Mental Health Consultation Response
July 2022

Summary

This report has been created as the Race Equality Foundation's response to the Department of Health and Social Care (DHSC) consultation on the Mental Health and Wellbeing Plan and call for evidence.

The Race Equality Foundation is a national charity tackling racial inequality in public services. We engaged with stakeholders representing a range of organisations and communities across the voluntary, community and social enterprise (VCSE) sector to form a collaborative discussion group. The group met for two online collaborative discussion events. The aim of this multidisciplinary working group is to improve knowledge and understanding of mental health, particularly from the perspective of Black, Asian and minority ethnic communities. In doing so, we aim to highlight best practice and effective strategies that can be implemented to enhance people's lived experience of preventative and remedial mental health support initiatives.

This response also seeks to provide a greater sense of clarity and contribute a significant but often overlooked perspective that is critical for enabling better outcomes for Black, Asian and minority ethnic communities. For those who are living with a severe and/or enduring mental health condition, as well as for those in the wider community for whom preventative action is crucial.

This document summarises the response of the Foundation and colleagues to the questions in the call for evidence and highlights areas where we believe it can be strengthened in order to address racial inequalities in mental health:

- How can we all support people with mental health conditions to live well?
- How can we all promote positive mental wellbeing?
- How can we all prevent the onset of mental health conditions?
- How can we all intervene earlier when people need support with their mental health?
- How can we all improve support for people in a crisis?
- How can we improve the quality and effectiveness of treatment or mental health?

Racial disparities

Evidence suggests that Black, Asian and minority ethnic communities are at comparatively higher risk of mental ill health and disproportionately impacted by social determinants associated with mental illness.

For instance, African Caribbean people are three times more likely to be diagnosed and admitted to hospital for schizophrenia than any other ethnic group, with prevalence and incidence rates of anxiety and depressive disorders being much higher for South Asian women than any other ethnic group (Bignall et al., 2019). After encountering the mental health system, people from Black, Asian and minority ethnic groups often experience further inequalities and discrimination (POSTNote, 2022; Bignall et al., 2019). There is evidence of ethnic bias, including greater uncertainty in diagnosis of emotional problems and depression, in Black patients (Adams et al., 2014). Mental health services need to be aware and recognise the impact of racism on accessing mental health care and in perpetuating ethnic inequalities.

Many recent reports have proposed that health inequality is not exclusively the result of the quality of healthcare experienced (EuroHealthNet, 2019). This publication once again highlighted what has been known for some time, that health outcomes and health inequalities are predominantly influenced by the social, economic, and environmental determinants of health – the conditions in which we are born, grow, live, work, and age. This finding was reiterated by Sir Simon Wessley in his recent Review of the Mental Health Act (Wessley et al., 2018), which set out recommendations based on four principles that the review believed should underpin the reformed Act - choice and autonomy, least restriction, therapeutic benefit, people as individuals.

The factors underpinning this experience became a key theme in the collaborative discussion group. As such, when discussing reform - particularly reform that aims to address health inequalities - it was agreed that it is insufficient to focus exclusively on what is happening within the health and care system, but it is equally important for us to understand and address what is occurring outside of this system. The Race Equality Foundation has previously focused on addressing this, for example through the Racial Disparities in Mental Health: Literature and Evidence Review (Bignall et al., 2019). This review also emphasised why it is crucial to understand wider systemic and structural inequalities in order to achieve the desired outcome of improving health and wellbeing, particularly among Black, Asian and minority ethnic communities.

All discussion group members agreed that this is a vital part of any reform seeking to succeed in bringing about meaningful and long-lasting change.

The Mental Health and Wellbeing Plan consultation represents a significant step forward in addressing inequalities within mental health services and we welcome it. As a group however, we believe that the root cause of many of the inequalities experienced with the mental health system is discussion without sustained action. The final suggestions made as a result of the discussions highlight the importance of the role of the VCSE sector in working with statutory services to provide solutions to the questions presented.

How can we all support people with mental health conditions to live well?

It is important to acknowledge the significant and compounding role of Covid-19 on the mental health of people from Black, Asian and minority ethnic communities over the last two years.

During the pandemic and associated lockdowns, evidence demonstrated mixed findings regarding the impact on the mental health of people in the UK. Whilst some studies found

that relationships have improved because men have been spending more time at home with a positive impact on the family and wellbeing (ONS, 2020), other work showed that Covid-19 and its associated impact has often exacerbated poorer mental health and exacerbated existing inequality (Raghavan and Jones, 2021). For example, Natural England (2017) highlighted that Black, Asian and minority ethnic children had less access to green space during the pandemic than their White counterparts. This occurred as a result of socio-spatial deprivation which meant that they were more likely to live in high-rise blocks, flats and inner-city areas that have less outdoor space. Research has acknowledged that green space is a key part of maintaining good mental health (Mental Health Foundation, 2021). This exemplifies the way that Black, Asian and ethnic minority communities experience health inequalities at a fundamental level.

The group discussion began by identifying what mental health support organisations, initiatives and practical intervention approaches currently exist and are working well. Group members proposed a multitude of methods that they or other organisations they know have used and that have been successful in supporting people with mental health conditions to work well. The key approaches were:

- Psychoeducation – teaching people self-awareness and strategies to recognise their symptoms and be more aware of how they are feeling mentally/psychologically.
- Ready-to-use digital initiatives – TechConnect is an example of a digital inclusion service where people can borrow broadband-ready tablets to stay connected to their friends, family and community. This initiative was funded by SCVO (Sheffield Council for Voluntary Organisations).
- Coffee mornings – This includes friendly discussions, non-medical health advice for common conditions (e.g. asthma, diabetes) and activities promoting gentle exercise. They can be grouped according to gender and/or age and feedback has shown that they help with social isolation.

The voluntary sector undertakes vital work in the process to support people with mental health conditions to work well. As a collaborative group, we all felt these are key services that we should continue to work towards building and supporting, utilising the ties and relationships within communities that many voluntary organisations have built. This is something which we delved deeper into when discussing other consultation questions.

How can we all promote positive mental wellbeing?

The overall benefits and success of community engagement is an activity which all involved in the discussions felt should be continued and further built upon.

A prime example of the ways which mental health services can continue promoting positive mental wellbeing can be found in the Active England programme which demonstrates how facilitated access for targeted groups improved use among Black, Asian and minority ethnic groups, especially women (O'Brien, L. and Morris, J., 2009). The programme aimed to increase community participation in sport and physical activity across England. The projects they launched focused on promoting exercise in woodlands and greenspace, especially targeting key under-represented groups.

As previously established, physical activity and access to green spaces are seen as key factors in improving and maintaining health; positive mental health being one of the many

health benefits listed. Within the recommendations outlined, this programme addressed the value and importance of publicity and communication when promoting activities which will promote positive health. It specifically highlighted that activities and 'facilitated access' should be promoted locally using existing community structures and also word of mouth and communication through social networks are critical to successful engagement. This access is key to the promotion of positive mental wellbeing.

The collaborative discussion group discussed the impact of ease of access to mental health services, including which mediums are used to advertise services. One member shared that in Norfolk and Suffolk, the wellbeing service advertises on the community radio (community radios reach different Black, Asian and ethnic minority groups) for people to come forward to access support for mental wellbeing. This is in spite of the services offered being quite limited in terms of capacity, due to being designed more for individuals with difficulties that require low-intensity interventions. Consequently, as people with more severe and enduring mental health difficulties were referred onto secondary services, the demand within these services saw a dramatic increase.

In a wider national context, there are statistics demonstrating how the need for mental health care has increased as a consequence of a general deterioration of mental health; for instance, the average ratings of wellbeing deteriorated in the year ending March 2021, notably taking place entirely during the coronavirus pandemic (ONS, 2021). However, these statistics do not show the entire picture for the demand of mental health services as they fail to highlight why these statistics have increased.

Some members from our discussion groups expressed the belief that the need for mental health services has not vastly increased in the country, but rather the increase has been in the demand for mental health services. Through encouraging more people to come forward for support from statutory mental health services, the NHS has seen some of its services become increasingly overwhelmed. This draws attention to a need for a greater focus on the suitability of services.

During the first discussion, it was agreed that greater attention and thought must be put into the prioritisation and methods with which a service is 'chosen' for an individual. Changes such as this will be beneficial in preventing people from repeatedly being moved around within services without effective support. This is a common occurrence in mental health services. For instance, if an individual seeks help from a service, they may be referred on to secondary services as they are classed as 'too severe'. This demonstrates an increased demand and not necessarily in help.

In summary, within mental health services there is a mismatch in terms of demands and needs through a mismatch of advertising/promotion and access to positive mental wellbeing and subsequent treatment that is available. Thus, the promotion of positive mental wellbeing needs to be reevaluated. One member of the collaborative group from the Asian Resource Centre Croydon shared instances where the implementation of awareness raising programmes had been successful. It was felt that employing a whole system approach which utilises multiple avenues of contact to promote positive mental wellbeing would mark great steps forward.

It is important to consider, where possible, promoting wellbeing for people with severe mental illness (SMI). It is well founded that people with SMI experience significant

inequalities and are much more likely to die prematurely due to avoidable physical health conditions (OHID, 2022). Specific measures should be adopted to ensure people in this group are supported to live as healthy a life as possible. This is particularly true for people with SMI who are not under the care of secondary services.

There needs to be adequate care within the community to ensure this group is supported to maintain their physical health, address substance use, and create social and community networks. Health services must engage with Black, Asian and minority ethnic-led voluntary organisations to ensure this group has a trusted and culturally appropriate source of support. This will help with increasing awareness of the link between SMI and physical health and promote attendance to physical health checks.

Through research carried out by the Foundation, we heard from African and Caribbean people with SMI that support - such as a ring and ride service and a full explanation of what the appointment will include - would help them attend. Lack of engagement with health services, whether through fears of being sectioned again or a lack of culturally appropriate services, can lead to deterioration in both physical and mental health.

How can we all prevent the onset of mental health conditions?

We believe that the prevention of the onset of mental health conditions can only be done through the direct addressing of structural barriers to engagement with statutory provision.

Currently, within the mental healthcare system there is a lack of clarity and some confusion of the suitability of services, waiting times, self-referral, timely self-recognition of symptoms and navigation of the system. When thinking about quality in relation to inequality, for example timely experience, there is a clear correlation between waiting times and likelihood of service engagement. There is also evidence of Improving Access to Psychological Therapies (IAPT) waiting times demonstrating a longer delay for clients from Black, Asian, minority ethnic communities (NHS Digital, 2016) which would undoubtedly be another detriment to the onset of mental health conditions. This could be the difference between preventative and remedial intervention. For those who do not receive adequate support in time, more severe mental health conditions may develop.

During the collaborative discussion, one member highlighted instances where those referred to their services scoring high on PHQ-9 or GAD- 7 would often result in a re-referral back into the NHS system, meaning a longer waiting time to be seen. As it stands, we believe that the preventative work of the existing mental health care system is insufficient.

Although the current public health strategy (NHS England, 2016) aims to prevent people from developing severe and enduring mental health needs, one member expressed that if individuals were unfortunate enough to receive a severe and enduring diagnosis, with no follow-up, their organisation found that it was beneficial to have care coordinators follow them on their journey back into the community and assess their wellbeing.

There is a strong need for more social-prescribing and support roles such as Advocacy Workers who support and empower people within their own communities. Examples of such social-prescribing and support roles which display this better practice can be found in some of the recent initiatives found in Croydon. One initiative shared with the group was the ‘Hear

to Talk' project which aims to raise awareness of mental health within the Asian community, acknowledging its taboo status within the community. The project uses a series of awareness events, workshops, and the option of being paired with trained Mental Health Champions to demystify mental health issues and to have community conversations and signpost people into appropriate services or groups. The project aims to increase people's awareness of mental health risk factors; to support people to seek help without feeling isolated and to reduce the stigma attached to mental health (Asian Resource Centre Croydon, 2022).

Another project involves working directly within the new Integrated Care Network Plus areas right across the borough and with clinical partners, including local GPs, in multi-disciplinary teams to deliver Mental Health Personal Independence Coordinators. This work joins up the support needs of clients and carers, whilst liaising with local services. The evidence shows Black, Asian and minority ethnic communities are less likely to access mental health support in primary care (i.e. through their GP) and more likely to end up in crisis care (Jeraj et al., 2015; Rabiee et al., 2014).

A call for more effective engagement with the VCSE sector is required, where truly integrated care systems are created through the joining up of statutory and VCSE sector support**.**

The discussion group unanimously placed significant value on the services provided by the VCSE sector, largely due to the relatability, shared lived experience and invaluable cultural knowledge of service providers. Without this richness and commitment, many people from Black, Asian and ethnic minority communities would not have access to effective support options, thus resulting in more tragic and preventable cases such as the death of Errol Graham (2018).

Members recognised that they served as that wedge between Black, Asian and minority ethnic communities and statutory services. Where possible, they worked to ensure that those in need were able to access services, empowering them to engage with the statutory sector where necessary and appropriate. However, this is not to say that there are no cases where people are missed.

Additionally, creating more awareness of mental health and illness including when to access services, enabling people to access services at the earliest opportunity, is helpful in terms of prevention. There is a need for greater support around post-diagnostic support and what that should look like but raising awareness about certain issues is likely to encourage people to attend primary care services such as GPs, for diagnosis and treatment and/or support.

How can we all intervene earlier when people need support with their mental health?

As mentioned previously, health and inequality is impacted by a variety of factors. The work of Sir Michael Marmot (Marmot et al., 2020), as well as the World Health Organisation (WHO, 2019), demonstrate that an individual's experience of healthcare and care itself only accounts for 10% of the inequalities experienced. Consequently, 90% of the health inequalities people experience are a direct result of other factors; namely, financial insecurity, poor quality housing and neighbourhood environment, social exclusion, and lack of decent work and poor working conditions (WHO, 2019).

It is vital that action is taken to ensure that good health is not solely a reality for some, but for every individual in the country. Indeed, recognising and directly addressing the wider determinants of health will enable earlier intervention and is one way we can support people with mental health conditions to live well.

One case to which our discussions regularly referred to was that of Errol Graham. Errol Graham, an African Caribbean man from Nottingham with long-term mental health conditions, was found extremely emaciated after his death. Prior to his passing, the Department for Work and Pensions (DWP) stopped his benefits. Errol was found by bailiffs when they broke into his flat to evict him. The withdrawal of support from the statutory agencies and departments involved in his care played a key role in Errol's death. The coroner's report highlighted a failure in the 'safety net' that should surround vulnerable people like Errol in our society (Disability Rights UK, 2021) to ensure that outcomes such as this do not occur.

It was unanimously agreed during our first discussion that there are significant flaws within the mental health pathway as it currently stands.

Moving forward, there needs to be a deeper understanding and action to address the interlinking connections between factors that impact mental health and mental inequalities.

This is particularly pertinent for individuals from Black, Asian and minority ethnic communities who often experience intersectional and compounded discrimination and disadvantage that subsequently impacts their mental health outcomes. The evidence on disproportionate care and experience has existed to some extent for several years.

Most clearly, the use of the Mental Health Act, particularly the detention of African Caribbean men, has been demonstrated and was repeated in Sir Simon Wessley's independent review of the Mental Health Act (2018). In Errol Graham's case, there was no inquiry into the consequences of his benefits being cut. Ultimately, no thought was given to the impact this ceasing of support would have on Errol, his mental health and ultimately his life. Errol's experience of the system was increased by racial inequalities and a lack of truly integrated care. It is a prime example of the experience of poor mental health particularly for Black, Asian and minority ethnic communities and unfortunately is not an isolated case, with the Disability News Service (2020) highlighting that the death of Errol Graham closely mirrored other tragedies.

Our group feels that there is an integral need for distinguishing between difficulties requiring material or social support and advocacy (psychosocial/socio-political) and difficulties requiring treatment and possibly medication (bio-psychological).

Some people experience mental health difficulty as a result of social issues that do not require psychological or psychiatric intervention. If the withdrawal of housing, socio-economic (including employment and financial) and other support is legal, then there is evidently an issue. We feel that it is important to know and highlight the difference so that we do not cluster all issues as mental health issues. This is because the treatment or intervention required is different depending on the nature of the challenge.

Another structural barrier to engagement with statutory provision that needs to be addressed and acknowledged is that of trust and confidence. Barriers to accessing services that continually prevent early intervention for people who need mental health support include a lack of knowledge of what is available, stigma, cultural/faith beliefs about mental illness and relationships with healthcare practitioners.

The Race Equality Foundation has started to regularly bring up the issue of trust, such as in the Race Equity Collaborative work on mental health (Raghavan and Jones, 2021) - not just trust in mental health services, but services full stop. For example, if individuals are regularly stopped by police, suspended from school and so forth this then undermines trust in others, particularly trust in state services (Jeraj et al., 2015; Rabiee et al., 2014). This is part of the reason that contact begins at crisis point rather than as mental health issues develop.

A further barrier is the presence of shame and stigma throughout Black, Asian and ethnic minority communities. It is crucial to value the expertise of practitioners and service providers within the VSCE sector in areas, such as community languages, cultural knowledge and connections with individuals and communities. As a collaborative group we felt that this would provide the opportunity to begin to expel and overcome some of these issues of trust, confidence, shame, and stigma.

The Bristol Somali Resource Centre shared that one of the main challenges they face on a regular basis is language barriers. People from Black, Asian and ethnic minority communities can find it hard to navigate through the system when they need help and to access the mental health services. There was a suggestion that the workforce and services, as they currently stand, are not representative. There is a poor cultural understanding of how to engage with service users from certain communities and this can often contribute to existing feelings of isolation. There is a need for the capacities of professionals across the health sector to be further built up to understand health inequalities. This will enable them to deliver appropriate, person-centred services and to work across a variety of sectors to improve the underlying determinants of health such as social exclusion.

Increasing evidence highlights how social exclusion and wider inequalities in areas of accommodation, education, and employment impact on the mental wellbeing of Gypsy, Roma and Travellers (FFT, 2013; Bristol Mind, 2008; Yin-Hur and Ridge, 2011; Thompson, 2013; Van Clemputt, 2000). One study found a lack of culturally sensitive counselling services available for Gypsy, Roma Travellers on a number of issues, such as depression. It also found a lack of understanding from practitioners of how the wider extended family can be a source for resilience and strength with health problems (Yin-Hur and Ridget, 2011).

Exploration of health experiences and of using NHS services found there is an accumulation of stress and anxiety from issues specifically affecting Travellers, such as living on the roadside; stigma and discrimination; the changing role of men as providers for the family; and their relationship with the police (Thompson, 2013). Services based in the voluntary and community sector are more likely to develop the relationship of trust that promotes access and awareness of mental health services. Ethnic-matching between service users and practitioners may improve treatment duration and outcomes among ethnic minorities. Whilst such matching can be problematic, in relation to confidentiality for example, some work suggests that ethnic-matching can improve treatment duration and

outcomes among ethnic minorities (Aggarwala et al., 2016; Ali et al., 2016; Memon et al., 2016).

Black, Asian and minority ethnic service users highly rate support provided through VCSE sectors in navigating the mental health pathway and in providing culturally appropriate advice and support. Better understanding of cultural and faith beliefs for Black, Asian and minority ethnic communities help with designing services to promote recovery.

VCSE organisations have an important role to support Black, Asian and minority ethnic people with mental illness in accessing therapies and in coping with everyday activities. Further to this, the role of faith organisations, particularly Black-led organisations can play an important role in supporting people from the African and Caribbean diaspora with mental health conditions to live well, such as the work carried out by Caribbean and African Health Network (CAHN). CAHN aims to lead, enhance, educate, support and advocate for those within African Caribbean communities. One approach CAHN takes is by raising awareness about prevention, early detection, effective self-care, and self-management, providing commissioners and service providers with insight and cultural awareness of the Black community (CAHN, 2022).

Mantovani et al.'s study (2016) gave insights into the intersectionality between stigma, spirituality and mental health arguing that spirituality and culture need to be considered in how they affect the perception of mental illness and how it is managed. Spirituality was seen as a key factor to helping those with mental illness keep well (Kalathil, 2011). The challenges faced in supporting individuals' mental health, and some of the actions necessary to achieve effective change, need to be achieved with faith communities working in partnership with mental services and other key organisations.

A growing number of studies suggest that membership of a religious community which is accommodating and compassionate can benefit an individual's overall mental and physical health, even the length of an individual's life (Mental Health Foundation, 2007). The faith community can provide valuable support and add its voice to advocate on behalf of people who have mental health problems and support their families at different levels. For instance, the Restoration Revival Fellowship have initiated several new activities to achieve this, through organised health fairs and local awareness campaigns, as well as inviting speakers to speak on different aspects of mental health. The health fairs and awareness campaigns are widely promoted to allow people from different communities to attend and learn about mental health themselves to support people from their communities.

By providing support to this sector, a more integrated care system for mental health can be created, resulting in more preventive, rather than reactive, support for mental health conditions. Consequently, if mental health conditions do develop, support is already a part of people's daily community lives and hopefully can be accessed and provided earlier. All those involved in the collaborative discussion group asserted that the provision of mental health services requires all segments of the community to become involved; mental health organisations, faith-based organisations, healthcare agencies, the criminal justice system and so forth.

Indeed, the VCSE sector, and spirituality-based organisations have played a key role in supporting those affected by mental illness, and filling the gap where the statutory service is missing or inadequate to the needs of Black, Asian and minority ethnic communities and

those in specific settings such as across the whole prison system (Yap et al, 2018; London Assembly Health Committee, 2017; Faith Action, undated; Mental Health Providers Forum, 2015; Rabiee et al., 2014). However, there still needs to be more effective engagement with the VCSE sector, even if this is at a root level through funding them as delivery partners, in order to maintain and expand their support of Black, Asian and minority ethnic communities. By helping local organisations, which act as the bridge between the mainstream services and the communities, support can reach many people who may have otherwise been lost within the current mental health system.

How can we all improve support for people in a crisis?

An area which our discussion highlighted as needing addressing in order to improve support for people in a crisis was yet again the improvement of access. Black, Asian and minority ethnic people are overrepresented in the prison system, with Black, Asian and minority ethnic people being 40 per cent more likely to access mental health services via the criminal justice system than White people (London Assembly Health Committee, 2017; Bradley Report, 2009). Whilst it is positive that individuals are provided access to mental health in these circumstances, it does raise the question of whether these people are in prison because they did not have access to this support initially with their community.

A consensus within the group was agreed that not knowing the mental health pathways available to them could result in a major barrier for people attempting to access services. There is a services gap that could be filled through the continued implementation and new introduction of more liaison services, the existing NHS Liaison and Diversion services at police stations is a prime example of this. A liaison service which identifies people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service allows for assessment of people who are in the early stages of the criminal justice system and divert people with suspected or recognised mental health needs away from criminal justice and into healthcare. This is one of the ways we can improve support for all people in a crisis and in some cases perhaps prevent the onset of a crisis.

For the application of such services to succeed, an awareness of the appropriateness of services also needs to be addressed and considered. There is a stark inequality highlighted by the case of 23-year-old Olaseni Lewis, who died after he was held down by six prison officers for more than 30 minutes after refusing to take his prescribed medication. This case demonstrates why safety must be a part of any assessment for quality.

Additional key points to be addressed

In order to explore and suitably discuss the questions outlined by the mental health consultation, the term ‘quality’ should be identified, as it will be invaluable when thinking about inequality, particularly as within healthcare, there is no universally accepted definition of ‘quality’.

Currently, the NHS is ‘organising itself around a single definition of quality’: care that is effective, safe and provides as positive an experience as possible by being caring, responsive and personalised. This definition also states that care should also be well-led, sustainable, and equitable, achieved through providers and commissioners working together and in partnership with, and for, local people and communities. (Health

Foundation, 2021). It is imperative that healthcare bodies consider all these dimensions when deciding any priorities for improvement. The Health Foundation's definition for quality provides a framework for this response.

In addition to this, this response approaches issues surrounding mental health with regard to the mental health care pathway; incidents, prevalence, access, assessment, treatment, and recovery. This perspective will be of great significance when thinking about the questions, as whilst prevention of mental health conditions is important, if we do not act along the pathway then we will not have the impact needed.

The availability of data, or lack of data, on Black, Asian and ethnic minority communities also needs to be considered and addressed. Inconsistency in sampling methodology in research studies raises questions about prevalence data across ethnic groups (POSTNote, 2022; Bignall, et al., 2019). Lack of data collection on ethnicity raises concerns over how this affects analysis and policy on mental wellbeing for Black, Asian and ethnic minority communities.

For instance, there is a need to record ethnicity of suspected suicides as well as at coroner's court when the suicide is officially recorded. It is vital we have robust data and information of death by suicide by racial group, including Gypsy, Roma and Traveller communities. A robust and accurate data set of ethnicity categories is also a must.

Better collection and quality of data would help design services that meet the needs of Black, Asian and minority ethnic communities.

Conclusion

The state of the UK's mental health service offer must continue to recognise the significance of Covid-19. The death rates for people from Black, Asian and minority ethnic communities remain markedly higher than their White counterparts. Although they changed over time within these communities, the evidence clearly demonstrates that deaths were higher amongst minority communities (Office for National Statistics, 2021). This raises a particular issue about dealing with bereavement. Bereavement is one of the key stresses that people experience and being able to cope with it poses some real challenges around mental health.

As such, Covid-19 is still a very real and immediate reality for many people within Black, Asian and ethnic minority communities. There is both a need and a demand for improvement within mental health service provision now.

This response has identified some causative factors and practices that could help to improve experiences and outcomes for Black, Asian and minority ethnic communities. Commissioners need to understand both the persistent nature of these inequalities, and that there are ways to address them. In turn this may lead to a greater focus on prevention through understanding and addressing the wider determinants of health.

Within the UK mental health system, there is a complex interplay between people, processes and pathways. The quality of the care delivered by the services depends largely on how successfully the system functions, and how well the service providers and practitioners work to provide and manage mental health care together.

In summary, our recommendations to improve the quality and effectiveness of treatment and mental health are:

- **Recognition and direct address of the wider (social) determinants of health**: deeper understanding and action to address the interlinking connections between factors that impact mental health and mental inequalities including a distinction between difficulties requiring material or social support and advocacy (psychosocial/socio-political) and difficulties requiring treatment and possibly medication (bio-psychological). As there are wider determinants on health, social provision of mental health services requires all wider segments of the community to become involved; mental health organisations, faith-based organisations, healthcare agencies, the criminal justice system and so forth.
- **Direct address of structural barriers to engagement with statutory provision:** improve access through local promotion using existing community structures, word of mouth and communication through social networks, greater attention and thought must be put into the prioritisation and methods with which a service is 'chosen' for an individual, implementation of awareness raising programmes and liaison services, more social-prescribing and support roles such as Advocacy Workers and care co-ordinators, increasing the capacities of professionals particularly with cultural understanding.
- **More effective engagement with the VCSE sector:** funding them as delivery partners, valuing their expertise in areas such as community languages, cultural knowledge and connections with individuals and communities, documenting, acknowledging and rewarding their work, truly integrated care systems can be created by joining up statutory and VCSE sector support.

Whilst some positive changes within mental health care have been observed, there are still some issues that need to be addressed in order to promote better outcomes for Black, Asian and minority ethnic communities. Evidently, some of the challenges outlined in this response require an integrated and sustained approach.

Building a stronger system of community support and action on the wider determinants of health equity will have a much greater impact on disproportionality and outcomes.

Race Equality Foundation
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