Early learning and insights

We established the Healing our Broken Village conference in 2008 to add value to the then Department of Health Delivering Race Equality (DRE) in Mental Health care programme and as a community led response to the continuing over representation of black communities in mental health services.

The DRE programme was clear. Race and racial discrimination are a determining factor in the rise of inequalities and in the poor health and social care outcomes achieved by black communities.

The evidence was overwhelming. Black communities are:

* ***44% more likely to be sectioned under the 1983 Mental Health Act***

* ***50% more likely to be placed in seclusion***

* ***29% more likely to be subject to control and restraint***

* ***50% more likely to be referred through the criminal justice system***

* ***14% more likely to be turned away than white people when they ask for help from mental health services***

In successive years of the conference, we have sort to bring together leaders and officers from our public services with the leaders and members of our communities who share an equal concern for these matters. Our aim was to generate better conversations, across all of our systems and structures, towards tackling these issues in smarter and better ways.

In the interim years, evidence of the effects that mental health has on destroying people's lives has continued to mount. The DRE programme was part of the Government response to the Inquiry into the Death of David Bennett, a 38-year-old black patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff.

Yet, this year, 14 years after, the Inquiry into the death in police custody of Sean Riggs, a 40 year old black man, found that lessons had not been learnt. The Coroners psychiatric expert reported that there had been "serious failings in providing basic medical care" Approximately half of all deaths in or following police custody involves detainees with some form of mental health problem.

Further evidence of a wider system failure includes a recent report into mental health in-patients in south west London. It found that 51% of in-patients had occupied a bed on more than one previous occasion and over 65% were previously known to services. Far from "recovery", a "revolving door" was in operation.

There is currently a great deal of activity in relation to the "integration" of health and social care as a necessary process to improve system design and to militate against some of these failures. Proposals include care planners and case managers to help people navigate the system, and provide a single point of access. Better measurement of patient and service user experience as a way to understand and improve services are also being thought about and developed.

These are all important and necessary. However, this framework continues to view the challenges which we face only through an institutional lens, and in doing so, continues to ignore and misunderstand the importance that relationships and social networks play in people's lives.

The current "whole system" and "integration" narrative is in effect a conversation only about partial integration of only a part of the system, excluding as much as 90% of our "core economy", families, communities, and the "social capital" which we we all hold to take care of ourselves and our neighbourhoods, all lost to public service.

A key insight from our work is the importance of shifting real resources and support towards locally owned innovations as a pre requisite to the institutional re orientation that is required to meet the immediate challenges of a huge reduction in public expenditure against an increasing demand on services. Only when we share and enable risk and responsibility across a wider range of interested stakeholders will we be able to face the social welfare challenges that society faces.

Over the past few years we have been testing what the new might look like in relation to providing better and smarter mental health support to communities. These pilot projects have included:

- Black Church Leaders being trained in systemic family therapy opening up the possibility of a redesigned pathway into services

- Improving Access to Psychological Therapies co produced in local community sites widening the range of venues where services can be delivered and accessed

- Identification and enablement of local community champions embedded within their own social networks, acting as early engagers of people who are vulnerable and cut off from services

- Strengthening families programme: sharing and exchanging parenting, life skills and experiences into communities and families. Embedding these within existing social networks allowing for more resilient relationships to be formed and extended.

The promise of the DRE programme was to provide more appropriate and responsive services and improve community engagement. Our work has shown that it is necessary to go beyond this as it is no longer possible (and it is questionable whether it ever was) for institutional led and managed interventions to provide the support and care that people within communities want and need to help themselves.

A genuine integration of health and social care systems with social and community networks at its core is the next intelligent iteration of public policy in this area. We must generate the courage and confidence to meet this challenge. This will require a shifting from central control to a conferring of leadership on the local, the enablement of citizen led innovation and management for social productivity.

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