Joined Up Care Derbyshire

A strategic needs assessment of the mental health of Black people and Deaf people in Derby and Derbyshire

Version 1.2

September 2023

NHS

The Derbyshire VCSE sector Alliance

Derby City Council

DERBYSHIRE County Council

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Acknowledgements

Sincere thanks are given to the Joined Up Care Derbyshire Population Mental Health Task and Finish Group who supported and advised this report. Special mention is attributed to:

Derbyshire County Council
James Creaghan, The Knowledge and Intelligence Team, Helene Denness, Rebecca Symes, Thomas Dunn

Erewash Voluntary Action
Jodie Cook

NHS Derby and Derbyshire Integrated Care Board
Jennifer Stothard, Ruth Thomason, Mick Burrows

Derbyshire Healthcare NHS Foundation Trust
Sabia Hussain, Richard Morrow, Arun Chidambaram, Ade Odunlade

Healthwatch Derbyshire
Niki Glazier

Derbyshire Deaf Mental Health Forum
All members

Communication Unlimited
Alison Jones

Derby City Council
Allan Reid

North of England Commissioning Support Unit
Andrew Willis

Thanks also to East Midlands Ambulance Service NHS Trust and RealWorld Health

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Version	Date	Distribution	Comments
0.1 to 0.5	30 May 2023 to 10 August 2023	Derbyshire County Council Public Health Specialty Registrar and Knowledge & Intelligence Officer	Development of report and analysis
0.6	11 August 2023	Derbyshire Population Mental Health Task and Finish Group	Comments from Derbyshire Public Health Lead for Mental Health and Suicide Prevention and Derbyshire County Council Assistant Director of Public Health
0.7	16 August 2023	Derbyshire Population Mental Health Task and Finish Group	Comments from Mental Health Policy Officer and Derby City Council Consultant in Public Health
0.8	23 August 2023	Derbyshire County Council Assistant Director of Public Health	Comments from Derbyshire County Council Assistant Director of Public Health
0.9	31 August 2023	Derbyshire Population Mental Health Task and Finish Group	Finalise recommendations
1.0	1 September 2023	Mental Health, Learning Disability and Autism, Children & Young People System Delivery Board	Draft report for Board
1.1	7 September 2023	Derbyshire County Council Assistant Director of Public Health	Comments from Derbyshire County Council Assistant Director of Public Health
1.2	20 September 2023	Derbyshire County Council Assistant Director of Public Health	Finalised draft for publication

1. Executive summary

The information analysis and engagement in this needs assessment have highlighted inequities in the way Black people and Deaf people access and experience mental health care and support in Derby and Derbyshire.

The findings suggests that Black people in Derby and Derbyshire are less frequent users of some earlier intervention mental health services including being less likely to access the local mental health helpline and support service, NHS Talking Therapies, and Child and Adolescent Mental Health Services (CAMHS).

Data suggests that relative to the makeup of the Derby and Derbyshire population, Black people are over-represented on community mental health team (CMHT) caseloads and are more likely to present in crisis while on a CMHT caseload. Black people are also over-represented on local general practice serious mental illness registers and in use of inpatient mental health services. Black people in Derby and Derbyshire are more likely to be detained under the Mental Health Act and are detained for longer than people from other ethnic groups. Ambulance and emergency department attendances for mental health issues were low for Black people in Derby and Derbyshire relative to the size of the local population.

A very limited amount of data was available to explore access and experience of mental health services for Deaf people in Derby and Derbyshire. Engagement with Deaf community groups in Derby and Derbyshire provided an insight to experience around mental health and health care services. Whilst there was positive feedback about some of the local support available from groups and charities, concerns were raised about availability and accessibility of information, access to interpretation, choice and flexibility of services, and awareness of Deaf people and their needs.

The following recommendations have been drawn from the data analysis and engagement with stakeholders including community members.

The Joined Up Care Derbyshire Mental Health, Learning Disability and Autism System Delivery Board seek assurance that Board members, specifically organisations providing mental health services and/or mental health support:

- Have developed improvement plans detailing actions to increase the proportion of service-users where ethnicity is recorded. This is required to effectively assess the equity of access, outcome and experience.
- Considered how data collection systems can capture the proportion of service users who are Deaf, including those who have a first or preferred language of British Sign Language (BSL). This is required to effectively assess the equity of access, outcome and experience.
- Are working across the system to improve sharing of information to reduce inequity and inequality, recognising that is the aspiration is to include the wealth of data available beyond the health service. The local system will not

be able to identify and address inequalities in access and outcomes without appropriate sharing of information.

- Consider how workforce planning initiatives can include efforts to increase the number of Black people and Deaf people employed within Joined Up Care Derbyshire organisations: strengthening cultural values and increasing trust, visibility and accessibility.
- Ensure the needs of Deaf people are appropriately considered in the design, procurement, and ongoing delivery of mental health services, including Safe Haven and crisis cafes.

System partners / system response consider:

- Identifying the colleagues and system forums best placed to lead the next steps of this work, including prioritising efforts to access relevant data from general practice. These services are the primary provider of mental health care, and their recording of Deaf people and ethnicity may be more complete and thus be a useful adjunct to increasing understanding of the inequities identified in this needs assessment and may give rise to additional recommendations.
- How existing efforts to prevent mental ill health, identify mental health issues early, and reduce mental health stigma, could give particular emphasis to Black and Deaf people in Derby and Derbyshire given the inequities they experience. This could include, for example, initiatives in local communities and settings such as hairdressing and barber shops.
- How the various system groups can share ownership for broad actions to reduce health inequalities and how the findings of this work can inform targeted strategies to influence the wider determinants of health.
- Any synergies between this needs assessment and other strategies and plans including Health and Wellbeing Board strategy, Integrated Care System strategy and Joint Forward Plan, and any Joined Up Care Derbyshire annual operating plans. Many of these include specific commitments to reduce inequalities in health.
- How, given the known link between wider determinants and mental health, targeted support is provided for Deaf people and Black people including regarding employment opportunities and access to welfare rights advice.
- How system partners can work together to increase the trust and confidence that Black communities have in statutory partners. This should recognise that mistrust may be based on experiences of structural inequalities and racism.
- How Joined Up Care Derbyshire organisations can best engage with Black people in Derby and Derbyshire through existing community groups. This would address the primary gap in this needs assessment and bring a better understanding of experiences of services for this population group. Engagement should include exploring apparent relative underuse of early help services, aim to build trust, and co-produce long term actions.

- How training can be commissioned and provided for staff providing mental health care and support to increase awareness of the societal influences on mental health, including racism.
- How the quality and availability of British Sign Language interpreting services can be improved. This should include renewed efforts to meet national standards and appropriate performance management of current arrangements. A long-term plan should be developed to ensure there is a suitable level of BSL interpretation resource within Joined Up Care Derbyshire.
- How a better understanding of the mental health service needs of Deaf residents of Derby and Derbyshire can be informed by existing health service data. This should include a review of the use of specialist Deaf mental health services in Birmingham and Manchester by Derby and Derbyshire residents.
- How the accessibility of website communications across Joined Up Care Derbyshire organisations can be improved.
- How awareness of the culture and needs of Deaf people among staff in local health services can be improved through the provision of training. Where possible, this training should be provided by local voluntary sector organisations.
- How training in mental health first aid can be commissioned and provided for Deaf people. Derbyshire County Council should arrange this, and it should be provided by someone with high proficiency in BSL.
- How employment in local health and care services can be made more attractive to Deaf people. This should include reviewing recruitment processes to consider how inclusive they are to Deaf people.

Further work / next steps:

- The members of the Joined Up Care Derbyshire Mental Health, Learning Disability and Autism, Children & Young People System Delivery Board should consider the role of their organisations in responding to the findings and recommendations of this needs assessment. Each organisation should develop and share action plans and share their progress on delivery of the actions. This would not replace other existing assurance mechanisms including through NHS England.
- In addition to existing and ongoing work to understand and address inequalities, Derbyshire Healthcare NHS Foundation Trust should explore the high rate of people of Mixed ethnicity groups accessing CAMHS and older person’s community care.

Limitations

Strong, trusting relationships with groups representing Deaf people in Derby and Derbyshire ensured their views were represented in this needs assessment. Full engagement with Black community groups was not completed due to time

constraints and lack of in reach into these communities by health and wellbeing partners. This shows the need for an improvement in how health partners engage with communities. This is a significant limitation and means that that conclusions about the experience of Black people in relation to mental health should be drawn with caution. Research indicates that stigma and a lack of trust may play a role and consideration should be given to how the system can create an environment where Black people are confident to share their views and experiences.

2. Introduction and scope

A health needs assessment (HNA) is a widely used public health tool that provides opportunities for cross-sectoral partnership working and engagement with specific populations. It is “a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities” (1). As full engagement with both communities was not possible due to time constraints a full HNA was not achievable. This report provides a strategic overview of the needs of the communities and identifies the next steps for a more complete assessment of needs.

This strategic needs assessment focuses on mental health for Black and Deaf residents of Derby and Derbyshire. The primary aim of the work is to better understand how people in these groups access and experience mental health services and to make recommendations to address any inequities.

Whist most of the data and engagement relates to the experience of adults. Children and young people are not outside of the scope of the work and the analysis includes access to NHS child and adolescent mental health services by ethnicity.

The use of language around ethnicity in this report is aligned with the 2021 UK Census (2). Unless stated otherwise, “Black” includes people from Black British, Black Caribbean and Black African ethnic groups. We recognise this a broad category with a potentially wide range of backgrounds, experiences, and influences. This report does not use acronyms such as BME or BAME unless it is part of a quote.

The word “deaf” is used to describe or identify anyone who has a severe hearing problem or is severely hard of hearing (3). Deaf with a capital D is more often used to refer to people who have been deaf all their lives, or since before they started to learn to talk (3). “Deaf” is often used as part of an identity as people with a strong cultural affinity people whose first or preferred language is British Sign Language (BSL) (4). For some, the capital D is used in a political sense to demonstrate the campaign for cultural and linguistic recognition (5). Unless stated otherwise, this report refers to Deaf people as those with a first or preferred language of BSL.

3. Background

This strategic needs assessment aligns with the Joined Up Care Derbyshire 2019/20 – 2023/24 strategy's priorities around improving population outcomes and prevention and self-management (6).

This strategic needs assessment is informed by NHS England's NHS Core20PLUS5 approach to addressing health inequalities. The Core20 gives focus to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The PLUS aspect of the approach are locally identified populations, for example groups with multiple long term health conditions, with protected characteristics (as defined by the Equality Act 2010) or experiencing social exclusion (7).

At the August 2022 meeting of the Joined Up Care Derbyshire Mental Health, Learning Disability and Autism, Children & Young People System Delivery Board (MHSDB), two population groups – Deaf people and Black people – were nominated to be a focus for local efforts to reduce inequalities in mental health. At the November 2022 meeting of the MHSDB, the Board endorsed a proposed needs assessment to explore and better understand this topic, particularly access to and experiences of mental health services.

3.1 Inequalities in mental health

3.1.1 Black people

People who live in poorer neighbourhoods are at higher risk of developing mental health problems (8,9). People from Black ethnic groups have higher rates of poverty and are more likely to live in the most overall deprived 10% of neighbourhoods (10).

Unemployment and unstable employment are both risk factors for mental health problems. The 2021 UK census showed that unemployment was highest for people who identified within Black ethnic groups (11).

Issues relating to housing impact on mental health (12). The 2021 census demonstrates that home ownership, rent and overcrowding vary hugely between ethnic groups. For example, around 17% of the population of England and Wales live in social rented housing (such as from a council or housing association). For people who identified as Black African this was 44%, 41% for Black Caribbean, and 48% of other Black backgrounds (8).

Physical health problems significantly increase the risk of poor mental health (13). Prevalence of physical health conditions in the UK vary significantly by ethnicity. For example, prevalence and mortality from cardiovascular disease is high in South Asian groups and prevalence of diabetes is up to three times higher in Black groups than in the White population (14).

A recently published survey illustrated the prevalence of racism and ethnic inequalities in Britain (15). Many Black Caribbean respondents reported experiencing racial discrimination in public settings (49.3%), racial discrimination from the police (42.7%), and racist assault (19%) (16). Exposure to racism increases the likelihood of experiencing mental health problems including stress, depression, and psychosis (17, 18). Experience of racism may influence whether people seek care when they need it (19). Research from the Care Quality Commission (20) found that people from a Black and minority ethnic backgrounds were less likely to raise concerns about the standard of care they receive, particularly in relation to mental health.

The 2014 Adult Psychiatric Morbidity Survey found that Black people were more likely to experience common mental health conditions (23% in the previous week) than people from other ethnic groups (Asian 18%; White 17%) (21). The prevalence of psychotic disorder in the past year (using combined 2007 and 2014 data) was higher among Black men (3.2%) than men from other ethnic groups (1.3% in Asian men; 0.3% White men) (21). Levels of treatment did not correspond with levels of need. White British people were the ethnic group most likely to report receiving treatment (14.5%); Black adults had the lowest treatment rate (6.5%) (21).

A wide range of issues have been reported that act as barriers to people from Black and minority ethnic groups in the UK from seeking support for mental health issues. This includes under recognition of mental illness due to stigmatisation; limited knowledge of how to access available support; fear of discrimination and distrust in healthcare professionals and services; and lack of appropriate interpreting services (17,22).

Stigma attached to mental disorders can prevent those affected from getting psychological help. A systematic review and meta-analysis of international studies found stigma around mental illness is higher among ethnic minorities than majorities (23). In the United Kingdom, Rethink Mental Illness and the Mental Health Foundation report that people from Black, Asian and Minority Ethnic groups have told them there are barriers in some cultures where mental health issues are not recognised and stigma that stops some people from seeking help (17).

An evidence review published in 2019 found that that people from minority ethnic groups were less likely to access mental health services through primary care, more likely to end up in crisis care and 40% more likely to access mental health care via the criminal justice system (18). A review from the NHS Race and Health Observatory (22) found ethnic inequalities relating to mental health services including differing access to Improving Access to Psychological Therapies (IAPT); evidence of harsher treatment for Black groups in inpatients wards (e.g. more likely to be restrained in the prone position or put into seclusion); and Black children being ten times more likely to be referred to child and adolescent mental health services via social services (rather than through a GP) relative to White British children.

The NHS Race and Health Observatory (22) noted “persisting ethnic inequalities in compulsory admission to psychiatric wards”. Between April 2021 and March 2022, Black people in England were almost five times as likely as White people to be detained under the Mental Health Act (23). Black people were detained at a rate of 342 for every 100,000 people, compared with 72 detentions per 100,000 people for White people (23).

Recent UK research took a meta-ethnography approach to explore why people from ethnic minority groups are underrepresented in primary care mental health service provision and overrepresented in crisis pathways and detention (24). The work found that current methods of assessment and treatment, particularly in psychiatry, were experienced as reductionist, oppressive, and racist. These approaches exclude “wider causes of mental illness such as racism and migration stress and locates the pathology in the individual rather than broader social circumstances”. The authors’ synthesis found that experiences of oppression were perceived to be most systemic and deeply entrenched for Black ethnic groups (24).

3.1.2 Deaf people

People who are Deaf or have hearing loss are twice as likely to experience mental health problems compared to people without hearing loss (25). In a study by SignHealth (26), Deaf people reported more depression (24%) than the rest of the population (12%). Another study found rates of depression to be higher in Deaf women (31%) than in Deaf men (14%) (27). Some estimates suggest a prevalence of mental health problems of 40% in Deaf children compared to 25% in their hearing counterparts (28).

Deafness itself is not a cause of psychosocial problems, but such problems are likely to be impacted by parental, societal and cultural factors such as communication and attitudes towards deafness (29). Deafness is associated with social exclusion and reduced educational and employment opportunities (30). Educational attainment for Deaf children is significantly lower than for hearing children. 28% of Deaf children in the East Midlands were considered to have reached a good level of development in the early years foundation stage in 2022 compared to 65% for all children in the region (31). 32.2% of Deaf children in the East Midlands achieved a grade 5 or above in both English and maths in 2022 compared to 47.5% for all children in the region (31) Deaf people and people with hearing loss are less likely to be employed than the general population. The Royal Institute for Deaf People (25) reported that 37% of people with BSL as their main language were in employment compared to 77% of people who are not defined as disabled under the Equality Act (2010).

Levels of smoking and alcohol use are lower among Deaf people than the general population (26, 27). SignHealth (28) reported that Deaf women are twice as likely to experience domestic violence than hearing women.

Deaf people face barriers to access healthcare and poorer outcomes. Research from Sign Health (26) found poor provision of information, limitations in communication with professionals and services and issues around under-diagnosis and under-treatment for Deaf people.

The Royal College of Psychiatrists (32) have argued that mental health care for Deaf people with the support of an interpreter can make treatment less effective due to potential stress and misunderstanding and that Deaf people should be able to choose to see a therapist fluent in sign language.

3.2 Local population

The combined population of Derby (261,400) and Derbyshire (794,600) was estimated to be 1,056,000 in 2021 (2).

People in White ethnic groups make up the majority of the population in both Derby (73.8%) and Derbyshire (96.3%). The 2021 census estimated there were 10,482 Black or Black British people in Derby (4%) and 4,085 Black or Black British people in Derbyshire (0.5%). This gives a combined estimate of 14,567 Black or Black British people in Derby and Derbyshire, 1.4% of the population (2).

British Sign Language was reported to be the main language for around 21,000 people in England (0.04%) in the 2021 census (2) This included 250 people in Derbyshire and 447 people in Derby (total of 697 in city and county). The Derby number equates to 0.2% of the population – this is the highest percentage of any area in England and Wales. The ONS (2) speculated that this high proportion could be as people move to Derby for children to attend the Royal School for the Deaf and remain in the area because of an active Deaf community.

An alternative, less robust, source for the number of Deaf people in Derby and Derbyshire is the annual GP Patient Survey. A total of 13,071 respondents to the 2022 survey were from the Joined Up Care Derbyshire area. 80 people (0.61%) reported being a “deaf person who uses sign language” (33).

3.3 Population mental health in Derby and Derbyshire

Social and environmental factors have a significant impact on mental health. People with mental illness are more likely to have higher rates of poverty, homelessness, incarceration, social isolation, and unemployment (34). Rewarding employment, stable housing, financial security, and social networks can all act as protective factors (34).

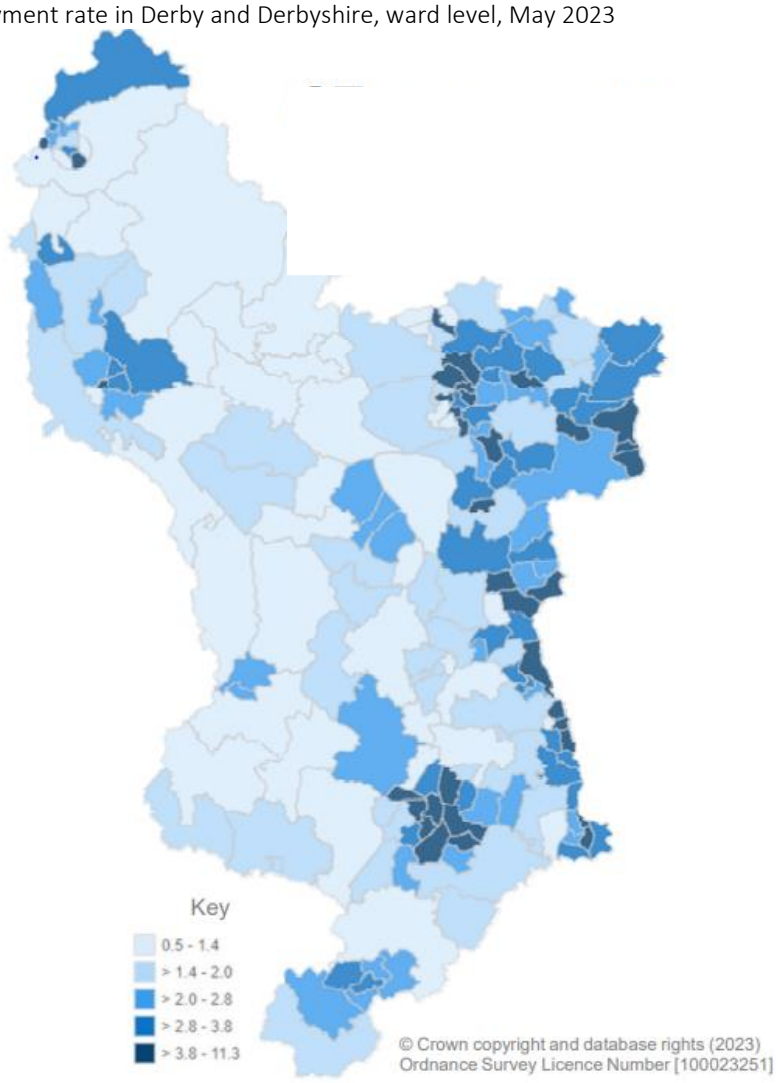
The crude rate of households in temporary accommodation was low in Derby (1.2%) and Derbyshire (0.7%) in 2021/22 compared to the England average (4%) (35).

8.4% respondents to England's 2021/22 Annual Population Survey reported a low happiness score. The figure for Derby was 11.2% and 9.9% for Derbyshire (35). These differences from the national figure are not statistically significant as the 95% confidence intervals for the estimates are wide.

The crude rate of long-term claimants of Job Seeker's Allowance in Derby was 2.5 per 1,000 in 2021. This is significantly higher than the England average (2.1 per 1,000). In Derbyshire, 1.6 people per 1,000 were long term claimants – significantly lower than the England average (35).

The Claimant Count unemployment rate for England in April 2023 was 3.9% (36). The overall rate for Derbyshire at this time was 2.8% - this differs by ward (see Figure 1 below). The Derbyshire ward with the highest unemployment rate was Rother (6.4%). 5.1% of people in Derby were unemployed in April 2023 (36).

Figure 1– unemployment rate in Derby and Derbyshire, ward level, May 2023



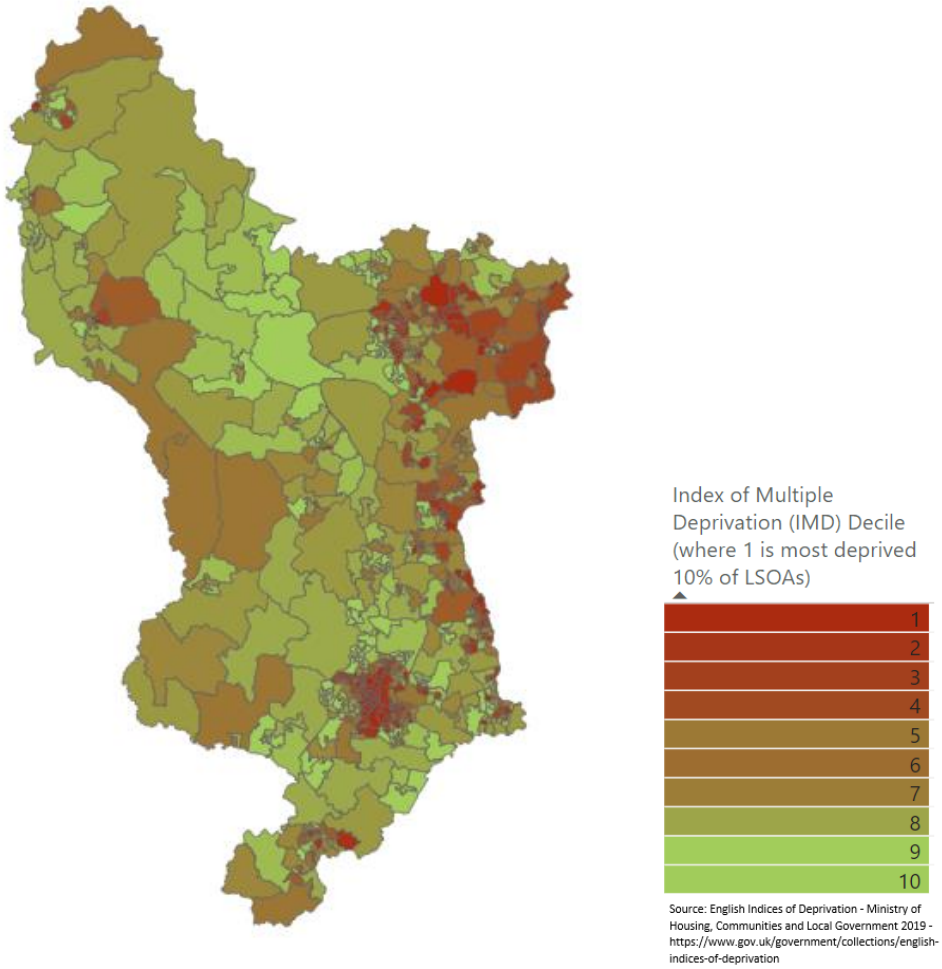
The Index of Multiple Deprivation (IMD) is the most commonly used measure of deprivation. It produces an overall measure of deprivation by combining indicators on income, employment, education, skills and training, health and disability, crime, barriers to housing services, and living environment.

The 2019 IMD index showed that 22 of the 491 (4.5%) small areas (lower super output areas) in Derbyshire fell within the 10% most deprived in England. Most of these areas are located in the North East of the county in the former coalfields areas. Of 317 local authority districts in England, North East Derbyshire is ranked 170 on average IMD score (number 1 being most deprived) (37).

Twenty-four (16.1%) of Derby small areas are in the most deprived 10% in England. Derby is ranked 67 out of 317 local authority areas in England (number 1 being most deprived) (37).

Figure 2 below shows the deprivation of small areas (lower super output areas) in Derby and Derbyshire.

Figure 2 – Index of multiple deprivation (IMD) decile in Derby and Derbyshire, lower super output (LSOA) level, 2019



Prevalence of depression among adults recorded in general practice (Quality and Outcomes Framework) in 2021/22 was higher in Derbyshire (14.9%) than the England average (12.7%). The percentage of adults in Derby recorded as having depression (12.5%) was statistically similar to the England figure (35).

Recorded prevalence of serious mental illness (all ages) was lower in Derbyshire (0.87%) in 2021/22 than England (0.95%). Prevalence in Derby (0.97%) was statistically similar to the England figure (35). Recorded prevalence may be an underestimate of actual prevalence.

The Derbyshire sustainability and transformation plan (STP) area includes Derby. This STP had one of the lowest rates of new referrals to secondary mental health services for young people of any area in England in 2019/20. The directly standardised rate for England in this time period was 6,977 per 100,000. For the

Derbyshire STP area this was 4,614 per 100,000 (35). Of the 42 included STP areas in England, Derbyshire (including Derby) had the third lowest directly standardised rate of inpatient mental health stays before people aged under 18 years in 2019/20 (35).

Between 2018 and 2020 suicide rate in Derby and Derbyshire was 10.6 per 100,000 – statistically similar to the England figure for the period (10.4 per 100,000) (35).

4. Methods

This strategic needs assessment collated and summarised data on mental health for these two groups. The aim was to consider data across a range of intensity of mental health support. This included calls to the local mental health helpline and treatment from NHS Talking Therapies (previously IAPT) through to crisis presentation in a range of settings as well as detention under the Mental Health Act (1983).

A wide range of data was requested with attempts made to source and include data beyond NHS services, for example from the police service, coroner's service, and approved mental health professionals. These requests were not successful, and the data analysis is limited to healthcare services.

- Data on general practice serious mental illness registers is collected by primary care networks, compiled by NHS England, and was provided to contribute to this piece of work by the NHS Derby and Derbyshire Integrated Care Board.
- Data on access to and outcomes from NHS Talking Therapies is publicly available via NHS Digital.
- Data on use of specialist mental health services was provided by Derbyshire Healthcare NHS Foundation Trust (DHCFT). Analysis of access DHCFT's services by a consultancy (RealWorld Health) were provided to use for this work by the Trust.
- Data on ambulance service attendances was provided by the East Midlands Ambulance Service NHS Trust.
- Data on emergency department attendances and referrals to specialist mental services was provided by the North of England Commissioning Support Unit.

Much of the information analysis takes the approach of comparing use of healthcare services to the demographics of the local population. Due to the size of the local Deaf population, and the limitations of the recording of Deaf people within healthcare information systems, this is almost entirely limited to ethnicity. This means there has been very little opportunity to explore equity of access to mental health services for Deaf people through the data analysis.

Where possible, the analysis applies frequency of service usage for mental health issues to the local population, split by high-level ethnicity grouping. This allows for some consideration about the rate at which different ethnicities are using different elements of mental health services. This calculation of rates is based on the size of the local population (from the 2021 Census) and does not attempt to factor in differing levels of incidence or prevalence of mental health issues by ethnicity.

Unless stated otherwise, the activity data relates to episodes of care. This means that individuals can be recorded within the dataset more than once. Where charts are included, ethnicity is ordered by lowest to highest rate within each high-level category.

The report presents summary findings from engagement with Deaf community groups on the subject of mental health in summer 2022 and early 2023. Efforts to engage with a small number of existing Black community groups in Derby and Derbyshire were made in the first half of 2023. Due to the limited time frame to complete the work, this engagement was not achieved.

5. Findings

5.1 Information analysis

General practice

Serious mental illness registers

NHS England hold data on the numbers of people on general practice serious mental illness registers, this data can be split by ethnicity. On 11 January 2023 there were 7,431 people on Derbyshire and Derby general practice serious mental illness registers (24). 220 (2.96%) were in Black or Black British ethnic categories. Ethnicity was not recorded for ten of the individuals (0.13%) in this data. Black people make up approximately twice the proportion of people on general practice serious mental illness registers than we would expect if recorded levels of serious mental illness were equally distributed in the local population (1.4% of people in Derby and Derbyshire are Black).

Referrals from general practice to specialist mental health services

31,844 referrals were made from Derby and Derbyshire general practices to specialist mental health services in 2022. 391 of these referrals (1.23%) were for Black people. Interpreting any difference between this figure and the local population (1.4% of people in Derby and Derbyshire are Black) should be done with some caution as ethnicity was not recorded for 1,467 (4.61%) referrals.

NHS Talking Therapies

The NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies) was developed to improve the delivery of, and access to, evidence-based psychological therapies for depression and anxiety disorders (38).

Activity data can be viewed at England level and by Integrated Care Board (ICB) or provider. The data can be further broken down by “ethnic group” and “disability” (39). The data set records problems with hearing as a “disability”. This is likely to include people with a first or preferred language of BSL and other people with severe hearing loss.

Between 1 April 2021 and 31 March 2022, 600 referrals were made for people recorded as having a hearing disability in the Joined Up Care Derbyshire area. Table 1 below shows that people recorded as having a hearing disability who are referred to NHS Talking Therapies are less likely to access the treatment and less likely to complete the treatment than people who are recorded as having no disability. Although it is likely that most of the people recorded in this data as having a hearing disability are not Deaf BSL users, there are some conclusions that can be drawn about the accessibility of these services for people with severe hearing loss.

Table 1 – Access to NHS Talking Therapies by recorded disability, Joined Up Care Derbyshire area, 2021/22, NHS Digital

	Recorded hearing disability	Recorded no disability
Referred to treatment	600	23,650
Accessed treatment	485 (81%)	20,540 (87%)
Completed treatment	325 (54 %)	16,375 (69%)

The outcomes for people who finished a course of treatment can be compared across a range of variables. Table 2 below sets out the outcomes from NHS Talking Therapies in 2021/22 for people recorded as having a hearing disability compared to those with no recorded disability. There are no statistically significant differences in outcomes between people recorded as having a hearing disability and people with no recorded disability.

Table 2 – Outcomes from NHS Talking Therapies by recorded disability, Joined Up Care Derbyshire area, 2021/22, NHS Digital

	Recorded hearing disability	Recorded no disability
Recovery	155 (51%)	7890 (51%)
Reliable recovery	140 (47%)	7475 (49%)
Reliable improvement	205 (63%)	10830 (66%)
No reliable change	65 (20%)	3755 (23%)
Reliable deterioration	20 (6%)	800 (5%)

Data from the same time period showed 555 referrals were made to NHS Talking Therapies in the Joined Up Care Derbyshire area for people recorded as being Black or Black British. Table 3 below shows that the percentage of Black people access and completing treatment was statistically similar to White people. Asian or Asian British people referred to NHS Talking Therapies were less likely to access it and complete it compared to White people.

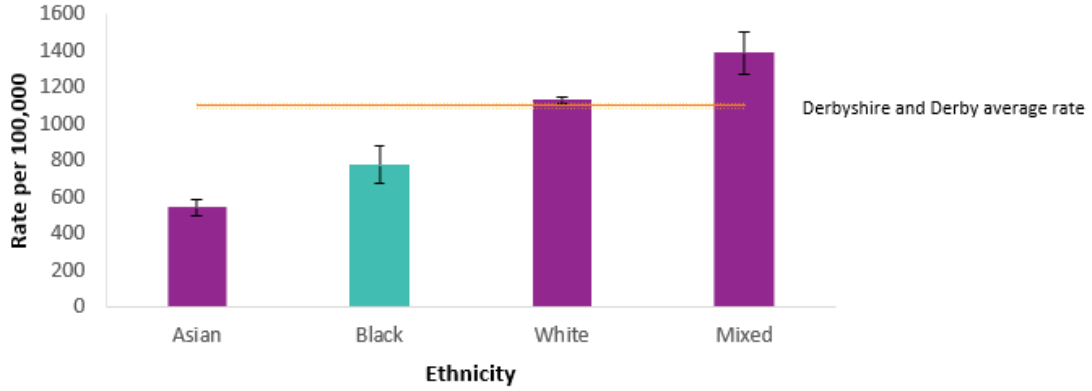
Table 3 – Access to NHS Talking Therapies by ethnic group, Joined Up Care Derbyshire area, 2021/22, NHS Digital

	Black or Black British (all)	Asian or Asian British (all)	White (all)
Referred to treatment	555	1,505	38,810
Accessed treatment	390 (70%)	995 (66%)	28,130 (72%)
Completed treatment	290 (52%)	770 (51%)	21,100 (54%)

Activity data received directly from the local healthcare trust was also analysed. Figure 3 shows that people from Mixed ethnic groups used Derbyshire Healthcare NHS Foundation Trust's NHS Talking Therapies / IAPT services significantly more

than the Derby and Derbyshire average in 2021 and 2022. Black people used these services significantly less than the Derby and Derbyshire average in this time period.

Figure 3 – IAPT / NHS Talking Therapies episodes per 100,000 population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

Pooled rates calculated using 2021 Census population data due to unavailability of 2022 Mid Year Estimates

Refused, Null, Unknown and Other ethnicities are excluded from the graph

Research has demonstrated that ethnic group codes for “other” and “mixed” are overused with poor alignment between census records and hospital data (40). This results in an overestimation of rates of activity for “mixed” and “other” groups and an underestimation of rates for the Asian and Black ethnic categories (41). This could partially explain the high rates of use of this and some other services by people in mixed ethnic groups.

Table 4 below sets out the outcomes from NHS Talking Therapies in 2021/22 split by three high level ethnicity groups. There are no statistically significant differences in outcomes by ethnicity.

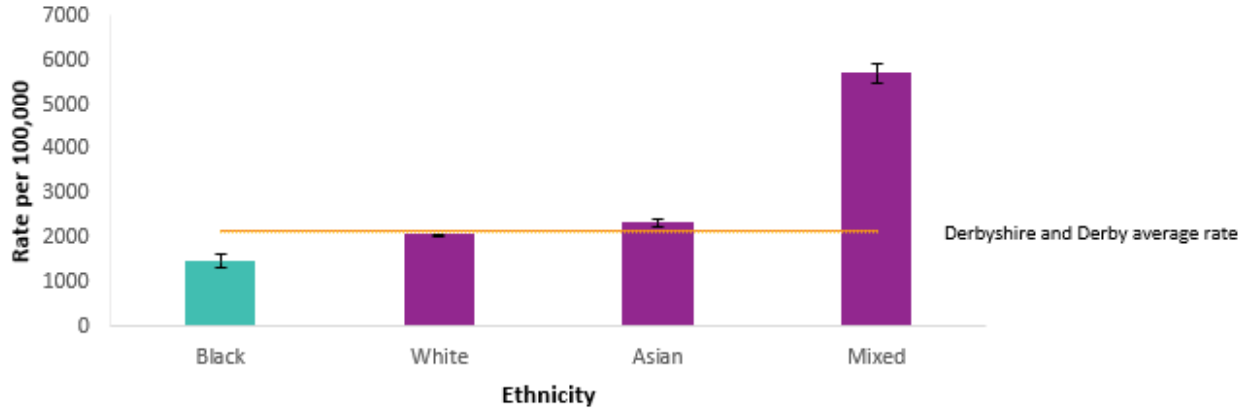
Table 4 – Outcomes from NHS Talking Therapies by ethnic group, Joined Up Care Derbyshire area, 2021/22, NHS Digital

	Black or Black British (all)	Asian or Asian British (all)	White (all)
Recovery	135 (50%)	345 (47%)	10,025 (51%)
Reliable recovery	125 (47%)	320 (44%)	9,455 (48%)
Reliable improvement	180 (62%)	505 (65%)	13,840 (66%)
No reliable change	80 (28%)	200 (26%)	5,170 (24%)
Reliable deterioration	10 (4%)	45 (6%)	995 (5%)

Mental Health Helpline and Support Service

The Derbyshire Mental Health Helpline and Support Service is a 24 hour a day, seven day a week freephone service for Derby and Derbyshire residents. People with mental health issues or concerns can call this service for advice and support. 52,322 calls were made to the helpline between January 2021 and December 2022. The ethnicity of the callers is set out in figure 4 below. This shows that Black residents of Derby and Derbyshire called the helpline significantly less than would be expected based on the demographics of the local population. People from Mixed ethnicities were statistically significantly much more likely to call the helpline for advice and support in this time period.

Figure 4 – Calls to DHcFT Mental Health Helpline and Support Service per 100,000 population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

Pooled rates calculated using 2021 Census population data due to unavailability of 2022 Mid Year Estimates

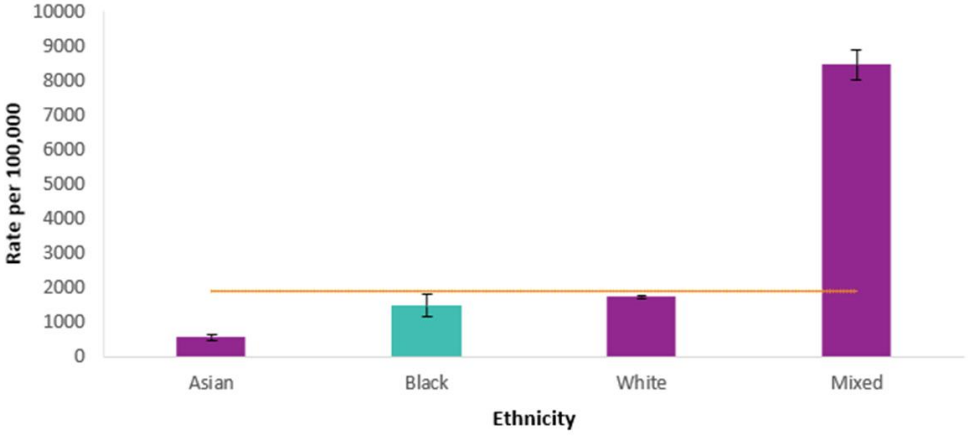
Refused, Null, Unknown and Other ethnicities are excluded from the graph

Filtered call duration to exclude minus values

Child and adolescent mental health services

Derbyshire Healthcare NHS Foundation Trust provides CAMHS in Derbyshire. There were 7,770 episodes of care for people aged between zero and 17 years in these services between January 2021 and December 2022. 79 (1.0%) of these were for children and young people in Black ethnic groups. 1,475 (19.0%) users of these services were children and young people from Mixed ethnic groups. Figure 5 below applies this activity to the Derby and Derbyshire aged zero to 17 years population. The figure shows that use of these services by children and adolescents in Black ethnic groups was significantly lower than the Derby and Derbyshire average in 2021 and 2022. Children and adolescents in Mixed ethnic groups used these services at a significantly higher rate across the two-year period.

Figure 5 – Child and adolescent mental health service episodes per 100,000 aged 0-17 years population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

Pooled rates calculated using 2021 Census 0-17 year age group population data due to unavailability of 2022 Mid Year Estimates

Refused, Null, Unknown and Other ethnicities are excluded from the graph

Numerator filtered to include ages 0-15 years and 16-17 years

Adult community mental health team (CMHT)

Real World Health were commissioned by Derbyshire Healthcare NHS Foundation Trust to undertake analysis as part of a programme of work to understand and reduce inequalities in the Trust's services. Part of Real World Health's analysis included consideration of the ethnicity of people on the Trust's CMHT caseload.

10,204 people were on the Derbyshire Healthcare NHS Foundation Trust CMHT caseload on 1 January 2023. 235 (2.3%) of these were people with a recorded Black ethnicity. As Black people make up 1.4% of residents of Derby and Derbyshire, this suggest that Black people were over-represented on the Trust's CMHT caseloads at the start of 2023. However, as numbers are relatively small these conclusions should be drawn with caution. Ethnicity was unknown for 300 (2.9%) of the data analysed by Real World Health for this purpose.

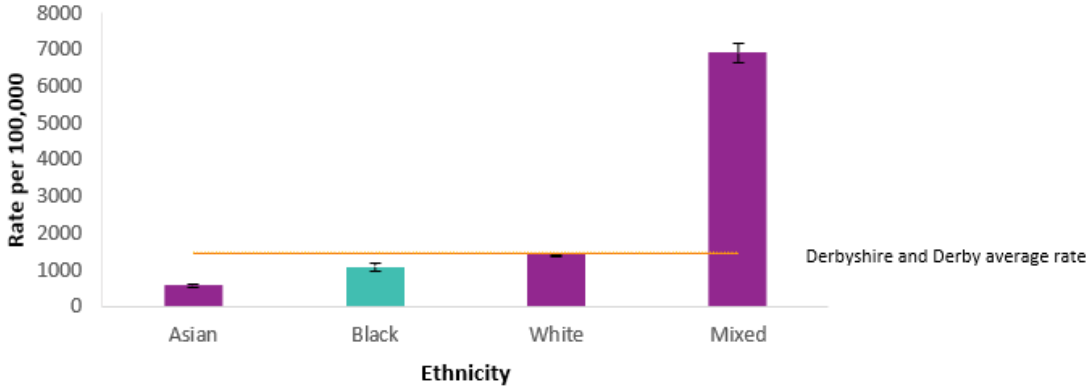
Real World Health's analysis demonstrated that there were 2,176 crisis presentations for people on Derbyshire Healthcare NHS Foundation Trust CMHT caseloads in 2022. 68 (3.1%) of these were people with a recorded Black ethnicity while ethnicity was unknown for 51 (2.3%). This suggest that as well as being overrepresented on CMHT caseloads, Black people are more likely to present in crisis while on a CMHT caseload than would be expected based on the size of the local Black population. As above, these conclusions should be made with caution because of the small numbers.

Older people's community care

There were 30,451 episodes of care in Derbyshire Healthcare NHS Foundation Trust's older people's community care services between January 2021 and December 2022. 313 (1.03%) of these were for people in Black ethnic groups. 2,818 (9.25%) users of these services were people from Mixed ethnic groups.

Figure 6 below shows that people from Mixed ethnic groups used Derbyshire Healthcare NHS Foundation Trust's older people's community care services at a significantly higher rate than the Derby and Derbyshire average in 2021 and 2022. Use of these services by Black people, and in particular Asian people, was significantly lower than the Derby and Derbyshire average.

Figure 6 – Older people's community care episodes per 100,000 population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

Pooled rates calculated using 2021 Census population data due to unavailability of 2022 Mid Year Estimates

Refused, Null, Unknown and Other ethnicities are excluded from the graph

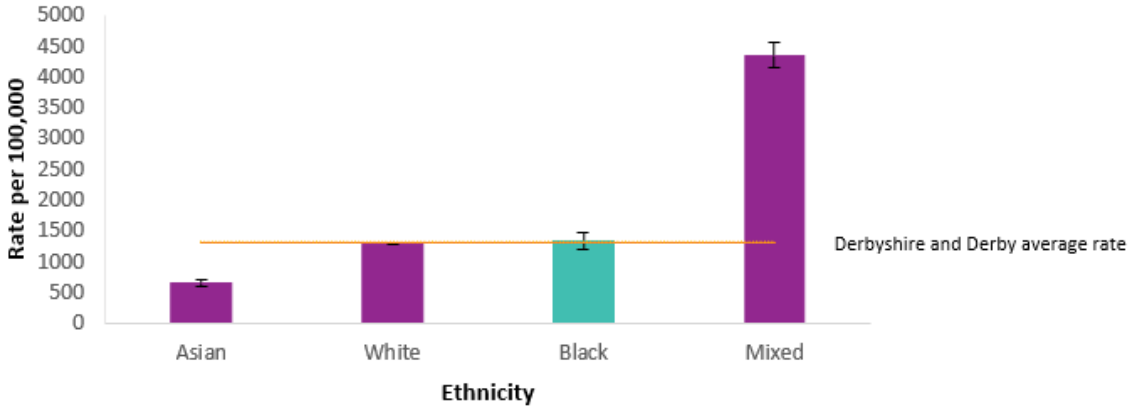
Adult urgent assessment

There were 27,578 episodes of care in Derbyshire Healthcare NHS Foundation Trust's adult urgent assessment services between January 2021 and December 2022. 386 (1.40%) of these were for people in Black ethnic groups. 1,772 (6.42%) users of these services were people from Mixed ethnic groups.

Figure 7 shows that Black people used these services at a rate similar to the Derby and Derbyshire average. Asian people in Derby and Derbyshire have significantly lower rate of use of Derbyshire Healthcare NHS Foundation Trust's adult urgent assessment service in 2021 and 2022 than the local average. People from Mixed

ethnic groups used these services at a significantly higher rate than the local average.

Figure 7 – Adult urgent assessment episodes per 100,000 population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

Pooled rates calculated using 2021 Census population data due to unavailability of 2022 Mid Year Estimates

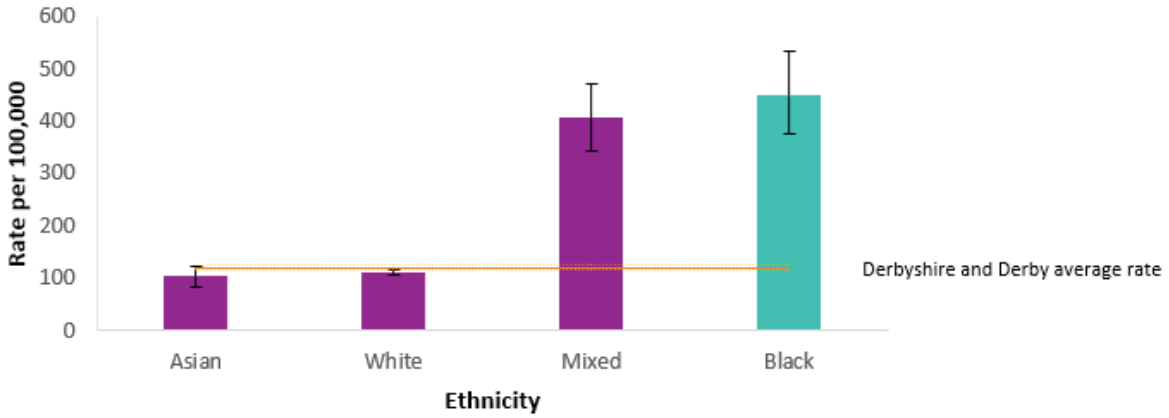
Refused, Null, Unknown and Other ethnicities are excluded from the graph

Adult inpatient services

There were 2,512 episodes of care in Derbyshire Healthcare NHS Foundation Trust's adult mental health inpatient services between January 2021 and December 2022. 131 (5.21%) of these were for people in Black ethnic groups. 165 (6.57%) users of these services were people from Mixed ethnic groups.

Figure 8 below shows that adults in Black and Mixed ethnic groups used Derbyshire Healthcare NHS Foundation Trust mental health inpatient services significantly more than the Derby and Derbyshire average.

Figure 8 – Adult inpatient episodes per 100,000 population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

Pooled rates calculated using 2021 Census population data due to unavailability of 2022 Mid Year Estimates

Refused, Null, Unknown and Other ethnicities are excluded from the graph

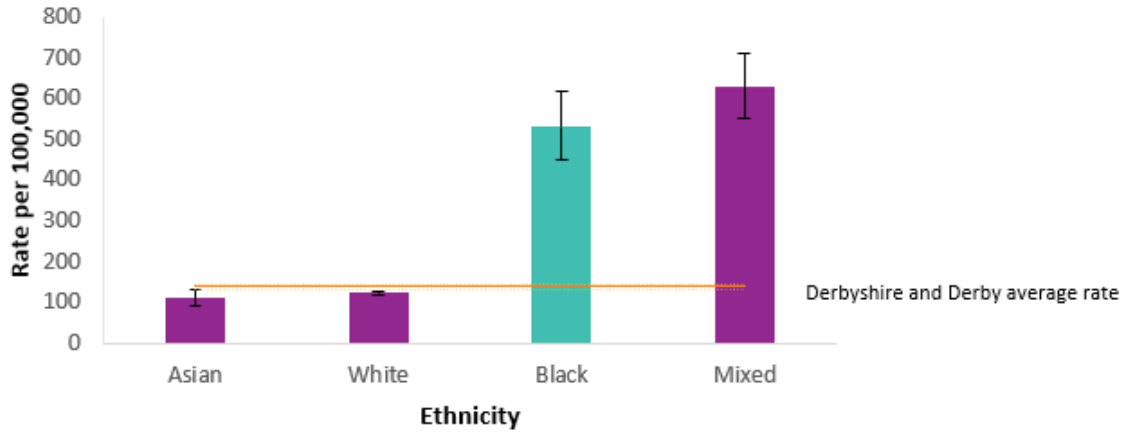
Mental Health Act detentions

The Mental Health Act gives powers to specific professionals to detain people if they think their mental health puts themselves or others at risk.

A total of 2,027 detentions were made under the Mental Health Act at Derbyshire Healthcare NHS Foundation Trust between January 2021 and December 2022. 104 of these episodes (5.13%) were for people recorded in Black ethnic groups. Some people were detained more than once in this period. When the data is filtered for individuals, removing any multiple detentions in the period, a total of 1,158 individuals were detained. Of these, 48 (4.15%) were Black.

Figure 9 below is based on episodes – as such, some individuals are recorded more than once. The figure shows that in 2021 and 2022 Black people in Derby and Derbyshire were detained under the Mental Health Act at significantly higher rates than White or Asian people. This is consistent with the experience of Black people relative to other ethnic groups across England (24).

Figure 9 – Detentions under the Mental Health Act per 100,000 population, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Error bars represent 95% Confidence intervals

Source: Derbyshire Healthcare NHS Foundation Trust

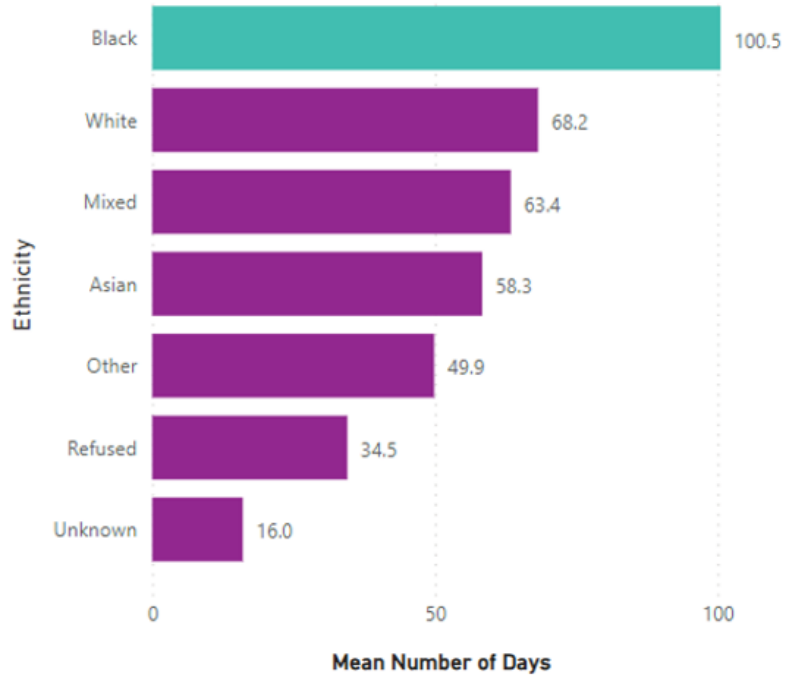
Pooled rates calculated using 2021 Census population data due to unavailability of 2022 Mid Year Estimates

Refused, Null, Unknown and Other ethnicities are excluded from the graph

The mean length of detention was calculated for individuals detained under the Mental Health Act at Derbyshire Healthcare NHS Foundation Trust in 2021 and 2022. This data relates to the use of these services by individuals and does not take into account whether those people have been detained more than once in the time period.

Figure 10 below shows that the mean length of detention for Black people was more than 100 days. This is more than 30 days higher than the next highest ethnic group (White).

Figure 10 – Mean length of detention under the Mental Health Act, Derbyshire Healthcare NHS FT, January 2021 to December 2022



Source: Derbyshire Healthcare NHS Foundation Trust

Section 136 of the Mental Health Act gives police forces powers to detain people who they think may have a mental disorder. In 2021/22, police services in England and Wales detained 36,594 people under MHA section 136; 2,302 (6.29%) of these were from Black ethnic groups (42).

Police services detained 270 people in Derbyshire under MHA section 136 in 2021/22, of which nine (3.33%) were from Black ethnic groups. Ethnicity was not known or not stated in only two (0.74%) of these. It is not possible to confidently draw conclusions from the Derbyshire figures due to the small numbers.

Ambulance service

There were 9,415 ambulance attendances for Derby and Derbyshire residents for mental health issues in 2022. The most common mental health reasons for an ambulance to attend were for incidents categorised as anxiety (3,265; 35%), depression (1,186; 13%), and intentional drug overdose (919; 10%).

Of the 9,415 ambulance attendances, 37 (0.39%) were for people with a recorded Black ethnicity. Ethnicity was not recorded for 450 (4.78%) of these attendances. Despite the limitations in completeness of the data, it appears that ambulances are attending to Black people with mental health concerns proportionately less than might be expected for the size of the local population (1.4% of people in Derby and Derbyshire are Black).

Emergency departments

There were 9,046 emergency department attendances for Derby and Derbyshire residents for mental health issues in 2022. The most common mental health presentations were for depressive disorders (1,845; 20%), anxiety disorders (1,571; 17%), and delirium (902; 10%).

Of the 9,046 emergency department attendances, 61 (0.67%) were for people with a recorded Black ethnicity. Ethnicity was not recorded for 821 (9.08%) of these attendances, limiting the ability to draw conclusions. Despite the limitations in completeness of the data, it appears that Black people are presenting at emergency departments with mental health concerns proportionately less than might be expected for the size of the local population (1.4% of people in Derby and Derbyshire are Black).

5.2 Engagement

5.2.1 Deaf Mental Health Day, 4 July 2022

In July 2022, a network of individuals, groups, and organisations met to share experiences around Deaf mental health and consider how services in Derby and

Derbyshire could be improved. The event was hosted by Derbyshire Mental Health Forum, Erewash Community Action, and Communication Unlimited and the below notes are adapted from their unpublished summary of the discussions (43).

Examples of local good practice, including Deafinitely Women (support group), were shared. Deaf people were positive about SignHealth (charity) and the BSL 999 service. Specialist mental health suites for Deaf people in Manchester, Birmingham, London, and Northampton were noted as were specialist services in Nottingham and Nottinghamshire.

Attendees reported that required information about mental health was often lacking or inaccessible and differed between the city and county. The limitations of arranging appointments via telephone and undertaking them using text services were highlighted. It was reported that the technology used for translation was not always accurate, and poor Wi-Fi in hospitals could make the technology difficult to use.

Discussions included the perceived limited input for Deaf people in the coproduction of local services and the limited information and support available for local Deaf young people. Attendees reported that self-empowerment resources were scarce and social and support groups were limited. Support was considered to be particularly needed for men, Deaf parents, and Deaf service providers.

A range of challenges around access to mental health services were raised. This included concerns around choice and flexibility of services. Mental health appointments were reported to predominately with hearing staff via interpreters. This was felt to lead to potential misinterpretation, reduced connection with the clinician, and issues around confidentiality. Attendees felt the mental health service offer for Deaf people in Derby did not reflect the size of the local Deaf population.

The lack of interpreters was raised as a concern. The booking process meant Interpreters would not be available in urgent or crisis situations. Experience of the third party responsible for making bookings was poor. Specialist skills are required to interpret a mental health consultation and not all interpreters have these. Relying on family members to provide interpretation was felt to be a potential safeguarding issue.

Issues around awareness were discussed. This included awareness of Deaf people by health service professionals and recognition of the cultural and other aspects of Deaf people’s lives. The lack of data on Deaf people accessing mental health services was noted.

Training in basic signing skills was suggested for hospital staff. In addition, training on Deaf awareness should be included as part of staff induction. Attendees wanted there to be more councillors and therapists proficient in BSL.

It was felt that awareness should be raised about Sign Health’s “SHOUT” text crisis service. Attendees wanted the local mental health helpline and support service to be

inclusive of Deaf people in crisis and suggested that the Derby Safe Haven should be able to support BSL users. It was felt that an inpatient mental health unit for Deaf people like the Jasmine Suite in Birmingham should be replicated in Derby.

A range of suggestions were made for how technology could be better used to improve communication. Greater use of WhatsApp (instant messaging), SignLive (on-demand BSL interpreting) and video relay services (video communication via sign language interpreter) were proposed. These require suitable WiFi on hospital wards. To better communicate existing information with Deaf people there should be more BSL videos on websites and social media and more QR codes on posters. Some Deaf people would like the option of recording appointments with health professionals so they can watch them back and reduce the chance of misinterpretation.

Attendees asked for more peer and community support – they felt these could improve employability and reduce mental health illness. It was felt that current arrangements are too reliant on a small number of volunteers. Many people wanted the process for booking interpreters to be improved and for organisations to take responsibility for timely booking.

An advocate role for the local Deaf community was proposed. It was felt this should be a paid role and Deaf people should be part of any recruitment process. In addition to this, local organisations should each have a “Deaf champion” to learn from the Deaf community and provide feedback to their organisation. Research to better understand the mental health needs of the local Deaf population were requested.

5.2.2 Deaf Mental Health Forum, 1 February 2023

This forum takes place every two months with members of the Deaf community, voluntary groups, experts by experience, and people who represent the Deaf teams within adult social care. It is co- chaired by Communication Unlimited and Derbyshire Mental Health forum. The health needs assessment was introduced to the group at the February 2023 meeting. Members shared some feedback on their experiences.

Access to interpreters

The shortage of BSL interpreters was felt to be severe.

A member of group felt that the 2021 census had significantly underestimated the number of Deaf people. With reference to the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD), they estimated that across England there were 15 Deaf people for each BSL interpreter; in Derby and Derbyshire they estimated this to be 23 Deaf people.

Mental health crises

A member of the group described how their mental health needs were not met early and they went on to experience a crisis. The group felt that more emphasis on prevention and early intervention could reduce mental health crises among Deaf people.

The group wanted the Derby Safe Haven (mental health crisis service) to be made accessible to Deaf people. It was agreed that this would be explored at a future meeting of the group.

The group noted a specific issue around access to BSL interpreters for people experiencing a mental health crisis.

Local service provision

Challenges around access to mental health services were noted. This included a lack of choice for counselling services – SignHealth are the only available option.

Concern that Deaf people who live in Derby need to travel to Birmingham for inpatient mental health services.

The group felt that Deaf people needed NHS Talking Therapies (previously IAPT) therapists to be Deaf so that they understood the experiences of Deaf people.

The group acknowledged that local wellbeing coaches were doing their best to break down the barriers to Deaf people accessing mental health support.

The group agreed they would like to a long-term plan for the mental wellbeing of Deaf people. This should include employment of more Deaf people into mental health roles, or hearing professionals with high proficiency in BSL.

Awareness and communication

The group felt there was a lack of awareness of Deaf people in local mental health services. An example of this was staff in a local emergency department not being aware of a tablet computer that would have supported communication between the Deaf person and staff. Another member of the group described how their GP sent them a link to join a consultation; the link was not sent to the BSL interpreter.

A member of the group felt that Deaf people were “starved of information and communication”. The group noted Newcastle as an example of an area that provided information around mental health to Deaf people.

6. Challenges and limitations

Data access

Timely sharing of health service data has been challenging. This is despite endorsement of the work and associated data requests from the relevant local delivery board and support of director level colleagues

90% of people with mental health problems are cared for entirely within primary care, which includes people with serious and enduring mental illness (44). This report draws on a relatively limited amount of primary care data.

The coroner's service holds data on recorded suicides. The coroner's service does not routinely collect ethnicity data. A sample of corner's reports were reviewed. These did not provide a level of detail that could have supported the drawing of themes (including relating to ethnicity or Deaf people) for this or other public health work.

Derbyshire Constabulary records include data on mental health incidents, use of MHA section 136, and crimes where a section 2 assessment occurred. This information was requested but not provided.

Data completeness

Completeness of the recording of ethnicity varied across the data included in the above analysis. Ethnicity was not recorded in 0.13% of general practice serious mental illness registers, 4.61% of referrals to specialist mental health services, 8.5% of calls to the Derbyshire Mental Health Helpline and Support Service, and 5.6% of the mental health community and inpatient care data. Ethnicity was not recorded or not known for 2.5% of detentions under the Mental Health Act. Ethnicity was not recorded for 4.78% of ambulance attendance for mental health issues and 9.08% of emergency department attendances for mental health issues.

The Nuffield Trust (45) have stated that longstanding problems with the accuracy and completeness of ethnicity data will continue to hamper progress to understand and tackle ethnic inequalities. They argue that until this changes, the NHS will be "flying blind" in its attempts to meet its legal, and moral, obligation to eliminate ethnic inequalities in care (45).

More problematic for this and other efforts to understand access and experience to services for Deaf people is the inability to draw relevant findings from many of the data sets. This is due to a combination of limited and inconsistent recording of data, and the relatively small numbers of individuals involved which makes comparisons challenging and raises issues of potential identifiability.

Engagement

It is a significant limitation of this health needs assessment that no engagement with Black community groups in Derby or Derbyshire has been achieved. This would have allowed opportunity to gain some understanding of how Black people in Derby and Derbyshire experience mental health and mental health care. Engagement would have also given the opportunity to present some of the findings from the data analysis and seek feedback on what may drive some of the inequities observed locally and considered how to respond to these.

7. Conclusions

The information analysis and engagement have highlighted inequities in the way Black people and Deaf people access and experience mental health care in Derby and Derbyshire.

Black people

The analysis aimed to take a view of service access that considered provision with a range of intensity and across the life course. The findings suggests that Black people in Derby and Derbyshire are less frequent users of some earlier intervention mental health services including use of the local mental health helpline and support service, NHS Talking Therapies, and child and adolescent mental health services. People from Black ethnic groups used older people's community care services at a lower rate than the Derby and Derbyshire average.

Data suggests that relative to the makeup of the Derby and Derbyshire population, Black people are over-represented on CMHT caseloads and are more likely to present in crisis while on a CMHT caseload.

Black people are over-represented on local general practice serious mental illness registers and in use of inpatient mental health services. Black people are more likely to be detained under the Mental Health Act and are detained for longer than people from other ethnic groups.

Ambulance and emergency department attendances for mental health issues were low for Black people in Derby and Derbyshire relative to the size of the local population. The numbers of Black people in Derby and Derbyshire detained by the police service under section 136 of the Mental Health Act is too small to confidently draw conclusions.

Deaf people

A very limited amount of data was available to explore access and experience of mental health services for Deaf people in Derby and Derbyshire.

Data suggested that people in Derby and Derbyshire with a recorded hearing "disability" who were referred to NHS Talking Therapies were less likely to access and complete it than people recorded as having no disability. There were no statistically significant differences in outcomes from this treatment between those two groups. It is likely that most people recorded in this data as having a hearing disability are not Deaf BSL users. However, some conclusions that can be drawn about the accessibility of these services for people with severe hearing loss.

Engagement with Deaf community groups in Derby and Derbyshire provided an insight to experience around mental health and health care services. There was positivity about some of the local support available from groups and charities. Concerns were raised about availability and accessibility of information, access to

interpretation, choice and flexibility of services, and awareness of Deaf people and their needs.

8. Recommendations and next steps

The Mental Health, Learning Disability and Autism System Delivery Board seek assurance that Board members, specifically organisations providing mental health services and/or mental health support:

- Have developed improvement plans detailing actions to increase the proportion of service-users where ethnicity is recorded. This is required to effectively assess the equity of access, outcome and experience.
- Considered how data collection systems can capture the proportion of service users who are Deaf, including those who have a first or preferred language of British Sign Language (BSL). This is required to effectively assess the equity of access, outcome and experience.
- Are working across the system to improve sharing of information to reduce inequity and inequality, recognising that is the aspiration is to include the wealth of data available beyond the health service. The local system will not be able to identify and address inequalities in access and outcomes without appropriate sharing of information.
- Consider how workforce planning initiatives can include efforts to increase the number of Black people and Deaf people employed within Joined Up Care Derbyshire organisations: strengthening cultural values and increasing trust, visibility and accessibility.
- Ensure the needs of Deaf people are appropriately considered in the design, procurement, and ongoing delivery of mental health services, including Safe Haven and crisis cafes.

System partners / system response consider:

- Identifying the colleagues and system forums best placed to lead the next steps of this work, including prioritising efforts to access relevant data from general practice. These services are the primary provider of mental health care, and their recording of Deaf people and ethnicity may be more complete and thus be a useful adjunct to increasing understanding of the inequities identified in this needs assessment and may give rise to additional recommendations.
- How existing efforts to prevent mental ill health, identify mental health issues early, and reduce mental health stigma, could give particular emphasis to Black and Deaf people in Derby and Derbyshire given the inequities they experience. This could include, for example, initiatives in local communities and settings such as hairdressing and barber shops.
- How the various system groups can share ownership for broad actions to reduce health inequalities and how the findings of this work can inform targeted strategies to influence the wider determinants of health.
- Any synergies between this needs assessment and other strategies and plans including Health and Wellbeing Board strategy, Integrated Care System strategy and Joint Forward Plan, and any Joined Up Care Derbyshire annual

operating plans. Many of these include specific commitments to reduce inequalities in health.

- How, given the known link between wider determinants and mental health, targeted support is provided for Deaf people and Black people including regarding employment opportunities and access to welfare rights advice.
- How system partners can work together to increase the trust and confidence that Black communities have in statutory partners. This should recognise that mistrust may be based on experiences of structural inequalities and racism.
- How Joined Up Care Derbyshire organisations can best engage with Black people in Derby and Derbyshire through existing community groups. This would address the primary gap in this needs assessment and bring a better understanding of experiences of services for this population group. Engagement should include exploring apparent relative underuse of early help services, aim to build trust, and co-produce long term actions.
- How training can be commissioned and provided for staff providing mental health care and support to increase awareness of the societal influences on mental health, including racism.
- How the quality and availability of British Sign Language interpreting services can be improved. This should include renewed efforts to meet national standards and appropriate performance management of current arrangements. A long-term plan should be developed to ensure there is a suitable level of BSL interpretation resource within Joined Up Care Derbyshire.
- How a better understanding of the mental health service needs of Deaf residents of Derby and Derbyshire can be informed by existing health service data. This should include a review of the use of specialist Deaf mental health services in Birmingham and Manchester by Derby and Derbyshire residents.
- How the accessibility of website communications across Joined Up Care Derbyshire organisations can be improved.
- How awareness of the culture and needs of Deaf people among staff in local health services can be improved through the provision of training. Where possible, this training should be provided by local voluntary sector organisations.
- How training in mental health first aid can be commissioned and provided for Deaf people. Derbyshire County Council should arrange this, and it should be provided by someone with high proficiency in BSL.
- How employment in local health and care services can be made more attractive to Deaf people. This should include reviewing recruitment processes to consider how inclusive they are to Deaf people.

Further work / next steps:

- The members of the Joined Up Care Derbyshire Mental Health, Learning Disability and Autism, Children & Young People System Delivery Board should consider the role of their organisations in responding to the findings and recommendations of this needs assessment. Each organisation should

develop and share action plans and share their progress on delivery of the actions. This would not replace other existing assurance mechanisms including through NHS England.

- In addition to existing and ongoing work to understand and address inequalities, Derbyshire Healthcare NHS Foundation Trust should explore the high rate of people of Mixed ethnicity groups accessing child and adolescent mental health services (CAMHS) and older person's community care.

9. Appendices

9.1 References

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