GK: As what was being discussed, they're trying to reorganise each service for each borough. If Lambeth already has that service, why hasn't Croydon?

Valentine: We need the money for diagnosis and assessment. They need a direct way to refer it.

Resident 5: My son is under the COAST team. They have a psychologist there. They have talking therapies, but he doesn't feel like he needs it. People who need it often feel like they don't need it. Some people get sent letters saying if they don't come again, they won't get another session. Often these people are in denial.

GK: GPs need to follow up letters. What do you feel as someone who knows about those teams?

Resident 5: I think they're really good. My son has a number for her CPA. It's really direct access. If I'm concerned, I just send her a text message. They don't always get it right away but 80% of the time they are.

GK: Texting must be an improvement?

Resident 5: He's medicated and watched anyway but it's an easy way to keep access. He had his physical test done there too. It's so simple. It's just a text message.

Resident 3: We're thinking of booking appointments by text.

GK: There have been issues when we were doing research on adult carers weren't allowed to do see the prescriptions for the severely mentally ill adults.

(Session ends)

Table 3 - Session 3: (17.58 to 18.17)

Gordon: Healthwatch Croydon Manager (GK)
Valentine Nweze, Service Lead for Mental Health Assessment and Liaison in Croydon, South London and Maudsley NHS Foundation Trust
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5

Themes that came out of the discussions:

Services:

- Taking time to get access to mood, anxiety and emotional services, due to delay in panel decisions for specific funding, as the CCG does not generally find this service.
- Impact of the panel decision process.
- Services exist in Lewisham which have to go via panel in Croydon. The impact of special measures.
- Issues with trauma services, with some too traumatised to access services, particularly refugees/ asylum seekers. Perhaps a dedicated service is required.

Resident 2: For the last 18 months, we've had many people walk through the door. My son is 21. I've been waiting for 18 months for therapies. He was going to the panel and discuss the matter. It's been dragging on.

Valentine: It's being funded by the CCG. There is a long wait. There are other things which cause delays. The CCG want to make sure they have all the information. There is a cost involved. There are other service available in the right place. We need a quicker response.

Resident 2: That lady was offering six weeks. Personally, the people who need the help aren't getting them. Also, why can't we have people who are housebound given therapies through sending people there?

Valentine: Firstly, specialised therapies are completely different. You can get a wide variety of therapies. There are so many. It doesn't need to go to funding. It must be a very specialised therapists which isn't provided, and they don't have the funding.

Gordon: There isn't defined funding, so it has to go to a panel.

Resident 1: How often do they meet?

Valentine: They meet every 2 weeks. They meet regularly.

Resident 1: Is it because there is a shortage of social workers?

Valentine: No. They a variety of people. They are senior managers. People like me are not involved.

Resident 3: If we talk about people who already have pre-diagnosed conditions. My son was diagnosed for over 25 years. Are you saying this panel is made of multi-disciplinary panel? Where is the mental health expert on this panel? Who is going to make that decision about that individual current mental health and their need?

Valentine: Let me explain more. It's a special panel. Everyone else that needs diagnosis and assessment which may include treatment do not need to go through to the panel. It's only with special people who have special treatments go to the panel.

Resident 2: My son went there, and they put the panel on wait because there was no funding. He went through three panels. I had to write to CCG to see what was going on.

Valentine: I think it's the right place to raise these issues.

Resident 2: They had gone over the budget that year illegally and put the panel on hold.

Resident 4: Community care means more patients are being put into care homes?

Valentine: You live in the community and they need help.

Resident 4: How do they provide that?

Valentine: We discuss that with people and we help them with support in their own homes.

Gordon: Is that a Croydon issue?

Valentine: The CCG have a tertiary panel everywhere but not all requests go to that panel.

Resident 3: Do they have more services?

Gordon: They're not commissioned in a block?

Valentine: Difference between Croydon CCG and Lewisham CCG. If you don't have enough money to contribute to the pot, that's where there is problem.

Gordon: It already exists in other boroughs?

Valentine: They're making the decision whether to fund Croydon. It's not making that decision.

Resident 2: Where problems arise is where the CCG want a service by a provider and they want this, this and this for some much of this budget but they can't provide

that service with the money which is being provided. Regardless of what is happening in other boroughs, Croydon which has been in special measures has really affected the funding. They've moved to required improvements. It's not straight forward.

Gordon: If this service is going to save money down the road, we need an earlier intervention. The experience of going into acute conditions due not getting the right service

Valentine: Croydon have an unusual population. They have a lot of newly created buildings which draws people here from outside who then also compete for funding.

Resident 5: We have a huge issue in terms of new people in a state of trauma who are considered so unstable that they can't receive state trauma therapy. They don't know whether their status Is confirmed or not. That is hugely delayed. We're carrying them and they're suicidal and traumatised, but they have no access. They can't stabilise. It's a mad circle.

Valentine: I think you're right. There are people who we can treat straight away such as bereavement. In the guidelines, there needs to be a timeline in between for them to stabilise.

Gordon: How old are they are?

Resident 5: 17-21. They're in that transition period.

Valentine: If they're both 18 and referred to treatment.

Resident 5: We do but they're rejected.

Gordon: What I hear is that we need a special treatment. Traumatised refugees might need an access course to help move them into the system.

Valentine: I work in an assessment team. I need to know why they're being rejected.

Resident 5: We need to swap contacts. They're being called into home office for interviews, being kept in detention and the health services are not responding.
Valentine: The reason is we have a service which is specifically for that. If they are rejecting people, I need to find out why.

(Session ends)

healthwatch Croydon

Table 4 - Session 1: (17.10 to 17.30)

Elsie Sutherland: Facilitator (ES)
Dr Agnelo Fernandes: Chair of NHS Croydon CCG and GP
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6

Themes that came out of the discussions:

Services:

- A hurdle to get to IAPT services, but promise this will is improving.
- More professionals supported and more service users and carers going into different places such as schools and community centres, not just GPs.
- Role of social prescribing as a starting point.
- Focus on services in the south of the borough, not just the north.

Knowledge and communications:

- Need for better ways of communication IAPT services.
- Change of name to talking therapies may help reduce stigma.
- GPs feel that things could be done differently in the same way social prescribing has been introduced.
- Marketing services better for different age groups and background.

Full Discussions

Elsie Sutherland: Let's introduce ourselves first. My name is Elsie Sutherland, I am a facilitator here and I volunteer for CCG and Healthwatch.

Resident 1: I work for CHASE Residents' Association.

Resident 2: I am a Croydon resident and a governor of SLaM.

Resident 3: I am also a Croydon resident and a governor of SLaM, and I have been a carer for over 25 years for people with mental health issues. I am familiar with CCG and CQC.

Resident 4: I am a carer.

Resident 5: I am in the process of setting up coffee mornings specifically relating to mental health.

Resident 6: I work with the elderly community to combat isolation. We have a monthly tea and chat with elders. We also try to bring issues alive through drama by going to schools and day centres and doing performances based on these issues. I also have a general interest because I have used IAPT myself and cared for someone with mental health issues for a number of years.

Agnelo: I am a GP and chair of CCG. I'm stepping in because our clinical leads aren't here. We are here to discuss talking therapies. The first step we have taken is changing the name from IAPT to Croydon Talking Therapies.

Resident 2: Previously Improving Access to Psychological Therapies?

Agnelo: The last time, we talked about communication between SLaM and Croydon. We had some leaflets that came through my door last year. They didn't mean anything to my wife, they just didn't make sense to her. I didn't even know the drop was going to happen and the numbers and other information were wrong. We fed that back to the communications team, but a lot of people had seen that and it ended up in the bin. We need to consider how we market these services.

Resident 1: I should let you know that I have just recently retired, I used to be a specialist in sickle cell. We have referred some of our patients to the long-term conditions team, but it was such a hurdle to get them into it. Once they were engaged most found it helpful.

Resident 2: I had an experience like that, too. My partner had a breakdown a few years ago and was referred to IAPT through her GP and it was a hurdle. It's not easy to get a hold of them.

Resident 1: I'm hoping that that's better now.

Agnelo: It's certainly better now. There isn't a surgery that goes by where I don't advise people to contact IAPT. People don't realise that it's multifactorial, so it may be that you're talking to somebody or you're using it online. At the moment, I'm seeing someone who is very depressed and needed a form of therapy but didn't want to talk to anyone. He's a type 1 professional in the UK Space Agency and for him the online service worked really well.

Elsie: Sometimes they don't want to talk face-to-face. There's a stigma.

Agnelo: Now that we've got more capacity in the system and we're changing the name, we need to ask how to get people to use the service. Some people's experience has been positive and they can tell people. We've got lots of people who have had positive experiences. One aspect of it is getting in and the other is the responsiveness.

Resident 6: My experience was to do with employment. I knew about the service but finding someone to talk to who doesn't just tell me what to do empowered me. I left with things to think about and things to do. For me, it was about taking control.

Agnelo: Now that we have got a service it's about how we get people to access it. There is still a stigma. People don't want to access specialised services even though they come see you regularly as your GP with these problems and you suggest that someone else might be better qualified to help.

Resident 2: My friend was referred by the GP but we had to wait for them to contact us.

Agnelo: Now you can just ring the number yourself. You can go through online as well but doing it by telephone is much easier.

Elsie: That word 'therapy' frightens a lot of people. It puts some people off.

Agnelo: We need to figure out how to get more people to use it. One in four people are going to have some kind of psychological need, so how do we signpost people? We are launching beta testing live tomorrow on the app Health Help Now of a button for mental health assessment. It will take people to a series of questions and if they need help it will point them to IAPT.

Resident 1: It is the Croydon app?

Agnelo: It is used in other areas but this is the Croydon version.

Elsie: How many people have apps? Not everyone is computer literate.

Agnelo: The people who ask me for apps the most are the older people in my surgery. They haven't got a smartphone but they say ask for it anyway, and say they'll get their grandson or daughter to do it. In any case, the older age group are the smallest one, and the ones who don't have smartphones in that population are a very tiny group.

Elsie: How do you deal with those people?

Agnelo: You've got different channels. In being more digital, age is not the issue

Resident 3: Your point about communication is a very valid one. I also think you need to market these things in places where people actually go irrespective of age, and we know that more young people are affected. We mentioned more capacity in the system, I don't know exactly what you mean by that, but I would like to see more professionals supported and more service users and carers going into different places. Let's start at schools. Let's go to community centres. What about the GP federations being more active? I know that GPs are overburdened and overstressed but so are service users and carers. I would like to see my GP practice at the end of the working day being opened up to invite some of the community to come in and learn about Croydon Talking Therapies.

Agnelo: That is part of the social prescribing offer for every practice.

Resident 3: There is an incorrect assumption that things in the south of the borough are easier than in the north of the borough. I know the data and I know there are

huge pressures and changes. The fact is that 1 in 4 people have mental health issues and they are based all over. I think it's about time that more positive action was taken in the south of the borough.

Resident 2: Like this lady's coffee mornings.

Agnelo: All GP practices are promoting talking therapies all the time and have got loads of leaflets.

Elsie: If they have a day centre or places like that they need to be involved.

Agnelo: Part of social prescribing is community hubs. When I talk about social prescribing, even the GPs believe something can be done differently.

Resident 3: How is the CCG going to encourage that?

Agnelo: I wasn't at the meeting yesterday, but the network had their meeting and my project manager texted me saying they all want it now. I don't need to move them along. There's a lot more happening at the moment. The other thing is that some practices have the talking therapies located in the practice themselves.

Elsie: I think that is helpful.

Resident 2: You know where your GP surgery is so that's helpful.

Agnelo: The whole point is to build resilience rather than dependency. If people are in need they should be helped to get back to normal. The other thing is how to prevent people from needing it at all, so we have to start at schools as well. We know that young people are under enormous pressure. Last week we had five young people at Croydon hospital that have self-harmed.

Elsie: I called in at 5:30pm yesterday to talk about the computer and the things that affect the children. Before you're 25 there's something in the brain that is turned off and that's why these young teenagers behave in this way.

Agnelo: Now they've got social media.

Resident 1: I think about all the foolish things I did when I was a teenager, but nobody knows about them because they're not on social media or anywhere online.

Elsie: The abuse, too.

Agnelo: The talking therapies are for adults but in Croydon you've got fantastic younger people services. There is Croydon Drop In, in the south, and Off the Record, in the north. I've only heard good things.

Elsie: We heard this young girl today (at BME Mental Health event) who worked with the young carers.

Agnelo: I know you're governors of SLaM and as a commissioner it's about spending resource. Are we spending the money the right way? For younger people for example

we've got CAMHS (Children's and Adolescence Mental Health Services). It's about how we can use our resources differently and how we change our statutory services.

Resident 2: We need to know how they're performing now to see whether they're attracting people.

Elsie: You started to gather evidence and that's what you're moving on.

Agnelo: I think the talking therapies went out of fashion in Croydon because it took so long to get an appointment, but now the waiting time is less than 2 weeks.

Resident 2: My friend had to wait very long.

Agnelo: We need to consider how to market it differently. It's about approaching each different age group.

(Session ends)

healthwatch Croydon

Table 4 - Session 2: (17.34 to 17.53)

Elsie Sutherland: Facilitator (ES)
Dr Agnelo Fernandes: Chair of NHS Croydon CCG, and GP
Resident 1
Resident 2
Resident 3
Resident 4
Resident 5
Resident 6

Themes that came out of the discussions:

Services:
- How can we get the community more involved, use volunteers to support services?

Knowledge and communications:
- Diversity of population make a challenge, particularly over 150 languages. How do we communicate and deliver services better?

Support:
- How do we provide support to diverse audience?
- Are there ways of connecting with people not in a focus of needing mental health? Promoting mental wellbeing as much as mental health services.

Full Discussions

Elsie Sutherland: Let's introduce ourselves. My name is Elsie Sutherland, I am a facilitator here but we have a doctor who can put information to you. I volunteer for CCG and Healthwatch.

Resident 1: My name is Dominic, often shortened to Dom, and I work in patient participation in the north of the borough.

Resident 2: My name is Jill, I'm living in the south of the borough now. I have been a governor of SLaM representing my constituency in Croydon now for 4 years. I've found that it is very difficult to get a hold of the public in Croydon, although we did have a meeting which was well attended.

Resident 3: My name is Angela. I'm a Croydon resident and governor of SLaM and have been a carer for over 25 years.

Resident 4: My name is Raghu Shetty. I am the president of Asian Resource Centre of Croydon. Before Healthwatch was born there was something called CLCC, of which I was a member. I live near Kenley but spend most of my time around here.

Resident 5: I'm Jane, I work for SLaM. I used to work in psychiatric clinics, and I have just started to work to help patient involvement in adult mental health services in Lewisham and Croydon.

Resident 6: I'm Gloria and I'm a semi-retired nurse in the health service. I run a few awareness groups and work with young people

Resident 7: I'm Agnelo Fernandes and I'm a GP in Croydon.

Agnelo: We recently rebranded IAPTS as Croydon Talking Therapies. However, based on the size of our population we are not getting enough referrals, so there is an unmet need and we now need to ask how to get people to use the services. We recently sent rebranded leaflets with correct information to households in Croydon, which we are hoping people will keep and use. There are two groups we try to target. The first is people with long-term conditions, who are likely to have a psychological need upon diagnosis. We hope that their GP or practice will encourage care. The second group is people with any other form of mental illness where they feel they need support. We've got a whole list of them on the leaflet, which is now available in all practices. Our services can be used online, face-to-face individually or as a group of about a dozen people at a time. We are rolling out group consultations for many long-term conditions. The last discussion was about empowering practices, but we also need to consider how to get the community involved. This service is for adults but we also have a voluntary sector for younger people. This is about minor mental illness, but people with major mental illness who might still benefit often don't get access.

Resident 2: I think it's quite daunting for some people to meet someone and just talk about it. It can be daunting to go to a party as well when you're not in a mood. There must be a way to ease people in. What's the process?

Agnelo: You have an assessment on the phone.

Resident 2: Some people don't like to talk on the phone.

Elsie Sutherland: Somewhere in the GP surgery they should have voluntary trained people who can listen face-to-face, because that is better to build a relationship. That's how I would like to see a way forward.

Resident 6: I suppose if you treat it like you're having a party you should invite people that you know. We can just say we're having a general talk and take it from there. If you have that on a regular basis, then you start getting to know people a bit better. It might take a longer time but it could be arranged at a GP surgery.

Agnelo: One of the things I noticed is the diversity of the population of Croydon. Over 50% is not Anglo-Saxon white and 150 different languages are spoken. It is especially hard to involve the Asian and Eastern European communities whose first language is not English.

Resident 5: Talking therapy is difficult if you don't have the language or don't have a verbal way of communicating. The word 'talking' is still quite a barrier to me.

Elsie: It's like a medical term.

Resident 5: Everyone who uses the word 'therapy' thinks their way is the only way to do it.

Resident 2: If you meet somebody who is not familiar with your background, culture, or language there is immediately a barrier.

Elsie: Once a month on a Wednesday we have the 'A Place at the Table' thing where you have speakers and people doing different activities, and most of the people there are from the Asian community. We go on outings and sometimes they go to the seaside with us.

Resident 2: You get to know them. You need an immediate rapport if you're approaching a stranger.

Elsie: One pulled me aside to talk to me about mental health and the services available.

Agnelo: My mother could not comprehend mental illness. If over 50% of the population does not speak English as their first language, how do we break away that taboo and encourage them to use any form of therapy or recognise mental illness?

Resident 5: Can we sell it as mental wellbeing?

Resident 3: That's a WHO term.

Resident 5: Mental health is not just the absence of mental illness but about having a good life. I don't know if it would be considered too much an unfocused use of public money to offer it as wellbeing.

Resident 4: How do you go about identifying the languages and cultures and then actually targeting them. That is not easy.

Resident 3: You're right about cultural differences in how people respond to mental illness. I come from an Italian background and we look after our own, as Asian cultures do, and there's often a stigma. Why don't we invest in some chain of development for people from those diverse ethnic backgrounds who can actually engage with their own populations. Not in a hugely difficult or very high-level way, but marketing and introducing them to this service. Maybe it would be somebody who has actually used it themselves.

Resident 5: Like a health champion. For a lot of people just a warm conversation and introduction helps.

Resident 2: They need to find their way to somewhere where they feel happy and at home.

Elsie: That lady knew me from going to dance class, and something I said made her think I seem knowledgeable so she pulled me aside.

Resident 4: It's quite complicated because if you do that you'll be accused of bias towards one group or other. This is what happens. That is why you've got a limitation of budget. You can't train so many when you've got 150 languages.

Resident 5: You could start with the bigger ones.

Resident 6: I find that food is the way to get people together. Dancing, too.

Resident 4: In my company we eat together all the time.

Agnelo: For example, the ARCC could promote it.

Resident 4: There should be some mechanism whereby we can refer them to somebody responsible.

(Session ends)

Table 4 - Session 3: (17.56 to 18.16)

Terence: Facilitator
Dr Agnelo Fernandes: Chair of NHS Croydon CCG and GP.
Resident 1
Resident 2

Themes that came out of the discussions:

Services:

- Which services are being used well and which not?
- GPs and other areas of access need to be mental-health friendly locations in a similar way that they are dementia-friendly, from receptionist to health professional.

Knowledge and communications:

- Message needs to get out about capacity.
- People with low level mental health issues don't realise that the service is for them.
- Need to get out into the community such churches, mosques rather than relying on online resources.
- How do we normal discussion of mental health issues?
- Promote mental health first aid training

Support:

- Difficulty in filling in assessment forms for those who cannot read and write.

Full Discussions

Resident 1: My name is Shirley. I am from the ABM Forum and I am trying to start an organisation called Health News.

Resident 2: I'm Jo and I'm a health and wellbeing worker at Crisis UK.

Terence: I'm Terence.

Agnelo: I'm Agnelo Fernandes and I'm a GP. This discussion is about general practice in the community in terms of how we identify people who might be suffering from minor mental illness and getting them to access services. The service in Croydon is currently underutilised. We have a national target to meet and there has been a lot of investment, but people are not using the services. IAPT has recently been rebranded Croydon Talking Therapies. We have done a leaflet drop in the last month or so but we haven't seen any change so far. We have online and face-to-face individual or group therapies. It's easy to access, people can self-refer online or by

telephone. Why are people not using them, considering that 1 in 4 people are likely to benefit?

Terence: I remember from the IAPT talk that there are online services, one-day workshops, six-week groups, guided help, counselling, and CBT. If it is not being used then the possibilities are either that the service is not needed, people don't know enough about it, or the barrier to entry is too high.

Resident 3: Everybody who has been to it has benefited.

Resident 2: I stopped referring people because there was such a long waiting list, so it's news to me that there's all this capacity. I think the message needs to get out.

Terence: IAPT being underutilised is interesting. It might be useful to see which services are utilised and which aren't. What are the barriers? These could be a lack of knowledge or a lack of easy access.

Agnelo: Access is easy.

Resident 2: Another barrier is that once you're accepted you have to fill out those scales. I support a lot of people who can't read and write so they can't do the questionnaires.

Resident 4: That can be done on the telephone.

Terence: There is demand, but a lot of people who have these low level mental illness don't recognise that they can be helped by somebody other than themselves. They don't realise it's a service for them. I don't know to what extent this is the issue.

Resident 2: Possibly.

Resident 1: I think it's a conflicting statement that you didn't refer because of the waiting time and he said it's not used.

Agnelo: The waiting time has come down.

Resident 1: Yet the uptake is still not good.

Agnelo: It's not being used across the board.

Resident 1: How many BME specific trained CBT therapists are there in proportion to the BME statistics in mental health?

Agnelo: The problem exists even before they get into it and before they contact the service. The dropout rate is negligible.

Resident 1: When you have a therapist, you need to have certain things like culture and faith. All that impacts your therapy. I think the public should go to the mosques or the Christian churches to make them aware of the service. Some people can't

even go online or don't bother to go online, so you have to go them. Go to the barbershops, the hairdressers, or the mosques.

Terence: We want people to feel it's a service for them. As a member of the public I would want somebody who comes to me who is my kind of person, and who says they are either a user or provider of the service.

Resident 1: We need people specifically trained in each person's issues.

Agnelo: That hasn't been the barrier so far. The barrier is getting people into the therapies in the first place. 50% of the population in Croydon is BME and we've got 150 different languages spoken. I know from my own patients who are Eastern European, Asian, and Afro-Caribbean, that it's very difficult to get them to think they've got a mental problem and that talking therapies will help. They want something physical, like tablets.

Terence: In those cultures, talking issues are dealt with by family or their network.

Agnelo: There is a cultural issue in people thinking they can't benefit.

Resident 1: Back home people don't get tablets, they talk. You've got extended family. They go for natural therapies or talking to the family.

Agnelo: Back home there is also a stigma attached to mental illness. My own mother didn't understand the concept of depression or mental health. Things get swept under the carpet rather than addressing them. But you're right, churches, mosques, faith groups, and barbershops are important. I didn't realise that young black men spend more time in barbershops than anywhere else, so we started a barber project with Nike.

Resident 1: Youth clubs.

Terence: If there is a cultural issue of stigma, I don't know, but normalising mental health issues is a big, critical issue. One idea was having ambassadors in the workplaces. We give them a template saying they should have an ambassador with certain traits and we help them with information. They keep tabs on people, so they don't suffer in their careers or are stigmatised because they have a periodic mental health issue.

Agnelo: The workplace and all these other areas are important. The message to employers is that 1 in 4 members of your workforce will have some kind of mental illness at some time. The bottom line issue is that these people will be off sick and affect your productivity.

Terence: What you've given us here doesn't tell us why people are not coming in. It could be stigma, it could be cultural, it could be lack of information, I don't know.

Agnelo: It could be a combination of all, but we don't know because those are the people who are not engaging.

Resident 2: Do GPs check in to see if people they've suggested the service to have used it? Should there be someone who facilitates referrals? In my role, a lot of what I do is making referrals and going to appointments with people because they just don't get there. It's a lot of picking people up and taking them places. It could be that there's a group of people who feel the stigma or are shy or whatever. You need an extra person.

Resident 1: Maybe we have to start to think outside of the box. We could use innovative ideas like drama and music to educate people.

Agnelo: We need to consider the different communities that might respond to this. We've got a lot of Eastern Europeans who aren't connected to the local community.

Resident 1: You're bringing culture into the drama and the music to communicate it.

Terence: I came here as a child and it took me 11 years before I felt I knew the system. I think people just don't know enough. GP awareness of mental health is very good. However, people can be very sensitive and if the first interaction with the system is negative then they retreat, especially if it's a lower level issue. The first interaction is the person who answers the phone, and this is not a medical professional. They could be having a bad day and if the person comes in and sees that they will not interact with the system at all again.

Agnelo: I think you've hit the nail on the head with that. We're talking about GPs but it's actually about GP practices. We've got dementia friendly places now, so why can't we have mental health friendly practices? We could have basic training and awareness training in terms of how you interact with people. The first point of call is the receptionist, so how do they respond?

Resident 2: I went to mental health first aid training, which was a bit too low for me but that normalises it and asks people not to be so scared of it. The Mental Health Foundation runs it. It's not free. It's ideally for people like receptionists.

Agnelo: We should emphasise this.

Resident 1: Sometimes you go to the GP and the receptionist asks why you want to see the GP. They should stop doing that.

Agnelo: It's a double-edged sword. As a GP I get people who don't want to tell the receptionist why they're there but it's for something somebody else is meant to do. They end up seeing the wrong person for the wrong thing.

Terence: Related to that, no shows are a problem but the number of no shows could be reduced.

Agnelo: Every practice has got policies in terms of how they address this problem, but it's about one fifth of all patients.

(Session ends)