Norfolk and Waveney ICS

Adult Mental Health Transformation Programme

Community Listening Report

January 2023 – June 2023

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1. Introduction

Rethink Mental Illness (Rethink) has been commissioned by the Norfolk and Waveney NHS Integrated Care Board (ICB) to facilitate co-production within the adult mental health transformation programme, including supporting people in Expert by Experience strategic influencing roles. As part of this work, and aligned with the statutory guidance for working in partnership with people and communities, Rethink has built on previous community listening. This activity was overseen by the Co-production Manager for Norfolk and Waveney with a Community Co-production Officer out and about in communities having conversations with people. The Community Co-production Officer builds relationships with grassroots community leaders who already have relationships with people they are connected to/support. This approach ensures that people feel as safe as possible having individual or group conversations, and so that lived experience influence and change can be communicated back to the community.

2. Project background

This coproduction programme has had a focus on community engagement as well as strategic coproduction – linking these together. Community engagement is essential to bring in diverse and representative lived experience evidence to influence change and improvement, and address inequalities. Within the Norfolk and Waveney ICB and the wider mental health Integrated Care System, there is a commitment to ensuring that there is a thread of lived experience influence from community voices within the transformation of mental health services going forward, and an ongoing conversation with feedback about what has been influenced by lived experience and what is changing for the better.

3. Approach of the project

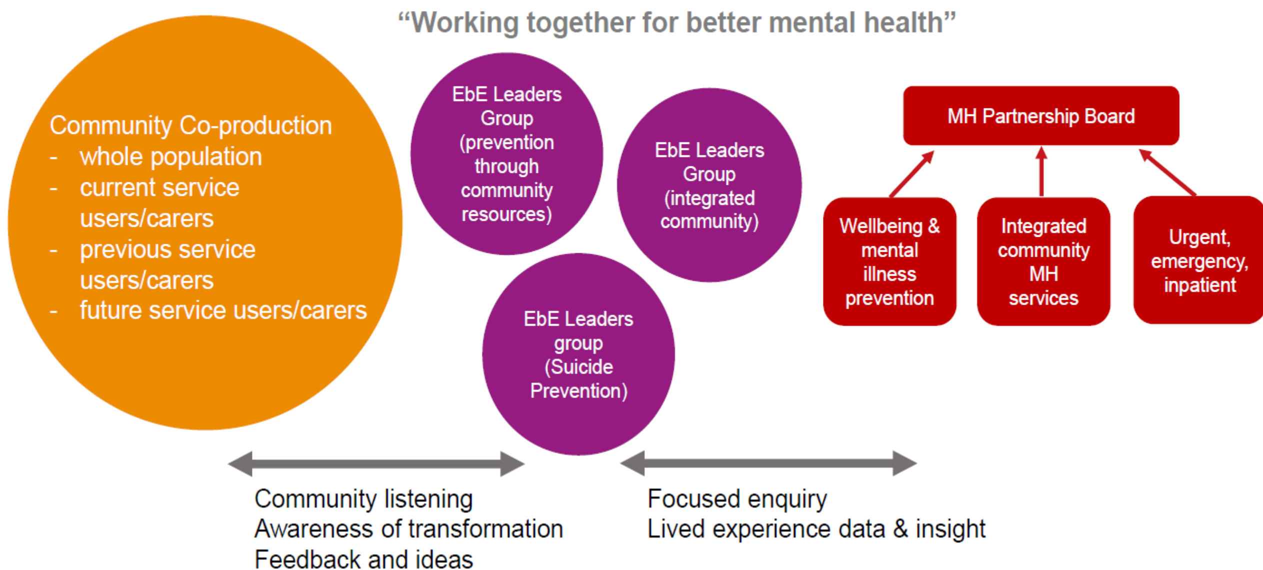
The Community Co-production Officer used an informal conversational approach while listening to what people said. People engaged in group discussions or on a one-to-one basis.

Mental health is not an easy topic to broach for varying reasons, for example because

- Some communities do not have a translatable word for it.
- There can be a lack of mental health awareness in many communities.
- The topic of mental health may be taboo due to several further reasons which contribute to making the topic difficult to approach.

With this understanding in mind, our Community Coproduction Officer joined different community activities and focused on what people did and did not find helpful and why, whilst taking notes. Whilst taking the notes during our community listening, the coproduction officer checked that people were okay, though, with the understanding in mind that notes being taken whilst listening to a speaker can be distracting. The Community Coproduction Officer wrote up their notes directly after listening.

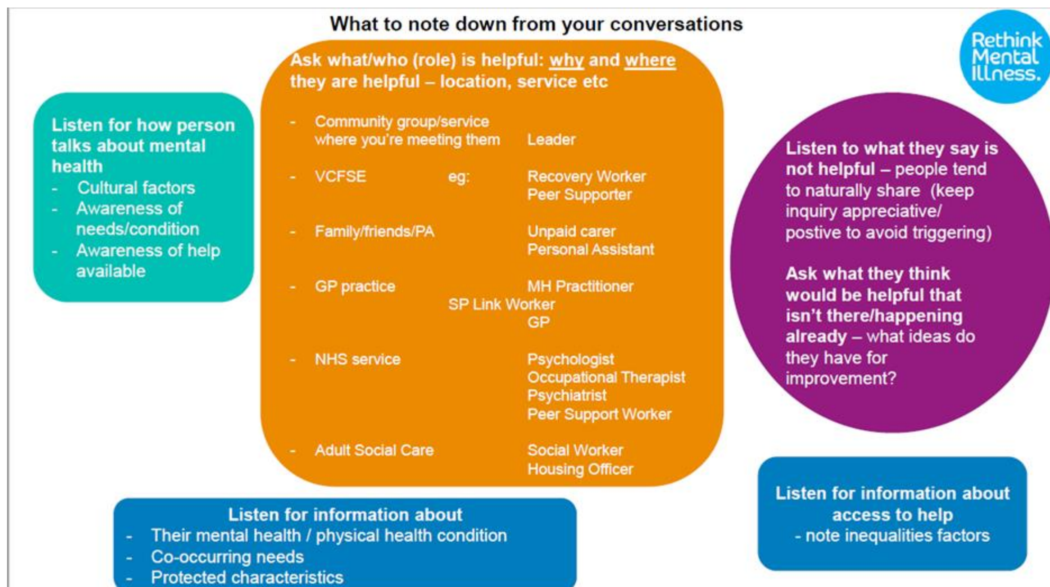
The community listening approach is outlined below



We focused on people and communities experiencing health inequalities, connecting with people most at risk of suicide, people who live in rural areas, asylum seekers, refugees, and vulnerable migrants, older people.

The information from the community listening activity fed into lived experience insights and strategic influencing by the Expert by Experience Leaders.

The diagram below outlines the conversational listening approach used.



4. Community listening activity

A crucial aspect of this project was to establish connections and initiate conversations with a wide range of people through the Voluntary, Community, Faith, and Social Enterprise sector (VCFSE) across Norfolk & Waveney. Between January and June 2023, 15 grassroots organisations/groups/events were visited by the Community Coproduction Officer, and 24 community listening conversations were arranged in different locations, mostly in rural areas across the county (see Appendix 1 and Appendix 2 for more information about the locations and community organisations/groups/events).

The Community Coproduction Officer gathered what 75 people said as collective lived experience evidence to generate insight for strategic influencing in the programme by the EbE Leaders.

The Equality and Diversity Monitoring form (see the sample in Appendix 3) was used to collect the demographic data of participants (see the results in Appendix 4). Please note the form was voluntary (people could opt in or opt out) therefore, the number of forms is lower than the total number of people engaged.

5. Theming (from conversation note buckets)

The lived experience information (data) was collected by the Community Coproduction Officer using the buckets below as a guide.

Conversation note buckets
(for co-consideration, co-theming, co-insight making and co-deciding other lines of enquiry)

Cultural (language/ communication/ approach/ stigma)	Access challenges re inequalities	Type/level of need and complexity	Co-occurring needs/factors eg poverty, insecure housing/homelessness, substance misuse, DVA,	Personal/care planning & support with it
Value of community resources in keeping well	Value of clinical resources in keeping well	Value of social work resources in keeping well	Helpful approaches eg joining up (not helpful/missing)	Helpful environments eg joining up (not helpful/missing)
Medicine management: access, reviews, joining up	Physical health (checks), resources	Very high levels of mental/emotional distress (crisis)	Lifestage considerations/ differences: 18-25; up to 60; over 60	Pregnancy, birth and early years Employment and meaningful activity

The notes made by the Community Coproduction Officer about what people said did not include any information that could identify anyone, and the collected data was anonymously organised to ensure privacy and data protection.

The next stage was for the Expert by Experience Leaders and Rethink staff, including the Community Coproduction Officer, to get together to make sense of the information collected. The data was analysed into thematic insights. It was important to look at this together at an in-person event to unlock a deeper understanding of the data.

These sense-making, insight events happened in March 2023.

6. Thematic insights

The community listening data was reviewed by the Expert by Experience Leaders under the conversation bucket titles and they then identified lived experience insights to take forward.

6.1. Access challenges & inequalities

Quote extracts

“NHS staff make assumptions about people’s gender identity.”
“NHS staff use my name on the system which I don’t prefer to use. This triggers me.”
Reimbursing transportation costs and offering taxi services for people with mobility barriers is important.
“There is no social life in these small towns like Bungay, Harleston, Beccles, and Halesworth. There are poverty and transportation deprivation. These towns need community hubs, drop-in places at any time for mental health support.”
“Existing services aren’t enough such as pharmacies and GP surgeries in small towns.”
There is no gender identity clinic in Norfolk and Waveney. It can be considered for long-term mental health transformation.
Expanding locations of available services, available treatments in primary care, increasing funding, and community groups in all areas.
Wider awareness of LGBTQI+ society and gender identities. A better understanding of LGBTQI+ mental health problems.
LGBTQI+ specific counselling service.
“Prejudice, racism, discrimination, and hate crime are the issues seldom heard communities face. Stigma is a barrier, especially for men.”
“Young people struggle with trans and gender issues.”

6.1a. Insights to take forward about inequalities in access

- Small towns and rural communities are struggling with poverty and their access to local service provision is a contributing factor in maintaining wellbeing.
- Services could be taken to rural areas e.g. mental health bus, drop-in services in village halls. If this can't happen then at the very least people need help with transport costs.
- The LGBTQIA+ community experiences stigma by some staff who make assumptions about them. Therefore, wider awareness of LGBTQI+ society and gender identities are needed in services.
- Various communities, for example racialised minorities, the LGBTQIA+ community, and many others face issues of prejudice, racism, discrimination, and hate crime when receiving care. Therefore, there is a need to increase services for local communities- i.e., services which provide support in the face of experiencing such issues.

6.2. Cultural factors(language/communication/approach/stigma)

Quote extracts

"Many people (refugees) have anxiety when a job offer comes. They step back and say they aren't ready to work. People need therapeutic intervention and long-term employment support for sustainable employability."
Why is there no specific workstream for refugees' needs? Services, being aware of lived experiences, and sensitive to cultural differences this should be prioritised.
"I have a stress problem but never went to the doctor. It is because of having many responsibilities."
We need home doctor's appointments, alternative ways to access services, and reducing stigma around MH. *This person talked about how within his culture, people with MH issues are stigmatised and don't want to access mainstream services in case someone sees them*
"Language is another barrier for non-native speakers. GPs are asking people to bring someone from the family who speaks English (they are generally kids) to translate and it creates a negative impact on the kids."

A useful interpreting service to have in NHS, having a regular budget for enabling people to explain their feelings in their first language before having any mental health treatment.

6.2a. Insights to take forward about cultural awareness

- People spoke widely about language barriers and the need for interpretation services (above are just a sample of comments).
- An awareness of the trauma patients could have experienced on their journey to England would improve decisions made when services are offered.
- Cultural awareness would also help, for example, having more recognition for cultural variation in patient identities such as language, when creating treatment pathway.

6.3. Type/level of need and complexity

Quote extracts

The Wellbeing Service discharges people without giving a reason and says that they cannot help you.”
This is the feedback from more than one person about the Wellbeing Services in Waveney • People shouldn’t be discharged before they are ready. • Tackling waiting lists is so important (more than tick boxing). • Need to increase the number of staff in all areas.
Communication between services and patients’ needs to be improved, also being informed about the process.
“I am referred to the hospital for the first time and waiting for my initial assessment. However, I feel anxious.”

6.3a. Insights to take forward about complex needs

- People would like information and insights about their treatment.
- Wellbeing services are understaffed with large waiting lists.
- Staff recruitment in wellbeing services needs to be prioritised.

6.4. Personal care planning & support with it

Quote extracts

“When a patient is sectioned to stay at the hospital, other family members are also affected and need help.”
Holistic care in services. Families with cancer treatment, mental health treatment, dementia treatment e.g. are badly affected. Family mental health support should be offered by services.

“Services are getting better about involving carers.”
Keeping carers’ voices within a person’s care/where permission is given.
“I needed grieving support after losing my husband. My husband and I were registered with the same GP. My GP didn’t contact me to check whether I am fine.”
Phone calls from GPs, signposting, and/or referring to the Wellbeing Service. More available peer support workers, promoting available services like grief webinars.

6.4a. Insights to take forward about planning support

- Families are integral to the care and support of a patient. They should be offered support too, whether this is access to family therapy, counselling or signposting to services they should be able to access care services.

6.5. Value of clinical resources in keeping well

Quote extracts

“I have a stress problem but never went to the doctor. It is because of having many responsibilities.”
Home visit model needed (for families with young children, older people with mobility issues).
“I called NHS 111 in a crisis time. It took 1 hour to talk to someone on the phone. It was a long time in crisis. However, it was a helpful experience.”
Having more options to talk to professionals when in crisis. Peer support phone line as an improvement to the NHS 111 option.
“Discharging people early from hospitals escalates their mental illnesses’’
Preparing people to integrate into daily life before discharge. Giving attention to what patients think about discharging decisions.
“Not reading patients’ records and asking the same questions are triggering patients.
Reading records to avoid repeating the same questions. Reviewing assessment questions to avoid irrelevancy.

6.5a. Insights to take forward about co-occurring needs

- Having tools and resources to identify what can be done to effectively help people experiencing crisis is needed.
- Being discharged from hospital creates anxiety, therefore, patients need to be better prepared and supported through this transition.

6.6. Value of community resources in keeping well

Quote extracts

“There were female participants too in this exercise group, but people lost their interest after the pandemic.”
Increasing signposting and opportunities for all
Positive – continue funding of community resources, looking for more opportunities in different areas including small towns.
Community buses, befriending schemes from peers for people facing isolation are needed

6.6a. Insights to take forward about community support

- Community resources are much needed and valued, more resources need to be offered to people facing isolation and/or living in rural areas.

6.7. Value of social work resources in keeping well

Quote extract

“I am very happy with my social worker. We meet once a week, and she is very helpful.”

6.7a. Insights to take forward about social work and other clinical practitioners

- People were happy with social work resources. However, comments were limited as most people spoke about mental health service provision.
- We could possibly focus on this area for future community listening to gain more insight and find out the further reasons behind why non-mental health specific practitioners can be helpful.

6.8. Helpful approaches & environments e.g. joining up (not helpful/missing)

Quote extracts

Communication and welcoming approach, explaining the process/limiting wait time to reduce anxiety/damage limitation.
No wrong front door, better communication of services, more active primary care.
Referring patients to Wellbeing Service (Talking Therapies).
Improving data sharing system, being able to see the records in primary and secondary care services.
“There is help there. You need to be active to find the right support. However, my depression doesn’t allow me to go out.”
“Nobody sees the whole picture of my illnesses and treatments.”
“This town is improving and better than before. Having a community hub would be very good.”

More community hubs in different towns with longer opening hours, adapting already existing resources to meet the needs.
Creating a safe and non-judgmental environment in services. Building trust with seldom heard communities and NHS services. Engaging with community organisations, promotion of services.

6.8a. Insights to take forward about help-seeking approaches

- People were forthcoming with their views on what is helpful, for example, having the process explained to them when it comes to waiting times.
- People throughout community listening activities whether in rural or urban areas recognise the importance of community hubs and would like more.

6.9. Physical health (checks/resources) & medicine management

Quote extracts

“There aren’t regular follow-up appointments in GPs after prescribing people with medication.”
“GPs tend to give antidepressants for common mental health problems, however, don’t follow the result of the medication.”
Checking patients regularly about their treatment process.
“There is no mental health check-up like physical health, but it is necessary.”
“10-minute GP appointments are not enough for people especially older.” Increasing appointment times, especially for older people, and talking about mental health.

6.9a. Insights to take forward about clinical management approaches

- GPs could carry out more medication reviews with patients themselves if not maybe ask other people e.g. mental health practitioners, to telephone patients for feedback.

- Older people may not feel comfortable talking about mental health issues because of stigma or fear of a ‘bad/unhelpful’ diagnosis and what it will mean for them, more time to build trust with older people might make a difference. This could be improved through offering Physical Health Checks.

6.10. Very high levels of distress

Quote extracts

"People are worried about being discharged from waiting lists without giving a reason. Nobody wants to be abandoned by the system."
Better communication and clear information are needed.
"I lost my mother in Covid time, and it was hard. I couldn't seek any help for myself, and nobody helped me either."
Awareness of available crisis helplines (promoting crisis services with an equity approach), ensuring there is contact and follow-up support such as bereavement services/counselling services.
Diagnoses of mental illnesses take a long time and waiting time is distressing people."
Managing waiting time effectively and being in communication with patients throughout.

6.10a. Insights to take forward about emotional distress & crisis

- Offer a supportive process whilst people are waiting to be seen.
- Give information early on what services are available in the community.
- How to link in with ongoing help for prevention of future escalation whilst waiting?

7. Insight sense making- the gateway for strategic influencing

From the community listening activity, we are bringing information and insights together to become a gateway for strategic lived experience influencing. To unlock this, the role of EbE Leaders is fundamental for sensemaking, as their insights evidentially affirm the collective lived experience influencing priorities. The insights from the community listening data are considered alongside our EbE Leaders' insights and possible actions for system and service change and improvement. This process demonstrates the potential for lived experience influencing further strategic change within Integrated Care Systems.

7.1. Help-seeking barriers & approaches

From the lived experience data, we understand there are many barriers before and during the process of seeking help, and certain approaches prove less helpful than others. Within the help-seeking barriers theme, the EbE Leaders' insight was there is lack of trust towards services and rigid approaches to treatment equate to inequalities of access and experience, sometimes involving stigma.

The data showed that individual preferences of people were not always enabled by the service and practitioners' approaches. The insight is that if people's beliefs and choices step outside of expectations, the services cannot work with these.

People need choice and control, and this data emphasises the need for good communication between the person and clinician to demonstrate how individual preferences, choice and control are possible to achieve. For example, through gender equality training. Also, our EbE Leaders' insights affirm the need for communicating positive examples of good service outcomes for people, and who offers what and where via different practitioner expertise.

Time constraints were found as another difficult element in the process of help seeking, both before and during, due to waiting times and the low amount of communication during the wait. This is followed by treatment time itself sometimes being too short to explore the breadth of the person's experience and to fulfil the co-occurring needs of patients.

The data supports the EbE Leaders' insights and forms a collective lived experience priority that practitioners need more time with people to understand individual preferences and co-occurring needs. Lived experience informed system change to put lived experience influence into action could be finding ways of creating more time for people with a range of practitioners (this does not necessarily have to be GPs or psychiatrists). In doing so, the opportunity to prevent very high levels of emotional crisis increases and care planning can have much higher quality long term value both for people and practitioners. This also becomes a good opportunity to review resource distribution and further understand what level of regular communication between people and practitioners can happen to mitigate waiting time-induced crises.

7.2. Cultural factors & cultural sensitivity

Waiting time reductions and more autonomy for patients is impacted by cultural factors as well as the cultural factors themselves leading to less autonomy. This insight combines with the insight above about rigid approaches to care not being helpful when thinking about solutions for cultural inclusivity in practitioner approaches. From our data, patients report a ranging number of cultural factors such as language barriers, communication challenges and a lack of overall understanding from practitioners. This evidently has a negative impact and consequences on access which furthers inequalities faced in the process. Identity-related access issues have meant people need to experience their practitioners "seeing" their patients culturally.

The EbE Leaders' insights indicate that language barriers hinder peoples' understanding of their conditions, medication, side effects and what happens during the process of help-seeking. This links back to the need for practitioners to clearly communicate what they can offer to the person and having more time and space between them and the patient, to listen and have a conversation.

To enhance strategic change, different forms of support and training initiatives can be introduced to allow for better outcomes which can themselves be used as examples for people to seek help. Some possible actions and solutions towards improving help seeking can be through for example, having intersectionality awareness training, general trained peer support, targeted communication for specific communities of

identity. Also, through training practitioners to use the social model of disability holistically, in which they are trained in person-centred and trauma informed approaches.

The EbE Leaders' insights demonstrate that integrated social care and support around mental wellbeing is vital and about knowing who does what and expectations – otherwise the system seems too complicated to both the clinician and the patient. This further leads to a negative cycle in which multiple communities continue to avoid seeking help due to their needs not being met and communicated adequately. In combining the emphasis on improved help seeking and communication strategies, there can be impactful action for better outcomes, for example access challenges can be reduced because there is much more holistic understanding for both the practitioner and the patient. Our community listening lived experience data takes the cultural context into consideration and points towards the need to promote person-centred care and resources.

The system can become more person-centred by taking a more culturally sensitive approach, through training in intersectionality and altering unhelpful terminology and language. EbE Leaders' insights that certain language and approaches are not helpful, combines with the insight of constrained waiting lists and recruitment issues. For example, the approach around discharge can lead to fear and anxiety about not being effectively supported and lead to distress.

7.3. Complex needs & "discharge"

The community listening lived experience data shows complex co-occurring needs among patients vary to a high degree. The EbE Leaders identified that the word and approach around discharge is not helpful. When complex needs, long waiting lists and inequalities language challenges are combined, there are opportunities for change. For example, if someone is ending their treatment with the Wellbeing Service (NHS Talking Therapies for anxiety and depression), there could be active signposting to someone else through the practitioner, rather than support stopping with no other care planned or even in sight after the completion of the treatment or period of support.

Potential changes to practitioner approaches from lived experience insights could be enhancing or adapting training and resources for practitioners so that people feel more held, and the potentially unhelpful impacts of 'discharge' are mitigated when course of treatment or period of support finishes. This could enable a tapering off experience, increasing the focus on the person's next phase of care. These sorts of adaptations in approach could have a positive wellbeing benefit for practitioners as well – because people have a more positive response to endings and follow-on treatment and support. Another EbE Leader insight is that not all individuals are asked how they are really feeling, or which stressors and life events are impacting on their emotional and mental wellbeing. This is evidenced by our community listening lived experience data which shows people are not being asked how they are by their clinician, not having enough time for a longer conversation or having someone to turn to when things are not working. This is happening alongside individuals not being able – for various reasons

— to speak to the true level of what is going on for them. These insights inform the collective lived experience priority that people need more time with practitioners, and deeper understanding of needs and further care planning produced from that increased time.

Deeper understanding of needs and further care planning would come from practitioners' approaches to considering the individual social and holistic factors for a person's mental health and wellbeing. For example, coproduced personal plans and communication preferences.

7.4. Inequalities & co-occurring needs

The community listening data shows that inequalities and co-occurring needs mean there is a risk that mental health needs may not be met by care and support options. This supports EbE Leaders' insights that people with some protected characteristics and co-occurring needs or co-morbidities are excluded from mental health care and support. There can be confusion around whether Autistic or other neurodivergent people, or people misusing drugs and alcohol can access certain mental health services. And having a diagnosis can be either helpful or unhelpful in terms of access and experience of care and support.

Training in approaches to enable access and positive experiences for people with protected characteristics, co-occurring needs and experiencing other inequalities could be helpful, using co-produced guidance. This could include care planning and patient reported outcome measurement.

7.5. Medication management

The community listening and EbE Leader insights indicate opportunities for improvement around medication management, such as communication and understanding about challenges and barriers connected to stigma around mental health and medication, time to discuss questions around medication, including side-effects, and opportunities realised around physical health checks.

8. Actioning insight sensemaking

The EbE Leaders' insights affirm the need for people to feel seen, heard and understood throughout their treatment and support. To reduce the impact of not joining up, there could be increased connection across different practitioners. For example, VCFSE practitioners and volunteers could enable more connection. EbE Leaders' insights affirm the need for clinical and social practitioners to network with each other so they themselves understand who does what. For example, EbE Leaders thought medication reviews with various practitioners involved offers an opportunity for practitioners to understand more about what they each offer and how they can connect around people. Another idea is VCFSE practitioners, volunteers and peer supporters

offering connection and support to help people waiting for clinical services to help them feel 'held' by the whole system.

There is an opportunity for the lived experience insights to influence changes to the approaches of practitioners through greater understanding from community listening. For example, the cultural identity of a patient can generate barriers towards help seeking because of the dissonance created between them and their practitioner. Practitioners can understand how to use more culturally sensitive communication, so the person is more likely to share information and decisions about their care with the practitioner.

The lived experience insights make a link between co-occurring complex needs and inequalities that offer an opportunity to make changes in how help is delivered, such as changes in the discharge process and increased empathy. Increased understanding can reduce distress and crisis. Another insight is that asking about wider determinants of mental health in appointments enhances the scope for better care planning. And to enable this, more time is needed between the person and the practitioner to discover hidden needs.

The benefits of this community listening approach include discovering opportunities to do things differently for better access, experience, and outcomes for the adults of Norfolk and Waveney around their mental health care and support. For example, opportunities for practitioners to understand more about helpful approaches. Also, opportunities to understand and note individual and co-occurring needs, to encourage feelings of autonomy and dignity and recognising the expertise of lived experience. And opportunities to provide enough clear information provided to people, with ongoing communication so that they are kept informed about what is happening during their care and support. Actively connecting people with additional, alternative and follow on care and support are indicated as being important. The community listening data has directly informed the EbE Leader's collective lived experience priorities and influencing of the adult mental health programme.

9. Learning

- The amount of community listening activity was limited by having one part-time community engagement officer for the whole of Norfolk and Waveney, and the fact that the community listening approach needs time to build relationships with people who are close to people who work or volunteer in the community as they can have the motivation and time to share information widely, convene and organise conversations. There is a level of trust and feelings of safety for people connecting with the system via people who work and volunteer in communities. Also, working in partnership with the Community Connectors and other roles in Norfolk and Waveney could lead to more lived experience information coming into the programme.

- Community listening did not seem to be very well understood as an approach within grassroots communities, and a clear narrative of how and what lived experience has influenced, and the scope for further influence could be helpful in future.
- It would be helpful to have written information about the community listening approach for community leaders and Community Connectors, including who is sponsoring the activity and where the lived experience information will go, and what the opportunities to influence are.
- It would be helpful to have visual communication about what is available to people by locality and how care and support is connected, and the access points, so that people and community leaders can build their knowledge about what the system offers for mental health care and support.
- It would be beneficial to encourage community leaders and staff to share their insights about what people share with them about care and support and their mental health needs.
- Community listeners need to have good understanding of the mental health programme and opportunities for lived experience to influence, as well as the care and support landscape. This is important so they can frame their listening based on the topic buckets so that the information collected has a good chance of influencing through the EbE Leaders' insights.
- It would be helpful to have Experts by Training involved in the insight sensemaking process, to generate further lines of enquiry to add to the buckets for further listening activity.

10. Next steps

- Integrating learning into the forward approach.
- This approach is already aligned with the draft ICS mental health coproduction strategy which is focused on gathering a wide range of insight, particularly people and communities experiencing the greatest inequalities.
- We are applying the learning from this approach to engage localities with the ICS coproduction strategy.
- We are already aligning with ICS Inequalities Strategy to target specific groups and engage in more depth on what matters to them.
- Coproduce specific lines of enquiry with Experts by Training to identify where community listening activity is needed to inform future mental health programme activities.

Thank you for reading this report. If you would like to make any comments or suggestions, please contact Samantha Holmes at samantha.holmes@rethink.org

11. Appendices

Appendix 1 Norfolk and Waveney Community Listening Locations

Please note areas not covered within Jan 2023 to June 2023 will be covered from June 2023 to Jan 2024

Appendix 2 Norfolk and Waveney Community Organisations/Groups/Events

Comm Org/Groups/Events	Location	Whom they support
1. The Garage	Norwich	Supporting people for improving well-being with creativity.
2. Trussell Trust	Norwich	Foodbank centres for people who face poverty, homelessness, and unemployability.
3. The Shoe Box	Norwich	Supporting people in reducing loneliness and isolation and empowering communities
4. Mind Rest Hub	Norwich	Supporting people with mental health conditions/Gardening group
5. New Routes Integration	Norwich	Supporting asylum seekers, refugees, and vulnerable migrants for integration
6. St Barnabas Counselling	Norwich	Supporting people with mental health conditions
7. University of Sanctuary	Norwich	Supporting Sanctuary students for loneliness and isolation
8. Bridge Plus	Norwich	Supporting Black and Asian Ethnic Minority groups
9. Mind Drop-in sessions	Cromer	Supporting people with mental health needs
10. Men's Sheds	Holt	Supporting men with loneliness and isolation
11. Mind Rest Hub	Aylsham	Supporting people with mental health conditions
12. Community Library	Dereham	Supporting women with loneliness and isolation/Art and craft group
13. Steam Café	Kings Lynn	Supporting people with mental health conditions
14. Mind Rest Hub	Thetford	Supporting people with mental health conditions

15. Physical Health Check	Thetford	Promoting exciting services for rural areas
16. Creative Arts East	Watton	Supporting older people with loneliness and isolation/Art and Craft session
17. Cuppa Care Bus	Attleborough	Supporting older people with hearing problems/Physical health conditions
18. The Wellbeing Trust	Diss	Supporting people with loneliness and isolation
19. The Pear Tree Centre	Halesworth	Supporting people with mental health conditions, loneliness, and isolation
20. The Wellbeing Trust	Beccles	Supporting people with loneliness and isolation
21. Access Community Trust	Lowestoft	Supporting people who face homelessness, housing issues
22. Migration Partnership	Waveney	Supporting Immigrants for sustainable employability
23. Caring Together - Carers Voice	Norfolk (Hethersett)	Supporting young carers/carers to reduce anxiety and depression
24. Norfolk Pride	Norfolk	Supporting people with trans and gender issues

Appendix 3 Equality and Diversity Monitoring Form

Equality and Diversity Monitoring Form

Rethink Mental Illness is committed to the implementation of its Equality and Diversity Policy in all aspects of its work.

It would assist us greatly if you would complete this form so that we can monitor the effectiveness of our Equality and Diversity Policy and find out whether there are any particular minority needs within our workforce.

Please tick the boxes that you feel most comfortable with. If you do not feel any of the boxes are appropriate, please tick 'other' and describe in your own words. **(P)**

Gender Identity			
Male		Female	
Transgender		Prefer not to say	
Do you live full-time in the gender role opposite to that assigned at birth? Yes/No			
Male at birth		Female at birth	
Ethnic Background			
White		**Black/African/Caribbean/Black British**	
British		African	
Irish		Caribbean	
Gypsy or Irish Traveller			
Any other White background please describe below		Any other Black, African, Caribbean background, please describe below	
Asian/Asian British		**Mixed/multiple ethnic groups**	
Indian		White and Black Caribbean	
Pakistani		White and Black African	
Bangladeshi		White and Asian	
Chinese		Any other mixed, multiple ethnic background, please describe below.	
Any other Asian background, please describe below			
Other ethnic group			
Any other ethnic group, please describe below		Do not wish to answer	

Religion or Belief			
Buddhist		Sikh	
Christian		Muslim	
Hindu		No Religious Belief	
Jewish		Do not wish to answer	
Other religion/belief, describe below			

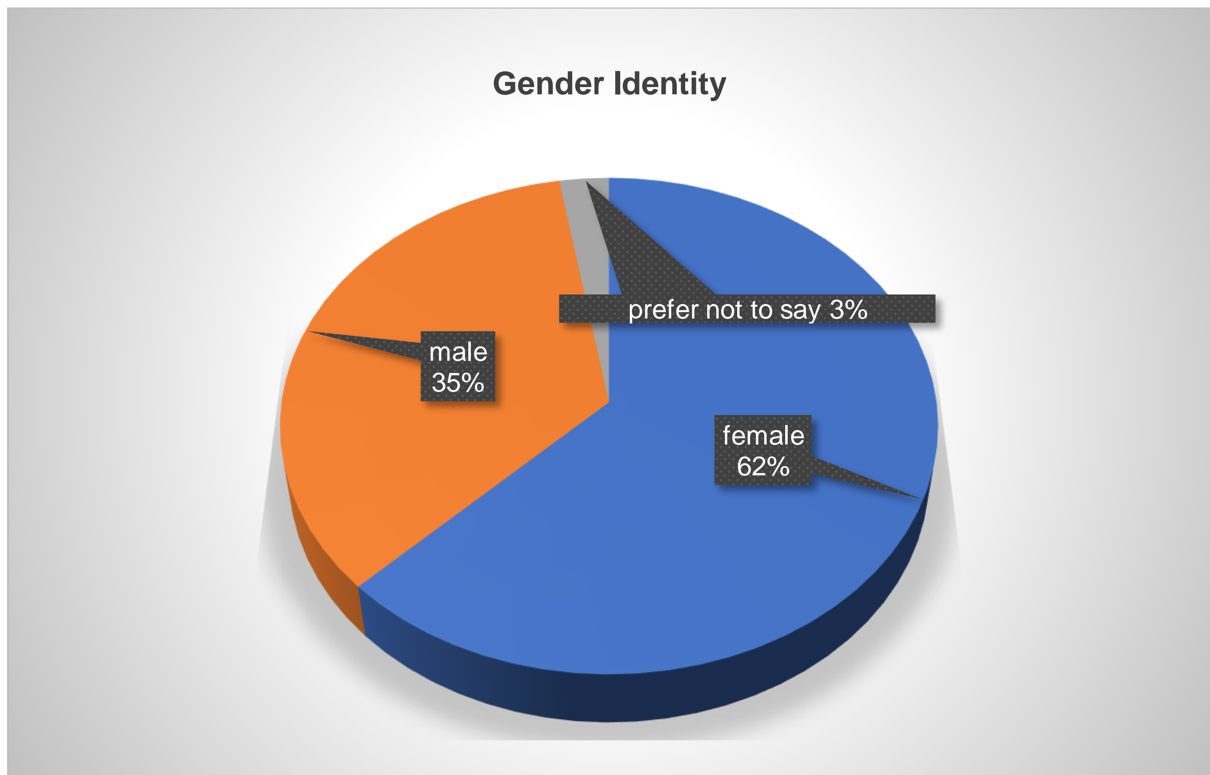
Disability and Mental Health		
Do you consider yourself to have a sensory disability?	**YES**	**NO**
Do you consider yourself to have a learning disability?	**YES**	**NO**
Do you consider yourself to have a physical disability?	**YES**	**NO**
Do you consider you have a mental illness?	**YES**	**NO**
Have you personally used mental health services?	**YES**	**NO**

Sexual Orientation			
Heterosexual/Straight		Homosexual/Gay Man	
Gay Woman/Lesbian		Bisexual	
Do not wish to answer		Other (please state below)	

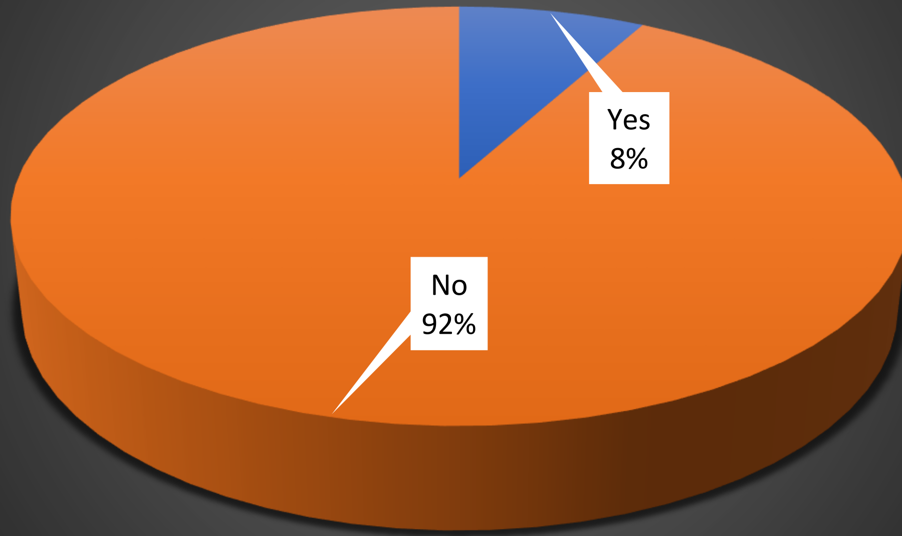
Caring Responsibilities			
Do you look after someone from any of the following groups?			
A child with a disability or special needs		An adult	
Someone with a disability related to his/her mental health			
Not a carer			
Do not wish to answer			
Other, please specify			
Have you used carers' services?			

Data Protection
The information will be kept in a database in accordance with the provisions of the Data Protection Act 1998 (which allows for sensitive personal data to be held where necessary to monitor organisations Equality and Diversity Policy). Access to information that identifies individuals will be strictly restricted and used only for implementation of Equality and Diversity policies. Employees and volunteers have the right to check that information held about them is correct.

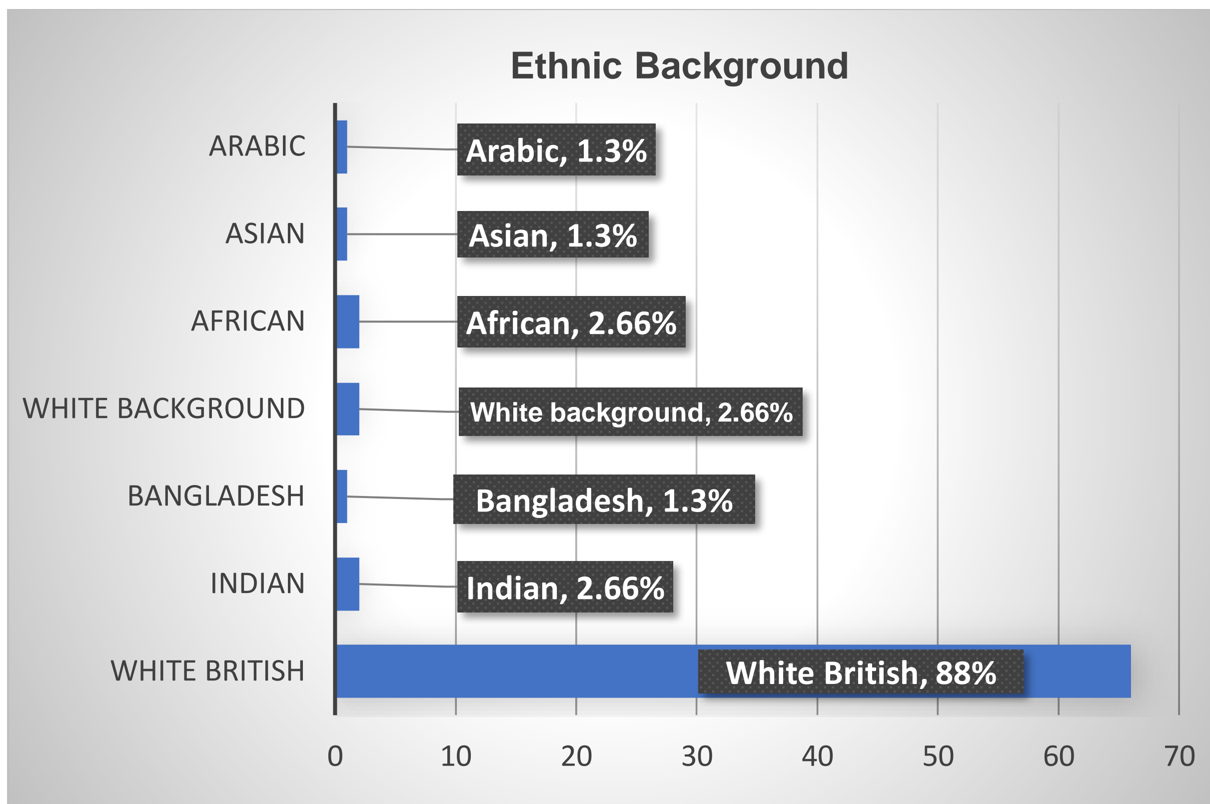
Appendix 4 Equality monitoring data from 75 people living in Norfolk or Waveney who completed the Equality Monitoring Form.



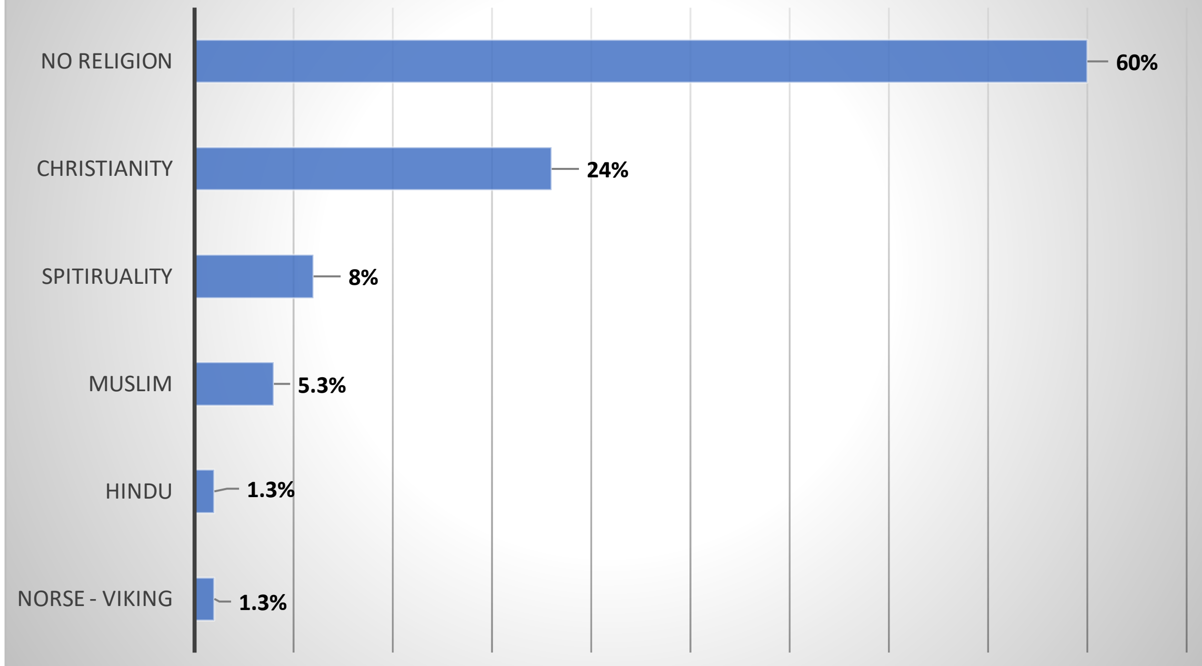
Gender	Count of Gender
Female	47
Male	26
Prefer not to say	2
Grand Total	**75**



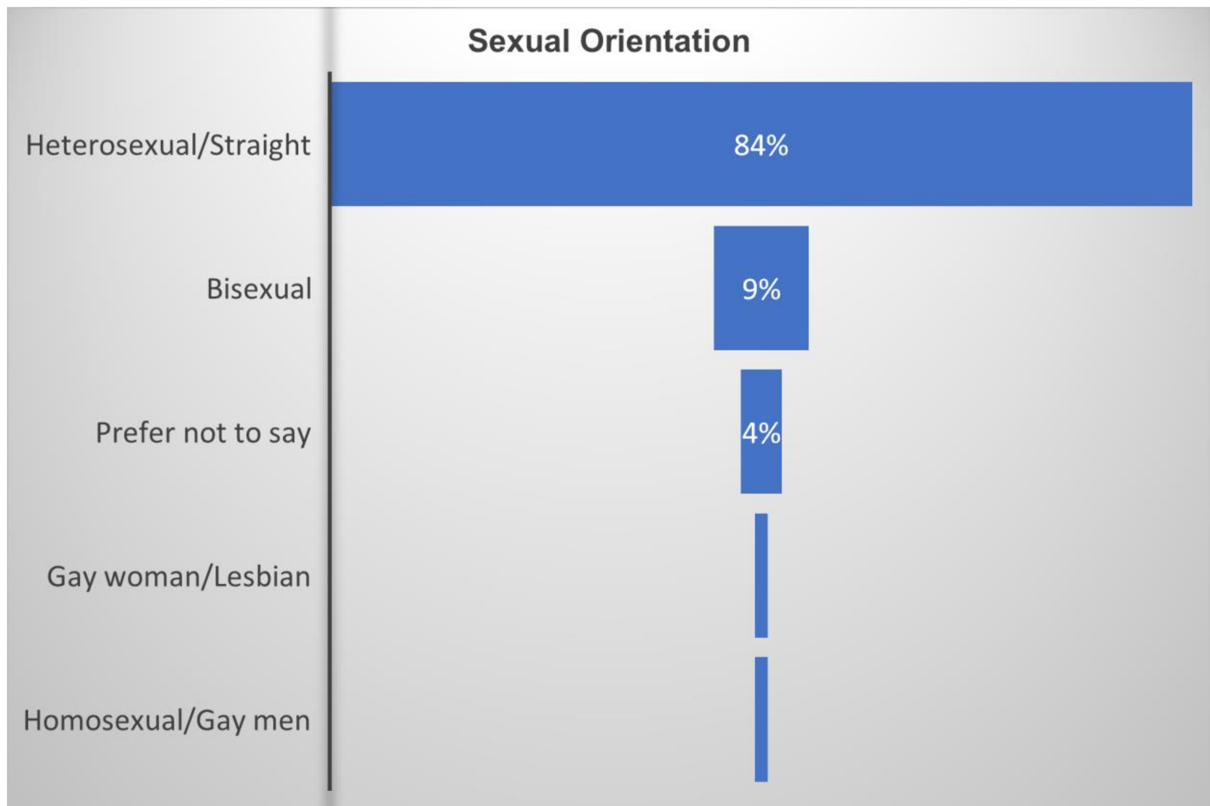
Do you live full-time in the gender role opposite to that assigned at birth?	Count
No	69
Yes	6
Grand Total	**75**



Ethnic Background	Count
Arabic	1
Asian	1
African	2
White Background	2
Bangladeshi	1
Indian	2
White British	66
Grand Total	**75**



Religion or Belief	Count
No religion	45
Christianity	18
Spirituality	6
Muslim	4
Hindu	1
Norse – Viking	1
Grand Total	**75**



Sexual Orientation	Count
Heterosexual/Straight	63
Bisexual	7
Prefer not to say	3
Lesbian/Gay woman	1
Homosexual/Gay man	1
Grand Total	**75**