

Racial disparities in mental health: Literature and evidence review

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Executive summary

Background

This research review has been created as part of the Racial Disparities in Mental Health project commissioned by NHS England. This project has sought to improve knowledge and understanding so that good practice and effective strategies may be implemented. This, in turn, will enable better outcomes for black and minority ethnic (BME) communities who have a mental illness and black and minority ethnic people experiencing mental health treatment.

This project was multifaceted, with an intersectional approach deployed. The project started by identifying a scoping literature review; two all-day seminars and finally, the identification of good practice on improving the experiences and outcomes of black and minority ethnic communities and the development of an infographic to visually illustrate this information¹.

Black and minority ethnic people experience a wide number of inequalities related to mental health. This ranges from particular ethnic communities having a higher risk of being detained in secure institutions to more general difficulties for all black and minority ethnic communities in accessing appropriate care and support their for mental health needs.

The evidence suggests that black and minority ethnic communities are at comparatively higher risk of mental ill health, and disproportionately impacted by social detriments associated with mental ill health. From accessing treatment to receiving mental health support, through to assessment and treatment, inequality and discrimination remains rife for black and minority ethnic communities.

What we found

The literature review highlighted evidence related to the prevalence of mental illness amongst black and minority ethnic communities (and specific ethnic groups). The literature found differences in experiences and outcomes of black and minority ethnic people with the white English community; possible explanations for these differences; existing gaps in current evidence and research and identification of good practice in addressing mental health and racial disparities.

¹ We have also had ongoing contact with other mental health projects of the Health and Wellbeing Alliance including the perinatal mental health project throughout this project and liaised over progress.

Prevalence

The evidence on prevalence suggests that black and minority ethnic communities are at comparatively higher risk of mental ill health, and disproportionately impacted by social detriments associated with mental illness. For example, people from African Caribbean communities are three times more likely to be diagnosed and admitted to hospital for schizophrenia than any other group. Irish Travellers are six times more likely to die as a result of suicide than non-Travellers. However, consistency in sampling methodology in research studies raises questions about the generalisability and comparisons of prevalence data across ethnic groups.

Access

The evidence shows black 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.

Black and minority ethnic people are 40 percent more likely to access mental health services via the criminal justice system than white² people.

There is a wide range of different barriers for black and minority ethnic communities accessing mental health care. Some of these include a lack of knowledge around mental health care, different cultural attitudes or ideas about mental health, and relationships with healthcare practitioners in the local area. For people without immigration status, who have a gender non-conforming or trans identity, and/or also have a disability, institutional attitudes towards minorities, really serve as a barrier for communities accessing mental health access and treatment. However, it has been shown that services based in the community (and particularly in the voluntary, community and social enterprise sector) are more likely to develop the relationships of trust that promote access and awareness of mental health services for diverse communities.

Assessment

Once in the mental health system, black and minority ethnic people experience further inequalities and discrimination. Poor health conditions of BME patients is likely to lead doctors to focus on physical conditions despite the fact that some diseases such as cardiovascular, are complicated by depression and other mental health conditions. There is no evidence of direct racial discrimination in assessments, but there is evidence of

² The term 'white' refers to the white English group throughout this document.

ethnic bias including greater uncertainty by clinicians in the diagnosis of emotional problems and depression in BME patients. However, mental health services need to be aware and recognise the impact of racism on accessing mental health care and in perpetuating ethnic and racial inequalities.

Treatment

After being assessed, inequalities persist into treatment. This can further compound the discrimination and inequality already experienced by black and minority ethnic people and affect their recovery. It has been proven that black and minority ethnic people are less likely to be referred to talking therapies and more likely to be medicated for ill mental health. It is absolutely pivotal that black and minority ethnic patients also want the impact of racism and wider inequalities on their mental health to be addressed in treatment for their mental illness. Some work suggests that matching the cultural, linguistic religious and/or racial identity between service users and practitioners can improve treatment duration and outcomes among ethnic minorities however, there was variability on impact within the literature evidence.

Recovery

Traumatic, inappropriate and discriminatory experiences of services can have a detrimental impact on chances for recovery, particularly if the same risk factors of bereavement, family breakdown, incarceration, poverty and exposure to racism continue to be present. There has also been criticism of an Eurocentric approach to recovery for black and minority ethnic people, as the definition does not take a race equality perspective and look at the external factors that impact on the individual. Better understanding of cultural and faith beliefs for black and minority ethnic communities will help with designing services to promote recovery. Furthermore, voluntary, community and social enterprise organisations play an important role in supporting black and minority ethnic people with mental illness in navigating the mental health pathway; providing culturally appropriate advice and support; access therapies and cope with everyday activities service.

Gaps

There are gaps within the evidence reviewed in terms of the experiences of Gypsy, Roma and Traveller communities; the Chinese community; and the different ethnic groups amongst the Eastern European apart from Polish, which includes Slovak, Czech and Romanian ethnic groups.

Case studies

There are a number of examples of projects and approaches that work specifically with black and minority ethnic communities across these issues. Some of these have been developed and led by the statutory sector, such as the Delivering Race Equality programme, but most have been developed by the voluntary sector. These projects are very diverse in the communities they serve (communities of different spiritual beliefs, refugees, women, and men), the issues they are addressing (from common mental disorders through to complex trauma) and the approaches they have adopted (from adapting common practices and therapies through to new treatments). These have been collated into a case studies document that sits alongside the literature review, and specific projects are also highlighted below as part of the literature and evidence review.

Resources

A series of infographic resources have been developed in line with five stages of the service user journey within the mental health system. These highlight specific points from the evidence, and how to reduce disparities:

- Incidence/prevalence/prevention looks at some of the issues around risk factors for mental health, the resulting different levels of incidence and prevalence, and the role of prevention.
- Seeking help/access examines the routes into services, such as primary care, crisis services, and the police/criminal justice, and how to improve early access.
- Assessment/diagnosis looks at issues around how black and minority ethnic people are assessed and diagnosed, what the evidence is around bias and discrimination in this process, and how this can be addressed.
- Treatment scrutinises disparities and inequalities in the experience of services, such as medication, access to therapy, and use of restraint with black and minority ethnic service users.
- Rehabilitation and recovery looks at long-term recovery and the role of community-based services and support in maintaining mental health.

The infographic accompanies the literature and evidence review.

Conclusions and recommendations

The literature review has identified some causative factors and practice that could help to address them and improve experiences and outcomes for black and minority ethnic communities. Commissioning needs to understand both the persistent nature of these inequalities, and that there are ways to address them. The collection and quality of data must be improved in order to improve evidence-based policies and interventions, particularly with regards to intersections of ethnicity, race, faith, disability, sexual orientation and gender identity. In turn this may lead to a greater focus on prevention through understanding and addressing the wider determinants of health.

Policy makers and commissioners should;

- take action on better collation of the data on different black and minority ethnic groups' usage of mental health services to enable specific research to address barriers to accessing services
- develop a clearer picture of the mental health needs of the different Eastern European ethnic groups and diasporas
- provide better access to talking therapies according to local need, and engagement with black and minority ethnic communities to ensure the therapies are culturally appropriate and geographically accessible
- provide better access to healing systems and therapies including yoga, meditation and complementary therapies
- consider the role of providing services in multiple languages to meet need
- Take action to ensure people with different addresses can have access to services, particularly Traveller communities
- take action to improve the experience of black and minority ethnic people in prison and improve timely access to mental health services. This includes taking action to support the families of people in prison, who will have their own mental health needs.
- influence the implementation of the Long Term Plan
- involve more black and minority ethnic people in patient, public involvement in NHS England and Public Health England
- implement the UN recommendations via Committee on the Elimination of Racial Discrimination (CERD) and follow up of PSED (Public Sector Equality Duty) in line with CERD.

By policy makers we include: Local Health and Wellbeing Boards, Clinical Commissioning Groups, and those responsible for making policy decisions about the health and priorities for local communities.

Mental health services should;

- be more constructive working with the voluntary sector, community sector and faith groups
- further examination of the different pathways to care and thresholds for admission,

Conclusions and recommendations

- access to home treatments and inpatient provision to determine any ethnic or racial bias and action to address this
- be aware and recognise the impact of racism and discrimination on accessing mental health care and in perpetuating ethnic inequalities
- ensure there is accountability especially where the patient is placed out of area
- ensure the patient participation in meetings about their care
- consider the impact of being sectioned on the individual and then being taken back to where the trauma happened
- provide financial help to families to visit the patient if they are placed out of area.

Practitioners should;

- have a better understanding of cultural and faith beliefs of black and minority ethnic communities and how this impacts on beliefs and behaviours around mental health
- improve their recognition of symptoms and how these are expressed in different ethnic groups (for example depression in members of the Caribbean community)
- increase their understanding of how loss (particularly for refugee/migrant children) and trauma are contributing factors of mental illness
- develop and change approaches towards a more holistic approach that integrates, mental health, physical health, culture and belief
- work to ensure services are accessible and non-stigmatising. For example, black and minority ethnic users of services felt the use of term 'wellbeing' was better and has less connotations than 'mental health'
- have a clear sense of the term 'self-care'. People felt it was useful but there is a different meaning of this between the statutory sector and user support groups.

By practitioners we mean those who provide a service and implement the health policy within the service provision, such as, GPs, nurses, therapeutic practitioners etc.

Researchers should;

- acknowledge that black and minority ethnic communities are over researched and under resourced, and actively seek to address that imbalance. This will ensure wider data and research sets on different groups, along with recognition of the societal factors that have led some ethnic and racial groups to be more studied and researched than others
- acknowledge the broad intersectionality and lived experience of black and minority ethnic people around mental health.

Racial disparities in mental health literature and evidence review

1 Introduction

It is well-documented that black and minority ethnic communities face inequalities in their experiences and outcomes in mental health (Fernando, 2017). The evidence shows over-representation and ethnic disproportionality for certain mental health conditions; differences in access and use of mental health services, particularly for those in high need of support.

This scoping literature review looks primarily at evidence between 2008 and 2018 on black and minority ethnic communities and mental health. The black and minority ethnic communities referred to include Asian, African, African Caribbean and other minority ethnic diaspora groups such as Chinese, Eastern European, Gypsy, Roma and Traveller, and Irish.

1.1 Policy

There have been attempts to address racial disparities in mental health through Government policy. Notably, the Delivering Race Equality in Mental Health Care action plan aimed to tackle discrimination and address ethnic inequalities within the mental health system for black and minority ethnic people, including those of Irish or Mediterranean origin and Eastern European migrants in England. Community Development Workers working with local communities were key players in the delivery of the goals of the Delivering Race Equality five-year strategy (Department of Health, 2005).

More recently, the government has stressed the need for 'parity of esteem between mental and physical health services' in the No Health without Mental Health strategy that sets out a 'life course' approach to mental health encompassing infants, children, young people, working-age adults and older people (HM Government, 2011). The intention is to;

- improve the mental health and wellbeing of the population and keep people well
- improve outcomes for people with mental health problems through high-quality services that are equally accessible to all.

Specific action to address ethnic inequalities and promote equality includes;

- local collection and monitoring of information on ethnicity and culture
- better use of data to inform the commissioning and provision of health and social care
- a focus on outcomes that work for individuals and communities
- monitoring and evaluating the effectiveness of service delivery, especially around equality needs
- establishing mechanisms that allow local user groups to engage with providers and commissioners, and then empower and support them so that they can engage effectively.

Despite these strategies, evidence continues to show racial disparities in the experiences and outcomes for black and minority ethnic people in mental health services (Cabinet Office, 2017; Mental Health Providers Forum, 2015). The recent Review of the Mental Health Act found inequalities in access to treatment, care experiences and quality of outcomes for black and minority ethnic people, noting that *'too often and in too many areas the experiences of those of black African and Caribbean heritage is one of either being excluded or detained.'* (Department for Health and Social Care, 2019).

1.2 Scope of the literature and evidence review

The scoping literature review is an exploration (or mapping) of the research evidence and identifying emerging themes on the topic. A search strategy of different ethnic groupings, terms and concepts was used to identify research studies primarily UK based, in the past 10 year period. This abled the project to build on existing work on mental health and black and minority ethnic communities.

Several themes emerged from the evidence relating to racial disparities and;

- the prevalence of mental health conditions
 - pathways to mental health support services
 - different mental illnesses
 - explanation for disparities
 - treatment
 - engagement with and uptake of services by black and minority ethnic communities
- Intersectional factors and mental illness.

Suggestions of what works or could work to address racial disparities emerged and several good practice and case studies that have made a difference to black and minority ethnic people experiencing mental distress.

Alongside the scoping review, a call for evidence was put out to a range of organisations working on black and minority ethnic health issues through the minority ethnic health jiscmail; and both statutory and voluntary sector organisations through a range of networks. This, in turn, elicited further good practice examples, and case studies.

Early on in the project a day-long seminar took place that was aimed at engaging those who had made a difference to present their work. Participants held detailed discussion of the issues for black and minority ethnic communities and mental health and how to address them. A report was produced and the consensus that a further event as the project progressed with input from system partners was needed. The later seminar provided the opportunity for those providing support to black and minority ethnic people with a mental illness, and users of mental health services to discuss issues relating to the themes of

engagement, intersectionality, and commissioning of services. NHS England, the Care Quality Commission and Equality and Human Rights Commission were present and provided insight into their regulatory role and their contribution to addressing racial disparities in mental health.

We have had ongoing contact with other mental health projects of the Health and Wellbeing Alliance including the perinatal mental health project throughout this project and liaised over progress.

1.3 Limitations of literature and evidence

There are limitations to some of the research studies discussed. A number of the research studies outlined were with small samples sizes. This raises the question of how generalisable the findings will be in relation to sample size (Mantovani et al., 2016).

There are issues relating to the categorising of ethnic groups in different studies. In Fernandez de la Cruz et al., (2015) for example, the ethnic categories have been grouped widely for analysis purposes with Asian including Asian British, Indian, Pakistani, Bangladeshi and Chinese. This does not enable analysis of specific ethnic groups, or enable understanding of their experiences under detention of the Mental Health Act, for example (Department for Health and Social Care, 2019). There is also some difficulty in making a comparison between studies due to a lack of consistency in the ethnic grouping; for example, Singh et al., (2013) included Chinese and Vietnamese under the 'other' ethnic category whilst other studies included Chinese under the Asian category. There is limited or no data for different ethnic groups in relation to specific mental illness, for example, lack of data collected on suicide rates for Gypsy, Roma and Travellers, has proved difficult to also examine the issues for specific ethnic groups (Parliament, UK, July 2018).

Incomplete records for patients examined in some studies has highlighted issues of accuracy of the data and methodological issues related to the use of analogue/simulated circumstances rather than real people raises issues of validity in 'real life' circumstances³ (Adams et al., 2015).

Furthermore, there are gaps relating to specific ethnic groups and mental health, such as Bulgarian, Hungarian, Romanian communities, Chinese communities, and on different ethnic groups experiences of treatments, such as mindfulness. Despite these issues, the literature overall gives insight into the experiences and disparities for black and minority ethnic people in mental health.

³ Analogue participants are used as proxies for clinical patients in simulated circumstances. The analogue patient closely resembles the characteristics of the target population according to the requirements of study.

2 Review of literature and evidence

This review starts by outlining some of the generic evidence relating to prevalence; black and minority ethnic communities and mental health and suicide and self-harm. The third section and sub sections within it examines the differences highlighted in research of the experiences of black and minority ethnic groups of the mental health system. Section four outlines some explanations for the differences across the ethnic groups; whilst the remaining sections look at intersectional issues. The review ends with suggestions of what works in support minority ethnic people with mental illness and recommendations for action drawn from the research evidence.

2.1 What we know from existing evidence

Racial disparities⁴ in access to treatment and prevalence of mental health conditions has been highlighted in the recent Race Disparities report (2017) and by Public Health England (2018). Overall, the evidence suggests that black and minority ethnic communities are at high risk of mental ill health and disproportionately impacted by social detriments associated with mental illness. Bereavement, family breakdown, poverty and exposure to racism are some factors suggested to influence the prevalence of mental illness among black and minority ethnic children and young people (Latif, 2014).

Once in contact with mental health services, black and minority ethnic people are more likely to report harsh experiences of services and poorer outcomes (Synergi, 2018). Additionally, evidence shows that rates of access to hospital care and longer term detention is much higher for the black and minority ethnic group than for the white British group (Health and Social Care Information Centre, 2014). Pathways to mental health services show less access via primary care and an overrepresentation of black and minority ethnic communities in crisis care, often with more negative than positive experiences (Jeraj et al., 2015; Rabiee et al., 2014). Furthermore, personal experiences within the mental health system show black and minority ethnic patients are disproportionately restricted in hospital settings with physical restraint instead of experiencing outpatient and holistic mental health care (Department of Health and Social Care, 2019).

2.2 Prevalence

There has been much stated about the prevalence of mental illness in black and minority ethnic communities and for specific ethnic groups. The prevalence of mental illness was

⁴In terms of a greater difference or inequality between groups.

found to be significantly higher among Irish and Pakistani men aged 35-54 than their white counterparts; and a higher prevalence of psychotic disorder among African Caribbean men (Public Health England, 2018; Rees et al., 2016). Other patterns suggest the prevalence of suicidal thoughts is lowest amongst South Asian men; and anxiety and depressive disorder is much higher for South Asian women than women from any other ethnic groups (Rees et al., 2016).

However, a recent study has questioned some of the conclusions drawn about prevalence and the generalisability of findings due to methodological issues. In 2016 the University College London published a systematic review of survey literature that has estimated the prevalence of common mental health disorders among adults from minority ethnic groups in England (Rees et al., 2016). The intention was to inform the sampling strategy to boost the sample from minority ethnic groups in the Adult Psychiatric Morbidity Survey in 2021. The report highlights issues with the evidence collected in surveys related to prevalence of mental health disorders for minority ethnic groups. They found only two of surveys on the rate of mental health disorders since 1999, were representative of minority ethnic populations in England. Moreover, that survey design did not effectively recruit minority ethnic groups resulting in a lack of effective analysis of the differences in prevalence of mental health disorders (Rees et al., 2016).

For adults as a whole, the analyses show a weak pattern in prevalence across different ethnic groups, and South Asian ethnic groups (particularly Pakistani) having a relatively high prevalence of mental illness when compared with other ethnic groups. No specific ethnic group by gender had consistently either the highest or lowest prevalence in any two studies.

Overall, the systematic review found limited numbers of surveys designed to provide estimates of prevalence of mental health disorders amongst specific minority ethnic groups. Survey analyses were presented in aggregated form for example 'South Asian', which restricted the exploration of differences between specific ethnic groups and different 'South Asian' diaspora communities to one box. The researchers found little variation between the surveys classification of the different mental health disorders; their choice of measurement instrument or the reference periods used to define prevalence estimates. However, they do suggest some caution as they did not conduct any statistical tests of their own on the patterns they highlighted, but built on existing systematic reviews (Rees et al., 2016).

2.3 Black and minority ethnic groups and mental illnesses

Evidence suggests that African Caribbean people are three to five times more likely to be diagnosed and admitted to hospital for schizophrenia, more than any other group (Mental

Health Foundation (accessed 2019). This is despite the lower rates of diagnosis for other common mental disorders (Mental Health Foundation, 2016). Some illnesses, such as personality disorders are less likely to be diagnosed in black African and African Caribbean patients compared to white patients (Synergi, 2018). Additionally, the expected uptake in clinical services for other illnesses such as Obsessive Compulsive Disorder (OCD) is lower than anticipated despite the prevalence in the local black and minority ethnic population (Fernandez de la Cruz et al., 2015).

Rates of depression are reportedly much higher amongst black and minority ethnic communities than for white communities (Memon, et al, 2016; Mental Health Foundation (accessed 2019). Some evidence suggests rates of depression are particularly high for South Asians, especially women (Karasz et al., 2016). For example, Lord et al., (2013) found South Asian cancer patients were more likely to express depressive symptoms of helplessness and hopelessness compared to white patients. Whilst there were high levels of depression amongst both South Asian and white cancer patients three months after diagnosis, the symptoms of depression continued for South Asian patients at the nine-month stage. The study was unable to explain why South Asians remained distressed for longer periods, withstanding various coping strategies, such as avoiding thinking about cancer or an adaptive fighting strategy with a determination to beat the disease.

It is worth noting that there are differences in experiences and presentation of mental illness in men, women, gender non-conforming people and self-identified trans people around gender. There has been recent concern in the growth in women, particularly young women under thirty, experiencing mental illness. There is a huge body of evidence that black African and African Caribbean women are more likely to have a common mental health disorder than their white counterparts (DHSC, 2018). Despite this, there is a lower engagement with services despite an urgent need for more access to mental care for black women in the NHS. The Women's Mental Health Taskforce review found black, Asian and minority ethnic women also experienced 'cultural naivety, insensitivity and discrimination' when accessing and interacting with mental health services (DHSC, 2018).

Asylum seekers and refugees are more likely to have poor mental health as a result of experiences of trauma and violence, as well as post migration experiences. Research suggests that asylum seekers are five times more likely to have mental health needs than the general population but less likely to receive support (Mental Health Foundation, 2016). A systematic review found high rates of common mental health disorders amongst refugee and asylum seekers (Turrini et al., 2017); and rape and sexual violence has been identified as the most common cause of post-traumatic stress disorder amongst women (WHEC et al., 2017; Psarros, 2014).

Experiences and interactions with state institutions can often be a source of retraumatisation for asylum seekers, refugees and people who have no leave to remain. Services like the NHS may have a poor cultural understanding or awareness on how to treat complex trauma, provide culturally specific health care or e.g. mental health care in different languages. These are just a few reasons why asylum seekers are less likely to seek support.

For minority ethnic Eastern European communities cultural misunderstandings and a lack of understanding of the healthcare system might affect their engagement with healthcare services in general, and could impact on access to mental health support. This may be particularly exacerbated over language, and the ability to access mental health support in different languages. Madden et al., (2017) found Eastern Europeans views of healthcare services were largely dependent on their interaction with GPs (often a first point of contact for newer communities with the NHS), which were predominantly unsatisfactory. Consultations felt rushed, and some patients expressed difficulties in relaying their symptoms where they did not have a good command of English language to describe their symptoms.

Madden et al., (2017) found the tendency towards self-help or 'wait and see' before being referred to specialist health services was not well understood by this group of patients. Eastern Europeans held a 'distrust' of GPs partly due to the perceived 'dismissive' attitudes of GP as patients felt they were not listened to, and they felt significantly less likely to raise mental health issues. This study highlights the need for GPs to help build trust with this group of patients for more effective experiences and consultations. One limitation of the study was the high numbers of Polish participants, when there has been recent wide settlement of other Eastern European groups. Given the growth in the different Eastern European diaspora communities, there is a pressing need for further research to be created on different Eastern European ethnic groups; and, the differing experiences in urban and rural areas across England.

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 cultural sensitive counselling services available for Gypsy, Roma Travellers on a number of issues such as depression and, practitioners lack of understanding 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 experiences 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).

Research in Leeds explored the health status and health needs of the Roma migrant community with two cohorts of Slovak, Czech and Romani communities (Thomson, 2013). Over 90 percent reported high levels of stress linked to money worries. Some respondents spoke of not wanting to raise issues of stress and felt there would be a racist response from the English community. Most respondents had poor health, and lifestyle habits in which high stress levels were seen as instrumental, such as smoking and alcohol consumption. A mistrust of GPs; stigma; discrimination and the language barriers were some reasons why Gypsy, Roma and Travellers were reluctant to talk about and engage with mental health services about their stress, depression and nerves (Thompson, 2013; Bristol Mind, 2008).

Suggestions to promote better mental health include targeted interventions focused on increasing Roma access and understandings of the nature of services and treatment, language interpreters, support with literacy and the development of appropriate communication tools (Thompson, 2013). There is also a preference for some generic support on a whole range of issues that affect mental wellbeing; such as sites and housing, which have a big impact on stress, depression and nerves (Bristol Mind, 2008).

2.4 Suicide and self-harm

There is variation by ethnic group in the percentage of people reporting suicidal thoughts, suicide attempts and self-harm in their lifetime. The white British group has the highest percentage of people reporting suicidal thoughts; 21.6 percent compared with 13.1 percent of the Asian/Asian British group. There are also disparities in those reporting self-harm, with 8.1 percent of those in the white British group compared with 4.2 percent of those in the mixed, multiple and other ethnic group (Public Health England, 2017b). There are differences in gender with men making up three quarters of all suicides in 2017 (Office for National Statistics, 2017) and a pressing need for intersectional research to be created on the experiences of black and minority ethnic trans people and gender non-conforming people in the lesbian, gay, bisexual and transgender (LGBT) community.

Within the prison system, some evidence suggests mental health disorders is higher for women, older people and those from ethnic minority groups (IAPT, 2013). However, there is growing concern as the evidence shows an increase in self-harm and suicide whilst in custody (Ministry of Justice, 2017). Self-inflicted deaths account for around 21 percent of all deaths in prison in 2017 of which the majority were male (House of Commons, 2018). Around a quarter of the prison population were of the non-white ethnic group in March 2018 (House of Commons, 2018). Whilst Inquest (2018) suggests the suicide rates amongst black and minority ethnic prisoners has reduced in the past few years from 17 in 2016 to 7 in 2017, the Ministry of Justice states the figures relating to ethnicity are much 'too small to draw firm conclusions' (Ministry of Justice, 2018).

The Irish Traveller communities are six times more likely to die by suicide than non-Travellers. Worryingly, the response to a recent parliamentary question about the collection of data on suicide and self-harm within Gypsy, Roma and Traveller communities was that 'There are no official statistics collected on suicide rates among Gypsy, Traveller and Roma residents in England' (Parliament, UK, July 2018). The parliamentary answer stated that suicide prevention is a priority and local authorities and other agencies should work together to tailor support for communities at risk including Gypsy and Traveller communities. Without the collection of official statistics on suicide rates amongst Gypsy, Traveller and Roma Residents in England, it is nearly impossible to undertake this work.

There is a helpline called One Call Away, and it is operated by a brother and sister from the Traveller community. They use a Facebook page to distribute information, and both use their own mobile phones to work on the helpline. The helpline provides immediate support to Gypsies and Travellers who are facing mental health crisis or suicidal thoughts. They offer immediate support and signposting to other organisations which are culturally aware and trusted by the Gypsy and Traveller communities. Along with this crisis support, One Call Away support clients with engaging, explaining processes, form filling, communication and advocacy mediation. One Call Away is ongoing and run on a voluntary basis.

3 Differences in support and treatment of mental illness

3.1 Pathways to mental health services

The barriers for black and minority ethnic people accessing primary health care are well noted and include: language barriers; lack of interpreters; lack of awareness and information of services, and discrimination. Barriers to wider health services can also impact on accessing support for mental health issues for certain minority groups as well.

3.2 Refugees, asylum seekers and migrants

There are specific issues relating to migrants accessing health care, such as, incorrect information on access rights and documentation for GP registration. There may be a fear of being reported to the Home Office or having their information shared with the Home Office or other agencies. These barriers are other deterrents for vulnerable migrants. Patients who have reported delaying or avoiding care because of these barriers have included heavily pregnant women and people suffering from cancer, diabetes, and kidney failure amongst other conditions (Doctors of the World, 2017; Psarros, 2014). Additionally, the process of dispersal has a negative impact on women in pregnancy or in early motherhood accessing the right medical support, including for maternal mental health (Psarros, 2014).

Furthermore, NHS charging has been found to be a deterrent and delays vulnerable people from seeking both primary and secondary healthcare. NHS charging refers to the recent practice of the NHS asking for payment or proof of documentation in hospitals before administering healthcare. For example, uncertainty over immigration status and changes in HIV clinic services has been found to have a detrimental effect to the mental and physical health of Africans living with HIV in England (National Aids Trust, 2014). Ultimately such factors that restrict access to healthcare for migrants overall, will have negative impact on accessing support within the mental health system. Both the issue of charging for health and 'Hostile Environment' policy were highlighted in-depth at the project seminar.

Several mental health projects and organisations have developed over the years to meet the various specific needs of refugees, asylum seekers and migrants. Touchstone worked with a local refugee and asylum seeker organisation to train their therapists in order to offer a better service to refugees, asylum seekers and migrants living with complex post-traumatic stress disorder (PTSD).

Rainbow Haven in the North West of England offers one-to-one sessions with a NHS mental health worker and Living Life to the Full courses. They work with asylum seekers

and refugees and especially with Eritrean and Sudanese men. They also have a wide variety of activities which address the causes of mental health problems among people who have been forced to flee their home country, dealing with loneliness and purposelessness.

3.3 Criminal justice system

What we know about people in contact with the justice system and their health needs mostly relates to prisoners. Those involved with the criminal justice system (CJS) experience significant health inequalities and many have complex and multiple morbidities and may experience difficulties accessing services to meet their needs, due to their involvement in the justice system. Almost half of prisoners have been identified as suffering anxiety and/or depression compared with only 15 percent of the general population. There are risk factors for poor mental health for young people with a body of evidence suggesting that young male offenders have much higher rates of mental health problems than their peers in the general population (Nacro, 2014; Ministry of Justice, 2015; Ministry of Justice, 2014).

Black and minority ethnic people make up 26 percent of the prison population (House of Commons, 2018) despite making up only 14 percent of the United Kingdom's population. Black and minority ethnic people are overrepresented in the prison system with black and minority ethnic people being 40 percent more likely to access mental health services via the criminal justice system than white people (London Assembly Health Committee, 2017; Bradley Report, 2009). Black african and african caribbean men are 26 percent more likely than white men to be remanded in custody (Prison Reform Trust, 2018). Some evidence suggests some black and minority ethnic individuals are less likely to be identified with a mental health problem or learning disability at prison reception (Yap et al., 2018; Lammy, 2017) and that black African and African Caribbean remand prisoners are less likely to have their mental illness recognised than other prisoners (Jeraj et al., 2015). However, Ministry of Justice data shows that once in prison 'black African and African Caribbean offenders were more likely to be identified with having a mental health need than offenders from all other ethnic groups' and Chinese or Other offenders were the least likely to have an identified mental health need. Over a third (37 percent) of black offenders were identified as having schizophrenia or another delusional disorder compared to 9 percent of white offenders (Ministry of Justice, 2016).

Women offenders face particular issues that impact on their mental health. They are separated from dependent children, or who are pregnant in prison, face additional distress, with adverse mental health consequences for both the mother and children (London Assembly Health Committee, 2017). Liaison services assess people in the early stages of the CJS and refer those for assessment with suspected or recognised mental

health needs (Ministry of Justice, 2016). One study found women are more likely to refuse access to liaison services despite having a mental health condition (Hean et al., 2101). Such refusal means many women enter custody with their mental health needs unmet and often greatly exacerbated by entering prison. Moreover, women were found to have multiple needs including poor housing, domestic violence, parenting and finance, which also impacted on their mental health. The study suggests the need for better working across the CJS, health and social care to better support women offenders.

The lack of robust data that looks at ethnicity, contact with the CJS and mental illness is problematic in understanding prisoner experiences and addressing inequalities. Nacro et al (2017) make a number of recommendations to address ethnic and mental health inequalities in the justice system including the triangulation of data to identify trends and issues relating to race and mental health in order to deliver appropriate interventions at various stages.

Criminal justice was an area addressed under the Delivering Race Equality programme. Morton Hall Prison in the East Midlands was one of a number of projects that developed good practice. Black and minority ethnic peer researchers were recruited from the prison community. The aim of this work was to focus research on culturally appropriate assessment, communication and translation needs. The project aimed to create less fear of mental health services, provide a more balanced range of services and support compliance with equalities law.

Birth Companions provide woman-centred, trauma-informed services in the community and within the criminal justice system to help improve the mental and physical wellbeing of these women, in a way that can support them to break cycles of disadvantage. These services include pregnancy and early parenting groups in women's prisons. They have also sought changes at a policy level within the criminal justice system, encapsulated in their Birth Charter. These have been widely cited by the Ministry of Justice, Public Health England's Gender Specific Standards for Women in Prison, and in a dedicated annex (Annex L) to the HM Prison and Probation Service's new Women's Framework. They train women to work as peer supporters and as peer researchers, and have over 30 women in their Lived Experience Team – a group of women whose first-hand knowledge of severe, multiple disadvantage during the perinatal period is now regularly called on to inform service design, delivery and consultation by organisations including NHS England, the Care Quality Commission and HM Prison and Probation Service.

Peer-led support networks were also highlighted in the project seminar as working well for black and minority ethnic communities. Participants also highlighted the importance of ensuring that peers are well-supported themselves.

3.4 Treatment of psychosis

A study of the long-term outcomes of psychosis by ethnic group following a first episode, found black Africans and African Caribbeans had worse outcomes than white patients around clinical, service use. Research of a 10 year follow-up of 48 patients from south London and Nottingham found black Caribbeans were three times more likely to have no remission of psychosis lasting more than six months. In follow up, they were less likely to recover from symptoms than white patients (38 percent compared to 55.5 percent). Black African and African Caribbean patients were also found to be less likely to be in employment than white patients during their follow up period (Morgan et al., 2017).

The police were more likely to be involved in the admissions for the follow-up of black African Caribbean patients than for white patients. This group were also more likely to experience compulsive admissions than other groups, too. Black african and african caribbean patients were admitted at a rate 20 percent higher than for white patients and for longer (37 median length days for white patients compared to 62 days for Caribbean and 54 days for African patients). Compulsory admissions were almost twice that of white patients being 79 percent for Caribbean, 84 percent for African and 58 percent for white patients. Whilst there are limitations with the findings, they are in line with evidence of the association between social deprivation and mental health; and compulsory detention and contact with mental health services via the police for black African and African Caribbean communities. More research to determine the factors that lead to poor outcomes in black and minority ethnic patients, particularly factors of social deprivation and isolation is suggested. Moreover, it is proposed that addressing the social needs of black and minority ethnic patients is likely to lead to improved clinical outcomes and engagement with services (Morgan et al., 2017).

The subject of policing was also raised by participants in the project seminar. There was concern that cuts to mental health services were having an adverse effect to the wider community. This means that the police are interacting with those experiencing a mental health crisis on a far more frequent basis than before wide scale cuts to NHS mental health services.

3.5 Treatment of Schizophrenia and Schizoaffective disorders

Secondary analysis of two waves of the National Audit of Schizophrenia explored whether there was a difference in treatment of patients with schizophrenia or psychosis across ethnic minority groups. The aspects of treatment covered were antipsychotic prescribing, psychological therapies, and shared decision making on receipt of care plans. Overall the findings show variation in mental health provision and offer of 'high quality' treatment to minority ethnic groups compared to white groups:

- High proportion of black African and African Caribbean service users were under a community outreach team
- White and mixed-race service users were more likely to exceed the British National Formulary dose limits
- Large proportion of black African and African Caribbean service users were prescribed depot (an injection giving slow release of medication) and were less likely to be offered Cognitive Behavioural Therapy
- Asian service users were more likely to be referred to family therapies whilst Chinese services users were more likely to be given a copy of their care plan
- Black african and african caribbean and Asian service users were less likely to be prescribed clozapine⁵ (atypical antipsychotic medication for schizophrenia)
- There was no evidence of an association between ethnicity and antipsychotic polypharmacy (use of multiple medications by a patient).

There were methodological issues with the study in terms of not having the complete clinical records for all patients; inconsistency in ethnic categorising; collection of ethnic data by different trusts; and a lack of interpreters, which could impact on differences in data outcomes. Nevertheless, the findings raised some concerns around coercion across different ethnic groups and the risk of harm/benefits of depot. The study highlights the need for more research on how cultural factors shape expectations in response to treatments particularly in relation to the differences in prescribing of antipsychotic drugs. The researchers recommend further exploration as to why black African and African Caribbean patients are less likely to be offered family therapies.

3.6 Treatment of Obsessive-compulsive disorder (OCD)

Some evidence suggests higher rates of OCD amongst minority ethnic communities. Therefore, Fernandez de la Cruz, et al., (2015) with the Maudsley hospital in South London explored whether minority ethnic groups were underrepresented in use of secondary and tertiary clinical services for OCD and depression in relation to their ethnic population in the catchment area. Clinical data for a 14 year period of 1528 OCD diagnosed patients was analysed according to five wide ethnic groupings. The expectation was that there would be similar proportion of ethnic groups using OCD services to the local population because of the high prevalence within these communities. The findings show a difference in the proportion of white, black African and African Caribbean and Asian groups on the clinical register compared to their

⁵ Authors suggest this may be due to clinicians concern about side effects of the medication, despite other studies including that in the US showing a delay in prescribing this to black African and African Caribbean service users.

proportion in the local population. 8.4 percent of black African and African Caribbean service users (who make up 23 percent of the local population) were using community/national and specialist services, compared to 77 percent of white service users (who make up 60 percent of the local population overall). Ethnic inequalities was more pronounced for OCD compared to depression. The reasons for the underrepresentation of minority ethnic patients in the OCD clinic population is unknown.

However, Fernandez de la Cruz et al., (2015) suggest some, including;

- the shame and stigma of OCD might prevent black and minority ethnic people seeking psychiatric help
- religious explanations for OCD and rituals maybe more acceptable
- there were different presentation of symptoms by minority ethnic patients compared to white patients
- non detection of symptoms of OCD by primary care clinicians or misdiagnosis.

Fernandez de la Cruz et al., (2015) suggest further research is needed to identify the reasons behind these disparities and barriers to accessing services. They suggest sensitivity for different cultural beliefs about mental health, and symptom recognition would improve access to mental health services.

3.7 Mindfulness

Mindfulness as a therapy was developed to help people deal with depression and build resilience. The Mindfulness All Party Parliamentary Group (MAPPG) enquiry in 2015 explored the role of Mindfulness as a strategy in different areas including mental health. Some evidence shows how mindfulness interventions have improved outcomes for patients. However, access to Mindfulness Based Cognitive Therapy (MBCT) has been limited partly due to its recommendation as a prevention intervention for recurrent depression rather than as a treatment for current depression (MAPPG, 2015).

Recommendations from the MAPPG include:

- commissioning MCBT in the NHS in line with NICE guidelines so that it is available to the 580,000 adults each year who will be at risk of recurrent depression
- making funding available through the Improving Access to Psychological Therapies training programme to train 100 MBCT teachers a year for the next five years to supply a total of 1,200 MBCT teachers in the NHS by 2020
- giving access to MCBT to those living with both a long-term physical health condition and have a history of recurrent depression, especially if they do not want to take antidepressant medication.

Whilst there is no evidence that ethnic inequalities were examined, a lack of availability and access to Mindfulness courses within the NHS (MAPPG, 2015) likely means that private provision of mindfulness courses will continue to grow. The cost of such courses can restrict access and further perpetuates inequalities amongst disadvantaged communities.

Research on racial disparities in the use of mindfulness is particularly scarce but a US study suggests mindfulness-based therapies are suitable for black and minority ethnic women because mindfulness encourages clients to use their own experiences to adapt coping skills, which could increase cultural relevance and engender an accepting and non-judgemental stance (Witkiewitz et al., 2013). However, Crawford et al., 2016 highlight the disparities and prevalence of risk factors in state-funded psychological therapy in the UK and asked patients about negative as well as long lasting effects. Individuals who felt they had been given sufficient information about therapy before it started were less likely to report lasting bad effects of treatment – they had a better sense of what was involved and more realistic expectations of how it would affect them. Whilst only 5.2 percent of 14,587 participants slightly or strongly agreed that they had experienced lasting negative effects from the psychological therapy; there were slightly higher rates of long-lasting negative effects reported by people from black and minority ethnic people and non-heterosexual people.

One positive example of mindfulness with black and minority ethnic communities is the 2016 Mindfulness without Borders project to provide mindfulness-based courses for stress reduction and trauma relief to Arabic and Farsi-speaking populations of asylum seekers and refugees in the UK (Oxford Mindfulness Centre (accessed 2018)). Pilots took place in Cardiff and London, both of which support large numbers of refugees. The intention was to help refugees learn mindfulness skills to reduce their stress, build resilience and coping mechanisms. It also aimed to improve understanding of how mindfulness can support the integration of refugees into local communities. The project produced resources for organisations and mindfulness teachers to run courses with these communities including a guide recorded in Arabic and Farsi in working with refugees and resources via YouTube videos (Mindfulness without Borders (accessed 2018)).

The ICope programme in Camden has also produced a number of culturally appropriate resources including a Mindfulness based audio recording in Bengali Sylheti dialect, which has been distributed to some community centres (Khamlici, 2017).

3.8 Improving Access to Psychological Therapies (IAPT) services

Evidence has shown a continual increase in recovery rates for those who use IAPT services but there is variation according to patient's ethnicity and faith. Recovery rates were highest for white – Irish females (50.5 percent) and the lowest for Asian or Asian

British-Pakistani males (33.5 percent). In relation to faith; Jain, Christian and Jewish patients had the highest recovery rates with Pagan and Muslim patients amongst the lowest recovery rates (NHS Digital, 2016). A review of participants experience of talking therapies over a two year period, included a very small sample of black and minority ethnic people ((20 out of 1600 respondents) Mind, 2013)). It showed only one in ten people felt their cultural needs were taken into account by the service that they were offered, though most others said this did not matter to them. The accessibility of psychological therapies is still not the reality for certain groups, including black and minority ethnic communities, older people, children and young people, people with severe mental illness and homeless people. Mental health charity Mind recommend raising awareness of psychological therapies widely including through faith and community networks. The commissioning of more culturally appropriate services is absolutely essential for good engagement with local black and minority ethnic communities to ascertain their needs around various treatments, including talking treatments. Services should then be commissioned once providers have demonstrated there is sufficient diversity and cultural appropriateness within the service they propose (Mind, 2013).

Participants at the project seminar mentioned several examples of counsellors being based in faith settings in order to make them more accessible. They also felt it reduced stigma by being in a familiar and trusted setting.

One example of culturally appropriate IAPT is ICope. The ICope Psychological Therapies programme is administered by Camden and Islington NHS Foundation Trust (Khamlici, 2017). The Trust looked to make their services more accessible to under-represented groups including black and minority ethnic people, in order to increase their recovery. This included providing culturally specific therapy services and resources, working with community organisations, providing education about the service and offering psychoeducational workshops within community settings. The service offers clinics in Bengali and creates resources for working with people from black and minority ethnic communities. The Bengali therapy also considers the impact of cultural, familial and social contexts with emotional problems and has incorporated findings from research with patients to improve the engagement of the Bengali community with therapies (Khamlici, 2017).

In relation to those within the criminal justice system a practice guide for IAPT was produced aimed at improving the quality of mental health support for offenders in prison or living in the community (IAPT, 2013). Key aspects include reducing offending related to offender's mental health problems; reducing rates of depression and onset of more serious mental health problems; and to reduce the rates of attempted and completed suicides. However anecdotal evidence suggests mental health care for prisoners is often patchy or poorly resourced. Indeed 'The frequent changes of location among offenders on

remand or serving short sentences mean that treatment received before imprisonment is often not continued to the same standard – if at all – in prison (IAPT, 2013).

Work to explore the understanding of IAPT amongst Gypsies and Travellers showed the need for mental health practitioners to be mindful in how they addressed mental health issues because of labelling and stigma (Weymss and Matthews, 2013). Gypsies and Travellers have reported barriers in accessing services because of stigma and discrimination. Most participants expressed a preference for support from local organisation Friends Families and Travellers (FFT) rather than counselling from the NHS. Suggestions to improve counselling services include;

- a good working relationship between healthcare professionals and the Gypsy community
- a good relationship between healthcare professionals and the Traveller communities
- Culturally sensitive provision (e.g. knowledge around what barriers may exist for people in accessing NHS services)
- peer support
- using social media, emails and texting to stay in contact.

All research studies overall recommend there should be cultural competence training for therapists, building a trusting relationship with patients as well as the need for staff to undertake other professional development activities in order to counter racial disparities in the treatment for mental health (Khamlici, 2017; Weymss, and Matthews, 2013). This is particularly needed for professionals working with the Gypsy and Traveller community owing to a resurgence of anti-Gypsy and anti-Traveller sentiment in recent years, and its knock-on effect to mental health.

4 Understanding racial disparities in mental health

A number of factors affect the understanding of mental illness by black and minority ethnic communities and their use of mental health services. The following areas came out of the literature and evidence we examined:

4.1 Stigma

Stigma is generic to all communities across society in relation to mental illness. Around one in three people experiences a mental health condition during their lives, but research has shown that some groups are less likely to feel confident seeking help than others. The stigma associated with mental health impacts on the help seeking behaviour and in turn the use of mental health services by minority ethnic communities. It then perpetuates a vicious cycle that is a detriment to the confidence and ability of the service user to feel comfortable in accessing help. Refugee and asylum seeker women for example, were not accepting of mental health conditions and the need to engage with mental health services because of the stigma associated with mental illness (Psarros, 2014). Participants at the project seminar highlighted the stigma and shame associated with mental health as one of the main barriers to care.

Stigma that affects help seeking behaviour of African descended faith communities from Christian based organisations include cultural beliefs about mental illness; practices within faith communities; family/kinship relations and a preference for non-disclosure and therefore 'suffering in shame' (Mantovani et al., 2016). Participants in the study spoke of mental illness in terms of being a 'curse', 'insanity' 'possession of the devil' and associated it with violence and danger. There was some form of moral failing or a weakness in those who were mentally ill, which was contrary to beliefs of being 'spiritually strong'. Denial and not 'talking about it' or avoiding contact with the individual or their family because of 'social stigma', contributed to the reluctance to seek help. Black and minority ethnic women in Kalathil's 2011 study gave similar descriptions including a belief that mental illness was 'hereditary madness' that needs to be hidden from others. Such responses to mental illness as a result of stigma not only isolates the individual but impacts negatively as the individual's mental illness could escalate.

Mantovani et al., (2016) suggest people of African descent with mental illness experience triple stigma – rejection from family, rejection from society and internalised self-stigma. Stigma then led people to engage with religion to cope rather than using mental health services. However, some participants did not feel religious practices addressed the issue but showed the pastor's lack of understanding about mental illness, instead of facilitating individual's engagement with mental health services. The researchers suggest that commissioners should establish effective partnership with community and

faith groups to communicate, inform and influence appropriate help seeking behaviour for a more holistic approach.

The stigma associated with mental illness remains with black and minority ethnic communities whilst in the justice system. As mental illness is less likely to be identified in prisoners, this compounds their mental health experience as their mental health needs will not be addressed and support is limited within the prison context. Action identified in a 2016 workshop of voluntary, community sector and social enterprise organisations to address stigma within the prison population include workforce training around mental health and cultural needs; easier access to mental health support, and the acceptance by prison staff of other interventions for mental health, such as faith-based programmes or mindfulness (Nacro et al., 2017)

Members of the Gypsy, Roma, and Traveller communities have highlighted the stigma associated with mental illness. One participant in a 2013 study with Gypsies and Travellers expressed how 'you don't come out and say that you're stressed, you don't say you have a mental health problem, not as a Gypsy woman, people will think you're proper mental, that you're cracking up' (Thompson, 2013). Additionally, Gypsy and Traveller women were especially concerned that a mental health diagnosis could lead to social services involvement and having children removed from their care (Psarros, 2018). Other research in this area has explored the meaning of mental illness with young travellers aged 15 to 21 and found mental illness was referred to negatively. Words such as like 'psycho' and 'mad' were used and there was proven to be little understanding of mental illness. Most young Travellers implied they would 'suffer in silence' with a mental health condition. Conforming to traditional hyper masculinity roles were reasons given for the lack of Gypsy Traveller men's interaction with mental health services (Yin-Hur and Ridge, 2011).

Mental Health Champions at Manor Gardens is one of the programmes that seeks to tackle stigma. The service provides four types of Mental Health Champions: work-based, outreach, community, and support champions. They support around 50 people a year to access mental health services. The Mental Health Champions reflect the local communities and provide support to people who live and work in the part of London where Manor Gardens is based and black and minority ethnic communities are one of the target group for the service; to improve access to mental health support. One-to-one support is offered and a specific annual event linked in with the Black History Month.

4.2 Access and use of services: men

Men's use of health care services is somewhat poor, and Memnon et al., (2016) also noted that black and minority ethnic men were less likely to access mental health support services than other groups, particularly White British groups. This behaviour is

not specific to black and minority ethnic men but associated with wider concepts about male masculinity, pride and self-reliance in managing physical and mental illness. Stigma amongst men remains a barrier to engaging with mental health services. Over a third of men were found to wait two years or more before disclosing a mental health problem; and men generally were too embarrassed or ashamed to take time off work for mental illness but are more likely to take time off for physical ailments (Stein, 2018). Whilst health professionals find it important to use clinical terms in talking about mental health, it has been suggested that the type of language used can impact on diagnosis, disclosure of mental illness, and men's engagement with services.

The Men's Health Forum found the term 'mental health' was seen negatively by men, as a 'problem', indicating a 'failure to cope'. Acceptable words about mental health included 'feeling down' rather than 'depressed'; also 'being worried' or 'lonely' as opposed to 'mental', 'psycho', or 'a bit weird'. While ethnicity, was not specifically explored, it is worth noting that ethnic differences emerged amongst the group with Muslim men preferring to seek help from their mosque. White young men, however, were more accepting of CAMHS (Children and Adolescent Mental Health Services) interventions. One practitioner commented that 'ethnicity was seen as a potential barrier for some young people, with black African and African Caribbean British young people facing specific barriers to accessing services'. Overall, the suggestion is for less use of clinical terms, and use of socially and colloquially acceptable language for effective engagement with men on mental health issues. The men also stressed 'how' an intervention was delivered, and by 'whom' was as important as the terms used in discussing mental illness (Stein, 2018) which demonstrates a need for broader training for professionals around this area.

Men's Health Forum used the Beat Stress online service to engage men and provide positive support on mental health. Evaluation of Beat Stress found a change in sentiment from the start to the end of a web chat; where on line chats were for some men the first time they could start to articulate their feelings and experiences.

The majority of men were reluctant to seek help offline but there was evidence of follow on action by the men at the end of the chats. However, the techniques used by counsellors led to changes in sentiment during the men's web chats. The four types of sentiment change were: an increase openness to talk about the issue; a recognition that services could help; a recognition that the issue was serious enough for offline support; and an improvement in how the men were feeling. Almost all the participants were white British and there are obvious issues in data collection around the gender binary and in the collection of information on transmen and other groups. Whilst it is questionable how accessible an online resource is for disadvantaged groups, the evidence does suggest that the anonymous and confidential nature of online chat enables men to talk about mental illness, and can be the start of help seeking behaviour for mental illness issues (Sweet and Robotham, 2017).

It seems that regardless of what stigma is associated with, it does impact on disclosure and help seeking behaviour of black and minority ethnic communities.

Friends, Families and Travellers set up a number of schemes providing places where men feel safe to talk have helped in reducing the number of suicides in many parts of the country. By facilitating a safe space and group they hoped that the project would have a positive trickle-down effect and improve mental health outcomes for Gypsy and Traveller communities. A toolkit in the form of a short leaflet and checklist were produced for peers within the Gypsy and Traveller communities. In the project seminar, there was an example of a project where workers in gyms and boxing clubs are trained to deliver some basic mental health support and conversations with men and young people.

4.3 Access and use of services: ethnicity

Memon et al., (2016) highlight personal and environmental factors, as well as the relationship between the service user and healthcare practitioner as key barriers to accessing mental health services. The inability to recognise symptoms or accept a diagnosis impacted on black and minority ethnic participants help seeking behaviour. This was a particular issue for participants born abroad. Cultural beliefs and expectations to 'deal with it' and to 'be strong' affected how mental illness was understood and how people coped. Kalathil (2011) similarly found that the stereotype of black African and African Caribbean women being 'strong' meant there was a lack of expectation that such women can experience mental distress and stopped them seeking help, as illustrated in the following quote:

'Oh yeah, women of colour, African Caribbean, African, whoever they are, there is a stigma attached. They are not supposed to have breakdowns. We are supposed to be strong black women. Put up an appearance and take care of the house and so on. How are you going to do those things?'

Coping with differing issues were also noted as barriers to engagement with services for black and minority ethnic women who had experienced mental illness as a result of violence (WHEC et al., 2016)

Lack of awareness, long waiting times for treatment, and lack of support for those with limited English to express themselves, were some factors affecting the relationship between the patient and healthcare provider (Memon et al.; 2016). Practitioners were perceived as finding it difficult to understand the minority ethnic experience, and an unwillingness to engage with or hear about racism and the impact this has on individual's mental health. Additionally, patients wanted to be matched with someone from their own background as they believed there would be cultural understanding which would be beneficial with their engagement and treatment plan.

Recommendations include awareness raising and work to reduce stigma amongst black and minority ethnic communities; empowering users to engage better with their own mental health and healthcare practitioner; training for healthcare providers to increase their understanding of cultural issues and be sensitive to the diverse needs of users; and using a reverse commissioning process to enable black and minority ethnic patients to identify gaps in service provision to enable the development of culturally appropriate interventions (Memon et al., 2016).

There is specific evidence relating to engagement with mental health services in the following areas:

4.4 Access and use of services: Perinatal mental health

Maternal mental illness can affect a woman's ability to cope, family life, and how she bonds with her child (Public Health England, 2017). A third of women diagnosed with postnatal depression continued to have symptoms well after the first year of childbirth and there is a risk that perinatal mental health problems can develop into long term mental health problems. However, maternal mental illness can be successfully treated (NCT, 2017; Redshaw and Henderson, 2013). A lack of time; focus on the baby; and how the subject of emotional wellbeing is approached, are some of the reasons why women's low mood and other mental health symptoms remain undetected at antenatal check-ups (NCT, 2017; Redshaw and Henderson, 2016). Stigma prevented most women from opening up about how they were feeling however, black African and African Caribbean and Asian women were amongst those who were less likely to be asked about their current and past emotional and mental health or offered treatment; and Asian women were less likely to receive support or advice postnatally (Redshaw and Henderson, 2016). Whilst being white, living in a less deprived area, and having high education meant these women were significantly more likely to receive support. Better knowledge of treatment options; cultural awareness; and specific funding for women's six week check are some suggestions to address the unmet needs of mothers and help services adhere to NICE guidelines on mothers mental and physical health checks (NCT, 2017; Redshaw and Henderson, 2016).

4.5 Access and use of services: faith

Faith can be a protective factor for mental health. Rabiee et al., (2014) explored the views of African and African Caribbean carers and users of mental health services in Birmingham and the role of faith in managing their mental health conditions. In terms of participants understanding of mental illness, loss was a big contributory factor of mental illness particularly for those experiencing loss as a result of war. For others, mental illness was seen as inevitable relating to life events such as, bereavement or a result of

depression and stress related to being uprooted and having to leave their home and family as a refugee. Some participants felt mental illness is caused by 'djinn' or 'magic' and could only be cured by a faith leader, and other participants also had faith beliefs which included that mental illness is related to witchcraft. Negative experiences of mental health services included a lack of continuity of care, staff attitude, not being understood or respected, lack of equity in accessing resources, and a lack of access to talking therapies. Mental health services were viewed as criminalising black African and African Caribbean people when they interact with them, particularly in crisis care. Racism was experienced with African people especially mentioning racist experiences both via care staff and in hospitals. Participants highlighted a lack of respect and understanding in relation to their religious and faith beliefs by health practitioners, and did not think western medicine was equipped to treat mental illness as a result of magic or possession (Rabiee et al., 2014).

4.6 Access and use of services: children and young people

Black and minority ethnic children and young people's access and use of mental health services appears to be a mixed picture. Ali et al., (2016) studied a group of young Pakistani people and explored views of barriers to accessing mental health services in order to inform the CAMHS provision in Peterborough. Despite stating that GPs would be their first contact for mental illness, the young people overall had poor awareness of mental health services and specific treatments such as family based cognitive behavioural therapy. Faith was a protective factor in coping with mental illness with some young people talking about seeking 'traditional healers' for treatments or using the teachings of Islam to cope with any risk factors of mental illness. Overall the young people voiced a lack of trust in school based services. The stigma attached to mental illness both in the Pakistani and wider community would affect those seeking help from CAMHS. Essentially the study suggested Peterborough CAMHS improve access for Pakistani young people, more awareness raising was needed within the community of risk factors of mental illness and for mental health information to be tailored for young people; cultural training for practitioners and importantly, a clear understanding of how religion is a resource in preventing mental illness.

Similarly, research in Scotland with families who had used CAMHS found stigma was a barrier to South Asian families' engagement with the service and 'fear of gossip about children's 'madness' constituted a major barrier to service use for Asian families in this city' (Bradby, 2008). Parents were found to describe their child's illness in different terms such as 'immaturity' or a result of other factors, such a racism, in order to minimise any potential stigma. As described by one Sikh women 'psychiatry is a bad word it means wrong in the brain'. In addition to stigma, most participants wanted to keep these issues private as they were 'family problems'.

4.7 Under use of mental health services

A number of factors impact on poor use of mental health services by black and minority ethnic communities. For example, low literacy levels; a distrust of mental health professionals and language barriers, are some reasons for Gypsy, Roma and Traveller communities. Barriers to engagement with services for Gypsies and Travellers include cultural ideas of mental health as a weakness and not wanting to disclose and seek support (Thompson, 2013). Whereas work by Kapaida et al., (2017) suggest the under use of services by some South Asian communities maybe due to their good social support network which reduces the propensity to develop mental illness and therefore the need to access services. The review of seven studies between 1960 and 2014 with Pakistani women found;

- rates for outpatient services (for example community psychiatric nurse, crisis home resolution treatment) were lower for Pakistani women, but there were higher rates for early intervention treatment
- Pakistani women were less likely to be referred to and treated by IAPT.

Overall, this research found Pakistani women to have high levels of social support primarily through family and friends, but less interaction with those outside of their community and networks compared to white women. Pakistani women were less likely to use specialist mental health services and, felt they had to deal with mental illness alone due to the stigma. Pakistani women wanted practitioners from their background but also feared opening up because of the risk of disclosure in the community. The study suggested the Department of Health and Social Care and NHS England publish specific figures on Pakistani women and mental health services to enable specific research to address barriers to access.

4.8 Cultural matching with health practitioner

Preference for health practitioners from the same cultural background has been raised by service users in the studies above (Kapaida et al., 2017; Memon et al.; 2016). 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).

Adams et al., (2015) explored the impact of patient race concordance and patient centred communication on the disclosure of depression symptoms during consultations. Caribbean and white analogue⁶ patients portrayed depressive symptoms using an

⁶ Analogue participants are used as proxies for clinical patients in simulated circumstances. The analogue patient closely resembles the characteristics of the target population according to the requirements of study.

interactive computer programme that simulated doctor engagement. The expectation that race concordance can have a positive effect on disclosure in the patient-doctor relationship was not found. There were no significant racial differences between white and black patients in how comfortable they were with disclosing to a specific race doctor. But there were some differences regarding treatment with white patients more likely to agree with taking medication (37 percent for white patients compared to 22 percent for black); and black African and African Caribbean patients more likely to want to 'wait and see' how symptoms develop. The majority of patients from both races preferred to disclose to doctors with high patient centred style; with black African and African Caribbean patients more willing to try therapy and also state their preference not to take medication with doctors that had a high patient style communication. It seems racial differences were really only evident in treatment preferences, which may have implications for black African and African Caribbean patient's ability to engage in treatment and the choice they make. However, there are limitations to using analogue patients in research and this study also highlights some interpretation issues as African American doctors were used therefore it was not entirely race concordance for the African Caribbean patients.

Touchstone found with their Behavioural Activation approach that cultural matching could help service users engage with therapy, particularly familiarity with their faith. Other services, such as Greenwich Counselling Services use multi-lingual therapists to match service users where possible, and includes an appreciation of cultural understanding and needs.

5 Impact of racism and discrimination

Racism impacts on mental health and is detrimental whether experienced or there is a perceived expectation of racism. Ethnic inequalities as a result of racial discrimination can also lead to health issues such as depression, or manifest physically, for example high blood pressure (Synergi, 2018; Kalathil, 2011; Connected Communities, 2015; Memon, et al., 2016; Rabiee et al., 2014).

5.1 On accessing mental health services

There is evidence of widespread racism and discrimination experienced by the Traveller community (Connected Communities, 2015; Thompson, 2013; Yin-Hur and Ridge, 2011). For example, a support organisation reported that Gypsy and Traveller service users have been denied GP registration on the basis of their ethnicity and identified racism, and prejudice as the main barrier to care for their service users (Psarros, 2018). Further, poor past experiences due to prejudice and racism has affected Gypsy and Traveller women's ability to access maternity services and healthcare, and impacts on their mental wellbeing (Psarros, 2018). The response to the recent parliamentary questions raised by Baroness Whitaker about what action is being taken to address the impact of racism on the mental health of Gypsy and Travellers stated that 'the impact of racism on the mental health and wellbeing of Gypsy, Roma and Traveller people is not routinely monitored'. The lack of data collection on ethnicity and how this affects any analysis and policy on the mental wellbeing for Gypsy, Roma and Traveller communities is of concern. Similarly, concerns about poor continuity for Gypsy, Roma and Traveller who move to new areas on a regular basis were raised in the project seminar.

5.2 On detention

Some research has attributed the higher rates of detention of black African and African Caribbean and Asian patients compared to white patients, to discrimination and racial stereotyping by health care practitioners. Singh et al., (2013) explored whether ethnicity was a predictor for detention under the Mental Health Act by examining 4423 mental health assessments between 2008 and 2011 in Birmingham, Oxfordshire and central and west London. Patients self-defined ethnicity and were categorised into four broad ethnic groups. The findings showed no ethnic differences in those deemed not to be 'at risk' (such as self-harm, deterioration in mental state, harm to property etc.). However, those assessed in London were twice more likely to be detained than in the other areas; and, those aged 30 and over were more likely to be detained than younger patients. The geographical site was found to be a predictive variable for detention with London having the highest detention rates; three out of four assessments. The highest number of Asian detentions were in Birmingham and highest number of assessments for black African and African Caribbean patients was in London.

The reasons suggested for the high rates of detention for different ethnic groups was partly attributed to the population proportion of ethnic groups in those different areas. Moreover, the study raised the lack of alternative to inpatient treatment or use of crisis care, as possible reasons to explain high detention rates for black African and Caribbean patients in London. The study suggests the need to examine the different pathways to care and thresholds for admission, access to home treatments and inpatient provision to determine differences between the sites. Whilst this research did not find ethnicity to be an independent predictive factor for detentions, ethnic bias in assessment under the Mental Health Act, cannot be ruled out.

Participants in the more recent review of the Mental Health Act highlight race based discrimination as a factor in their detention, and treatment by mental health staff (Gov.UK, 2018). This referred to a range of practices including unnecessary use of force or more restrictive care, and that mental health professionals were influenced by stereotypes of black African and African Caribbean men being dangerous.

With regards to racism and institutional racism contributing to ethnic inequalities in mental health, it is suggested that health agencies need to look at their policies and interactions with minority ethnic groups to avoid reflecting similar power and ethnic inequalities that exist in the wider society (Synergi, 2018). Moreover, in order to address these differing experiences and outcomes between white and minority ethnic groups, mental health services need to be aware and recognise the impact of racism on accessing mental health care and in perpetuating ethnic inequalities (Synergi, 2018; Kalathil, 2011; Memon et al., 2016).

Research has also explored bias and discrimination as explanations for racial disparities:

5.3 Conscious or unconscious bias

The suggestion that healthcare practitioners are biased or racist in their decision making about mental illness was considered by Adams et al., (2014) who investigated the influence of African American and African Caribbean race on primary care doctors' decision making about depression. Specific interest in clinician's decision making related to how people of African descent presentation of depression was interpreted compared to white people; and whether African Caribbean's language, speech, and gestures can lead to misunderstanding and fear among white practitioners. 256 primary care doctors in Massachusetts, Surrey, South West London, and the Midlands were shown scripted video narratives suggestive of depression using black and white actors. Overall doctors had difficulties diagnosing depression with African Caribbean patients which was confused with other physical conditions, such as diabetes. There were also no differences in the types of interventions mentioned for black compared with white patients.

Key findings were:

- a greater uncertainty in diagnosis of emotional problems and depression in black African and African Caribbean patients
- a greater focus on physical problems for black African and African Caribbean patients suggesting the need for the development of a mental health model of depression presentation
- the need for specification in detecting depression in black African and African Caribbean communities in both countries.

It is proposed that the poor health conditions of black African and African Caribbean patients in both countries was likely to lead doctors to focus on physical conditions despite the fact that some diseases, for example cardiovascular disease, are complicated by depression. Ultimately, further studies would be useful with patients presenting depression, rather than by use of an analogue study.

5.4 Impact of discrimination on mental health

Discrimination is a factor for some people when in contact with mental health services (Rethink, 2017; Colledge et al., 2015; Wymess and Matthews, 2013; Singh et al., 2013). One study explored whether there was a relationship between discrimination and common mental health disorders (CMD) according to migrant status and ethnicity (Hatch, et al., 2016). Researchers undertook two follow up surveys of 1052 adults from South East London Community Health. Data was obtained on major discrimination such as stop and search, being fired or not hired for a job, and everyday discrimination such as receiving poor services or being called racist names. The most commonly reported discrimination was reported from African Caribbean community (mainly police incidents); mixed race and African Caribbean community (in education); non-white other groups (not being hired for work) and discrimination according to migrant status (not being hired). There was a greater association of CMD of discrimination experienced for major events such as, employment; or being denied services. Those who had migrated for 10 or less years experienced the most common anticipated discrimination.

Essentially this study found participants who had recently migrated, and black ethnic groups, were two or more times more likely to experience discrimination than any other group. The researchers suggest a need for more consideration of migration status along with ethnicity in examining the impact of discrimination on mental disorder in community and clinical samples.

6 Intersectionality and mental health

Research has explored intersectionality on mental health in different ways.:

Intersectionality is a black feminist concept, coined by Kimberly Crenshaw in a legal paper in the early 1990s to explore how different matrixes of power coalesce for some groups in particularly ways: such as working class men, women and gender non-conforming people from African backgrounds.

6.1 Stigma, faith and mental health

Montavani et al's study (2016) gave insights into the intersectionality between stigma, faith and mental health arguing that faith and culture need to be considered in how they affect the perception of mental illness and how it is managed. Faith was seen as a key factor to helping those with mental illness keep well (Kalathil, 2011). However, the situation is complicated when more than one type of discriminatory factor is present and can impact on experiences or outcomes in mental health. For example, Muslims accessing IAPT services had a lower rate of recovery than those of other faiths. However, there is little information on the ethnic background of the Muslims in the research. Therefore, it is difficult to assess whether it was their faith or race that made the difference in their experiences (NHS Digital, 2017). Better collation and monitoring of faith data would be helpful to analyse such issues.

There are a number of case studies that address faith and mental health. Touchstone in Leeds have adapted a behavioural activation approach for depression that involves supporting and motivating patients to engage in rewarding activities based on their own personal beliefs and goals. In the Touchstone example, there was a specific focus on supporting practicing Muslims through behavioural activation, and two studies of the project found the participants were positive about the approach.

Mindworks offers counselling, psychotherapy and faith based therapy. They work closely with women who have suffered or going through domestic violence and sexual abuse and work collaboratively with other agencies to support these women. Their approach includes faith based therapy which incorporates looking at faith, mental, physical and emotional self, your outside world as well as your inner world.

Faith projects were also included in the Delivering Race Equality programmes, with one example being the Jinn project, which delivered a more holistic approach to the care of male Muslim patients by including spiritual therapy as part of the Focused Implementation Site in Bradford.

Similarly, there are examples of faith-based organisations reaching out to people who do not have a religious faith, such as Open Doors- a church-based project in East London for

people of any belief or no belief. Their vision is to combat isolation and fight poverty by offering one-to-one support for vulnerable families, usually referred by statutory services.

6.2 Gender, race and migration

The intersectionality of gender, race and migration experiences is limited in evidence. Lane et al., (2010) argue that this intersectionality alongside social and linguistic isolation, and financial insecurity (due to working in the family business resulting in no pension), are factors that place Chinese women at long lasting risk of poor mental health in later life. The researchers suggest that combined forms of structural inequality (particularly emphasising the personal and historical experiences of migration) put Chinese older women at greater risk of poor mental health. Racism, financial abuse and sexual violence were other intersectional issues affecting black and minority ethnic women's ability to seek help with their mental health and wellbeing (WHEC et al., 2016)

6.3 Sexual orientation, race and mental health

Evidence suggests that lesbian, gay, bisexual and transgender (LGBT) people are at higher risk of common mental health disorders, marginalisation and issues related to 'coming out' (Government Equalities Office, 2018; Stonewall, 2018; Rethink, 2017). For example, young Gypsy Travellers said that sexual orientation was a trigger for mental health difficulties and that the complications of 'coming out' in the Irish Traveller community, and fears about sexuality, were a contributing factor to the high rates of suicide in the Traveller community (Yin-Hur and Ridge, 2011). The risk of mental illness some suggest is partly due to internalised psychological stress because of stigma relating to mental illness and sexuality, homophobia and direct and indirect discrimination (Rethink, 2017; Colledge et al., 2015). Shame, guilt, low self-esteem and/or self-blame in relation to HIV positive status were feelings experienced by half of men who have sex with other men in the Stigma Survey of 2015.

High rates of suicide and self-harm are highlighted for young LGBT people (Stonewall, 2018; Henderson and Varney, 2017). Some 52 percent of young LGBT people reported self-harm compared to 25 percent of heterosexual non-trans young people. This increased to 5 percent for black and minority ethnic men, 5 percent of bisexual men and 7 percent of gay and bisexual men with a disability (Henderson and Varney, 2017).

The recent Stonewall survey finds rates of depression to be high amongst LGBT people surveyed (52 percent) and much higher for those who had experienced a hate crime based on their sexuality or gender orientation. Black and minority ethnic LGBT people were amongst those most likely to have higher rates of depression (some 62 percent); eating disorders (22 percent compared to 11 percent for white LGBT people) (Stonewall, 2018).

Hickson et al.'s (2016) survey of gay and bisexual men found key indicators such as education, migrant status, age, geography, and education were associated with poor mental health. Whilst only around 5 percent of respondents were from a minority ethnic group, black African and African Caribbean and Asian men still had higher chance of depression and of suicide attempts than their white counterparts.

There are also higher rates of mental illness for bisexual and lesbian women compared with heterosexual women; and that bisexual women have higher chances of poor mental health (Public Health England, 2018; Public Health England, 2018a). Bisexual women were 37 percent more likely to self-harm; 64 percent more likely to have an eating disorder and 26 percent more likely to feel depressed or sad in the past year than lesbian women (Colledge et al., 2015). The research highlights how internalised stress impact on bisexual women's mental health as a result of the concealed sexuality and the discrimination and stigma associated with it. Moreover, it is suggested that healthcare staff may not be adequately trained to deal with mental health issues for lesbian and bisexual women, and a lack of awareness of services and stigma prevent these women seeking support (Public Health England, 2018). For example, lesbian and bisexual women may not disclose their mental distress as it would be necessary to inform GPs about their sexual orientation, and risk the possibility of homophobia (Psarros, 2014). Intersectionality compounds their mental health experiences and Colledge et al., (2015) raise the need for the bisexual identity to be accepted in order for services to be tailored equitably to address mental health needs.

In their review, Public Health England (2018) note there is limited evidence of intersectionality of ethnicity for bisexual and lesbian women. However, black African and African Caribbean bisexual or lesbian women will likely experience discrimination and stigma in terms of their gender, sexuality and race. Colledge et al., (2015) suggest the increased use of marijuana by black and minority ethnic bisexual women compared to lesbian women could be attributed to a coping mechanism for these intersectional issues.

Some research has suggested minority sexual groups within the wider LGBT communities have higher rates of suicide, self-harm and mental illness (Public Health England, 2018; Hickson et al., 2014; Public Health England, 2014; Varney, 2014). Moreover that some groups such as black and minority ethnic bisexual women, experience 'minority stress' impacting on their mental health. In their US study, Calabrese et al., (2014) compared the experiences of discrimination and mental health between black and white sexual minority women. Black sexual minority women reported poorer psychological and social wellbeing and higher depressive symptoms compared to white sexual minority women, and black African and African Caribbean women had higher rates of discrimination. Overall the black African and African Caribbean women experienced poorer mental health and discrimination based on their race, gender and sexual orientation. However, the research could not explicitly indicate the extent of the impact

of either race alone or sexuality on mental health, and questions how well the intersections can be measured.

The limited evidence and research on the transgender community and mental health suggests a high use of mental health services (not related to gender medical reassignment) than the general population (Government Equalities Office, 2018; Stonewall, 2018; Ellis et al., 2015). However, the situation is complex with contributory factors such as discrimination impacting on mental health, as well as whether transgender people are treated for gender dysphoria within a mental health framework. Nevertheless, one research study found over 80 percent of Transgender people experienced depression and had thought about ending their life (Rethink, 2017). Ellis et al., (2015) found there were varied experiences of mental health services and practitioners understanding of transgender issues, with some practitioners narrow definition of gender leading to the expectation that transgender people would conform to stereotypical notions of the 'male' and 'female' gender binary. A real concern from respondents was that their mental health issues would not be taken seriously and that 'being Trans' would be seen as a symptom of their mental health issues. There is limited demographic data to enable the exploration of intersectionality of race, transgender identity and mental health. For example, Ellis et al., study (2015) had less than seven percent of the 889 participants from an 'other' ethnic background than white, and no detail as to 'who' the 'other' ethnic referred to.

Unequal treatment due to sexual orientation and race has been mentioned by LGBT people accessing mental health services. Inappropriate curiosity; negative remarks and being outed without consent were some of what the LGBT people surveyed experienced from healthcare staff (Stonewall, 2018). One in eight LGBT people said they had experienced some form of unequal treatment from healthcare staff because of their sexual orientation; one in five for black and minority ethnic LGBT people, including 24 percent of Asian LGBT people (Stonewall, 2018). Further 5 percent of LGBT people; and 9 percent of black and minority ethnic LGBT people have been 'pressured to access services to question or change their sexual orientation when accessing healthcare services'. This raises great concern in relation the understanding of the health needs of LGBT people by health care staff and in relation to equality of access to services.

Essentially, the limited research on intersectionality and mental health does show similarities in mental health risk and experience for some minority groups compared to the wider community, but there are still differences. Bisexual women appears to have poorer mental health experiences than lesbian women, and it is evident minority ethnic LGBT people have poor experiences too. More research is needed to understand the impact of different oppressions on mental illness and what interventions can be developed.

7 What works in supporting Black and minority ethnic people with mental illness?

7.1 Resilience and recovery/learning from mental health survivors

Recovery approaches and building resilience are often used in mental health. However, some question how such approaches relate to black and minority ethnic people's experiences of mental health, particularly acknowledging how personal, social and cultural factors can enable and promote resilience (Kalathil, 2011; Tang, 2018; Montavani et al., 2016; Kapadia et al., 2017).

The definition and understanding of resilience was found to vary amongst black and minority ethnic women to that of mental health services (Kalathil, 2011). The concept of resilience for these women varied from a notion of inner strength, to undertaking practical tasks to help them keep well, and drawing on support systems; be it faith, care services, or family in order to maintain their resilience. Feeling safe when using services from violence and sexual safety on hospital wards; supportive professionals; working with the whole family; regaining control over your own body and life, particularly in relation to decisions about treatment and life in general, were other aspects of positive support for these women. The study however, found a need for more access to talking therapies and counselling within the context of recovery.

It is argued that the premise of recovery is not as useful to minority ethnic communities if the definition does not take a holistic approach with race equality at its core and examine at the external factors that impact on the individual. The majority of African, Caribbean and South Asian women in the Kalathil's study expressed that 'recovery' within mental health services did not resonate with their own definitions and meanings, but was a professionally led process (Kalathil, 2011)

Some women felt the models of recovery used in mental health services need to take on board cultural and linguistic expressions and experiences when working with black and minority ethnic communities. There was an issue with the perception of the women's mental 'distress' as an illness and not as a result of life events; and as such, the recovery approach is seen as the way professionals managed 'the clients'.

Overall Kalathil highlights that an approach to recovery needs to take account of the 'context of an individual's distress, acknowledging that a person needs to recover not only from mental distress but from the underlying causes of it'. She advocates for a much broader approach in recovery that includes ways of overcoming socio-political oppression and acknowledging the role these factors can have on individual's quality of life. Most importantly, the author finally highlights that using a Eurocentric view of

distress within mental health services, does not allow for cultural perspectives of minority ethnic communities to be considered as part of the recovery approach.

7.2 The role of the voluntary, community and social enterprise sector

The voluntary, community and social enterprise sector, and faith 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 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). In particular where there is little trust, or concerns about health professional's lack of understanding about culture, and fears related to racism and discrimination. The Race Equality Foundation were commissioned in 2018 to undertake focus group consultations with black and minority ethnic communities in the review of the Mental Health Act and women's mental health provision. Black and minority ethnic services users highly rated the support provided through voluntary, community and social enterprise sector organisations both in navigating the mental health pathway and its provision of culturally appropriate advice and support.

Newbigging et al., (2017) raised that the range of services provided by voluntary and community sector (VCS) organisations is not well understood or how these services can integrate/interface with statutory services. They outline a forthcoming study that will use both quantitative and qualitative methods to explore the range of VCS contribution to crisis care pathways to strengthen the crisis care response in mental health. This involves a national scoping exercise of the range of VCS organisations and their contribution to crisis care and interviews with national stakeholders. Data gathered will produce information on what factors shape the provision and potential impact on delivering crisis care at local level including a focus on black and minority ethnic communities. The system level analysis will enable exploration of how different organisations are working together at crisis care and what influences effective integration so that service users have good experiences and can access support effectively.

Participants in the project seminar said the voluntary sector needed sustainable funding in order to deliver long term change. They also felt that social prescribing had had a positive impact where implemented well.

8 Suggested action from literature review and evidence

The reasons for racial disparities in mental health are multifaceted and complex from the literature and evidence reviewed. However, the literature and evidence review and the accompanying events have identified a number of actions which could help to address the disparities.

Policy makers and commissioners should;

- take action on better collation of the data on different ethnic groups use of mental health services to enable specific research to address barriers to accessing services
- develop a clearer picture of the mental health needs of the different Eastern European ethnic groups.
- better commissioning of talking therapies according to local need, and engagement with black and minority ethnic communities to ensure the therapies are culturally appropriate
- provide better access to healing systems and therapies including yoga, meditation and complementary therapies
- consider the role of providing services in multiple languages to meet need
- take action to ensure people without addresses can have access to services, particularly Traveller communities.
- take action to improve the experience of black and minority ethnic people in prison and improve timely access to mental health services. This includes taking action to support the families of people in prison, who will have their own mental health needs.
- influence the implementation of the Long Term Plan
involve more black and minority ethnic people in patient, public involvement in NHS England and Public Health England.
- implement the UN recommendations via CERD (Committee on the Elimination of Racial Discrimination) follow up of PSED (Public Sector Equality Duty)

Mental health services should;

- be more constructive working with the voluntary and community sector and faith groups
- further examine the different pathways to care and thresholds for admission, access to home treatments and inpatient provision to determine any ethnic bias and action to address this
- mental healthcare services need to be aware and recognise the impact of racism and discrimination on accessing mental health care and in perpetuating ethnic inequalities
- ensure there is accountability especially where the patient is placed out of area
- ensure the patient can participate in meetings about their care

- consider the impact of being sectioned on the individual and then being taken back to where the trauma happened
- provide financial help to families to visit the patient if they are placed out of area.

Practitioners should;

- have a better understanding of cultural and faith beliefs of black and minority ethnic communities and how this impacts on beliefs and behaviours around mental health
- improve their recognition of symptoms and how these are expressed in different ethnic groups, for example depression in members of the Caribbean community.
- increase their understanding of how loss (particularly for refugee/migrants), and trauma are contributing factors of mental illness
- develop and change approaches towards a more holistic approach that integrates, mental health, physical health, culture and belief.
- work to ensure services are accessible and non-stigmatising. For example, black and minority ethnic users of services felt the use of term 'wellbeing' was better and has less connotations than 'mental health'
- have a clear sense of the term 'self-care'. People felt it was useful but there is a different meaning of this between the statutory sector and user support groups

Researchers should;

- acknowledge that black and minority ethnic people are over researched and under resourced, and actively seek to address that gap and inequity to create a better-rounded body of information for practitioners and service users alike.

9 Concluding remarks

The research reviewed identified persistent racial disparities in mental health. These included some of the more well-known issues, such as overrepresentation in detained settings, experiences of psychosis in African Caribbean men, and the poor experiences of care across black and minority ethnic communities.

The review also found issues that are less present in discussions of black and minority ethnic mental health. For example, evidence of underrepresentation in OCD services, poorer rates of long term recovery, the importance of faith and a more intersectional approach.

Several factors have been suggested that contribute to these disparities such as discrimination, ethnic bias, prevalence or barriers to engagement with services, cultural factors and wider inequalities.

Whilst the reasons for the disparities are complex, the literature has identified some factors and practice that could help to address them and improve experiences and outcomes for black and minority ethnic people. At a fundamental level the collection and quality of data needs to be improved in order to improve evidence-based policies and interventions, particularly with regards to intersections of ethnicity, faith, disability, sexual orientation and gender identity. In turn this may lead to a greater focus on prevention through understanding and addressing the wider determinants of health.

Commissioning needs to understand both the persistent nature of these inequalities, and that there are ways to address them. The examples in this review, and the further case studies that accompany this document can be drawn on to develop such services at a local and national level. Voluntary and community-based services are a vital part of this response, being able to draw on a relationship of trust that is often absent from statutory health services. These organisations, when supported, are also well-placed to develop new interventions and approaches that address the causes of mental ill health.

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