LONDONASSEMBLY

Supporting mental health for all

Health Committee

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Holding the Mayor to account and investigating issues that matter to Londoners

LONDONASSEMBLY

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The Health Committee reviews health and wellbeing across London, with a particular focus on public health issues and reviewing progress of the Mayor's Health Inequalities Strategy.

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Chair of the Health Committee

Marginalised groups continue to bear an undue proportion of mental ill health in London, through a lack of access to timely, appropriate and acceptable support. We welcome the Mayor's focus on mental health in London and the encouraging beginning that has been made through the development of Thrive LDN. Addressing mental health inequalities will not happen overnight, however, and raising awareness of the issue will not be enough on its own. It is vital that new efforts are made to identify and reach out to people who are currently excluded from accessing the support they need.

There is no silver bullet for tackling mental health inequalities in London: the complexity of the issue requires an ongoing, multi-agency strategy and considerable investment of time and resource in finding out why previous efforts to support mental health and wellbeing for marginalised groups have not been as successful as they could be. Without additional focus on these groups we run the risk that the same people will remain shut out of opportunities to live mentally healthy lives.

> "It is vital that new efforts are made to identify and reach out to people who are currently excluded from accessing the support they need"

The potential social and economic benefits of tackling marginalisation from mental health services are enormous; so are the challenges. This report can only begin to scratch the surface of these complex and highly emotive issues. Determined efforts to address exclusion must be encouraged throughout the system, from individual services at grassroots level to policy makers across the city. We hope that by providing some practical examples of how to achieve this we can help to make London's mental health offer more widely inclusive. The Mayor can, and should, act as a powerful advocate on behalf of those Londoners whose voices are often still not being heard.

Summary

Mental ill health is one of the greatest public health challenges for London. Serious mental illness can reduce life expectancy by 15 to 25 years, and any level of poor mental health can have profound effects on everyday life. There are significant variations in mental health experience and treatment across the capital.

Many Londoners currently feel excluded from accessing the mental health services they need. Over the last year, we have examined the problems facing four marginalised groups in London: LGBT+ communities, disabled people, Deaf people, and those with experience of the criminal justice system. This report brings together the cross-cutting issues we have identified that the Mayor's Thrive LDN programme and other policies should address as a first step to ensure that all Londoners receive the help they need to live mentally healthy lives.

Prevalence of mental ill health in London is high: around one in four adults experience a mental health issue in any given year. But the prevalence of mental ill health is significantly higher among the groups we looked at, reflecting the negative experiences that many people in these groups may face on a daily basis. There are a number of complex factors that contribute to this; but the issue is compounded by services that do not currently seem designed to understand and meet their specific needs.

We have identified four key problems that people in marginalised groups can encounter when trying to get mental health support.

"Thrive LDN will need to demonstrate clearly that it represents a genuine change of approach to including marginalised groups"

There can be physical barriers to accessing mental health services, in terms of where, when and how the services operate. This means that some people are being excluded from the outset.

The language used by health professionals can be off-putting, intimidating or discriminatory – and this can prevent people from using particular services or discussing sensitive mental health issues with them. Ensuring that services are inclusive and reflective of the diversity of cultures, physical ability, sexual orientation, gender identity and life circumstances of all Londoners must be a priority, to break down barriers between services and the people who need them.

Many GPs and other primary care staff lack the skills and/or the capacity to deal appropriately with mental health issues in ways that are supportive and inclusive of the diversity of London's population. The Mayor should lead efforts to change this, recognising that the significant capacity and workload pressures facing GPs across London increase the challenge.

Specialist mental health services are being replaced by generalist services, which lack expertise in dealing with the needs of marginalised groups. London's third sector organisations, with their strong track record in building and maintaining relationships with marginalised groups, have often been successful in filling some of the gaps in provision, but are unable to meet growing demand in a difficult financial climate, and some of these vital services have been, or are in danger of being, lost. Nor should this sector be expected to plug these gaps on its own: the need for adequately funded and resourced mental health services across London is an issue that the Mayor must champion to Government and to NHS partners. The crucial role of the third sector should also be recognised and included in the development of mental health policy across London, with proper representation on the London Health Board.

The Mayor and partners have launched Thrive LDN as a citywide 'social movement' to improve the mental health and wellbeing of all Londoners. It has the potential to transform mental health services in London. But it must be designed from the outset to be fully inclusive of currently marginalised groups, or run the risk of repeating the mistakes that have created barriers between marginalised groups and existing support services.

Thrive LDN will need to demonstrate clearly that it represents a genuine change of approach to including marginalised groups. To do this, it must lead work to improve data to ensure services are commissioned for all Londoners, make it easier for people to find and access support and advice, and promote innovative approaches including peer-support services, which can provide positive role models as well as the type of practical and emotional support that may not be readily available from healthcare professionals.

Above all, it must involve service users – and potential service users – from marginalised groups in its planning and discussions on an ongoing basis; they know their own needs best, and should be considered as key partners in the design and shaping of services.

Addressing London's mental health challenges is not just a role for healthcare services. Supporting good mental health must be a golden thread that runs through all the Mayor's policies. Our work has highlighted two policy areas that are particularly important to the mental health of Londoners – housing and employment. The Mayor should clearly set out how he will consider the needs of marginalised groups in developing his policies in these and other areas.

Recommendations

London's mental health challenges

Recommendation 1

Thrive LDN should work with organisations representing marginalised groups to design and disseminate resources that are specifically targeted at helping GPs and mental health trusts to develop more welcoming environments and practices.

The Mayor should also work with London's GP leaders to lobby Government to address the concerns of GPs regarding the impact of high workloads and short consultation times on the mental health of both service users and staff.

Recommendation 2

Through Thrive LDN, the Mayor should work with the third sector to broaden the availability of specific diversity and inclusion training that focuses on the experiences of LGBT+ people, disabled people and Deaf people, identifying the common behaviours and actions of staff that give rise to an increased experience of marginalisation. This should form part of the Mayor's drive to increase mental health first aid training.

Recommendation 3

The Mayor should press Clinical Commissioning Groups to jointly commission communication support services to Deaf patients, to improve the level and standard of these services, achieving economies of scale. This process could be managed through the London Health Board.

Recommendation 4

The Mayor should include the adequate and sustainable funding and provision of mental health services as one of the key assurances he is requiring of all five London STP plans. Any further analysis of the five London STP plans conducted by the Mayor should include a specific assessment of the impact of the proposals on access to mental health services, based on current and future demand. The Mayor should write to the committee setting out how he intends to hold STP leadership to account on this issue.

Recommendation 5

The Mayor should review the membership of the London Health Board to ensure that third sector organisations working with marginalised communities are represented at Board level. This will help ensure that the increasingly key role that the voluntary sector plays in supporting health in London is recognised.

Making Thrive LDN more inclusive

Recommendation 6

As part of his plans to lead efforts towards a zero-suicide city, the Mayor and Thrive LDN partners should produce an updated suicide audit tool or template for use across all London boroughs, identifying and addressing gaps in the data that is currently collected. The Mayor should write to the Chief Coroner to request guidance be issued to provide for more consistent recording of data on deaths by suicide.

Recommendation 7

Thrive LDN programme leads should publish details of how it will evaluate its activity to date, and how it will monitor its future activity, to identify whether it is reaching the particular demographics who are under-served by existing mental health support. Thrive LDN programme leads should also develop best practice guidance for local partners on how to monitor this.

Thrive LDN programme leads should publish details of how they have engaged with Healthwatch and other patient and service user representatives groups in the development of the programme and how they will continue to do so in the future.

Recommendation 8

The Mayor should examine the potential role of his office and/or Thrive LDN in signposting people towards appropriate third sector services. Thrive LDN programme leads should also review the accessibility of existing information relating to the programme. Specifically, the website should be updated to include British Sign Language content, text contacts for support services and plain English versions of key documents.

Recommendation 9

Thrive LDN programme leads should review all public facing materials including advertising and case studies, to ensure that these are representative of the full range of people in London who experience mental illness.

Recommendation 10

Thrive LDN partners should explore how to help and resource organisations that have proved effective at peer-led support for marginalised groups. At the same time, the Mayor should look at how he can supplement the work of the voluntary sector in this space. This could additionally have dividends in terms of boosting employment.

Mental health in all policies

Recommendation 11

In response to this report, the Mayor should write to the committee and set out how the specific needs of each group we have identified are being considered in the development of his housing and employment policies.

1. Introduction

Key findings

- Because mental health is a product of people's surroundings and experiences there are huge variations across London. Serious mental illness can reduce life expectancy by 15 to 25 years, and any level of poor mental health can have profound effects on everyday life.

- Many Londoners are currently excluded from accessing the mental health services they need. Over the last year, we have examined the problems facing four marginalised groups in London: LGBT+ communities, disabled people, Deaf people, and those with experience of the criminal justice system.

- This report brings together the cross-cutting issues we have identified that the Mayor's Thrive LDN programme should address to ensure that all Londoners receive the help they need.

1.1   Mental ill health is one of the greatest public health challenges for London. One in four adults will experience mental illness at any given time. It is also a product of people's surroundings and experiences. Because of this –as with physical health– some people and groups of people within London experience mental health inequality due to economic, social, geographical, or other factors. These differences can have a huge impact, because they result in the people who are worst off experiencing poorer mental health and shorter lives. Serious mental illness reduces life expectancy by 15 to 25 years, especially when people find it difficult to access appropriate support and treatment. And even 'milder' mental ill health can have profound impacts on everyday life.

1.2   The Mayor has promised to lead pan-London efforts to make London a mentally healthy city. To do this, a concerted effort will be needed to reach those people who, for many reasons, are not yet getting the mental health support they need. We are encouraged that the Mayor is prioritising mental health through the development of the Thrive LDN programme. This has been described as a 'collective vision' for action on mental health across London. But this citywide approach must ensure that people in marginalised groups are not excluded, as they so often are.

1.3   Marginalisation refers to the exclusion of people (or groups of people) from mainstream activity due to a lack of access to rights, resources, and opportunities. Marginalisation may be conscious: for example, deliberate homophobic, biphobic or transphobic discrimination, or the physical act of segregating prisoners from mainstream society; or it may be due to ignorance of issues; for example, not recognising the need for linguistic support for Deaf users of British Sign Language. Different people and groups in London experience marginalisation in different ways. And people who are marginalised are often subject to multiple layers of discrimination when they belong to more than one marginalised group.

1.4   Our investigation has focused on some broad groups who report feeling excluded from current mental health efforts – the LGBT+ communities, disabled people, Deaf people, and those with experience of the criminal justice system. We have previously looked at the experience of BAME people and young people accessing mental health support, and issues around perinatal mental health support. We have published specific findings relating to each of these groups separately. However, these are not the only groups who experience marginalisation in London. This report draws together some of the cross-cutting themes that we have identified through our investigation, to give an overview of the key factors that need to be considered to ensure that everyone can benefit from a renewed London-wide focus on mental health.

Thrive LDN

Thrive LDN is a city-wide 'social movement' that aims to improve the mental health and wellbeing of all Londoners. It is supported by the Mayor and led by the London Health Board.

Thrive LDN has set out six key aspirations:

- **A city where individuals and communities take the lead,** empowering individuals and communities to lead change, address mental health inequalities and create their own ways to improve mental health and wellbeing.

- **A city free from mental health stigma and discrimination,** ensuring support is available to help improve people's understanding of mental health so London becomes a city that is more mental health aware and equipped to act.

- **A city that maximises the potential of children and young people,** engaging them in mental health and encouraging them to lead initiatives and develop resources and training.

- **A city with a happy, healthy and productive workforce,** bringing partners together to develop and implement a programme to help people who experience poor mental health access support to gain and maintain work.

- **A city with services that are there when, and where needed,** creating new ways to access services and support and investigating how to use digital technologies to promote positive mental health and improve information about accessing support.

- **A zero-suicide city,** working with partners across the city to reduce suicides and build on existing suicide reduction and prevention initiatives by establishing a zero-suicide ambition for London.

Thrive LDN was launched by the Mayor and partners in July 2017. Its first phase has focused predominantly on establishing a brand for the programme and raising awareness, through initiatives such as the public *Are We OK London?* campaign and a range of local activities and workshops.

1.5   The first part of this report sets out the scale of the issue in London. In the second part, we set out the cross-cutting themes that we have identified in relation to weaknesses in the mental health support currently available to these groups. In the third and fourth parts we consider how the Mayor can tackle these issues through Thrive LDN and his other policies.

1.6   We would like to thank the many individuals and organisations who took part in our investigation. Particular thanks are given to the speakers and attendees at our LGBT+ event in October 2016, staff and patients from the National Deaf Mental Health Service at Springfield Hospital, and participants from the Revolving Doors Agency who took part in our ex-offender roundtable at City Hall. We would also like to thank all those who gave oral and written evidence. Details are attached in the appendix.

2. London's mental health challenges

Key findings

- The prevalence of mental ill health is higher among the marginalised groups we looked at.

- We have identified four key problems that people in marginalised groups can encounter when trying to get mental health support:

- There can be physical barriers to accessing mental health services.

- The language used by health professionals can be off-putting, intimidating or discriminatory.

- Many GPs and other primary care staff lack the skills and/or capacity to deal appropriately with complex mental health issues.

- Specialist mental health services are being replaced by generalist services, which lack expertise in dealing with the needs of marginalised groups.

Better mental health for all Londoners

2.1 There are many potential barriers that prevent people from accessing the mental health support they need. And, for those with more complex needs, a wider combination of barriers often needs to be overcome. **The responsibility to overcome these barriers lies with the system, not with potential service users.** London's mental health offer must be made accessible for all those who need it. And improving mental health support for those who are currently excluded is not a zero-sum game; removing barriers for these groups need not lead to creating barriers for those who already benefit from those services.

2.2 While we have focused our investigation on four specific groups of marginalised people, our work has also explored the intersectional nature of mental health experience. This approach recognises that people are not neatly defined by 'labels' such as 'Deaf', 'bisexual', 'minority ethnic', 'disabled', 'transgender', and that a person's identity doesn't disappear when they are diagnosed with a mental illness. Nor does being in one or more of these groups automatically mean a person will experience mental illness.

2.3 Nevertheless, our research has suggested that each of the broad groups of individuals within these 'labels' are more likely to share some common experiences of marginalisation from the existing mental health support systems in London. Many experience difficulties in their lives that increase their risk of having poor mental wellbeing or developing mental illness, such as bullying, rejection from family or community members, harassment at work and hate crime.

> "We hear the damaging message that our lives are smaller, sadder and shorter than our straight, cisgender peers"

> "Disabled people not actually being noticed, or being seen as people themselves. Not being treated as people who have something vital to say, that [are] of value to society"

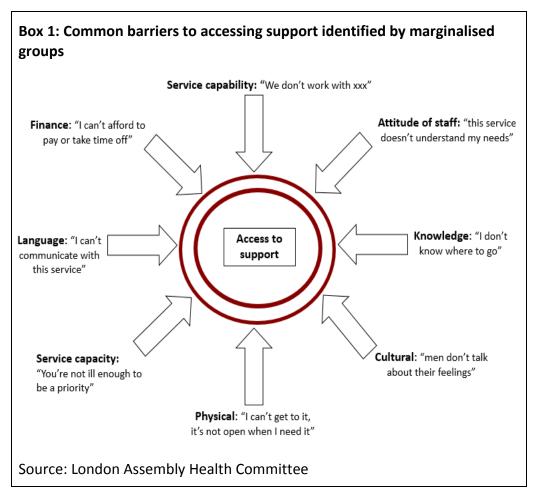> "There's no empathy, no compassion for prisoners. We all come from somewhere"[1]

2.4 The mental health consequences of being marginalised by society are compounded if people are then also prevented from accessing the support they need from health services. We know that early intervention can prevent mental illness from developing and from worsening. Failure to ensure that *all* Londoners can access the support they need, both to live mentally healthy lives and to gain treatment when needed, is storing up problems for the future; not only for the individuals concerned and their families, but for health and care services, the criminal justice system, and wider society.

Mental health among marginalised groups

2.5 People in marginalised groups are more likely to suffer mental ill health than the rest of the population. The prevalence of mental health problems within marginalised groups is higher than in the general population. While the majority of people within these groups live mentally healthy lives, others experience prejudice and discrimination on a frequent basis. The cumulative effects of fear and stress brought about by this can contribute considerably to poorer mental health and wellbeing.

2.6 A range of studies have shown that LGBT+ people are more likely to experience mental health problems than the wider population. Around 40 per cent of LGBT+ people experience a mental health issue, compared to 25 per cent of the wider population. But there are huge variations in mental health outcomes for different groups under the LGBT+ umbrella. According to MIND, the mental health charity, 42 per cent of gay men and 70 per cent of lesbians experience mental health problems.[2] And bisexual people have been found to have even worse rates of mental health problems (including high rates of depression, anxiety, self-harm and suicidality) than lesbians and gay men.[3] The limited evidence around transgender people indicates that they also experience particularly high levels of mental health problems: CliniQ, a service working with transgender people in London, reports that over 50 per cent of transgender people have considered or attempted suicide, and over 80 per cent experience depression.[4]

2.7 Studies have also shown that disabled and Deaf people are more likely to experience common mental health issues, especially anxiety and depression. Around one in three people with chronic physical impairment experience a mental health problem, compared to one in four in the wider population.[5] Deaf people are twice as likely to suffer from depression as hearing people,[6] and around 40 per cent of people who lose their sight develop depression.[7] Prevalence of common mental health disorders for people with learning difficulties is similarly elevated, with around four in ten experiencing anxiety and/or depression. For those with hidden conditions such as autism, prevalence can be higher still: research by MIND shows that up to 70 per cent of people that are on the autistic spectrum will suffer at some point in their lives from anxiety or depression.[8]

2.8 Rates of mental illness in prisons, and for those in contact with the criminal justice system (CJS) more widely, are alarmingly high. This is a complex issue: research suggests that people with mental health problems are increasingly coming into contact with the CJS because of the difficulty in accessing mental health support, and also that prison environments are likely to exacerbate existing mental illness. Seven per cent of male prisoners have experienced a psychotic disorder within the previous year, a substantial increase over the prevalence within the general population (0.7 per cent). 33 per cent of male and 51 per cent of female prisoners suffer from depression, while the

prevalence in the general population is nine per cent and 13 per cent respectively.[9] Thirty per cent of female offenders have previously had a psychiatric admission before they entered prison, and 46 per cent had attempted suicide at some point in their lives, compared to 6 per cent of the general population.[10]

2.9   During the course of our investigation we identified a number of common barriers that people in marginalised groups face when trying to get help with their mental health. These ranged from practical problems of physical access to attitudinal perceptions around whether services would accept them for who they are and be able to help with their specific needs.

Box 1: Common barriers to accessing support identified by marginalised groups

Service capability: "We don't work with xxx"

Finance: "I can't afford to pay or take time off"

Attitude of staff: "this service doesn't understand my needs"

Language: "I can't communicate with this service"

Access to support

Knowledge: "I don't know where to go"

Service capacity: "You're not ill enough to be a priority"

Cultural: "men don't talk about their feelings"

Physical: "I can't get to it, it's not open when I need it"

Source: London Assembly Health Committee

2.10   These may not affect everyone equally; however, addressing these strategically would significantly improve the chances of people being able to get the support they need in a timely and effective manner. Some of the barriers identified need to be tackled at an individual service level, while others point to a more system-wide scale of marginalisation. In this chapter, we examine four of the key barriers we have identified, and discuss some of the steps that could be taken to address them.

Accessing mental health care

2.11   At the most basic level, some people are simply not physically able to get to the services they need. For example, health care staff have described how patients in prisons frequently missed their health care appointments because there was no staff member to escort them. HMP Pentonville's Independent Monitoring Board reported that one-to-one mental health treatment sessions were taking place on a landing or at an open cell door. It also reported:

> "Worst still, however, is the problem of prisoners not being unlocked at all which is attributed mainly to a shortage of custodial staff. It is bound to be detrimental, and is, in any case, wholly inappropriate, that mental health assessment and therapeutic support should have to take place through the locked doors of cells."[11]

2.12   For other groups, the location and environment of services are inaccessible. Simple adjustments that would allow people in wheelchairs, for example, to access buildings are not always present. Deaf people told us of their frustration at missing appointments because they could not confirm by telephone, or hear their name being called out. And getting to the services is made difficult by the continuing lack of accessibility of large parts of London's transport system. Further barriers exist where services are commissioned in some boroughs but not others, and are restricted to residents of that borough, creating a postcode lottery.

2.13   Assuming that a person can physically reach a service, they may find that when they get there they are not deemed to be a priority. Experts working with marginalised groups told us that there were long waiting times for existing services and that rising demand was forcing services to restrict access based on perception of highest need. For those who are able to afford it – or find it – there are some alternatives in terms of private counselling services. But for those on low incomes or insecure employment these are often out of reach, particularly when combined with transport costs, or the need to take time off work.

Language barriers

2.14   Addressing the language of exclusion will also be critical. Our research suggests that many people find much of the language used to discuss mental health off-putting, intimidating or plainly incomprehensible.

2.15   For some, this is a result of a direct language barrier. As one Deaf person told us, "they never book an interpreter for me. They tell me to use a pen and paper instead. It means I can't communicate to anyone how I'm feeling."[12] We were also told that many of the terms used in programmes such as Mental Health First Aid training do not translate effectively into BSL. And some phrases used

by health workers, such as 'hearing voices in your head', can be meaningless to someone who is Deaf from birth.

2.16 Others told us that health professionals often used language or made assumptions that made them feel uncomfortable revealing aspects of their identity, and that this was a barrier to creating a situation where they felt safe to talk about their mental health. Transgender people particularly highlighted how the misuse of pronouns made them feel like their gender identity was not being accepted by the person they were talking to.

2.17 Being misgendered by others contributes to feelings of isolation and anxiety which have a negative impact on mental health, especially if repeated over time. Staff in health and care settings (and the wider public sector workforce) need to consider the long-term effects on mental health and wellbeing if people are not treated with respect when people turn to them for help.

> "Trans people are consistently told by society that they are not the people they know themselves to be"[13]

Misuse of pronouns is the most common form of verbal harassment that trans people report experiencing. Asking "what pronouns do you prefer people to use when talking about you?" – and paying attention to the answer – can help demonstrate that services are inclusive.

2.18 Reinforcing binary definitions of gender also excludes people who do not identify in these terms. Reviewing data collection practices, training frontline staff, asking more inclusive questions, and ensuring that documents such as registration forms do not exclude people from the outset, can help to overcome barriers to accessing services.

Skills among primary care staff

2.19 Ninety per cent of all health contacts are with primary care providers, placing GPs on the front line of mental health support. GPs also act as the main gateway to secondary mental health services, which usually require a referral. But the pressure on GPs to provide a comprehensive service for their patients is increasing. Staff shortages, high caseloads and short appointment times affect the level of support that GPs can practically offer, especially for those with complex needs. According to the Londonwide LMCs workforce survey, almost half of GP practices (46 per cent) reported staff shortages, potentially affecting over 2.25 million patients on their lists.[14] And the British Medical Association has warned that "as patients increasingly present with more complex conditions, longer consultation times are necessary to ensure safe and high quality patient care."[15]

2.20 During this investigation we have heard from many people who felt that GPs did not understand their specific mental health needs in the context of their

sexual orientation, gender identity, physical impairment or life circumstances. Some people felt this had happened as the result of ignorance and lack of awareness, while others felt it been caused by outright prejudice. Either way, they had the same effect: they made people feel uncomfortable, disrespected and excluded from support.

2.21 Concerns about being misdiagnosed was a common barrier for all groups we spoke to. Two main issues were reported:

- Assumptions from health professionals: including that mental illness was a direct result of being disabled, or transgender, or because of sexual orientation, rather than because of the negative experiences associated with being stigmatised and marginalised. The phrase "she's disabled so of course she's depressed" sums up this way of thinking. People with learning difficulties also reported issues around diagnostic overshadowing, where it is wrongly assumed that an individual's mental health symptoms are a symptom of their learning disability. And professionals 'pathologising' a person's gender identity, sexual orientation or disability as the only factor contributing to their mental health, rather than looking more widely at the impact of life events such as bereavement, job stress or relationship breakdown, was also seen as a barrier.

- Misunderstanding of behaviour: Deaf people in particular reported that their frustration at being prevented from being able to communicate was often categorised as aggressive behaviour and diagnosed as a symptom of mental illness.

2.22 GPs need better training and support to deliver effective mental health care to marginalised groups. The NHS Five Year Forward View for Mental Health highlights that "primary care staff are not yet fully equipped to provide high quality mental health care" and that "more could be done to improve training of GPs so that they are fully supported to lead the delivery of multidisciplinary mental health support in primary care."[16] Research by Mind in 2016 showed that less than half of trainee GPs undertook a training placement in a mental health setting. The research also pointed out that none of the hours GPs spend on CPD training need to have a mental health component.[17]

> ## Recommendation 1
>
> Thrive LDN should work with organisations representing marginalised groups to design and disseminate resources that are specifically targeted at helping GPs and mental health trusts to develop more welcoming environments and practices. The Mayor should also work with London's GP leaders to lobby Government to address the concerns of GPs regarding the impact of high workloads and short consultation times on the mental health of both service users and staff.

2.23 Ensuring access to ongoing training for GPs and staff who come into contact with the wider public is critical. And generalised equality and diversity training is not sufficient: as a minimum, there is a wider need for specific training on Deaf awareness, disability awareness (including hidden and learning disability), sexual orientation and gender identity. Further training on intersectionality, to help GPs recognise 'labels within labels', would also be beneficial.

2.24 Providing more opportunities for frontline workers to interact directly with people from marginalised groups can also help to overcome negative attitudes and ignorance, "giving people the space to ask questions they are uncomfortable to ask so they feel confident and comfortable engaging".[18]

2.25 The Mayor has identified boosting the number of Londoners who receive Mental Health First Aid Training as a key objective of his draft Health Inequalities Strategy. This is a good opportunity to develop and deliver complementary training that highlights the impact of marginalising behaviour.

> ## Recommendation 2
>
> Through Thrive LDN, the Mayor should work with the third sector to broaden the availability of specific diversity and inclusion training that focuses on the experiences of LGBT+ people, disabled people and Deaf people, identifying the common behaviours and actions of staff that give rise to an increased experience of marginalisation. This should form part of the Mayor's drive to increase mental health first aid training.

Loss of specialist mental health services

2.26 If it is important that GP services become, and are seen to be, more inclusive, it is *imperative* that mental health services are.

> "If an LGBT person is facing prejudice elsewhere in their lives, they need to feel absolutely sure that they are safe in the mental health service they are trying to access."[19]

But the move towards more generalist service provision is reportedly having the opposite effect, by reducing specialist capability and knowledge.

2.27 We heard that at the local level, there was rarely enough funding or identified need to justify commissioning specialised services, and that local Clinical Commissioning Groups are increasingly tending to commission generalist services. MIND reports that it has also seen a trend towards the reduction of equality and diversity training for staff.[20] This is a double blow: cutting the training that would allow generalist services to respond more effectively to specialised needs risks further disenfranchising those groups who already feel excluded from the services available.

2.28 This is not just an issue for clinical mental health services. The loss of specialist social workers to support disabled people and Deaf people is resulting in worsening social isolation. The Association of Directors of Adult Social Services (ADASS) told us that local authorities were increasingly using "generic teams working in geographical patches"[21], but service users told us this generalised approach had led to an erosion of understanding of the specific complex needs of particular groups, such as Deaf people.[22] As MIND told us, "that support is gone, effectively."[23] The situation is being made worse by the cuts to training that would give social workers the tools they need to work with people with complex and intersecting needs. The result is a further increase in people being referred back to GPs for support with issues such as housing, piling more pressure onto an already overstretched system.

2.29 People who experience mainstream services as being 'not for them' or who have had previous negative experiences are less likely to place their trust in generic services. A survey of LGBT+ users of counselling services found that 89 per cent of users said it was important to have LGBT+ specific services.[24] Transgender people report that they have to "educate" professionals about transgender issues. The dual stigma of mental illness and being part of one or more marginalised groups can make it extremely difficult for people to share their experiences with statutory or clinical 'authorities'. Organisations working with ex-offenders described a profound lack of trust between their client group, health services and criminal justice services. This has particularly been highlighted for certain communities which experienced discrimination historically and may continue to do so today. Talking particularly about its work with African and Caribbean communities, the Centre for Mental Health described:

> "a real fear […] that if you got involved in mental health services, you would end up in hospital under the Mental Health Act and potentially be at risk of losing your life. There is a real fear on the part of mental health workers on how to provide good quality care to people. There [is] a real circle of fear"[25]

Specialist mental health services for Deaf people in London are lacking

Research shows that recovery rates for Deaf people with mental illness who are able to access support in BSL are significantly higher than for those who are referred to generic support with an interpreter. And, although the National Deaf Mental Health Service is based in London, and provides excellent BSL-based support, the British Society of Mental Health and Deafness told us that many GPs and other health professionals are not aware of the service or how to refer people there.[26] This means that many Deaf people are forced to rely upon interpreters; a daunting prospect when sensitive issues around mental health are being discussed.

Deaf people have been challenging the quality and availability of BSL interpreting across London for many years. Despite this, contracts are increasingly being let to generic interpreting agencies that cover a whole range of languages, and are not always required to demonstrate particular competency in BSL. The Mayor has committed to taking pan-London action to support Thrive LDN where there is a role for him to do so. Clearly, the lack of suitable and effective communication support for Deaf users of BSL is an area where he needs to step in to galvanise progress.

Deaf people have also highlighted concerns over changes to commissioning, which means that individuals now need to apply individually for funding through their CCGs to access certain types of specialist support, rather than these being block funded locally.[27] For people who are already experiencing stress and anxiety, this can act as an impenetrable barrier to getting help.

Recommendation 3

The Mayor should press Clinical Commissioning Groups to jointly commission communication support services to Deaf patients, to improve the level and standard of these services, achieving economies of scale. This process could be managed through the London Health Board.

2.30   Strengthening integration across the health and care system could bring huge benefits to service users – allowing for a more seamless care pathway – as well as relieving some of the pressure on frontline services. Sustainability and Transformation Partnerships (STPs) have the potential to achieve this in London, but only if both mental health and social care needs are fully considered as the plans are developed.

2.31   The Mayor has promised to challenge STP leadership to ensure that the plans support the reduction of health inequalities. But dedicated mental health services are just one part of a much wider picture of services, all of which will

need to work together to provide holistic support 'wrapped around the individual'. Otherwise, as MIND told us: "those that come with multiple needs and those that have always been excluded by services are going to be even more excluded now because there is nothing for them."[28]

2.32   The next section of this report looks at the role of the third sector in providing support to marginalised groups. There are a number of ways in which the sector could be supported to work alongside statutory services to benefit service users. However, the third sector cannot and should not be expected to fill the gaps left by inadequate investment in statutory services. Ultimately, there is little point in identifying mental illness within the population if there are not services available to treat people.

> **Recommendation 4**
>
> The Mayor should include the adequate and sustainable funding and provision of mental health services as one of the key assurances he is requiring of all five London STP plans. Any further analysis of the five London STP plans conducted by the Mayor should include a specific assessment of the impact of the proposals on access to mental health services, based on current and future demand. The Mayor should write to the committee setting out how he intends to hold STP leadership to account on this issue.

The role of the third sector

2.33   Voluntary and community sector organisations, especially those which are peer-led, can help to bridge the gap between authorities and individuals with complex needs. These organisations play a pivotal role in supporting people who have been marginalised from mainstream services, and in educating others on how to best work with these groups. But worryingly, much of this expertise is in danger of being lost from London.

> "With the sudden closure of Pace in January 2016 the capacity of the LGBT voluntary sector in London to provide direct services around mental health decreased drastically, and much of this has not been replaced. The capacity of the sector to advocate for and represent the needs of LGBT people around mental health has also been drastically reduced [...] This has implications for the provision of training, good practice resources, drawing on the lived experiences of service users, and the generation of original research."[29]

2.34 The loss of specialist third sector organisations is damaging to mental health support in three key ways:

- It increases the strain on the remaining voluntary providers, especially those who also act as direct service providers, many of which are already struggling to meet demand.[30]

- These specialist organisations have often worked for years to build credibility and trust with the complex and intersecting groups of service users they represent. The closure of these organisations therefore represents not only a loss of capacity but the severance of established community links and loss of a depth of first-hand knowledge which is not available to mainstream services. This means opportunities for mainstream services to learn from these organisations about how to offer specialist support are also in danger of being lost.

- The loss of specialist organisations can reinforce the sense of exclusion and isolation felt by people who have come to rely on these services as 'safe spaces'.

2.35 The diversity of London's mental health need cannot be addressed by a one-size-fits-all service. The increasing move towards generalist provision therefore risks more people finding that the support on offer does not meet their needs. However, encouraging more equitable partnership working between commissioners and the third sector can have benefits on both sides, reducing the pressure on statutory services while also improving the sustainability of the third sector.

> "We would call on the Mayor and the Assembly to encourage statutory providers to listen to voluntary agencies who can add value to their work and act as a bridge between them and some of the more vulnerable ex-offenders with mental health needs. This group can be challenging to work with and take up a lot of precious time and resources for statutory agencies. By working with us and sharing information, we can help relieve some of this pressure."[31]

2.36 Given the increasingly vital role that third sector organisations play in supporting people with mental ill health, the voice of community and voluntary organisations should be given a more prominent voice in the development of strategic mental health policy in London. The Mayor has already taken steps to broaden the knowledge base of the other strategic boards in City Hall. For example, the new membership of the London Food Board includes a number of experts from the third sector. The Mayor should similarly champion the inclusion of third sector organisations as part of the tapestry of London's health and care services and review the membership of the London Health Board to include representation from third sector organisations working with marginalised communities. This will help ensure that the valuable role that the

voluntary sector plays in supporting the health needs of marginalised groups is recognised as policy is developed.

2.37 Smaller and more specialist voluntary sector service providers can struggle to stay afloat in increasingly straitened financial circumstances. The Mayor has identified the need to support the voluntary and community sector in his draft Health Inequalities Strategy:

> "the sector is faced with huge challenges due to the fall in public sector investment and the growing demand and complexity in the needs of service users […] we need a sustainable way of funding the community and voluntary sector."[32]

2.38 We were concerned to hear that successful services in London, such as the Campaign Against Living Miserably (CALM) suicide hotline for men, were at risk due to uncertain funding. The hotline is currently funded by three London boroughs but this presents challenges in providing consistent pan-London coverage:

> "We are not going to be able to sustain a dedicated helpline for men in London much further if the [tri-borough] funding runs out […] effectively the tri-borough has been subsidising the other London boroughs by enabling us to take their calls, but we are able to support and signpost back only to agencies within the tri-borough area or agencies nationally."[33]

2.39 Addressing the funding crisis in the third sector is a long-term project. In the meantime, the Mayor should seek to use his existing leverage to support the continuation of vital services. In particular, he could consider options to make short-term hardship or bridging loans available to voluntary organisations to help ensure continuity of service.

Recommendation 5

The Mayor should review the membership of the London Health Board to ensure that third sector organisations working with marginalised communities are represented at Board level. This will help ensure that the increasingly key role that the voluntary sector plays in supporting health in London is recognised.

3. Making Thrive LDN more inclusive

Key findings

- Thrive LDN has the potential to transform mental health services in London. But it runs the risks of failing to address the needs of currently marginalised groups. To avoid this, it must:

- Lead work to improve data to ensure services are commissioned for all Londoners.

- Involve service users from marginalised groups in discussions; they know their own needs best.

- Make it easier for people to find and access support and advice.

- Promote peer-support services, which can provide positive role models as well as the type of practical and emotional support that may not be readily available from healthcare professionals

3.1   Thrive LDN has the potential to transform the mental health landscape in London from the ground up. But in order to reach currently excluded groups, it will need to demonstrate a genuinely new and inclusive approach which explicitly recognises the needs of marginalised groups, not just an expensive rebranding of the status quo.

3.2   Thrive LDN is focusing on low level activity at a population-wide level that can help normalise conversations around mental health and encourage people to take the first steps towards positive wellbeing. However, the campaign's activity to date has not always been designed inclusively, so marginalised groups are unlikely to benefit. The next phase of this work must go beyond the straightforward and really drill down into how to make the offer more accessible to all. This will require a far more detailed analysis of who is being marginalised in London, where they are, and how to reach them.

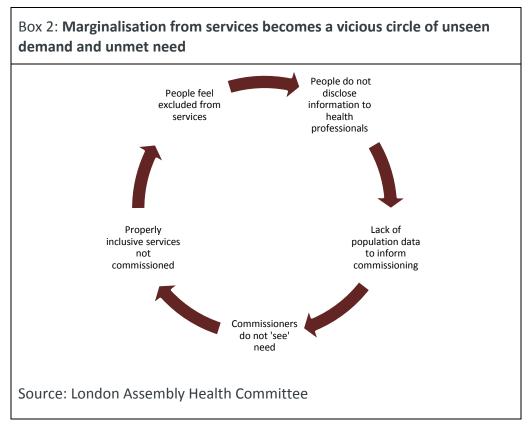> **Case study: Making Problem Solving Booths accessible**
>
> The aim of Problem Solving Booths is to encourage conversations between Londoners. The booths consist of two chairs and some signage, encouraging members of the public to sit and take the role of either the 'helper' or 'helped', to "starting to think about some small ways we can improve all Londoners' wellbeing."[34]
>
> This is a useful beginning, but reaching those who are currently excluded from this type of conversation will require additional effort on the part of organisers. For example, people with language support needs, including Deaf users of British Sign Language, are excluded by design unless additional communication support is provided. Similarly, the location and setting where the booths are held can exclude some people by default: Problem Solving Booths on the Piccadilly Line might help boost awareness, but the Underground is well known for being largely inaccessible for many disabled people, and there is a cost required to access it. This is not to suggest that the booths do not have any merit in their current format; rather, that thinking about how to address the practical barriers to communication that people face could enable the project to have a wider reach.

Data

3.3   Getting accurate data on marginalised groups can be difficult. The nature of marginalisation can mean that people are often reluctant, or unable, to engage with statutory services. When they do, they may not wish to share personal information about themselves, for fear of facing discrimination.

3.4　However, even working within the limits of 'best guess' data, the number of people who potentially fall into one or more of these marginalised groups is significant:

- Public Health England suggests that up to one in ten Londoners – some 800,000 people – may identify as lesbian, gay, bisexual and/or transgender or non-binary.[35]

- Around 40 per cent of Londoners – some 3.2 million people – are from Black, Asian and Minority ethnic communities.

- There are over a million people with hearing loss, including over 80,000 profoundly or severely Deaf people, in London.[36]

- Around 469,000 people in London have some form of mobility impairment.[37]

- There are 175,000 people living with sight loss in London,[38] with an extra 74,000 expected to be living with some form of sight loss by 2030.

- Around two per cent of the population have a learning disability, which for London would give an estimated 170,000 people who would have a range of mild to more profound and multiple learning disabilities.[39]

- London has disproportionately more offenders than any other area in England and Wales, with 17 per cent of all offenders and reoffenders (75,000 and 18,000 respectively). The total joint adult caseload for the probation services in London is approximately 45,000 offenders.[40] There is also an unknown number of ex-offenders still living with the consequences of past contact.

3.5　Our investigation found that the health needs of these groups were not always effectively captured by local authority joint strategic needs assessments or health and wellbeing strategies. This needs to change. As Richard Holmes of the RNIB told us, "How can you plan a service when you do not really know accurately how many people you are delivering that service to?"[41] The lack of data is a real challenge for commissioning mental health services. The diagram below highlights a vicious circle, where a lack of data is perceived as a lack of need. Over time, this leads to a reduction in inclusive services, which further marginalises people.

Box 2: **Marginalisation from services becomes a vicious circle of unseen demand and unmet need**

Source: London Assembly Health Committee

3.6   It is often local organisations who are closest to the communities and groups they represent, but many lack the capacity or resources to gather the evidence they need to convince service commissioners to act. Without this data, commissioners and services struggle to justify spending decisions when resources are scarce.

> "if the system doesn't count you, it doesn't care about you"[42]

3.7   Data on suicide in London is one key area for action. The data that is currently collected varies between boroughs and there are significant gaps that need to be addressed. For example, there is no routine collection of data about work status or ethnicity. And because of the way that coroners record verdicts on deaths by suicide, there is a wealth of data that is generated by their investigations, such as family history and medical records, which is not routinely and systematically stored to create databases which could be used for suicide prevention and public health planning purposes.

3.8   Better data on deaths by suicide which can establish the network of contacts could also be used to provide better support for those bereaved by suicide – an area which according to Professor David Mosse, has "hardly got off the ground in London"[43], although we know that bereavement raises the risk of suicide ideation.

3.9 More detailed 'audits' on deaths by suicide in a particular locality are extremely resource intensive, and each London borough takes a slightly different approach to doing these.

3.10 Local suicide prevention plans will need to be based on local data and local need. But standardising and enhancing what data is collected by suicide audits will strengthen the evidence base across London and could help inform whether particular interventions are likely to be successful in particular localities or within particular communities. This data can then be used to refine and develop further local action plans. Including data on sexual orientation, gender identity, disability, and other factors known to be related to increased risk of mental ill health could help to create a clearer picture. The Mayor should also consider what can be learnt from best practice across the UK:

> "A coroner in Cambridgeshire […] was able, through regular contact with the local suicide prevention group, to make information available so that they had early notice of a cluster of suicides.. they were able, with public health, to get information and support out to families[…] in a way that simply would not have been possible if one had to wait until after the inquests"[44]

Recommendation 6

As part of his plans to lead efforts towards a zero-suicide city, the Mayor and Thrive LDN partners should produce an updated suicide audit tool or template for use across all London boroughs, identifying and addressing gaps in the data that is currently collected.

The Mayor should write to the Chief Coroner to request guidance be issued to provide for more consistent recording of data on deaths by suicide.

Engagement

> "Experts by Experience are at the heart of everything we do because we believe in people's capacity to turn around their own lives, no matter what challenges they've faced in the past."[45]

> "LGBT+ people are experts of their own lives. Ask the service user about their identity, preferences, pronouns, and trust them"[46]

> "Nothing about us without us"

3.11 The most direct route into finding out what would work better for people marginalised by existing services is to ask them. There are no real shortcuts for this, and time and resources are needed to reach out to excluded people. Given his statutory duty in reducing London's health inequalities, the Mayor should

play a central role in this. And, while local intelligence can help identify those who are excluded in particular locations, a pan-London overview would help.

3.12 Thrive LDN could provide a framework for better capture and sharing of data based on collective intelligence gathering. In theory, a community hub model – where organisations and individuals can pool their data and intelligence to evaluate existing support and identify gaps in provision – is a sound one. But success will depend on making sure the right data is being captured to persuade policy makers to make changes.

The committee speaks to the service user group at the National Deaf Mental Health Service at Springfield Hospital.

3.13 Thrive LDN has made a promising start through its community workshop programmes, but it could be better. It should specifically focus on those groups who do not currently get the opportunity to contribute to the development of policy and services. However, it is not clear what monitoring is taking place so that people from excluded groups are informed about them and encouraged to participate in them. As part of ongoing evaluation, Thrive LDN programme leads should work with local Thrive LDN teams to develop a methodology for doing this, to identify who is being missed. And Thrive LDN partners need to feed back to service users how their ideas and suggestions are being used to shape and refine services.

> **Revolving Doors Agency User Forum**
>
> The Revolving Doors Agency is a charity working to break the cycle of crisis and crime. A central element of its work is enabling people to use their personal experiences to help shape policymaking in the health and justice systems. It provides direct intelligence on how the systems currently work (or fail) in practice, and offers a powerful insight into how to develop effective solutions that work for real people. The committee spoke to forum members as part of its investigation and encourages Thrive LDN partners to use this valuable resource to identify ways in which they can improve their services for people with experience of the criminal justice system.

3.14 Healthwatch organisations are the independent national champions for people who use health and social care services. Local Healthwatch organisations often have very good intelligence on what is happening within their local communities, while at a regional and national level they can help to identify issues that recur in different locations and help to disseminate best practice. Mental health service providers at all levels should be encouraged to make better use of these resources.

> **Recommendation 7**
>
> Thrive LDN programme leads should publish details of how it will evaluate its activity to date, and how it will monitor its future activity, to identify whether it is reaching the particular demographics who are under-served by existing mental health support. Thrive LDN programme leads should also develop best practice guidance for local partners on how to monitor this.
>
> Thrive LDN programme leads should publish details of how they have engaged with Healthwatch and other patient and service user representatives groups in the development of the programme and how they will continue to do so in the future.

Signposting

3.15 Not knowing what support is available was a barrier highlighted by all the groups we engaged with during our investigation. And, in a complex and fluctuating landscape, it can be difficult for even health professionals to know what services are available to support people locally. Thrive LDN provides an opportunity to bring this information together in a more centralised way, providing an online resource which is accessible to service users, their families, and to professionals. One of Thrive LDN's six key aims is to:

> "build on existing work investigating how best to harness the powers of digital technologies to promote positive mental health

and improve information about accessing effective support so that Londoners can better help themselves and support each other."[47]

3.16   But it should also be recognised that not everyone wants to use online services – for example, one in four disabled people has never used the internet. While improving digital literacy and access across the population is an important long-term aim, Thrive LDN partners should consider what other avenues can be used to disseminate information for those who are not online. This may require additional work at local levels to identify points at which individuals from marginalised groups access services within communities; this should then be fed back to the Thrive LDN programme team so that best practice can be shared across London.

3.17   We have also identified some specific changes that need to be made to the existing online offer to improve its accessibility. Thrive LDN should start with its own website by providing information on how to get involved in British Sign Language and plain English formats, and reviewing its advice on how to get help in a crisis, which currently excludes people who are unable to call a phone line. Adding a text and/or email contact option would help rectify this. It should also explicitly set out Thrive's commitment to being LGBT+ affirmative.

> "Deaf people experiencing a mental health crisis are not able to access crisis lines in British Sign Language. There is an emergency text messaging service via 999 but you have to register before using this. However, reading ability may vary and this needs to be taken into account."[48]

Recommendation 8

The Mayor should examine the potential role of his office and/or Thrive LDN in signposting people towards appropriate third sector services. Thrive LDN programme leads should also review the accessibility of existing information relating to the programme. Specifically, the website should be updated to include British Sign Language content, text contacts for support services and plain English versions of key documents.

3.18   In addition to the *where* and *how* of providing access to information, Thrive LDN should seek to focus on the *when* – that is, identifying how to provide support and advice at critical life points and in response to particular circumstances which contribute to poor mental wellbeing, for example:

- **Leaving home.** More than a quarter of students (27 per cent) report having a mental health problem of one type or another. LGBT+ students

have a particularly high likelihood of mental health problems compared to their heterosexual counterparts (45 per cent vs 22 per cent).[49]

- **Coming out**. Just because a person identifies as lesbian, gay, bisexual or trans doesn't mean that they will necessarily struggle with coming out, accepting their sexual orientation, gender identity or worry about being honest with other people. But many people do, fearing rejection, abandonment, violence and abuse.

- **Contact with the criminal justice system.** Recently-released prisoners are at a much greater risk of suicide than the general population. Suicide rates are higher in recently-released prisoners than in the general population, and a fifth of deaths by suicide in this group occur within the first 28 days after release. [50]

- **Receiving a diagnosis of a long-term physical health condition or disability.** Eight out of 10 people with a physical impairment were not born with it. The vast majority become impaired through injury, accident, or illnesses such as stroke. But emotional support is often lacking; for example, RNIB found that only 17 per cent of people were offered any emotional support at the time of their diagnosis.[51]

- **Bereavement, especially in connection to death by suicide**. People bereaved by suicide are at greater risk of attempting to or taking their own lives by suicide by up to 300 per cent.[52]

3.19 All groups we spoke to suggested that increasing visible diversity was important in helping people to realise that there was support available. In particular, they highlighted the need for real-life, positive examples of people like them who were experiencing mental health issues:

> "There are not examples of people with a learning disability experiencing mental health issues, as there are for the general population. Seeing real life stories can help improve our own attitudes to our own mental health, reduce feelings of shame and encourage people to seek help."[53]

Recommendation 9

Thrive LDN programme leads should review all public facing materials including advertising and case studies, to ensure that these are representative of the full range of people in London who experience mental illness.

Peer support

> "Rather than having a formal diagnostic thing where you go to your doctor, get diagnosed with a problem and then get offered treatment, it is having a service that is much more open-access and people bring their friends along and you receive mental health support alongside other things in a building that does not say "mental health" on it."[54]

3.20 All groups we spoke to highlighted the potential of peer support to improve mental health outcomes for marginalised groups. Peer support helps to reduce people's feelings of isolation and exclusion, and can provide positive role models as well as the type of practical and emotional support that may not be readily available from healthcare professionals. Peer-led services can also be in a better position to build trust with those service users who are less willing to engage with statutory services, can help people navigate the complex landscape of available support, and act as advocates for marginalised people.

3.21 Voluntary sector organisations and communities are often more adept at providing peer support than statutory services, and there are examples of peer support groups that have grown up organically within communities. However, to scale up this approach will require more than altruistic good intentions. Furthermore, peer support, however effective, should not be expected to replace professional mental health support.

3.22 The Mayor could consider options for developing peer support through the Team London volunteering programme to develop an extended network of mental health champions with a specific focus on currently marginalised groups.

Recommendation 10

Thrive LDN partners should explore how to help and resource organisations that have proved effective at peer-led support for marginalised groups. At the same time, the Mayor should look at how he can supplement the work of the voluntary sector in this space. This could additionally have dividends in terms of boosting employment.

4. Mental health in all policies

Key findings

- Supporting good mental health must run through all the Mayor's policies like a golden thread.

- Our work has highlighted two policy areas that are particularly important in the mental health of Londoners – housing and employment.

4.1 Addressing marginalisation in the Mayor's other policy areas will help to create an environment where good mental health is supported and illness prevented or reduced. As the UK Faculty of Public Health notes, there are complex linkages between social conditions and mental distress, which contribute to deaths by suicide:

> "Deprivation and its associations to unemployment, poor housing and homelessness, debt, poverty, social isolation and other poor social conditions contribute to adversity, erode resilience and result in coping strategies such as alcohol, drugs, gambling and an increase in mental distress. Attention must be paid to addressing these root causes [of suicide], reducing poverty and social inequalities."[55]

4.2 Supporting good mental health needs to become a golden thread that runs through all policy areas. The groups we spoke to particularly highlighted the importance of housing and employment in supporting mental health; the Mayor's economic development and housing strategies should highlight this.

Housing

4.3 London's housing crisis is also a mental health crisis. All the groups we spoke to highlighted action on housing as a critical area for mayoral intervention to improve mental health in the capital. Research by Shelter has shown that GPs spontaneously identified housing issues when discussing factors involved in their patients' mental health presentations – both as a sole cause and as an exacerbating factor of existing mental health conditions. One in five people said a housing issue had negatively affected their mental health in the last five years.[56]

- Between 2010 and 2016, the number of households accepted as being homeless by local authorities rose 49 per cent for those classed as vulnerable through physical disability, and 53 per cent for those vulnerable through mental illness.[57]

- A quarter of homeless young people are LGBT+.[58]

- 33 per cent of rough sleepers in London have some experience of prison.[59]

- Over half of people with mobility impairments who have looked for accessible homes said they were difficult to find.[60]

4.4 Being without secure accommodation also increases the risk of violence, sexual exploitation, and substance misuse – all of which have negative impacts of mental health. And being housed in inaccessible accommodation can effectively

render people housebound and increasingly socially isolated, with detrimental impacts on their mental health and quality of life.

4.5   A better awareness of the needs of marginalised people among staff working in housing services would help – for example to reduce instances where unsuitable accommodation is offered. Lewisham Health Oversight Committee has recently reviewed mental health and housing. It found that, according to local mental health services, "housing providers don't seem to have proper training or be willing to engage with services like theirs. They said that the general mental health training that housing staff commonly receive isn't focused enough for what they need, and that housing staff need specific training on spotting when mental ill health may be the cause of the housing problem and what to do next – similar to mental health first aid."[61] Beyond this, the Mayor should consider making London's local authority housing officers a priority group when considering how to roll out mental health first aid training.

Employment

4.6   Marginalisation in relation to employment was also highlighted by all the groups we spoke to. The positive impact of healthy work in promoting mental wellbeing is well-established, and the negative impacts of unemployment (or unhealthy employment) are also increasingly recognised. It is encouraging that Thrive LDN has made this an area of focus. The programme aims to:

> "bring partners together to develop and implement a programme to help people who experience poor mental health access support to gain and maintain work."[62]

4.7   Supporting people with existing mental health conditions to enter and stay in work is an important focus. However, there is further scope here to prevent mental ill health arising in the first place and ensure the benefits of healthy work are shared across society by closing the employment gap for people from marginalised groups.

Access to employment

4.8   Disabled people and people with experience of the criminal justice system are often shut out of employment altogether. Less than 40 per cent of disabled people are in employment, compared to around 80 per cent of the non-disabled population. For ex-offenders, the route back into work is made harder by employer attitudes to employing people with criminal records. A report by the Government's Work and Pensions Committee, Support for ex-offenders, suggests offering incentives for employers to actively recruit ex-offenders, who the committee describe as an 'untapped' resource.

4.9   But more than 50 per cent of businesses surveyed for the report said they would not consider hiring an ex-offender.[63] Highlighted are "assumptions around perceived risk to security and prevention of harm, concerns that ex-

offenders lack honesty and reliability, and the potential damage to the image of the business". Organisations that employ ex-offenders report that their recruits tend in fact to be grateful for an opportunity of a second chance, and are hard-working and loyal employees.

4.10 The Government is due to devolve the new Work and Health Programme to London. The previous Work and Health Programme has been strongly criticised in some quarters for contributing to increased mental distress for vulnerable people, and for failing to help the 'hardest to reach' into work. The Mayor should work with devolution partners to ensure that the new Work and Health Programme avoids making the same mistakes, and has specific regard for the groups we have identified.

Experiences within the workplace

4.11 Workplace bullying of LGBT+ and disabled people is disturbingly prevalent. The Faculty of Public Health reports that gay employees report more than twice the level of workplace bullying than heterosexual employees, while Stonewall research shows that over 10 per cent of trans people experienced being verbally abused and six per cent were physically assaulted at work.[64] As a consequence of harassment and bullying, a quarter of trans people will feel obliged to change their jobs. According to research by Scope, 53 per cent of disabled people have been bullied and 58 per cent feel at risk of losing their jobs.[65]

4.12 Making work healthy for all has been identified as a key element of the Mayor's health inequalities strategy. Encouraging employers to take action to address marginalising behaviours within their workplaces should be a central element of the Mayor's efforts, and evidence of specific action to improve the workplace experience of LGBT+ people, disabled people and Deaf people should be one of the required criteria for Thrive partners and for signatories to the Mayor's Healthy Workplace Charter.

Recommendation 11

In response to this report, the Mayor should write to the committee and set out how the specific needs of each group we have identified are being considered in the development of his housing and employment policies.

Our approach

The Health Committee agreed the following terms of reference for this investigation:

- To examine the current landscape for mental health for particular at-risk groups within London.

- To identify and make recommendations to the Mayor and partners on how to support better mental health for these groups and reduce mental health inequalities in London.

At its public evidence sessions, the committee took oral evidence from the following guests:

- Roger Hewitt, General Secretary and Chief Executive Officer, British Society for Mental Health and Deafness

- Richard Holmes, Policy and Campaigns Manager (London), Royal National Institute for Blind People

- Joan Hutton, Head of Adult Care, London Borough of Lewisham

- Alessandro Storer, Equality Improvement Manager, MIND

- Jane Powell, Chief Executive, CALM (Campaign Against Living Miserably)

- Joel Beckman, General Manager, CALM (Campaign Against Living Miserably)

- Paul Plant, Deputy Director, Public Health England (London)

- Amanda Coyle, Assistant Director, Health and Communities, Greater London Authority

- Professor David Mosse, Professor of Social Anthropology, University of London; Chair, Haringey Suicide Prevention Group; Lay member, NICE Public Health Advisory Committee on Preventing Suicide in the Community

- Dr Tamara Djuretic, Association of Directors of Public Health (London); Public Health Consultant, Haringey

- Sinéad Dervin, Senior Mental Health Commissioning Manager, Health in Justice, NHS England

- Glyn Thomas, Head of Implementation, Health in Justice, NHS England

- Helen Dyson, Operations Manager for Health and Justice Department, NACRO

- Cassie Newman, Head of Contract and Partnerships, London Community Rehabilitation Company

- Andy Bell, Deputy Chief Executive, Centre for Mental Health

The committee held a stakeholder event in October 2016 to discuss LGBT+ mental health. The following speakers took part:

- Dr Antoine Rogers, Associate Professor in Sociology, London South Bank University

- Michelle Ross, Co-Founder, CliniQ

- Aedan Wolton, Co-Lead for Service Development, CliniQ

- Matthew Todd, Author and Editorial Director, Attitude Magazine

- Dr Greg Ussher, Chief Executive Officer, METRO Charity

- Alessandro Storer, Equality Improvement Manager, MIND

- Dr Justin Varney, National Lead for Adult Health and Wellbeing, Public Health England

- Cllr Sarah Hayward, Leader of Camden Council and London Health Board Member

During the investigation the committee also met with the following groups:

- 6 July 2017: Revolving Doors Agency staff and service users focus group

- 21 June 2017: St Giles Trust

- 29 March 2017: National Deaf Mental Health Service at Springfield Hospital, Tooting

The committee also received written submissions from the following organisations

- UK Faculty of Public Health

- London Friend

- METRO Charity

- Mental Health Foundation

- MIND

- Stonewall Housing

- Young Minds

- Tavistock Relationships

- The British Psychological Society

- Dr Billy Gazard*

- Dr Charlotte Woodhead*

- Dr Katharine Rimes*

- Dr Qazi Rahman*

- Dr Stephani Hatch*

- Professor Martin Milton

- London Borough of Hackney Public Health Team

- London Borough of Lewisham

- London Borough of Southwark

- GMB Shout (LGBT+)

- Mencap

- Action on Hearing Loss

- British Society for Mental Health and Deafness

- Healthwatch Wandsworth

- South West London and St George's Mental Health Trust

- Signhealth

- Thomas Pocklington Trust

- British Association for Counselling and Psychotherapy

- The Prisons and Probation Ombudsman

- The Howard League for Penal Reform

- St Giles Trust

- Step Together

- The British Medical Association

- Revolving Doors Agency

- Contact Consulting and Adaphus Consulting

- Women in Prison

- NHS England HiJOVA

- Transport for London

- Individual members of the public

*joint submission

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Other formats and languages

If you, or someone you know, needs a copy of this report in large print or braille, or a copy of the summary and main findings in another language, then please call us on: 020 7983 4100 or email: assembly.translations@london.gov.uk.

Chinese

如您需要这份文件的简介的翻译本，
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Email 与我们联系。

Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Greek

Eάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.

Turkish

Bu belgenin kendi dilinize çevrilmiş bir özetini okumak isterseniz, lütfen yukarıdaki telefon numarasını arayın, veya posta ya da e-posta adresi aracılığıyla bizimle temasa geçin.

Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਉੱਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Bengali

আপনি যদি এই দলিলের একটা সারাংশ নিজের ভাষায় পেতে চান, তাহলে দয়া করে ফো   করবেন অথবা উল্লেখিত ডাক ঠিকানায় বা ই-মেইল ঠিকানায় আমাদের সাথে যোগাযোগ করবেন।
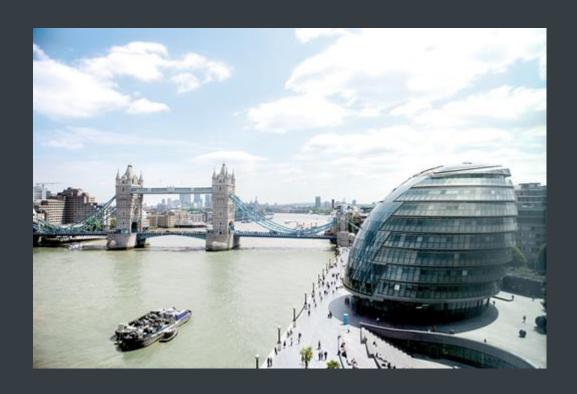
Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں درکار ہو تو، براہ کرم نمبر پر فون کریں یا مذکورہ بالا ڈاک کے پتے یا ای میل پتے پر ہم سے رابطہ کریں۔

Arabic

للحصول على ملخص لهذا المستند بلغتك، فـرجاء الاتصال برقم الهاتف أو الاتصال على العنوان البريدي العادي أو عنوان البريد الإلكتروني أعلاه.

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં જોઈતો હોય તો ઉપર આપેલ નંબર પર ફોન કરો અથવા ઉપર આપેલ ટપાલ અથવા ઈ-મેઈલ સરનામા પર અમારો સંપર્ક કરો.

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