People's Health Trust report summarising workshops to explore the experiences of a) people belonging to marginalised ethnic groups and b) men with mental health, wellbeing and statutory services

In response to the Department of Health and Social Care consultation, *Mental health and wellbeing plan: discussion paper and call for evidence*.

July 2022

Department of Health and Social Care
Mental health and wellbeing plan
Consultation events convened by People's Health Trust

Introduction

In June 2022, People's Health Trust held two workshops with a specific groups of community leaders and residents from our funded networks from the 30% most deprived LSOAs in the country, using Indices of Multiple Deprivation. The target participants for this work, following discussions with Department of Health and Social Care (DHSC), were men and minoritised ethnic groups across England. As well as working for organisations that engage with these specific groups as part of their day-to-day activities, many participants had lived experience themselves. In the week of 4 July 2022, follow-up calls were made with two groups who had particular insights into working with men.

With prior agreement with the DHSC, these sessions focused on specific areas of the consultation where participants were likely to have particular experience and insight. These were:

- Preventing mental illness or reducing the frequency and recurrence;
- Getting help to people when they need support with their mental health;
- Promotion of mental health.

Insights gained from the discussion relate to individual needs, experiences of specific communities, the social determinants of health and the role of the voluntary and community sector.

The Trust has supplemented this information with the wider evidence base where relevant and we have additional insights to offer that can impact policy.

Executive Summary of key points

Preventing mental illness or reducing the frequency and recurrence

- Across both the workshops as well as views reflected through the Trust's broader networks of funded partners, **the issue of waiting times mean that for many, mental health services were simply not accessible or available** to them. Many felt services were impossible to access until the point of crisis at which point intervention was considered likely to only have limited benefits.
- Many of the root causes of preventing mental ill health were felt to be drawn from **everyday challenges** experienced in relation to the social determinants of health – be that quality and security of housing; lack of social connections and control over life; or having sufficient income from good work to meet basic needs. For many people and their families living in communities experiencing disadvantage, not being able to meet these needs was felt to be a key stressor in relation to mental health. This had been exacerbated by the pandemic, particularly in relation to isolation but also deepening levels of poverty in relation to cost of living issues.
- **Marginalised groups and men are less likely to attend mental health services if they have to wait,** due to fears concerning what will happen with their data and a lack of trust in the system, which can then lead to problems worsening.
- For many **minoritised ethnic communities**, including refugees and people seeking asylum, racism and other forms of **direct and indirect discrimination had worsened mental health and compounded the effects of other stressors** they experienced.

- **Community sector groups** led by trusted community leaders were identified as having **a critical role** in providing informal and direct mental health support. However, the burden placed on them in responding to multiple needs and complex issues is immense and they are often on the verge of burnout.
- A greater recognition of **community leaders as a critical part of the mental health system** is required in order to make more effective use of their valued access and support to marginalised communities.
- **Mental health training is required** at scale to support community leaders – both to work even more effectively and to protect against the real threat of burnout.
- The Department for Health and Social Care should **adopt the Marmot Indicators at the ICS** level across the country in order to create better foundations for the prevention of mental ill health through a focus on social determinants.

Getting help to people when they need support with their mental health

- Community organisations provide a critical support role for mental health by supporting social networks that instil key benefits to mental health and wellbeing, including reduced isolation, the development of trust, confidence, and control.
- Community organisations are small and local and can offer tailored and more nuanced support to the community around them. This local intelligence attuned to diverse needs can be transformative in levelling up health at the neighbourhood level as part of the successful implementation of ICS structures.The capacity of community organisations to respond appropriately and sensitively to different minoritised groups stood out as a key feature of their success in supporting mental health
- **Informal routes** to mental health support are vitally important and more oblique activity-based sessions that take the focus away from mental health directly are an important means of engaging men specifically, but also some minoritised ethnic groups.
- **Men are characterised as taking longer to engage** overall, to build trust with and to open-up around mental health issues and **this needs to be taken into consideration by both funders and the mental health approaches** to support men's mental health effectively.
- The importance of the first point of contact for mental health support and creating welcoming spaces to facilitate support was emphasised – which necessitates trusting relationships and cultural sensitivity
- However, referrals into the voluntary sector without additional funding and capacity building support is not a viable means of working together effectively.

Promotion of mental health

- Drawing insights on the promotion of mental health was the most challenging area. On the whole, community leaders were much clearer about things that felt would not and did not work around the promotion of mental health.
- The importance of who is delivering the message around the promotion of mental health was stressed alongside the value of peer communication in promoting mental health effectively – generic translated materials were not felt to go far enough.
- Finding ways to **combat wider discrimination that minoritised ethnic groups experience** was identified as critical to supporting positive mental health and this included the ways in which services responded to them.
- The **de-stigmatisation of mental health** was felt to be important in health promotion and community leaders felt the best means to achieve this was through creating strong peer spaces

- Ultimately, having access to positive experiences of the social determinants of health – good work, stable housing, social connections for example, were felt to be core to the promotion of positive mental health as discussed in section one.
- As noted, the importance of **accessibility of services** was also raised throughout all sessions and interviews as important in health promotion work with lower thresholds for access identified as critical for health promotion work to be effective.
- The connectivity between different elements of mental health services and community leaders and the voluntary sector was felt to be an area for development which could yield positive results if focused on.
- Protecting mental health ultimately requires **cross-government working and commitment**, since the social determinants of health play such a critical role in health creation and the protection of mental health.

1. Preventing mental illness or reducing the frequency and recurrence

1.1 Key issues

To prevent mental illness an understanding of the causes of mental health issues is needed. We asked: "What are the big challenges to mental health and wellbeing?"

Our workshop participants highlighted several common challenges to mental health and wellbeing from their experience in their communities. These often over-lapped to compound negative impacts. Participants highlighted:

- **Issues relating to the Covid-19 pandemic**, including 'long Covid' and its impacts, limited and challenging access to physical and mental health services, dealing with a fear of contagion and constant stream of negative news and the toll that shielding has taken on family units, particularly for families with members with special educational needs. They continue to contribute to rising anxiety, stress and mental ill health which intersects with other issues.
- **Living in poverty** and the associated strains caused by financial insecurity, food insecurity, rising inflation, challenges in accessing welfare benefits, finding decent work and pay, and poor-quality, inadequate, and insecure housing. In many communities it was noted that these issues are structural, and deeply embedded.
- **Loneliness and isolation**, which was an issue highlighted in particular for men and for refugees and people seeking asylum. Loneliness and isolation have been exacerbated across neighbourhoods and communities experiencing the highest levels of disadvantage during the pandemic and have been widespread.
- **Challenging familial circumstances,** which were also heightened during the pandemic. This was noted with particular reference to the strain of breakups, domestic violence and caring for dependent and vulnerable relatives including elderly parents and children, with high levels of bereavement both within families and within disadvantaged communities.
- **Racism, discrimination and stigma** were also cited as significant barriers to wellbeing for people from marginalised ethnic groups. These experiences are long-lasting, particularly if no support is available or accessible, or, in incidents reported to the police, they face long waits for justice. For some ethnic groups, stigma related to engaging with the state: fears that seeking mental health support might lead to people's children being taken away or lead to new or

renewed scrutiny from the Home Office were cited. Additionally, a number of workshop participants supporting people seeking asylum noted the way the asylum process treats vulnerable people creates fear and anxiety on top of the trauma they experience fleeing conflict or violence.

Other life challenges cited included work and social pressures, the pressure to be a good parent, constant barriers to opportunities for particular ethnic groups, dealing with addiction, physical ill health, and feeling unequal and unheard in society. As noted above, workshop participants were clear that these issues were both accelerated by the pandemic and were likely to intersect.

1.2 Analysis

The pandemic, poverty, and social determinants of health

Participants pointed to the wider social and economic determinants as being critical to their mental health: a sufficient income to live on; decent employment and housing; and places to build social connections. It is well-documented that mental ill health is shaped by exposure to adverse circumstances[1] so recognising and addressing those broader issues is key to prevention and requires action beyond those services classically defined as 'health'.

> *"I think they're all connected. So, for example, if someone's got no money, then they can't afford to get the bus to go somewhere to do something else. So that's a practical challenge, and then it all spirals into depression. Yeah. I just think it's all it's all interconnected."*

> *"Some of the services have no accountability. For example, with Houses of Multiple Occupation – nobody is enforcing standards, so mental health worsens."*

It is therefore unsurprising that issues relating to the Covid-19 pandemic and to living in poverty were prominent. Workshop participants testified that the pandemic had magnified the challenges people face, particularly with access to services, with trust in the system, and various social determinants of health.

> *"Particularly the younger generation, they missed a lot of time in their education, and that will impact them into their future progress. Where we've clearly seen the impact is made to the education level of students and GCSE students in our area, particularly for minority groups. And it's going to be a huge problem."*

> *"During COVID, one of the main struggles was getting through to your GP via phone. So a lot of confidence has been lost there. In the system."*

The consequences of life in poverty were sharpened by the pandemic and this has not eased in the proceeding inflation crisis.[2,3] Workshop participants reported that the pandemic has strained the family unit, particularly for families with members who are disabled or have special educational needs. Disabled people and children with special

[1] World Health Organization, *Social determinants of mental health* (2014)

[2] Child Poverty Action Group, Church of England, *Poverty in the pandemic: An update on the impact of low-income families and children* (2020)

[3] Joseph Rowntree Foundation, *Not heating, eating or meeting bills: managing a cost of living crisis on a low income* (2022)

educational needs are disproportionately likely to also be members of minoritised ethnic groups.[4,5] This caused stress both in terms of the demands of full-time care in a pandemic as well as the requirement to shield. While the strain of shielding has lessened, participants reported the impact of palpable fear, anxiety and isolation that remains. This pressure on the family unit was also compounded by issues relating to financial insecurity and resultant housing insecurity and food insecurity, as well as difficulty accessing benefits and finding new jobs with decent working conditions. Participants reported this accelerating break-ups, spiking rates of domestic violence and straining relationships.

> *"What has come to our attention is that some people are even struggling to get up in the morning, because they are just very worried about what the day holds."*

> *"There's something about how you help people to both understand and respond to trauma when you're caught up in it. Even the smallest thing is experienced and interpreted through trauma."*

The impact of significant numbers of bereavements within families and within neighbourhoods was also highlighted as a stressor.

Race, discrimination and stigma

The lived experience of racialised communities, particularly the impact of racism and discrimination, intersected with the pandemic, poverty, and pressure on family units. Experiences of everyday racism and discrimination were noted as adding to feelings of isolation and anxiety. Relatedly, culturally insensitive services were described as *"feeling racist"* at a systemic level. This reflects the evidence base, which suggests experiences of racism carry an enduring impact to mental and physical health.[6]

> *"It's quite multi-layered, the perception of inability to access services, because you're not in if you don't speak the right language. You don't look the right way. That's a block, the racism in how you perceived it and how you see yourself within that. You know, we don't look right so we don't fit in."*

This was relayed in response to feeling 'othered,' associated with a lack of control and trust, and feelings of isolation. Greater levels of control, and feelings of control, are health protective and a crucial determinant of mental and physical health.[7]

Levels of stigma that exist in many marginalised ethnic groups also play a key role in preventing people from seeking support. Participants discussed women from Black, Asian and Minoritised Ethnic Groups fearing having their children taken away if they admitted they were struggling and engaged statutory services, because that is what they had heard within their community. Additionally, for some groups, even seeking mental health support is a taboo. One participant reported that to some he worked with, *"you're either completely mad or you're okay."*

This was also said to impact young people, who may have differing experiences to their first, second or third-generation migrant parents or grandparents.

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[4] Lindorff A, Strand S, *Ethnic disproportionality in the identification of Special Educational Needs (SEN) in England: Extent, causes and consequences*, University of Oxford (2018)

[5] Williams ED, Cox A, Cooper R, *Ethnic Differences in Functional Limitations by Age Across the Adult Life Course*, The Journals of Gerontology 75, 5 (2020)

[6] Hackett, A et al., *Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom*, BMC Public Health 20, 1652 (2020)

[7] Marmot, M et al., *Health inequalities among British civil servants: the Whitehall II study*, The Lancet (1991)

> *"Young people have to deal with cultural differences and constant misunderstandings at school and in their family. This can be challenging to navigate and can impact negatively on their mental health and that of their families."*

One workshop participant, who works with refugees and people seeking asylum, reported that many fear engaging with mental health services in case it affects their claim for asylum, or they face deportation. Many workshop participants working with refugees and people seeking asylum were clear that they already have fragile mental health following the trauma they fled, their experiences during flight, and arriving to find they cannot work, cannot receive child benefit, and will live in overcrowded accommodation or cheap hotels.

Participants suggested that prevention strategies could target support towards communities where people are likely to be facing the most challenges. They emphasised that these strategies needed to be underpinned with an understanding of the stigma that exists around mental health in certain cultures and communities, fears in some communities of engaging with the state, how this manifests itself differently across different communities, and being culturally-sensitive – the same message will not resonate across different communities.

Building trust through cultural sensitivity

Trust was felt to be a critical to the success of prevention strategies. Several workshop participants from minoritised ethnic groups emphasised that people needed to feel there were safe spaces for them to go to and share within that would be health protective. It was felt these scarcely existed and were the preserve of the voluntary sector:

> *"**Once we start going into formal mental health settings it feels all about data collecting. People don't want to have that**. Community groups won't require people to provide all their details. People will be worried about what services will do with their information. They don't want this on their medical record because of stigma and being worried about employers."*

A 'one-size' or 'top-down' approach was felt to be inappropriate because of the diversity of cultural understandings of mental health. Several workshop participants emphasised that a grassroots-driven approach would be more productive in preventing mental ill health because people are more comfortable in spaces they are familiar with.

This means that community leaders' efforts in providing mental health support is critical to recognise within the wider system of mental health support, particularly for minoritised groups. It was felt that this might be a reasonable way to improve trust with statutory services – by linking them with localised voluntary and community groups. Workshop participants requested that their grassroots organisations become recognised and involved as essential parts of the mental health system. As such, several participants requested that training be provided so that they could 'professionalise' their support, maximise their potential and be better recognised as an essential part of mental health protection.

In the first workshop, several community leaders discussed the strain of being relied upon to provide informal mental health support. There is a risk of burnout due to the increased pressure on them as a result of the pandemic and the issues it both created and exacerbated, which remain entrenched in many disadvantaged communities. This further emphasised the need for widespread mental health training and support for grassroots, voluntary sector leaders and workers who can then provide more impactful preventative support within spaces that minoritised ethnic communities will feel comfortable in. This

also tallies with research that People's Health Trust has recently published regarding the wider needs of voluntary sector workers responding to mental health issues.[8]

Several workshop participants noted that a key part of prevention was early intervention and access to support to stop people's mental health declining at a point of fragility. Present levels of demand for mental health services were identified as a serious issue and many participants felt they could only be accessed when in crisis, long after people would ideally want professional support. Workshop participants also stated that long waiting lists and slow assessment processes result in many people not getting support at the time they need it, often waiting several months – and many reported witnessing people's mental health declining to a much more serious crisis point. This was noted in both workshops, for men and for minoritised ethnic groups. An inability to access mental health services was felt to be hugely damaging:

> *"The bar is set so high, the triage is minimal and you can't get anywhere else. Even if you're sick, even suicidal, you don't seem to be able to get professional help. I do think that any strategy needs to be realistic about this and address it by bringing in more professional staff to bring the waiting list down."*

> *"Men, and I will say Asian men… don't want to go to the doctors. So, if they have started to take that first step, and can't get an appointment… [they will give up trying]."*

It was suggested that communication with local support groups could be improved with regards to mental health referrals but, beyond that, participants perceived this issue to be rooted in NHS staff shortages and insufficient funding for mental health. High mental health staff turnover and slow recruitment for replacements were also mentioned. It was notable across the responses from participants that the NHS level of mental health support was largely absent from the discussions, simply because people were not able to access this and so focused on the support that was available through trusted voluntary sector groups.

1.2 Recommendations

At the root of many of the issues presented as challenges to mental health are the experiences of people in relation to local social determinants of health and so a key recommendation is to focus on improvements with respect to these. Positive progress has been made with regards to the social determinants of health in Coventry in particular, which is a Marmot City and adheres to the Marmot Principles.[9,10] These have expanded beyond those indicators published by Public Health England's Fingertips in 2014 and 2015. Coventry maintained similar inequality in female life expectancy between 2010-12 and 2016-18 while it widened nationally, and reduced inequality in male life expectancy by 0.5 years during the same period while it grew nationally. Additionally, the number of neighbourhoods in Coventry amongst the 10% most deprived in England according to the Index of Multiple Deprivation reduced from 18.5% to 14.4% between 2015 and 2019.[11]

[8] People's Health Trust, *We were absolutely invisible: The impact of Covid-19 on the mental health of grassroots voluntary and community sector workers* (2022)

[9] Institute of Health Equity, *Coventry – A Marmot City: An evaluation of a city-wide approach to reducing health inequalities* (2020)

[10] Institute of Health Equity, The Health Foundation, *Health Equity in England: The Marmot Review 10 Years On* (2020)

[11] Institute of Health Equity, *Coventry – A Marmot City* (2020)

Similar plans have since been adopted by the Greater Manchester Combined Authority, Cheshire and Merseyside, Lancashire and Cumbria, Waltham Forest and Luton.[12,13]

A more inclusive approach, such as place-based partnerships – being rolled out as a function of Integrated Care Boards – may go some way to redress the issues of trust and understanding that are outlined. Taking a whole-system approach to mental health, building on Harry Rutter and Jane South's work on public health[14,15] and ensuring diverse representative community groups are involved in co-designing services that directly and indirectly support better mental health will better-equip commissioners and service providers to offer the right culturally appropriate support and to better understand the issues of population groups health services have historically struggled to reach. Adopting this model would be a positive step towards greater grassroots input into service design. At a more granular level, local organisations can help services to build trust through association and to gain greater cultural awareness for marginalised ethnic groups.

Working closely with representative organisations can also ensure better buy-in from these community-based organisations, a better understanding for them of where best to signpost and when, as well as improved engagement and outreach through their networks. These organisations exist to reflect the needs of their service users and, as such, are well-placed to advise on the building of trust and the delivery of culturally appropriate and sensitive support.

Furthermore, with acknowledgement that voluntary and community organisations are part of the mental health system and are often the first port of call for people who need support, these groups need capacity-building and some degree of mental health training to ensure that an adequate level of support can be provided, as sector workers are already at capacity and at risk of burnout. In summary:

- The Department of Health and Social Care should devote resources to addressing the social determinants of mental health and prioritise **rolling out the Marmot principles and indicators as targets across the country**.
- The Department of Health and Social Care should facilitate partnership work with representative community organisations (perhaps building on or working within the **place-based partnerships model** being rolled out by NHS England) within the Integrated Care Board structure, to ensure better service design, understanding, communication and engagement with marginalised communities.
- These partnerships should include smaller and more locally rooted organisations that may not serve the entire region of their ICS, which would support more nuanced delivery and ensure that statutory mental health services benefit from the insight of local needs and expertise. This will support the design and delivery of culturally appropriate and sensitive services that can better build trust with minoritised ethnic groups.
- Community organisations should be acknowledged as the first port of call in the mental health system, with essential capacity-building support and mental health

[12] Institute of Health Equity, *Build Back Fairer in Greater Manchester: Health Equity and Dignified Lives* (2021)
[13] Institute of Health Equity, *All Together Fairer: Health equity and the social determinants of health in Cheshire and Merseyside* (2022)
[14] Rutter H. et al., *The need for a complex systems model of evidence for public health*, Viewpoint, V.390, 10112 (2017)
[15] Stansfield J, South J, Mapplethorpe T., *Community-centred public health: Taking a whole system approach*, Public Health England (2020)

training for staff provided at scale. This can be highly preventative and reduce the need for more 'formalised' support.

2 Getting help to people when they need support with their mental health

Group discussions highlighted projects and activities that could fit under both 'prevention' and 'support' headings. Participants described interventions that help to stave off mental health problems through bringing people together and forming meaningful connections which helped to address isolation. **They created spaces for people to talk about their lives and share concerns in informal settings, which helped to prevent decline and provided support for those experiencing problems even in the absence of an explicit 'mental health support' label.** Positively, this mirrors the evidence base for the relationship between social connection and wellbeing. The following insights can be considered as applying to both prevention and support:

2.1 Key issues

- It is vital to **facilitate community connections**. Strong social networks provide key benefits to mental health and wellbeing, including reduced isolation, the development of trust, confidence, and control.
- Groups which are **not explicitly labelled 'for mental health'** can have wide-ranging benefits, and activity-based meetings that provide a more oblique means of coming together may be more suitable for mental health support for some groups, specifically men and for some people belonging to marginalised ethnic groups where mental ill-health and support is stigmatised.
- There is a much greater possibility of referring people to trusted VCS organisations for support, but capacity-building mental health training and support for those organisations is essential to this being successful. **Community groups can offer more nuanced support**, and closely involving them would be beneficial for population mental health and a route to groups which are underserved by mental health services and a means of supporting alternative 'softer' service provision.

2.2 Analysis

The role of connections and control

For many participants, **facilitating community connections** was viewed as vital. They observed that spaces and projects that bring people together can help reduce isolation, but also provide the opportunity for people to talk about their mental health with their peers and others whom they trust. By bringing people together to socialise, offering a range of social activities designed to improve wellbeing, they are able to access peer support and develop life skills, which would make a positive contribution with regards to prevention.

Strong social connections have a significant benefit on individual wellbeing through the influence of our peers on physical activity, diet, smoking, our sense of self-worth, predictability and stability, purpose and belonging, as well as our security.[16] Social connections are also hugely influential on community wellbeing, as they bridge individuals, communities, groups and institutions in order to build healthier and more

[16] Cohen S, Underwood L, Gottlieb B (2000) *Social support measurement and intervention: A guide for health and social scientists,* London: Oxford University Press.

cohesive societies. The build-up of social capital that takes place when community wellbeing grows benefits community health directly and can also work to reduce health inequalities.[17,18] Beyond these, strong connections have a range of health-protective benefits, including lowering mortality risk for those with serious medical conditions. Amongst adults with coronary heart disease, the socially-isolated remain 2.4 times likelier to die from cardiac arrest than those who are more socially connected.[19]

Many **workshop participants noted the importance of people connecting in local groups which are not labelled 'mental health'**, even if they have been established with that purpose in mind. This was highlighted both for men and for minoritised ethnic groups, although more strenuously for men. Examples included activities such as creative arts, gardening, woodwork, walking and cooking, which attracted people to engage. While they are doing the activities that interest them, participants build up trust, confidence and connections within the group, often developing close peer support as people share their stories. These sorts of activities, which support social connections to build but also the development of new skills and increases in confidence, are a useful mechanism for the development of collective control. Such activities must be coupled with mental health training and support for these groups, to enable them to effectively support and refer.

Research from New Economics Foundation tells us there are three critical components to control: people's capabilities, their critical awareness, and their sense of agency**. Control is generated when people have both the resources and the capacity that enables them to lead the kind of life they value**, and to do this at a communal level by doing something together.[20] Control is both a mechanism of change and a determinant of health. Greater control facilitates influence over the socioeconomic factors that affect people's health and reduces risks that can arise to health from a lack of control.[21]

Tailored support

As with prevention, workshop participants emphasised that there was not a 'one size fits all' approach to mental health support, as different communities and individuals will be attracted to engage with different things in different ways.

> *"And something that works for one person may not work at all for another one. That's why I put that comment in about the walking groups is a lot of people like to talk but sometimes it's just to participate in something without the pressure of talking."*

One charity worker who works with Afro-Caribbean men emphasised the importance of working with groups where Afro-Caribbean men congregate, for example domino groups, to help gain access to older men within their own community in a space in which they felt comfortable. Other groups also mentioned that having **this oblique activity focus helped men to open-up** and talk about wider issues impacting their mental health, as they were at ease.

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[17] Putnam R.D. (2000) *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster

[18] Marmot M, et al., *Fair Society, Healthy Lives (The Marmot Review)*, UCL Institute for Health Equity (2010)

[19] Brummett BH, Barefoot JC, et al. (2001) 'Characteristics of socially isolated patients with coronary artery disease who are at elevated risk for mortality', *Psychosom Med.* 63(2):267-72.

[20] New Economics Foundation, *Control and health inequalities* (2017)

[21] Commission on the Social Determinants of Health CSDH (2008), *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health*. Geneva: World Health Organisation.

> *"We've done a Men's Shed for probably about six or seven years now. And that's really geared up as a social woodworking space. It's been funded by People's Health Trust… And what we have found is that* ***men talk shoulder to shoulder****, but they don't talk face to face… men are brought up not to talk about things like this because you've got to be big and you've got to be 'butch', but actually men's mental health is probably harder to tackle than it is for anybody else."*

The concept of "*men talking shoulder to shoulder rather than face to face*" was widespread amongst groups working with men, with workers explaining that approaches which bring people together to undertake an activity are much more effective in building trusting relationships, as a foundation for conversations around mental health to open up over time.

> *"One of the things about working with and supporting men is the need for flexibility and openness [to] enable them to drive the agenda. There is something important about allowing men to feel that they have a level of autonomy and feel in charge of what happens to them. And I think there is a real deficit in what's provided for men across the age range, especially for fathers who are sole carers. I've been in situations where they need support and help as a parent, but they are directed to a mother's group. Well, yeah, I get it, but on the other hand, you know, they may be the only man there which again makes them feel isolated. I think services [must] recognise the changing role of men, and [that] the pressures that they feel are significant and important."*

The importance of **informal, welcoming and trusting spaces** as the foundation for mental health support was prevalent across responses about support for both men and minoritised ethnic groups. But with men specifically, a request to fully **consider the amount of time that it can take to create the right conditions for mental health support to take place** was raised as an area that is important to take on board:

> *"I think funders and those that support men's groups ought to recognise the long lead-in time, and the time it takes to engage men. Because sometimes some of the reporting periods are quite short, and it might seem like nothing is happening, but because it takes a long lead-in… [to make progress, little appears to be made]."*

The value of community groups' support has also been recognised within the social prescribing movement. But it should be noted that some community leaders were clear that the volume of people being socially prescribed was overwhelming, particularly for smaller organisations with few staff. Many of **those prescribed require complex and nuanced support, and many voluntary and community sector workers are untrained in the mental health support they require**.

> *"We get so many referrals… We can't even start clinical assessments for half of these referrals. People don't get support for the issues they're facing, or legal advice. Before our worker [who has some foundational mental health qualifications] even carries out their assessment, they spend half their time listening to service users talking about issues they're not trained to deal with."*

2.3 Recommendations

- Supporting awareness within a community, for example through **training community champions to support their own communities,** is key, and was keenly recommended by workshop participants. This might mean the champion noticing people disappearing or absenting themselves from activities and checking in with them or focusing on developing trust and more open dialogue within communities to act as a bridge to other or more specialist mental health support services.
- In order for this to work, community organisations who can act as both a first port of call and gateway to mental health support will require greater **capacity-building support,** to ensure that an adequate level of mental health support can be sustained in communities, as well as **training for front line workers to provide early stage mental health support**. This investment would ease the burden on voluntary sector organisations who are, in turn, easing the burden on statutory services.
- Some of the most effective community organisations, who are usually the most trusted in their communities, are those who are small and local. It means they can offer tailored and more nuanced support to the community around them. While this is a national initiative and the new ICS system works regionally, **local intelligence – particularly attuned to diverse needs at the neighbourhood level – should be built into each Integrated Care System**, as it can be transformative in levelling up health.
- One key adaptation proposed for marginalised ethnic groups was for **culturally sensitive counselling**, particularly services that are meaningful, understanding, and in the service user's desired language. One workshop participant reported that some languages do not even have a word for 'trauma' in the sense of a mental health crisis.
- It is also crucial to **understand that men may need more oblique, 'shoulder to shoulder' opportunities**, rather than 'face to face conversations' to meet and support their mental health. This includes any form of activity. There does, however, need to be capacity building for those providing activity to be able to spot and act on emerging mental health isssues. Support for men should also acknowledge that, as a group, it tends to take longer to engage them, and longer to get from activity to sharing and peer support, but that once they are established they provide an invaluable support service.
- Additionally, for some minoritised ethnic groups of people, being involved in something **not overtly about mental health** was a helpful way around existing stigma.

3 Promotion of mental health

3.1 Key issues

- Participants at the workshop found practice around the promotion of mental health the most challenging area to propose concrete ideas for.
- On the whole, community leaders were much clearer about things that they felt would not and did not work to promote mental health, based upon their experiences.
- Participants often reverted back to the importance of who is delivering the message as a key part of mental health promotion, determining its impact and the value of peer communication in promoting mental health effectively.

- Finding ways to de-stigmatise mental health was felt to be important in health promotion to provide greater opportunities for opening up the conversation around mental health (see section 1).
- Finding ways to combat wider discrimination that minoritised ethnic groups experience was identified as critical in supporting positive mental health (see section 1).
- Many of the concepts around trust, building social connection and supporting people to have control described in section one were relevant here (see section 2).
- Ultimately, having access to positive experiences of the social determinants of health – good work, stable housing, and strong social connections for example – were felt to be core to the promotion of positive mental health (see section 1).
- The importance of connectivity of people and accessibility of services were also raised as vital parts of health promotion work (see section 2).

Several ideas were proposed to open and strengthen new and existing community gateways to support, improving the first point of contact across communities, and ensuring the mental health system is easier to navigate.

Workshop participants proposed a few innovations at the community level that would support the accessibility and connectivity of mental health services. These included:

- **Mental health training** (as referred to in section 2), including Mental Health First Aid at minimum, for voluntary and community sector staff – particularly in those organisations receiving referrals. VCS employees should be equipped to help their service users manage their own mental health, with a particular focus on anxiety and post-traumatic stress, and processes to support wellbeing.
- **Greater connectivity between services and community groups who support mental health**, ensuring all actors involved in a locality are communicating, are aware of one another, can raise issues and share best practice.
- **Funding for those organisations who offer support beyond 9am to 5pm, Monday to Friday**, when clinical services are unavailable in many areas.
- **Access to mental health support before crisis**, as community leaders noted early intervention must be more cost-effective for services than crisis management, as well as better for the service user. This also eases the burden on community support services as they would be better able to refer those in need of further support, so long as referral pathways are clear and obvious.

3.2 Analysis

Challenges in opening up the conversation around mental ill health

For men, it was noted that issues and traumas may go back decades, which can take time to unpick, and simple mental health promotion messaging is likely to be ineffective. As described above, **men's groups were felt to need time to come together effectively to build trust initially** as well, meaning that the overall timeframe to make progress needs to be sufficiently long-term to have an impact, but could ultimately be hugely beneficial. Some felt that men would also benefit from more family-focused support spaces as a means of opening up conversations around mental health promotion. For example, men who had children with special educational needs indicated they had been particularly hard-hit in the pandemic with little or no outlet or support (also discussed in section 1). Co-productive approaches with people who had expertise or lived experience around men's mental ill health were felt to be important for service design and understanding how to open up the topic of mental health with men.

For marginalised ethnic groups, co-production was also suggested as an important method for overcoming barriers to communication around mental health issues and the engagement of certain minoritised ethnic and specific faith groups. Having trusted peers involved in this process was felt to be critical for both mental health promotion and intervention. English being a second language, or not comfortably or spoken at all, could also be a challenging issue. One workshop participant working with refugees gave the example of people finding it very challenging to communicate the extent and impact of trauma they experienced because they didn't have the confidence or vocabulary in English to fully express this. Subsequently this could detract from the assessment of their condition and fully understanding the impact of their trauma.

Workshop participants also described challenges around the language of mental ill health, noting that depression is untranslatable in some languages. This limits the potential for translation services in health promotion to be effective and means a more thoughtful approach to engagement is required that can effectively bridge language and cultural divides. **Hiring staff who speak the community's languages could help facilitate stronger links into minoritised communities and workshop participants stressed the importance of staff being available at a local level**. Some felt that at the very least, informative mental health promotion videos and communication materials could be produced in different languages. There was a widespread feeling that it was important to build cultural awareness with statutory partners, but that even within cultures second or third-generation migrants have different perspectives and needs from older generations.

Stigma and discrimination's impact on creating mental ill health

An approach to mental health promotion that serves to effectively de-stigmatise mental health was seen as imperative by workshop participants belonging to marginalised ethnic groups. Participants made clear that greater emphasis should be placed upon the role of stigma in impacting mental health, with for example Asian men being cited as a group which would find it uncomfortable to openly discuss mental health issues.

The impact of racism in mental ill health was also mentioned, and the evidence linking hate crime and public health was referenced, as detailed in section 1.Research by Kings College London and University College London into the impact of racial discrimination on health in 2020 stated that "those who reported [to the study] racial discrimination had poorer self-rated health, poorer physical functioning scores and a greater likelihood of having a limiting longstanding illness than those who did not report racial discrimination".[22] The study also showed that racial discrimination was associated with greater psychological distress, poorer mental functioning and lower life satisfaction.

The connection between discrimination and reduced mental and physical health comes from cultural stereotypes. Stigmatisation then influences institutional discrimination (the policies created, and services provided). These policies, in turn, have a disproportionate negative impact on marginalised people in education, employment, economic wealth, social inclusion, confidence, etc. Marginalised groups then experience psychological distress or mental ill-health. This can also have biological impacts or as one study describes it, discrimination becomes "*embodied*" or 'gets under the skin' and

[22] Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom (2020). Hackett et al., available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-09792-1#ref-CR14

creates direct physiological negative impacts, in addition to the persistent mental health impacts.[23]

Combatting stigma both within and beyond health services was put forward as key to mental health promotion for marginalised groups. Although it was acknowledged this may be beyond the sole remit of the Department of Health and Social Care, they were felt to have a leading role as convenor and owners of the mental health strategy.

Importance of peer spaces

Regarding earlier intervention to prevent crisis, the creation and promotion of targeted group sessions for specific cultural groups were suggested, to encourage sharing and peer support in safe spaces. For example, one organisation discussed the importance of black-led spaces to create a feeling of trust and how important this had been for the community he worked with to feel safe. Feelings of safety were referenced in view of several community leaders' successes running sessions. Greater funding to support these spaces, as well as counselling services, was suggested, and it was noted these softer spaces can ease the burden of serious mental ill health if they are adequately supported.

Workshop participants emphasised the importance of the first point of contact and more attention should be paid to creating a welcoming space as it is a brave step for many individuals to access mental health services – particularly if they come from backgrounds that might discourage engagement with statutory services or stigmatise the receipt of mental health support. Points of engagement including after the birth of a child and at broader GP visits were suggested, as was better signposting through existing community hubs, for example places of worship.

Clearer communication and collaboration between voluntary and community organisations, faith groups, support groups and mental health services was a key recommendation, as touched upon above. Community leaders stated this would ensure better signposting is possible, capacity issues and other risks can be shared and worked through collectively alongside best practice, and communications and engagement can improve.

> *"We need to hear more of the success stories and that's where you find what works and different cultures. Asian men didn't speak about mental health to each other. Testimony."*

Ultimately, workshop participants said they needed service user-designed projects and things that are consistent for the long-term and not just short-term – so that they can be embedded into the community and across interventions. Within this they felt it was important to have consistency to build trust. People also need to know where to go in a crisis and to feel that this is a stable form of support available from people they can connect with and trust.

3.3 Recommendations

Given the feedback from participants and the wider evidence base, the Trust recommends in addition to the related points in sections one and two:

[23] Understanding how discrimination can affect health (2019). Williams et al., available at: https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13222

- **There is funding available for peer support spaces** that provide more effective means of supporting mental health promotion for minoritised groups, with community-level counselling
- **Approaches to de-stigmatise mental ill-health are introduced** through support for peer-led spaces
- **Mental health training is provided** for voluntary sector staff and other community leaders (as described in section 2)
- There is **facilitation of greater connectivity between community organisations and services** in the mould of place-based partnerships in order to bridge potential divides and enhance the impact of mental health promotion (as detailed in section 2)
- There is a clear area of **focus on reducing institutional discrimination that can impact the mental health of marginalised groups** as part of the ten-year strategy.

4 Conclusion

The discussions highlighted some key points about what works and is considered less effective in supporting people's mental health. While some of the issues are common to many communities experiencing disadvantage, there were some specific challenges identified both for minoritised ethnic groups and for men. Key points raised by the workshop participants include the importance of tailored responses to meet the needs of particular communities and embedding cultural sensitivity into the delivery of services, whether that be directly, or as implied here, by working with communities to design appropriate support and draw on their expertise to bridge cultural divides or to work more obliquely. An overall challenged raised throughout was that statutory services are inaccessible, both in terms of the waiting times and the perceived lack of trust in the system itself which was often felt to be culturally insensitive. Community leaders also raised the issue of discrimination and stigma, which manifests differently among different groups but requires a strategic and committed approach to combat it effectively, including at the institutional level.

What comes across most powerfully is the importance of the role trusted community organisations play in creating the conditions for informal mental health support, as well as the critical role they play in delivering direct mental health support despite having a lack of sufficient training. It is therefore critical to recognise the voluntary and community sector as an essential part of 'the system', with adequate training in mental health to be provided at scale. At the same time, they cannot be relied on to be the answer to challenges within the mental health system itself and there clearly needs to be investment in services to make them available, accessible and culturally appropriate for marginalised groups. It is also clear that protecting mental health requires a cross-government initiative, as identified by the Inequalities in Health Alliance for example[24], since the social determinants of health play such a critical role in health creation and the protection of mental health.

[24] Royal College of Physicians, *Inequalities in Health Alliance*