Mental health commissioning with migrant communities
A guide for mental health service providers
We're Mind, the mental health charity.

We believe no one should have to face a mental health problem alone. We're here for you. Today. Now. We're on your doorstep, on the end of a phone or online. Whether you're stressed, depressed or in crisis. We'll listen, give you support and advice, and fight your corner. We'll push for a better deal and respect for everyone experiencing a mental health problem.

mind.org.uk/equality

This manual was co-written by Josie Hinton and Yohannes Fassil in partnership with the following local Minds:

- Mind in Bexley
- Mind in Brent
- Mind in the City, Hackney and Waltham Forest
- Mind in Bromley and Lewisham
- Mind in Ealing and Hounslow
- Mind in Greenwich
- Mind in Harrow
- Mind in Wandsworth & Westminster

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The term “vulnerable” in this guide is broadly used to highlight the conditions a wide range of people are in. They include: “asylum seekers, refugees and those with humanitarian protection and their families, separated children, Roma, Gypsies and travellers, people who are undocumented, refused asylum seekers and those who are trafficked for various forms of forced labour, sexual exploitation and modern labour”. For full definitions of this terms please go to the web link in the foot note.1

How many people in the UK are asylum seekers?*

An estimated 65 million people throughout the world have been forced to flee their homes. The numbers of protracted conflicts have increased. This has created more than 22 million refugees worldwide – but developing countries host over 80% of people. The latest net migration statistics show that in the year ending December 2016, net migration to the UK was 248,800.

How many asylum seekers came to the UK in 2016?*

39,000 Asylum applications received in the UK in 2016.

117,000 Germany
83,000 Italy
692,000

Showing the much higher amount of asylum applications in other European countries.

Turkey now hosts the highest number of refugees with 1.84 million, followed by Pakistan with 1.5 million. Half of the top-ten refugee-hosting countries in the world are located in Sub-Saharan Africa.**

Which countries do asylum seekers in the UK come from?*

- Iran 4,192
- Pakistan 2,857
- Iraq 2,566
- Afghanistan 2,341
- Bangladesh 1,939
- Albania 1,488
- India 1,488

What are the common mental health problems caused by Migration?*

Rates of post-traumatic stress disorder (PTSD), anxiety, depression and phobias are 5 times higher among asylum seekers, refugees and economic migrants compared to the general population.

- UK population
- asylum seekers, refugees and economic migrants


Foreword

We know that the most disadvantaged migrants are those fleeing persecution and conflict in their home countries. They are traumatised not only by the experiences that drove them into exile, but also by the perilous journeys they make, and, on arrival in the UK, by the suspicion, disbelief, abuse and arbitrary detention they may face.

Though the UK asylum system provides a roof and basic subsistence for all who claim asylum, it is ill-equipped to deliver the vital specialist therapeutic help that’s needed to stabilise lives and help people come to terms with the pain and dislocation they have experienced. Expected instead to look to the NHS for help, their access problems are exacerbated by language difficulties, social inequality and by differing cultural attitudes to mental health.

Mind’s new manual is a timely and highly practical resource that addresses this mismatch between need and provision. As a toolkit for mental health practitioners, it highlights the importance of cultural sensitivity. As a guide for organisations in the field, it provides clear guidance on how to engage decision makers, locally and nationally, in mapping and meeting the needs of refugees within their communities who may otherwise remain invisible, with no voice or stake in the design or delivery of mental health services. By encouraging collaboration between voluntary and statutory services, Mind’s new manual also paves the way for a richer, more inclusive, intercultural dialogue about the future of mental health provision in the UK.

As a provider of innovative specialist therapeutic services, the Refugee Council is committed to working closely with Mind to inform and influence mainstream mental health service provision. This guide provides a welcome and insightful route map for taking that work forward.

Maurice Wren, Chief Executive officer, Refugee Council
About this manual

This manual was created in partnership with local Minds in:
> Bexley
> Brent
> Bromley & Lewisham
> City, Hackney and Waltham Forest
> Ealing and Hounslow
> Greenwich
> Harrow
> Wandsworth & Westminster

The information it contains is based on their collective experiences of engaging migrant communities and commissioners in the process of commissioning mental health services.

The manual is aimed at anyone involved in commissioning at local Minds in England, from staff who are already working with migrant communities, or managers who want to expand service provision to meet local needs, to members of migrant communities looking for effective ways to raise awareness of their needs and work to improve services.

It is designed to be a practical guide to help you to:

- inform and influence local commissioning through effectively engaging with migrants
- make mainstream mental health services culturally responsive to the needs of diverse, vulnerable and transient migrant communities*
- commission specialised services where appropriate – for example: culturally sensitive talking therapies; and community development and outreach support to raise awareness and improve accessibility
- reduce the inequalities in mental health services for migrants.

How to use the manual

We recommend using this manual alongside the 2015 guide from Mind: Commissioning mental health services for vulnerable migrants – guidance for commissioners. This offers good practice to boost understanding among commissioners of the cultural needs of these often hard-to-reach communities, and the best ways to deliver services for vulnerable migrants.

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* This means communities that move from place to place. People from these communities don’t have a fixed abode until their asylum claim are accepted

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2 Ibid page 6
There are seven sections and appendices in this manual, each aimed at supporting your influence and participation activities. Together, they cover:

- How local commissioning works
- Who to contact in local service development departments
- How to influence service design and development
- How to mobilise service users and communities
- How to build a business case for services to meet migrant needs
- How to build links with GPs, primary care and mental health support groups
- Influencing mental health commissioning

The manual also includes case studies from local Minds in Harrow, Bromley & Lewisham, Wandsworth & Westminster, and City, Hackney and Waltham Forest.

Who will benefit

We hope this manual will help those involved in the commissioning of mental health services to understand the unique and sometimes challenging needs presented by vulnerable migrants with mental health problems.

As a result, well-informed and knowledgeable local commissioners and providers can better engage with local migrant populations, service users and community groups, to identify their mental health and cultural needs and analyse how these could be met.

In turn, commissioners and providers can develop and deliver robust and accessible mental health services, and help empower the most vulnerable people to get the support that’s most appropriate for them.

This will lead to migrant communities accessing a more inclusive referral pathway into services, which ultimately minimises demand and reduces pressure on acute mental health services.

By working together and involving migrant communities in the commissioning process, we can all make sure that the most marginalised in our communities have equal access to appropriate services and support.
Mental health commissioning with migrant communities | About this manual

Case study

The value of advocacy and community support

This case study from City and Hackney Mind describes a day in the life of a young refugee seeking mental health support as a result of his traumatic migratory experiences. It highlights the importance of his needs and appropriate support.

R arrived in the UK from Afghanistan – unaccompanied – when he was just 14. After claiming and initially being refused asylum, he was later granted leave until he was 18.

When, at 18, he tried to renew his leave to stay in the UK, he was detained and later sent back to Afghanistan. There, he was homeless, slept on the streets and witnessed extreme physical violence.

In 2016, R ended up back in the UK and his latest asylum claim is currently pending. He is yet to receive any asylum support.

Experiencing depression, insomnia and nightmares, R went along with a support worker to his local GP practice and was prescribed medication for his mental health problems. But, unable to afford the prescription charges, he resorted to taking a cheaper over-the-counter painkiller.

With increased feelings of loneliness, fear and abandonment, and experiencing nightly flashbacks of the atrocities he’d witnessed in Afghanistan, R eventually ended up in A&E, where he was diagnosed with more complex mental health problems and again prescribed medication. He attended a migrant centre, where he was able to talk to a mental health advocate about different types of support that were available. The advocate also helped him to complete a form to exempt him from prescription charges.

Staff at the migrant centre referred R for talking therapy, and helped him to access volunteering opportunities, which would enable him to improve his language skills and combat social isolation.

Over seven months, the community advocate worked closely with R to support him to access mental health services. He was also referred to specialist support for asylum seekers. This enabled R to build trust and rapport with people around him, and gave him the confidence to become involved in influencing and participation activities in order to give something back.

R particularly enjoyed meeting other people with similar experiences, and this has helped him to become more aware of how he can speak up about his needs. He has also established a good support network in London while he hopes to be granted refugee status.

Sometimes I feel very low because of things that have happened to me. I’m afraid of what will happen if I go back.

I have no home, my family and friends are no more – everything spoiled. Work with Mind and the centre make me feel able to speak up. It’s nice to not feel alone and know people care.
1) What does good commissioning look like for migrant and BAMER communities?

Key principles for good commissioning for migrant and Black, Asian, Minority Ethnic and Refugee (BAMER) communities

- Sustained and meaningful engagement with, migrants and minority ethnic community members, and their families and carers, can help to improve understanding of the problems these communities face and lead to creative, viable solutions.
- To make this happen, we must consider and make effective use of wider evidence and follow best practice examples.
- Working collaboratively with stakeholders is important in a number of ways.
- Accessing, interpreting and applying evidence about ethnic and cultural inequalities in health and social care is often challenging. But, these difficulties can be overcome if commissioners are proactive in working with stakeholders to collect and analyse data.
- Stakeholders should also be encouraged and equipped to both challenge and support commissioning organisations to take effective action on health inequalities that exist among migrant and minority ethnic communities.
- Two key stakeholder groups are GPs and mental health support networks. GPs play an important role in influencing commissioning, because they are arguably best placed to understand their patients’ needs, and as such, to represent their views. Equally, it is essential that mental health support networks build strong links with GP patient participation groups, in order to reflect the views and experience of migrants with mental health problems.

What does positive influencing and participation mean to migrant communities?

Based on feedback at a Mind workshop from migrant communities on what good influencing and participation looks like, participants told us:
- It is important to build strong, two-way relationships with community groups before beginning to engage with them.
- Commissioners and providers should actively reach out to the community they want to engage with by going to where they are, rather than expecting community members to come to them.
- It is essential that communities feel included in meetings, decisions and activities, and that they are able to participate on a level playing field with leaders and professionals where possible.
- Devoting sufficient time to a project will elicit the best response from communities. It’s not worth rushing in half-heartedly or carrying out

activities simply to tick boxes. You need to invest time to nurture relationships.

- Communities should be enabled to have a voice and give honest input and feedback.
- Migrant communities have a wealth of valuable experience and therefore, members should have an opportunity to influence activities.
- It is essential that people you work with feel welcomed and valued.
- Local black and minority ethnic (BME) groups should be adequately represented.
- Confidentiality is crucial, as is creating safe spaces where people feel supported.
- It is important to find a shared language around coproduction and innovation.

- You should outline the scope of your work – and of the extent to which people can be involved – and take care to not give false promises. Clarity and transparency are key at all times.
- Some people believe that user engagement has become over-professionalised and that influence and participation activities require more of a ‘human touch’. You should bear this in mind when working with migrant communities in particular.
- When working with any community, it’s important to treat people as individuals and not as a homogeneous group.
- Culturally sensitive language and approaches must be used where applicable.

### Barriers to influence and participation

We have identified a number of barriers to migrant populations being able to productively influence and participate in activities aimed at improving mental health commissioning and support.

People have told us that migrants’ needs are not prioritised. This is in part due to a lack of understanding among these communities about how the health system works, including difficulties registering with appropriate primary care services, such as GP practices, and feeling unsupported when they do.

Historically, some GPs are inadequately informed about mental health in general – not to mention how to communicate with migrant patients. This can mean doctors ask the wrong questions and fail to elicit the right information, leading to misdiagnosis or even to migrants being turned away.

Even if migrants have accessible and supportive GPs, mental health services are spread very thinly, creating long waiting times for resource-poor services and therapies. The stigma and taboo associated with mental illness can be harder to overcome in migrant populations, where cultural beliefs may perpetuate stereotypes and make it hard for families and communities to accept mental health problems.

In addition, there is a limited understanding of the ‘lived migratory experience’, which might feed assumptions about migrants being difficult to reach or engage with.

The very nature of having a mental health problem can make it difficult for anybody with lived experience to access support and be able to participate and influence. Being unwell can lead to apathy and hopelessness, reluctance to open up and be honest about personal experience, and a fear of not being heard. Some people may find it hard to engage with technology, limiting opportunities to participate.

These difficulties are magnified in migrant communities. While there may be a wealth of local research about these communities, it is not always taken seriously – and more information is needed about the impact of mental health problems on Black, Asian, Minority Ethnic and Refugee (BAMER) groups.

Notwithstanding, there is no cure-all solution: everybody’s mental health problems and experiences are individual to them, and their recovery unique.
Improving access and support to boost participation

To increase influence and participation among migrants, we must first improve access to support services. This means calling on a number of culturally inclusive methods, which can be broadly summarised as follows:

**Language**

- Make sure you have on board qualified interpreters of both genders, to reach out to men and women in migrant communities.
- Focus on meaningful interpretation rather than just translation.
- Involve a health advocate who can ‘speak the community’s language’ – both literally and in terms of making mental health accessible and palatable.
- Have leaflets and information readily available in different languages.
- Avoid jargon and acronyms; they are hard to understand and can be intimidating. Use plain English and simple translation into other languages.
- Where possible, work with trained mentors or points of contact in GP practices who can support migrants with language – specifically with vocabulary related to mental health.

**Religion/culture**

- Work with professionals who are themselves from BAMER communities, and support workers who are trained to engage with these communities.
- Include in your activities religious and spiritual leaders who understand the systems and can help to navigate services.
- Take time to understand and appreciate cultural norms, and use them to engage and communicate through social events and peer support networks.
- If necessary, implement awareness training for staff to improve understanding of cultural and religious models, with a focus on terminology around mental health and spirituality.

**Community**

- Make use of community hubs to reach out to migrants.
- Take time to build a rapport with community groups so members trust you and buy into your activities.
- Think about setting up or using a system of community peers, encouraging migrants to help and support one another.
- If necessary, implement local awareness training about health in general, with a steer towards mental health.
- Work with the community to establish how to conduct meaningful equality impact assessments.
2) CCGs and commissioning - an overview

Understanding the framework within which those involved in commissioning operate is key to strategising your influence and participation activities. This section is aimed at helping you to identify where, how and with whom to work.

Below is an NHS diagram of the health and social care system. It shows how key structures and organisations come together at a local and national level.\(^5\)

**Key players in local commissioning – an overview of their roles**

Identifying who the decision makers are, what they are responsible for and how they are held accountable is essential for successful engagement. The decision-making structures and hierarchy in your local area might not be visible, but we’ve summarised the key stakeholders we’ve worked with and on whom we recommend you focus your efforts.

**NHS England Commissioning Board:** authorises local clinical commissioning groups, allocating their resources and holding them to account. The NHS Commissioning Board also commissions certain services, including those in primary care (GPs, dentists, pharmacies). The Board also hosts clinical networks to advice on single areas of care and clinical senates to provide clinical advice on commissioning plans.\(^5\)

**Health and wellbeing boards (HWBs):** These local-level boards have a duty to encourage integrated working to improve local health and wellbeing between local health and social care commissioners. Statutory membership of the boards include at least one elected representative (this might be the elected mayor, leader of the local authority and/or a councillor or councillors nominated by them), the

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\(^5\) Ibid Page 4
It’s important for us to be committed to equality, diversity and inclusion. Setting ourselves up in ways that enable us to reach and meet diverse needs within our local communities.

directors of adult social services, the director of children’s services, the director of public health, representation from the local clinical commissioning group, and a representative from the local Healthwatch (representing patients’ views).6

The HWB is responsible for drafting the local joint strategic needs assessment (JSNAs), which are crucial in planning and commissioning local services. The HWB is also responsible for drafting and agreeing a Joint Health and Wellbeing Strategy for its local area, having considered ‘evidence-based’ data. The key part of the strategy is focused on how different services work together around patients’ needs.7

Local authorities (LAs): Also known as local councils, LAs have responsibility for public health, with a ring-fenced budget to tackle public health issues such as obesity, smoking, sexual health and promoting good mental health. LAs are tasked with shaping local services and improving the health of their local populations by pulling together work done by the NHS, social care, housing, environmental health, leisure and transport. LAs have a duty to employ a director of public health who is responsible for the health and wellbeing of the local population.8

Healthwatch (HW): HW is funded by local authorities and acts as the champion of local voices on health. Your local HW is responsible for local involvement in the community and ensuring members of the public understand the choices available to them. One elected representative from your local Healthwatch will have a statutory seat on your local health and wellbeing board with views to improve local health and wellbeing through joined-up thinking with other key decision makers on the board.9

Clinical commissioning groups (CCGs)

Under the Health and Social Care Act 2012, CCGs directly commission NHS services for their local populations. They include at least one specialist doctor, one nurse, and one lay member. CCGs have to consult the public on their annual commissioning plans and involve them in any changes that affect patient services. The CCGs are held accountable for their decisions by NHS England against the NHS Outcomes Framework. The framework is designed to ensure transparency and accountability for achieving quality and value for money.10

Commissioning is about getting the best possible health outcomes for the population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health services, etc. It is an ongoing process, and CCGs must constantly respond and adapt to changing local circumstances. CCGs are responsible for the health of their entire population, and are measured by how much they improve outcomes.11

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6 Ibid page 3
7 Ibid Page 3
9 Ibid page 3
10 Ibid Page 3
11 Ibid Page 3
This diagram, produced by the former NHS Information Centre, shows the commissioning cycle with three phases: strategic planning, procuring services, and monitoring and evaluation – though there are a number of similar representations, using slightly different terminology. Some people may know the summary of each stage but not necessarily the details of what this involves.\textsuperscript{12}

This can make it tricky to identify what happens at each stage and the kind of issues to raise. We’ve put together key points worth considering to increase understanding of the commissioning process and support local influencing activities.

### Strategic planning of services

**Includes:** assessing needs, reviewing provision, and deciding priorities.\textsuperscript{13}

Strategic planning should:

- recognise the complex links between ethnicity and health and explore the causes of observed inequalities
- include data drawn from monitoring ethnicity at service level
- draw from other sources of information, for example patient satisfaction surveys and analysis of service users’ complaints or the experiences of front-line professionals
- systematically identify priority actions for addressing unmet needs and ethnic inequalities, whether in specific areas of commissioning work or more broadly.

### Procurement and commissioning of services

**Includes:** service development and design, shaping the structure of supply and managing demand.\textsuperscript{14}

Procurement and commissioning should:

- challenge and support providers of existing services to make improvements, for example by carrying out an equality impact assessment or reviewing services if and when it is appropriate
- shape service developments that aim to tackle priority gaps or inadequacies in existing provision, whether in the form of specialist services or training (for example, equality, diversity and cultural competency) to enhance current services

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\textsuperscript{13} Ibid page 8

> involve expertise and evidence from varied sources in order to understand how to overcome obstacles to reducing ethnic inequalities. This could include:
> > learning from innovations taking place in other local areas or services
> > synthesising published evidence on ‘what works’
> > engaging with high-risk communities
> > working with local and national voluntary and community organisations.

Monitoring and evaluation

Includes: understanding how services are running, reviewing services to make sure they are meeting local needs, improving performance indicators to manage performance and measure outcomes, demonstrating the impact of any changes made, and swiftly identifying emerging issues that may require adapting services.15

Monitoring and evaluation should:
> specify outcome indicators in terms of ethnicity and other community needs
> include specific outcome/KPIs relating to BME/migrant uptake of services and experience of recovery
> use general statements around improving equal access to services for minority ethnic people
> analyse user experience and level of satisfaction of local services
> carry out regular equity/equality impact assessment of existing and new services.16

Reflection exercise

It is useful to consider the points raised in the section above. Here are some questions to get you thinking.

1. What do you know about your local commissioner’s engagement process in terms of strategic planning, contracting and procurement and monitoring and evaluation?
2. What are the outcomes of the engagement?
3. What change has been agreed as a result of engagement?
4. How do you make sure monitoring is ongoing and not just a ‘one-off’ exercise?

15 Ibid pages 8-12
Using local strategic and policy documents

Local voluntary and migrant community organisations can positively influence commissioning with better understanding and effective use of national strategies, policies and legal frameworks. This can help you identify ways in which you can influence strategic documents, hold commissioners to account and encourage them to take positive action.

See Appendix 2 for a full list of relevant national policy and guidance references.

Tools and frameworks

Once you’ve identified local strategic documents to influence, it’s important to review them to identify how responsive they are to ethnicity, and to consider simple and practical ways to encourage commissioners to commit to including migrants’ needs in their strategic plans.

We have created a diagram based on the Race Equality Foundation’s framework, a tool that helps commissioners in developing culturally responsive joint strategic needs assessments (JSNAs).17

There are three key stages to this framework, each corresponding with the steps commissioners should take and the important areas – developing, achieving, excelling – that may need to be considered in order to create change in a JSNA.

See Appendix 3 for six innovative case studies about this approach and how to create change in a JSNA.

Stage 1: Presenting data18

This stage explores the availability and quality of the core data presented in the JSNA, in order to identify gaps and any new data that needs to be gathered. This is with the aim to encourage commissioners and service providers to broaden their data collection methods to enable JSNA to become reflective and representative of the diverse needs in their local areas. It’s also based on the idea that broad data is the foundation for a clear needs assessment.

Developing → Achieving → Excelling

- Developing core data (for example, demographic data on ethnic profile by age, gender, migration, mental health).
- Adding ethnicity across service data
- Identifying potential for the development of new data (this could be due to limited data on migrant community engagement with primary care services).
- Embedding other relevant data (for example, service user feedback on experiences of services)
- Specifying KPIs relating to migrant communities’ uptake of services and experiences of recovery
- Carrying out regular equality impact assessment of existing and new services.

Stage 2: Assessing needs

Assessing needs is really important to make sure information reflects the needs of everyone in the local community and echoes the voices of underrepresented groups, including vulnerable migrants. It also ensures decision makers and communities access the right information to help them make robust, evidence-based decisions about services and support. It also provides the opportunity to collect data that can influence local decision making.

Joint strategic needs assessments (JSNAs) should go beyond profiling a population or using data simply to describe health and wellbeing. According to the Race Equality Foundation’s original framework, JSNAs should also produce and analyse the data to paint a picture of: where needs are significant; where there are issues that partners should be aware of; and how needs overlap (for example, housing, mental health, low income, employment, criminal justice).

Developing

> Drawing from other sources of information (for example, referral data, service user satisfaction survey, experiences of front line staff).

Achieving

> Carrying out an equality impact assessment
> Including data drawn from monitoring ethnicity at service level
> Identifying priority actions for meeting needs and ethnic inequalities whether in specific areas of commissioning work or more broadly.

Excelling

> Identifying and reflecting the difference between real and perceived health needs
> Drawing from different data to understand need (for example, service user consultations)
> Analysing user engagement, experience and level of satisfaction of local services (for example, talking therapies)
> Identifying community strengths and assets.

Gathering broad data is the foundation for a clear needs assessment.

Ibid Page 9
Mind’s values-based commissioning

Mind’s concept of values-based commissioning summarises some useful approaches and ideas for you to think about, to boost the involvement of migrant communities in your local commissioning process.


The key principles of this approach are:

- The views and experiences of people who use services have equal value to the scientific and research evidence.
- People who use services should be involved at every stage of commissioning.
- Sharing of power – transparency is essential to help people understand who makes the decisions, how they are made, and why.

This approach can benefit commissioners in a number of ways. It helps commissioners to identify relevant healthcare needs, gaps in existing services and priorities, what the priorities for local healthcare ought to be, and the providers that can meet those needs and priorities.

Reflection exercise

Think about how migrant community members are currently involved in the commissioning cycle in your local area. Ask yourself:

Do they participate in any of the following?
- Workshops/consultations
- Asking public questions
- Monitoring a service provision
- Advisory groups
- Commissioners’ network meetings
- GP practice-based patient participation groups

How could they be further involved?
Who within your organisation might be useful to talk to and/or gain support from in order to move forward?
3) Mobilising your organisation

This section highlights key learning and best practice from Mind in Harrow’s experience of influencing the commissioning of mental health services, and how those involved at both grassroots level (for example project workers, community development workers and advocates) and at strategic level (service managers and chief executives) within organisations are mobilised to ensure effective dialogue with commissioners.

We cannot stress enough the importance of involving chief executives of local minds, VSO’s and BAMER Organisation’s in your work to effectively engage with commissioners. They are often the main point of contacts with commissioners, and usually know about their priorities and agenda for discussion at health and wellbeing boards.

Their input and support is crucial, and can make all the difference. Make time to meet with your chief executive to share project findings and get their input on how to drive your activities forward. We would also encourage running a workshop to secure their commitment to supporting this work at strategic level. CEOs’ experience could also help shape recommendations in a way that is appealing to commissioners.

Chief executives have a vested interest – as well as a responsibility – to make sure their organisation is fit for purpose, in order to reduce health inequalities among local communities, including vulnerable migrants. Running a separate workshop for them is a great way to inform and develop a joined-up approach not only to influence local decisions, but also to make sure your organisation is ready to support and meet the mental health needs of vulnerable migrants.

Without taking time to get chief executives and key members of staff on board, it’s difficult to effectively influence commissioners, let alone offer relevant support to migrant communities.

We found Mind service design tools useful in helping us think creatively about how we could effect a joined-up approach internally, in order to effectively engage commissioners.

> Stakeholder map (pages 14-15): getting individuals to think about how various stakeholders can contribute to this kind of work. This is about mobilising resources internally.

> Stakeholder profiles (pages 16-17): getting individuals to think about the priorities of other stakeholders. This is vital for influencing and asking what the priorities of your commissioners are.

Using the Mind Quality Mark (MQM)

Under the Mind Quality Mark (MQM) programme, local Minds conduct self-assessments to monitor their performance against 12 standards across a number of

Public authorities need to consider how their policies and decision making affect their local communities including vulnerable migrants.
areas. The MQM self-assessment tool is a great way to check your organisation’s readiness to support and address the needs of vulnerable migrants, and prepare to reach out to engage with marginalised communities.

Outlined below are some points from the MQM programme that might be useful in thinking about your engagement process.

> Considering the self-assessment indicators (20 and 21): your local Mind is committed to equality and diversity and provides equal opportunities to users, volunteers, staff, trustees; your local Mind provides a consistent and effective service to all people who use the service.

> The MQM specifically states under equality and diversity: ‘There is an equality and diversity policy and procedure which is implemented and monitored. The organisation has knowledge of the local community and its make-up, and services provided are appropriate for that community. Trustees, staff and volunteers complete training in equality and diversity and understand the importance of equality and diversity.’

Mind has updated the Mind Quality Mark to more closely align with the implementation of the 5 year Network Futures plan.* The MQM will assess local Minds against 3 key areas. These are:**

1. Leadership and governance
2. Sustainability and growth
3. Influence and engagement

The table on the right provides details about these areas, the themes they cover and what they aim to achieve. For more information, please click on the web link in the footnote.

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* Mind, Network Futures plan [2016] London, Mind Open Hub [on line] available at https://openhub.io. Please note: this site is only available to our local mind network and will need to sign up to open hub to access this document

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<th>Areas</th>
<th>The 16 themes</th>
<th>MQM seeks to see</th>
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<tbody>
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<td><strong>Leadership and Governance</strong></td>
<td>1. Board of trustees</td>
<td>A strong and diverse board</td>
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<td></td>
<td>2. Risk and planning</td>
<td>Effective risk management and planning for the future</td>
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<td></td>
<td>3. People</td>
<td>Robust staff recruitment, training and support</td>
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<td>4. Information governance</td>
<td>Robust policies on how data is gathered, used and stored</td>
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<td>5. Finance</td>
<td>Financially sound and transparent</td>
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<td>6. Equality &amp; Diversity</td>
<td>Committed to equality and diversity. E.g include these priorities within recruitment and performance management processes to ensure work integrates the needs of marginalized communities</td>
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<td>7. Safety of services</td>
<td>Services are a safe place where staff and people that use services are valued and supported</td>
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<tr>
<td><strong>Sustainability and Growth</strong></td>
<td>8. Quality &amp; effectiveness</td>
<td>Services are personalised, focused on recovery, inclusive and accessible to meet the diverse needs of the local community.</td>
</tr>
<tr>
<td></td>
<td>9. Sustainability</td>
<td>Longer term planning to continue the provision of Mind services in the area.</td>
</tr>
<tr>
<td></td>
<td>10. Service design and innovation</td>
<td>An innovative approach to meeting the needs of people with mental health problems. Robust monitoring and evaluation systems in place. Inclusion and participation of people that use and deliver services in the design and implementation process to ensure services are relevant to the diverse needs of the community.</td>
</tr>
<tr>
<td></td>
<td>11. Quality and Safety of services</td>
<td>Regularly monitor and evaluate services and support to ensure they’re safe and operating at a good standard. Robust safeguarding and health and safety procedures in place.</td>
</tr>
<tr>
<td></td>
<td>12. Environment</td>
<td>Work place and service environment contributes to people’s wellbeing.</td>
</tr>
<tr>
<td><strong>Influence and Participation</strong></td>
<td>13. Service user voice</td>
<td>Providing opportunities/platforms for a diverse range of people to influence and participate in shaping services</td>
</tr>
<tr>
<td></td>
<td>14. Tackling stigma and discrimination</td>
<td>Campaigning with local community members and organizations to reduce mental health stigma and discrimination</td>
</tr>
<tr>
<td></td>
<td>15. Partnership working</td>
<td>Collaborative working with statutory, voluntary sector organisations and local decision makers</td>
</tr>
<tr>
<td></td>
<td>16. Engagement with Mind network</td>
<td>Contributes to One Mind and committed to the furtherance of Mind’s values and mission.</td>
</tr>
</tbody>
</table>
4) Involving migrant and BAMER representatives in influencing the process

Key principles
The Bradley Commission Briefing\textsuperscript{26} sets out some key principles for effective work with black and minority ethnic (BME) groups in a mental health context – and this is equally relevant to migrant groups. It’s important that mental health commissioners and voluntary sector organisations are aware of and embrace these principles.

1. Cultural competence
This includes:
- better understanding of people’s cultural background, and avoiding generalisations; wide cultural diversity exists within migrant communities
- taking into consideration people’s circumstances and roles within their respective communities
- recognising the hardship faced in people’s home countries and during their journeys, including possible experience of separation from family, friends and loss of social status and cultural networks
- reducing the danger of adding cultural behaviours to a list of mental health problems and symptoms: we should be working towards a diverse workforce reflecting the community’s make-up in terms of ethnicity, gender and other diverse characteristics.

2. Person-centred intervention
This includes:
- ensuring services are tailored to the needs of the individual
- making sure families and carers are more readily involved
- eliminating labels and stereotypes, so that services are working with individuals
- identifying untreated underlying mental health problems in services, which normally takes longer than normal mental health diagnosis.

3. Holistic approach
This includes:
- meeting unmet and basic needs – unsecure housing, irregular and undocumented immigration status – which make access to services and benefits difficult
- ensuring that services work holistically
- implementing drop-in services with outreach, advocacy and language support.

4. Mentoring and service user involvement
This includes:
> peer support and user-led services
> incorporating migrants’ expertise, ideas and energy into the decision-making and agenda-setting processes and systems.

5. Working in partnership – a co-production approach
Creating and formalising links with BAMER community-based organisations can help to give context during assessment, supporting with translation and onward referrals. Communication with community-based services enables early identification of needs and resources within migrant communities, in line with the co-production approach.

The key principles of co-production are: accessibility – diversity – equality – reciprocity – this extends far beyond involvement and recognition of expertise.27

Key principles for involving migrant groups and service users in influencing the commissioning of mental health services

The principles below have been developed as a result of Mind in Harrow’s work in influencing the commissioning of mental health services for vulnerable migrants. The aims and project plan of their work is set out in Appendix 4.

1. Involving service users that reflect the ethnic demographics of your local area alongside representatives from key culturally specific organisations including migrants and refugees.
> Use existing networks and partnerships – for example, culturally specific projects within your organisation or drawing on existing partnerships with external voluntary and community organisations.
> Build trust with BME and migrant groups, and be prepared for this to take time.
> Prepare for long and sustained engagement: involving migrant communities in service planning and delivery means more than just completing a consultation questionnaire or attending an event.

2. Consider your methods of communicating with migrant and BME communities.
> Some migrant and BME communities come from a strong and long-held tradition of verbal communication. As a result, sending out letters or leaflets inviting community members to participate might yield a low response. Face-to-face contact and making good use of existing relationships is key.
> Language may be a barrier: be realistic about if and how this can be addressed. Overcoming this barrier will require additional time and resources; for example, distributing simplified/ easy-read policies and strategic documents. Involving bilingual workers within your organisation can help people with limited English language skills to participate. However, this means allowing additional time and resources for translation/ interpreting.
> Set out the aims and work plan.

3. Be clear about the difference you want to make: people need to understand why their involvement is important.
> Set out key milestones and time frames: identify the steps you are going to take in order to achieve your overall aim. For example, if there is a need to

upskill or develop the knowledge of community representatives, be clear about when this will be done.

> Be clear about who you want to be involved and what support they can expect. Mind in Harrow set out criteria for who they wanted to be involved in influencing the commissioning of mental health services (Appendix 4)

> Think about the support you’ll be able to offer: be clear about who is the main point of contact and if out-of-pocket expenses will be reimbursed and child care support provided.

> For migrant communities, ‘engagement’ means being recognised, having a safe space to meet, providing mutual support, gaining knowledge, skills and confidence to engage more widely, being listened to with respect and receiving honest feedback about decisions.

4. Take time to build capacity, share intelligence and develop a shared language.

> The world of commissioning is confusing and not always visible to service users and community organisations. Therefore take the time to develop their knowledge base, demystify the process, and simplify the commissioning language.

Migrant and refugee hubs/forums are often well placed to reach out to vulnerable, isolated and undocumented migrant who have no access to services and support.
Case study

Mind in Harrow

Central and North West London NHS Trust (CNWL) was working on implementing a Single Point of Access (SPA) for adult mental health services in the area (Brent, Harrow, Hillingdon, Kensington, and Chelsea and Westminster). This involved restructuring Harrow’s community mental health services working together with Harrow Clinical Commissioning Group (CCG).

Mind in Harrow wanted to be involved in helping to shape services in the area. Its aim was to broker a dialogue between Harrow CCG, CNWL’s mental health service improvement team leads, local community representatives, and service providers, to ensure that:

- the restructure of Harrow’s adult mental health services take into consideration the specific needs of vulnerable migrant groups
- Vulnerable migrants living in Harrow have access to mental health services that are responsive and culturally appropriate.

Some of the ways in which Mind in Harrow achieved this are outlined below.

Engagement

Staff harnessed 10 years of work Mind in Harrow had been doing to engage and build trust with the borough’s culturally diverse population, including Somali, Tamil, Afghan, South Asian communities. This had developed mainly through culturally specific projects and activities. Staff were able to recruit people from each of these groups to support this piece of work.

Capacity-building workshops

Holding capacity-building workshops helped to increase knowledge and understanding of commissioning among the target populations. They focused on boosting awareness of the processes involved, including:

- Summarising the roles of key public bodies, such as Healthwatch
- Creating easy-to-read, bulleted summaries on national policies and guidance
- Exploring joint strategic needs assessments (JSNAs), local health and wellbeing strategies; CCG strategic documents & key terminology
- Exploring legal frameworks, such as Public Sector Equality Duty, Equality Act 2010, Health and Social care act 2012
- Exploring a mixture of influencing strategies from Mind in Harrow’s influencing mix tool
- Providing a timeline of public questions at CCG board meetings and public stakeholder engagement meetings
- Identifying key community intelligence, such as data on migrant needs, experiences of services, and gaps in service provision
- Developing written responses to public questions.
Half-day workshops on migrant mental health and support needs

Mind in Harrow held half day workshops, which were attended by migrant community representatives, organisational representatives, and CCG mental health and engagement leads. Running these workshops included:

- Outlining who will be at the meeting?
- Providing an overview of timing
- Taking notes and summarising them after the event
- Clarify individual involvement
- Ensuring participants all work together towards the principles of the workshops: shared learning, focusing on solutions, and exploring ways of meeting needs collectively with limited resources.

What the workshop covered

- Terminology (refugee, migrant, asylum seekers)
- Migration experience and mental health
- Personal testimonies of unmet needs
- Service design POINTS exercise (Points stands for Problem, Opportunities, Insights, Themes and System challenges)
- Reinforced incentives for commissioners
- Brought together local and national evidence base – commissioning services for BAMER groups
- Explored what active engagement mean compared to passive recipients (Commissioners, service providers and service users)
- Challenges in service provision – opportunities for addressing these (what works)

Impact of these workshops

- Engaged 20 community and organisational representatives and developed their knowledge and skills about commissioning and influencing
- Effectively used individual stories to convey broader unmet needs
- Achieved some commitments towards this agenda in commissioning intentions 2015/16 – harrow CCG require providers to make ‘reasonable adjustments’ for underserved groups including migrants
- Developed mental health service provider group with engagement from culturally specific organisations (CNWL & CCG)
- As an organisation Mind in Harrow are more visible to commissioner
The information in the box are useful steps to go through in an activity to help gather key information about migrant population and their mental health needs.

**Group work**

**Who is in your community?**
> Tamil/Afghan/Somali/South Asian
> Numbers
> Demographics

**Social and economic circumstances**
> Work/Unemployment
> Education
> Language skills
> Housing/Homelessness

**Health and wellbeing needs**
> Key vulnerabilities
> Mental and physical health care needs

**Health promotion**
> Circumstances and coping strategies that are impacting on wellbeing
> Services and support that are helpful

**Accessing services**
> Which services are accessed?
> Why?
> Barriers to accessing services?
> Current gaps in services and support
> Future needs

**Priorities for Action**
> How effective is current service provision?
> How can future investments be better targeted to meet the needs of this target group?
> How can this group be involved in shaping future priorities?

“It has given me an opportunity to improve my confidence, believe in myself and have my voice heard. I’ve increased my knowledge and understanding about the complexity surrounding mental health awareness and stigma – particularly amongst BAMER groups.

I have developed an awareness about how important it is to engage within BAMER groups when designing mental health services. One size doesn’t fit all!”

Sandra
Building your business case

If you are involved in influencing commissioning of mental health services, you might need to build a business case for the consideration of provision targeted specifically for migrants.

This can be challenging, given that not only do mental health needs vary among diverse migrant populations; but also, commissioners have different priorities and identify different levels of need for mental health services, commissioners allocate different levels of funding and choose different ways to deliver them.

A robust business case should make clear the inadequacies and inequalities that permeate mental health service provision for migrant communities.

Inadequacies and inequalities

Variations in funding and response come about for many reasons, including, for example, disparities in:

- demography and immigration conditions (recent arrivals, migrant labour, refugees, etc)
- the general health conditions in a migrant’s country of origin and experience during their journey
- reception of the host community, including the political environment in relation to migrants and refugees’ socioeconomic circumstances
- level of education and employment opportunities
- the way migrants settle into their new environments (some experience cultural shock and come up against language barriers)
- the impact and conditions of detention centres on arrival.

What is undoubtedly clear, however, is that in many areas, mental health care for migrants and ethnic minorities is either grossly unidentified or underfunded. It is often time-limited, one-off funding at best. At worst, the very specific needs of migrants are completely ignored as though they do not exist.

There is a high prevalence of mental health problems among migrant populations, together with a strong association between migration and deprivation. Furthermore, the body of evidence pointing to the cost-effectiveness of early intervention and prevention-focused awareness programmes is constantly growing.

Despite this, the proportion of overall spending on preventive migrant-focused mental health care is often very small and woefully inadequate.

Inequalities that exist among migrants are not solely due to lack of funding or unidentified need. They are perpetuated by a lack of good-quality and statistically significant data on migrants and their health needs. In addition, migrants often do not prioritise their health needs in general (and mental health specifically), due to fear of sectioning and the stigma of mental illness, which is an enormous barrier to action in some cultures.

The rationale to invest in appropriate mental health support

Improvements in mental health support for migrants, and widening access to services and to participation opportunities, need little more justification. These points summarise the rationale for greater investment, which could help inform and form part of your business case:

- The costs and consequences of poor mental health problems account for most of the total burden of ill health among migrants.
- There is evidence that most migrants use A&E for all kinds of ill health, including mental health problems.
GPs currently spend a lot of time and resources dealing with migrants’ and refugees’ asymptomatic conditions.

> Poor mental health has an impact on an individual’s physical health; levels of co-morbidity and mortality are significantly higher in migrants than in the general population.

Health inequalities among migrant communities result in a significant burden of mental health problems, and the disproportionate impact on poor people. It can also affect the ongoing reform of mental health systems across England and Wales.

<table>
<thead>
<tr>
<th>Making a business case involves outlining the following:</th>
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<tbody>
<tr>
<td><strong>A clear vision</strong> – This will be linked to commissioners’ priorities/established targets.</td>
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<tr>
<td><strong>The need for change</strong> – Consider the sort of information commissioners will respond to, such as: varied data evidence types; statistics and local service user stories; local good practice examples that will resonate (for example, using drop-in or outreach services helps to identify mental health issues earlier); links to mental health service provision more widely; examples of where services are failing to meet need; and inclusion of a range of views (for example, those of other voluntary sector organisations, Healthwatch, etc.).</td>
</tr>
<tr>
<td><strong>Clear expectations</strong> – Highlight what you are asking of commissioners, taking care to anticipate any key concerns they might have. Also point out opportunities for doing things differently, and – importantly – focus on the cost benefits of your plans (undertake a cost-benefit analysis if possible).</td>
</tr>
<tr>
<td><strong>A joint plan of action</strong> – Summarise what your actions will be, who will be responsible for each point of action, where they will take place and when they will be completed.</td>
</tr>
<tr>
<td><strong>Influencing partners</strong> – Identify who your strategic allies are, and outline your understanding of commissioners’ perspectives. Account for the sources of funding you need or have secured, and include any other relevant information.</td>
</tr>
<tr>
<td><strong>Your influencing mix</strong> – Summarise how you intend to work with and mobilise different grassroots stakeholders, such as other voluntary sector organisations, culturally specific groups, community leaders, and service users. Identify platforms for influencing activities, such as public meetings, stakeholder engagement, patient participation groups, migrant and refugee forums. Outline your strategic alliances and relationships you have in place that can benefit your activities.</td>
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</table>
When making your case, be sure to think about not just the problems and what commissioners are failing to do. Instead, focus on positive solutions and opportunities, and on what you can do to make things better. Encourage your local commissioners to do the same.

For example, Mind in Harrow presented service user stories to members of Harrow Clinical Commissioning Group as part of its involvement in helping to influence commissioning of adult mental health services in the borough. The stories highlighted some of the issues minority ethnic community members had encountered when accessing mental health services. At the same time as hearing these testimonies, commissioners were asked to complete an adapted version of Mind’s service design tool called POINTS. They were asked to identify the problems with the current situation, opportunities for doing things differently, key insights, the needs that were going unmet, emerging themes and any systemic issues. This strengthened relationships with Harrow commissioners, and shifted their focus towards Mind in Harrow being part of the solution to meet these needs.

Reflection exercise 1

Imagine you are meeting with your local mental health commissioning leads. Consider the following points.

Describe the ethnic inequality you are looking to address

> How is this aligned to the goals of your commissioners?
> What urgent needs need to be highlighted and tackled?

Explain your understanding of the ‘why’?

> What kind of local data are readily available?
> What evidence do you have that could suggest doing things differently could yield improvements? For example;

published research; user feedback; local insight; third sector reports; expert opinion.

Recommend how this can be addressed

> What is your service offer and how can it help commissioners to tackle the issues?
> What NICE/other guidance, published research, or good practice examples of local innovations can you use to benchmark what should be done?

Build in time to follow up!

Reflection exercise 2

Based on the ‘Presenting your Case’ diagram on page 26, we have outlined four important steps to build your case for change and influence commissioning effectively.

Step 1: Understanding your commissioners’ priorities and establishing national and local mental health inequalities targets, and best-value public health performance outcomes.

Step 2: Finding examples of where services are failing to meet migrants’ needs.

Step 3: Identifying platforms for influencing, for example, commissioners’ forums or network meetings.

Step 4: Identifying and building links with your strategic alliances, for example, Heathwatch, user involvement groups/forums, and patient participation groups in primary care, refugee and migrant forums/hubs.

It may also be helpful to think about who within your organisation might be useful to talk to and/or gain support from in order to be able to move forward.

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Top tips for engaging commissioners

Commissioners are human beyond their roles and titles. Getting to know them and finding out what they value is important in order to build a shared language around innovation, co-production and meeting outcomes.

Below are our top tips for creating the right incentives for commissioners, and to get your business case on their agenda:

1. **Build links with other untapped networks**
   It is important to think about other influential stakeholders that commissioners listen and respond to, and how you can include those stakeholders in your work. Involving your local MP or councillors is a great way to explore key priorities and methods of raising the profile of migrant mental health needs and support.

2. **Use the influence of CCGs from neighbouring boroughs**
   Commissioners in nearby areas who are interested in your work might be keen to put some of your recommendations into practice. Invite them to meetings to showcase their work as examples. See how you can use their interest and influence to build momentum. Alternatively, bring commissioners together to have an informal chat about how they can meet local needs, and how your work can raise the profile of what they are doing.

3. **Encourage peer support**
   Gathering together CCGs from different areas to support each other to put recommendations into practice. This is also a great way to increase accountability.

4. **Create a story board**
   Build a portfolio or story board of testimonials and case studies of migrant experiences and promote that widely to build momentum and influence.

5. **Highlight cost benefit**
   Commissioners will be keen to find out about how different work streams can boost cost-effectiveness. It will be useful to highlight how much money they will save if they change the way they meet the health needs of their populations, as well as how your ideas can help them to do this. On the other hand, you can show the impact that ignoring mental health needs and recommendations will have on the health care system, and on commissioners’ purse strings.
### Schematic representation and summary of influencing commissioning – a project approach

<table>
<thead>
<tr>
<th>Understanding commissioning</th>
<th>Influencing mental health commissioning</th>
<th>Engaging for change</th>
<th>Challenges/barriers; engaging migrants?</th>
<th>Engaging migrants in commissioning – what works?</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Establish links with CCGs and other local stakeholders</td>
<td>Expected outcomes</td>
<td></td>
<td>» Limited knowledge of and information about migrants and their needs</td>
<td></td>
</tr>
<tr>
<td>» Understanding of national policies and strategies</td>
<td></td>
<td></td>
<td>» No effective engagement structure of migrants in commissioning – just one off</td>
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<tr>
<td>» Improved awareness and use of Equality duty &amp; legal framework</td>
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<td></td>
<td>» Mobile and transient migrant population</td>
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<tr>
<td>» Develop better quality standards and performance indicators of equality and equity of care</td>
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<td></td>
<td>» Fear of authority and lack of trust</td>
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<tr>
<td>» Playing key roles in the commissioning cycle</td>
<td></td>
<td></td>
<td>» Irregular/undocumented with high level of destitution and lose of benefits</td>
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<tr>
<td>» Participate in the monitoring and evaluation of services</td>
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<td></td>
<td>» Mental health related stigma</td>
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<tr>
<td>» Attend commissioner’s network meetings and forums, migrant hubs</td>
<td></td>
<td></td>
<td>» Mobilize community organisations to get engaged in commissioning</td>
<td></td>
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<tr>
<td>» Better quality data on migrants to inform joint strategic needs assessment</td>
<td></td>
<td></td>
<td>» Better understanding of legislations in involving users in commissioning</td>
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<td></td>
<td></td>
<td></td>
<td>» Establish links with Health Watch and other patient/user participation such as GP PPGs</td>
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<td></td>
<td></td>
<td></td>
<td>» Building trust and confidence with migrants on longer and sustainable engagement process</td>
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<td></td>
<td></td>
<td></td>
<td>» Migrant social media for better engagement and involvement</td>
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<td></td>
<td></td>
<td></td>
<td>» Provide peer support</td>
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</table>

**Understanding commissioning**

- Establish links with CCGs and other local stakeholders
- Understanding of national policies and strategies
- Improved awareness and use of Equality duty & legal framework
- Develop better quality standards and performance indicators of equality and equity of care
- Playing key roles in the commissioning cycle

**Influencing mental health commissioning**

- Culturally sensitive JSNA
- Making a business case to commissioners
- Mainstream mental health services sensitive to cultural needs of vulnerable migrants
- Commissioning of specialised services e.g. talking therapies, outreach support and community development schemes
- Early identification and intervention
- Promote mental health wellbeing
- Holistic approach to delivery of care pathways and referrals
- Performance indicators to monitor equality and equity of care
- Reduced mental health inequalities
6) Case studies

In this section, we have collected some case studies that exemplify Mind’s approach to influencing commissioning and working with vulnerable communities. Together, they are designed to give you some useful things to think about, to help put you in the best position to engage with migrant communities and influence local mental health commissioning decisions.

CASE STUDY 1

Bromley & Lewisham Mind

Background

In 2015, Bromley & Lewisham Mind’s Community Support Service (CSS) became part of a pilot project funded by Mind in seven local Mind areas in London. The pilot aims to support local CCGs to include specific provision for migrant mental health services in their commissioning plans.

As its name suggests, Bromley & Lewisham Mind works across two boroughs – Bromley and Lewisham – and this has its benefits and drawbacks. One benefit is that the organisation can broaden its reach both to migrant communities and to commissioners.

The drawback is time and capacity. As a result, we decided to focus our efforts in Lewisham and to use the good practice generated to replicate similar outcomes in Bromley. Being involved in the pilot enabled staff to develop their understanding of the specific needs of the boroughs’ adult migrants, and to build the trust of the migrant-specific organisations supporting them. Local mental health commissioners supported the project, and throughout 2016, Bromley & Lewisham Mind worked with migrant community organisations to support their involvement in the pilot as well.

Recruiting and engaging migrant community members

Active engagement to date has mainly been through working with local organisations and groups, including:

- Lewisham Refugee and Migrant Network (LRMN)
- Action for Refugees in Lewisham (AFRL)
- Afghanistan and Central Asian Association (ACAA)
- Healthwatch Lewisham.

Progress so far

Migrant community representatives have attended meetings held by mental health joint commissioners, alongside the commissioner responsible for Lewisham’s Public Mental Health and Wellbeing Strategy 2016-19. A report was prepared and circulated ahead of the meeting that presented evidence of migrant and refugee needs in the borough.
Bromley & Lewisham Mind’s Service Manager also lobbied for migrant and refugee issues to be acknowledged and included in the Public Mental Health and Wellbeing Strategy, through involvement in a series of strategy development workshops. This strategic document notes that Lewisham is the 15th most ethnically diverse local authority in England, and that Black, Asian, Minority Ethnic and Refugees (BAMER) communities are underrepresented in referrals to the Improving Access to Psychological Services (IAPT) initiative. The strategy acknowledges that more than 130 different languages are spoken in Lewisham, and that “for those who do not speak English as a first language, there is great stigma around the topic of mental health”.

The pilot was included as part of Lewisham’s mental health and wellbeing stakeholder day. Members of vulnerable migrant and refugee communities took part in the event, and representative organisations were able to promote their services and network with other people and groups in the sector.

The pilot was also featured at a local neighbourhood health improvement stakeholder events and meetings. This enabled vulnerable migrant and refugee organisations to learn more about influencing and participation opportunities, in order to support service user involvement in mental health service provision.

CASE STUDY 2

Mind in the City, Hackney and Waltham Forest

Background

Work at City, Hackney and Waltham Forest Mind has focused on supporting existing and sometimes-isolated migrant communities, who are often ignored as a result of stigma and inflow of new arrivals.

Staff set up a network of migrant organisations in Hackney. This included Hackney CVS, Hackney Migrant Centre, Akwaaba (a social drop-in project), and Praxis Community Projects. The network organisations met every six weeks to discuss how to improve mental health support for vulnerable migrants.

These meetings were insightful on a number of counts. They highlighted that migrant organisations only had the capacity to cater for urgent needs – such as providing food, water, and shelter – and nothing else. As a result, City, Hackney and Waltham Forest Mind explored how its project could support migrants’ mental health and wellbeing needs.

Its community advocate ran a series of outreach activities at Hackney Migrant Centre to raise mental health awareness and identify needs. This was followed by self-advocacy training to upskill community representatives, to empower them to raise their views and needs with Hackney’s mental health commissioner.

Key learning

- Staff involved their CEO in the project, enabling them to develop a co-ordinated approach to influencing local decisions.
Mind CHWF’s community advocate worked with a local migrant organisation to inform community members of their rights to local services. She also delivered mental health awareness training to volunteers within the centre.

It was important to secure commitment at all levels within migrant and other culturally specific organisations.

The organisation’s mental health awareness training equipped trustees, the CEO and frontline staff with knowledge to support community members effectively, and signpost them to relevant mental health services.

Self-advocacy support enabled community representatives to actively seek mental health services and their experiences and thoughts also informed discussions with commissioners.

Regular contact with Hackney commissioners boosted commitment and identified simple and effective ways to take positive action.

**Progress so far**

As a result of work on the project, City, Hackney and Waltham Forest Mind was able to identify that migrant numbers and demographics were not included in the local joint strategic needs assessment (JSNA), and, subsequently, brought that to the attention of the local authority.

Hackney’s strategic commissioning manager for mental health and prevention has committed to recruiting a community researcher to examine the migrant population in Hackney, to update the JSNA and use the data to commission more appropriate services.

Migrant community representatives involved are now aware of mental health services, what they are entitled to, and where to find safe places they can go to talk about their needs, which was not previously available in the borough.

Working with network partners and commissioners has enabled City, Hackney and Waltham Forest Mind to explore possibilities of co-producing a culturally relevant befriending service. This would bridge a gap in services, especially for people in crisis who either don’t think A&E is appropriate because of negative past experiences, or can’t afford secondary care.

Partnering with Hackney Council has empowered service users to make lasting changes and advance the health, wellbeing and safety of borough residents – including vulnerable migrants – by influencing policy and practice.

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Section 6 | Mental health commissioning with migrant communities
Wandsworth and Westminster Mind (WWM) decided to build on their existing experience of training and supporting peer wellbeing coaches to develop migrant peer coaches. This would mean that staff would create a community asset of people with lived experience, able to support others who had gone through difficult or traumatic migrant experiences, with a collective “voice” to influence commissioning decisions within the local Clinical Commissioning Group (CCG), wherever possible.

Working in financially strapped times, with commissioners needing to make savings and address budget deficits, meant that WW Mind would need to think creatively about how to develop effective dialogue with their local commissioners. WW Mind offer a successful Mother Tongue counselling service in West London, as part of the Community Living Well programme, and was keen to explore with their local commissioners how this specialist mental health support could meet migrant needs. WW Mind also have good links with the Home Office through their involvement in the Community Alliance to Combat Hate Crime (CATCH), which has provided opportunities to talk to local commissioners about resettlement issues and other difficulties faced by migrant communities.

WWM are currently exploring the opportunities of engaging local councillors – good allies to have because their roles include contributing to the development of local policies and strategies, budget setting and scrutiny of decisions made.

**CASE STUDY 3**

**Wandsworth & Westminster Mind**

**In terms of migrant engagement:**

WWM staff ran a well-attended five day Mental Health Awareness training programme specific to migrant communities. People were encouraged to attend by the local Migrants Resource Centre.

- Thirteen migrant service users successfully completed the training to become Wellbeing Coaches and attended monthly group supervision provided by the Wandsworth & Westminster Mind
- Four Wellbeing Coaches attended the Migrants Resource Centre’s summer event to engage with people from similar and new migrant communities:
  - Each guest was given a name badge showing which language/s they spoke - a great conversation opener.
  - Artwork on display showed different experiences migrating arriving in the UK.
  - Guests shared food from their communities – creating a hub of activity around the delicious variety of food on offer.
  - WW Mind Wellbeing Coaches engaged in conversation sensitively, aware that this was a public forum.
- Mental health can be a difficult subject to talk about, particularly for some communities.
Talking to peers with similar lived experience helped guests to be forthcoming in conversation.

Christian, one of the Wellbeing Coaches read aloud a poem at the event.

Two of the migrant representatives attended the Migrant Health Stakeholder Meeting, in advance of International Migrants Day on 18 December 2016. Other attendees included CCG, NHS and local authority staff, so this was an excellent engagement opportunity.

Key learning

- It is helpful to review existing work to identify synergies with this work – both to build on existing skills and activities and to save costs
- It is important to be clear about the time and capacity that you have for upskilling community representatives because developing understanding of the commissioning process can be time-consuming
- Take advantage of opportunities for engagement about these issues as they arise, as well as being pro-active.
- Share learning about what works – finding out about Mind in Harrow’s approach demonstrated effectively what might work for WW Mind’s project. It also helped staff tackle challenges experienced along the way
- Keep in touch with the wellbeing coaches – WW Mind have experienced staff turnover and it is essential to engage with service users throughout organisational change to maintain support and engagement.

The following poem was written by Christian, one of Wandsworth & Westminster Mind’s wellbeing coaches, while he was being held in a detention centre.

Thoughts filled with hope

I stare at the sky,
I gaze at the happenings, I glance at the gates,
Mind wander everywhere.

Thoughts imbued with hopes and wishes For I long to be home with my lovely ones. Keys rattle at nights,

Adjacent rooms conversations too loud. Screams below through the corridor,

for the night is long and desolate. I long for my lovely ones.

Fleeing persecution is not a joke. They ask for fleeing proof.

I wonder how to gather proof when fleeing. No proof means nights of desolation.

I live for hope and wish God hears my plea. For I long for peaceful nights and days, where thoughts are free and wander continuously.

Whatever the situation is, we need to keep hope because we can experience life changing in a second, in an action, through a stranger.
Mind’s service design toolkit is a resource that can transform services to become relevant to the needs of migrant communities. The tools that comprise the toolkit enable you to bring together people that use, deliver and fund services to explore what good services look like. It’s a great opportunity to explore service design, development and provision from all perspectives, in order to identify what’s important to each audience, and to co-produce simple and practical ways to meet needs.

The toolkit examines how you can open up discussions around service provision. Local influencing is sometimes approached with the aim of highlighting what decision makers are doing badly, rather than focusing on ways to help them bridge gaps. The latter, however, is more likely to encourage them to listen and take positive action.

The toolkit helps you to come up with and develop creative ideas that you might previously have dismissed as unviable. This can really promote the design and commissioning of better services.

It also enables you to establish themes and principles of good service delivery and commissioning. Staff at Mind have found the toolkit to be a great starting point for opening up conversations with a range of stakeholders who would benefit from improved services: people who use them, people who deliver them, and people who pay for them.

One of the great insights Mind has gained is that really great service needs to have the overarching aims, objectives and the service’s legacy built into the provision. This ensures that commissioners, those who deliver services, and other stakeholders that benefit from the service look towards legacy as part of a committed partnership, over and above a contractual agreement. This approach challenges the usual expectation that the provider would seek alternative funding after the award period, or the commissioner would recommission.

Here is some of the feedback from commissioners, service providers and people with lived experience, after their involvement in the Mind service design process:

“Supporting each other in capacity building. Especially to improve communication about service priorities and realistically what we can all do to meet needs.”

“Working alongside community groups, clubs and networks in some of the remote areas to develop a good database of information and enhance peer and self-referrals pathways, to better reach and support migrant communities.”

“If we are not funding specialist projects, we run the risk of losing the range of specialist expertise they bring and use to innovate services to better cater for migrant communities.”

“Creative and closer working relationship between commissioners and providers.”

“It’s about clearer communication channels and working together to map out user journey experience.”

“Sustainability and legacy through strong and committed partnerships.”

“Working towards long-term and diverse funding sources.”
The following case studies are about Mind in Harrow and a community member’s experiences of creating change in mental health service design and delivery.

CASE STUDY 5

Increasing uptake of primary care services

Mind in Harrow

There is a huge movement towards IAPT in Harrow. The key issue is that data around migrants was not being collected, and even if it was, the Mind in Harrow team weren’t aware of how the data was being used and fed back to local communities.

Mind in Harrow did know that in terms of contracting and procurement, reaching migrant communities was not part of key primary care service outcome measures. So they brought key migrant organisations and CCGs together to explore how they could make it more accessible and inclusive to migrant communities.

It was really important at this stage to discuss how CCGs can show more commitment. The team shared their own insights into the diverse needs and experiences of migrant community members who had engaged – and then disengaged – with primary care services. Only a few had used IAPT and ended up dropping out due to fear of immigration status and being deported. The majority could not be referred because they weren’t registered with a local GP. Reasons for this included stigma around mental health, language barriers and not having a permanent address.

One local Somali group had access to faith healers, who are a much-revered resource used by swathes of people who visit them for mental health support. So, Mind in Harrow explored the idea of harnessing these faith healers as an alternative care pathway into services.

Most had limited knowledge of mental health conditions and support services. However, staff recognised the connection they have with the Somali community as an asset that could help bridge the gap into services. Under public sector duty, commissioners have a budget estimated by the number of local residents on their patch. This includes ethnic minorities, such as vulnerable migrants, so Mind in Harrow used this to build a compelling case and to explore what commissioners could commit to.

Mind in Harrow also explored ways to improve ethnicity data collection, in terms of how it can be broken down by ethnicity, uptake of services, experiences of recovery and impact of services. This led to discussions with local commissioners about creating a key performance indicator for services that relates specifically to migrant communities.

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CASE STUDY 6

Improving access to GP practices

Iman Rafatmah Mind
Equality Improvement
Leader and Co-chair NHS
England National Asylum
health pilot

Some 40 per cent of vulnerable
migrants are denied GP registration
due to their immigration status
or lack of appropriate ID. Mind’s
Equality Improvement Leader, Iman
Rafatmah – who also co-chairs
NHS England’s refugee and asylum
seekers health pilot – worked
alongside GPs and other key health
champions to explore ways to
improve equal access to primary
care services.

Part of the underlying cause of this
problem is that NHS staff are often
confused by the complex policies
concerning access to free healthcare
for foreign nationals and, as a
consequence, many migrants have
been wrongly denied primary and
secondary mental health services.
As a result, their mental health
deteriorates to the point of crisis.

Drawing from his own lived
experience, Iman worked with
asylum seekers, refugees, clinicians,
and health policy makers to identify
the levers that would work within GP
practices. He also brought together
Doctors of the World, the Equality
and Diversity Inclusion Health/Lived
Experience subgroup, the Greater
Manchester NHS Values group,
and the NHS England
refugee and asylum
seekers health pilot.

These stakeholders worked together to co-
design a leaflet aimed at supporting refugees
and asylum seekers to register with a GP.
Sponsored by NHS
England, the leaflet outlines
that GPs have an obligation
to register refugees and asylum
seekers in need of support. It informs
GP practices of the new NHS England
guidelines that clarify that patients
should not be refused registration on
the grounds of immigration status and
lack of ID. It includes information on
free health care and how to get help
with prescription costs, and explains
how to make a complaint if a migrant
or refugee is refused registration. The
leaflet also gives clear guidelines for
GP practices on what to do if they
are unable to register a patient. For
electronic copies of this leaflet, please
visit the web link in the footnote.*

* NHS England Asylum seekers and Refugees. How to register with a doctor (GP) [on line] available at http://www.nhs.uk/
7) Appendices

Appendix 1: Commissioning language and jargon busters
Jargon buster in ‘Influencing mental health services: A guide to values-based commissioning’ Mind and NSUN.36

Appendix 2: Using local strategic and policy documents
Joint strategic needs assessment (JSNA): CCGs and local authorities are required to produce a JSNA of the health and wellbeing of their local community. This is a requirement of the ‘Local Government and Public Involvement in Health Act 2007’.31

The needs of populations require joined-up work, for example, the collaborative provision of stroke care services, and co-ordinated approaches to obesity and physical activity. Current policies aim to ensure that services are provided more flexibly, better support the needs of local communities, and are more effective at targeting the causes of health problems by intervening at earlier stages. In order to support this challenging agenda it is essential to have a clear understanding of the needs of the whole population and the wider determinants of health, from both the perspective of the NHS and the local authority. A copy of your local JSNA should be available from your local council’s website.32

Health and Wellbeing Strategy (HWS): drafted by the local health and wellbeing board, this strategy should consider evidence-based data. It is not a one-off document but a live, continuous process of strategic assessment and planning, which will build on and inform other local assessments and strategies. In this way, HWSs do not stand alone, but are a vital part of the local array of strategies, reports and assessments, including: the director of public health’s annual reports; clinical commissioning groups’ (CCGs’) needs assessments; child poverty strategies; community strategies; local economic assessments; and strategic housing market assessments.33

CCG strategic documents: your clinical commissioning group should have published a set of strategic documents. You should be able to find these on their website. The following are a range of public sector legislation on Equality and Health Care that can be used to hold commissioners to account:

Public sector equality duty: this states that meeting different needs involves taking steps to take account of disabled people’s disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the duty may involve treating some people more favourably than others.

The equality duty covers the protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status. This means that the first aim of the duty applies to this characteristic but that the other aims (advancing equality and fostering good relations) do not apply.34

Health and Social Care Act (2012): this legislation puts clinicians at the centre of commissioning, frees up providers to innovate, empowers patients and gives a new focus to public health.35

Good practice in joint health and wellbeing strategies: a self-evaluation tool for health and wellbeing boards: this document offers a range of simple and practical approaches to encourage commissioners to actively engage in the health and wellbeing issues affecting their local community. We found these suggestions really helpful in developing

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an effective dialogue with commissioners and involving them in consultations with migrant communities.36

Appendix 3: Examples of innovate ways to create change in JSNA37

Below are six case studies highlighted in the Race Foundation document about the key challenges within the three stages of their culturally responsive JSNA framework, and how to overcome them. This has been helpful in understanding the best approach to make JSNA more culturally responsive. It also helps you to think through how to gather and present service data to encourage commissioners to take positive action.

Presenting data 2038

Availability and quality of data

Case study 1: North Tyneside Council used monitoring data on the use of social care services to present a picture of the challenges facing particular groups of residents. Using monitoring data enabled the local area to identify barriers in how services are accessed and the type of services provided.

Going beyond research generalisations

Case study 2: Suffolk County Council used its ‘2008 Director of Public Health report’ to deepen local research on ethnicity presented in its original JSNA. The report includes findings from qualitative research with the Bangladeshi community. This research was particularly important, because sufficient routine data was not available at a local level. Presenting this research helped Suffolk County Council avoid making generalisations about the needs of the community in Suffolk.

Developing and sustaining joint intelligence

Case Study 3: Joint intelligence was central to the successful development of Birmingham city council’s council JSNA. Birmingham city council has established a single public portal presenting intelligence data that is used by a variety of stakeholders. The partnership prepared a framework document with an explicit philosophy of ‘integration, support and empowerment of existing networks’ in relation to data collaboration. As a result, the public health information team at the heart of the JSNA draws on a wide array of intelligence and research.

Analysis needs39

Involving the community in needs assessment prioritisation

Case study 4: NHS Central London CCG (Westminster) has taken a novel approach to building a better understanding of diverse community need. In addition to developing the BME Health Forum, NHS Central London (Westminster) has employed community researchers. The training and use of community researchers in forum projects relating to access illustrates a commitment to developing skills that can provide an insight about need ‘on the ground’. It provides vital links with marginalised and harder-to-reach communities.

Identifying positive action40

Working within the context of effective policy making

Case study 5: Luton borough council JSNA has sought to address the ‘so what can we do?’ factor – rather than simply presenting needs, “the whole point of the JSNA is to influence commissioning plans”. Central to its strategy to boost influence has been an evaluation of the JSNA process and its impact. The evaluation positions the JSNA in the context of the complex and fluid environment in which health priorities are set and commissioning takes place.

Case study 6: Newcastle city council’s first-generation JSNA was less about setting new priorities and more about bringing together current priorities. This time around, its second JSNA is seeking to take positive action. To make this happen, each section of the JSNA has been assigned to a local authority lead and a health lead. The leads have been tasked with working together to identify gaps and appropriate collaborative points of action.


38 Ibid page 18

39 Ibid page 11

40 Ibid page 11
Appendix 4: Creating change in service delivery or commissioning a new one

Mind Active Monitoring: a new mental health service for primary care

Mind’s Active Monitoring service enables GPs to refer patients directly to a dedicated mental health practitioner as soon as they present with problems such as anxiety, depression, feeling alone or stress. Active Monitoring is delivered in five sessions over an eight week period and is based on cognitive behaviour therapy (CBT) approaches with the added benefit of self-directed exercises using our workbooks. Practitioners are employed by local Minds but deliver the service in GP surgeries which means people are seen in familiar surroundings close to home. Informing commissioners about this service could help build a case to improve vulnerable migrants’ access to GP services. For more information including key contacts, please click on the web link in the footnote.

Appendix 5: Guidance for commissioners

The following resources provide a range of good practice to support the commissioning of mental health services for vulnerable migrants

Mind Commissioning mental health services for vulnerable adult migrants: Guidance for commissioners (2015)

Race Equality Foundation (Briefing Paper 28): High Quality Healthcare Commissioning: Obstacles and Opportunities for progress on race and equality

NHS England guidance to support the introduction of access and waiting time standards for mental health services in 2015/16

Maternity Action and Women health consortium: Commissioning health services for vulnerable migrant women in England—Evidence on policies and practices

Department of Health and Mind Mental Health Crisis Care Concordat: Moving forward

The Bradley Report (2009) and The Bradley Report five years on

Equality and Human Rights Commission: Making fair financial decisions

Appendix 6: NHS entitlement Facts

Are services free to all? GP and nurse consultations in primary care and treatment provided by a GP are free of charge to all, whether registering as an NHS patient, or as a temporary patient, when the patient is in the area for more than 24 hours and less than three months.

The National Health Service (Charges to Overseas Visitors) Regulations 2015 and Guidance on implementing the overseas visitor hospital charging regulations outline the following services in the NHS that are currently free of charge irrespective of country of normal residence (as long as the overseas visitor hasn’t travelled to the UK for the purpose of seeking that treatment):

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> emergency treatment at any accident and emergency (A&E) department, walk-in centre or elsewhere (but not further emergency treatment away from these locations, for example, operations or subsequent outpatient appointments)
> services provided for the diagnosis and treatment of a number of communicable diseases, including HIV, TB and Middle East Respiratory Syndrome (MERS) (see regulations for full list)53
> services provided for the diagnosis and treatment of sexually transmitted infections
> family planning services (does not include the termination of pregnancy or infertility treatment)
> services for the treatment of a physical or mental condition caused by torture, female genital mutilation, domestic violence, or sexual violence
> services provided outside an NHS hospital, unless the staff providing the services are employed by, or working under the direction of, an NHS hospital.

The following groups are exempt from charge:

> Refugees (those granted asylum, humanitarian protection or temporary protection)
> Asylum seekers (those applying for asylum, humanitarian protection or temporary protection whose claims, including appeals, have not yet been determined)
> Individuals receiving support under section 95 of the Immigration and Asylum Act 1999 (the 1999 Act) from the Home Office
> Those whose application for asylum was rejected, but they are supported:
> under section 4(2) of the Immigration and Asylum Act 1999 by the Home Office
> by a local authority under section 21 of the National Assistance Act 1948
> under part 1 (care and support) of the Care Act 2014
> Children looked after by a local authority
> Victims and suspected victims of modern slavery or human trafficking, as determined by the UK Human Trafficking Centre or the Home Office, plus their spouse or civil partner, and any children under 18 provided they are lawfully present in the UK
> Those receiving compulsory treatment under a court order, or who are detained in an NHS hospital or deprived of their liberty (for example, under the Mental Health Act 1983 or the Mental Capacity Act 2005) who are exempt from charge for all treatment provided, in accordance with the court order, or for the duration of their detention
> Prisoners and immigration detainees.

There may also be exceptional humanitarian reasons where the secretary of state can determine that treatment should be provided. This exemption also applies to their child and/or companion child who is authorised to travel.

with them, for whom the exemption is limited to treatment that cannot await their return home. See NHS Choices website for further exemptions and information.

NHS entitlements: Migrant Health Guide (England only)54
A series of guides for commissioners of mental health services, published by the Joint Commissioning Panel for Mental Health55

Faculty of Homeless and Inclusion Health (2011) standards for commissioners and service providers56

Appendix 7: Migrant Help’s Glossary of Refugee and Migrant related terms57

Appendix 8: Mind in Harrow project promotional material to engage migrant Communities

What are the project’s aims: The project aims to ensure that vulnerable migrants living in Harrow have access to mental health services and that these mental health services are responsive and culturally appropriate.

Who do we want to be involved?
We want to recruit four community representatives from the Somali, Tamil, Afghan and South Asian communities who meet the following criteria:

> Those who are carers for or have used/are accessing mental health services from the respective migrant groups
> Those who can speak and understand English
> Those who are able to articulate their own experience and the needs of their respective community group
> Those who have the time to commit to the project
> Those who have a commitment to the aim(s) of the project and want to make a positive difference to the experience of migrant groups in accessing and receiving support from mental health services.

Why should you be involved?

> Be part of making a sustainable change to the way mental health services are commissioned.
> Increase the awareness of GPs and mental health commissioners about the needs and experiences of your community.
> Develop your understanding of the way mental health services are commissioned and who is involved in the process.
> Develop existing skills.

What support you can expect?

> Reimbursement of all travel expenses.
> Support from the Project Lead (Josie Hinton) and your Project Co-ordinator.

What project processes are involved?

March
Project Lead Josie Hinton (JH) attends local community groups to explain:

> about the project/process
> NHS commissioning – key partners
> who we want to be involved
> benefits and support
> names of those who are interested in taking part
> relevant Project Coordinator to facilitate recruitment.

May
JH facilitates two workshops to develop the skills and knowledge of community representatives with four organisational representatives for co-production of a workshop session to:

> Harrow CCG mental health commissioning leads
> GP mental health leads
> Local Healthwatch representative.

June
CCG workshop with community and organisational representatives will present:

> community representative feedback about the need to achieve culturally accessible local mental health services
> Mind in Harrow’s holistic refugee community engagement and service model.

July – October
Feedback and legacy:

> Debriefing/feedback session with Harrow CCG and community representatives to plan sustained engagement by these representatives with Harrow CCG (July/August)
> Follow-up telephone interviews with Harrow CCG mental health leads and GP leads to hold them to account for the actions agreed (September/October).

55 Joint commissioning panel for mental health [online] available at http://www.jcpmh.info/ [accessed 2016]