



PURSUING RACIAL JUSTICE IN MENTAL HEALTH

How the voluntary sector can help meet the needs of racialised communities - learnings from Bradford and Craven

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A NOTE ON TERMINOLOGY

At Centre for Mental Health, when we describe ethnicity, we aim to be specific wherever possible. Where we are referring to multiple communities who experience racial inequality, we use the term 'racialised communities' rather than the acronyms BME or BAME. We use the term 'racialised' to underscore the fact that race is a construct; 'racialised' doesn't seek to define people's community or identity, but the phenomenon that is happening to them. We do not use the term 'ethnic minorities' because the people who are usually referred to as minorities are actually part of the global majority. Where other language has been used within this report, it reflects that of the original source.

EXECUTIVE SUMMARY

In early 2023, Bradford District and Craven Health and Care Partnership commissioned Centre for Mental Health to help design their approach to understanding, engaging, and supporting people with mental health needs from racialised communities, with a particular focus on the role of commissioned voluntary and community sector services.

We rapidly reviewed relevant literature and population health data, analysed performance data from locally commissioned voluntary and community sector organisations, and engaged 51 local stakeholders – managers, front line workers and volunteers – from all sectors. In addition, 37 service users, mainly South Asian women, attended one-to-one interviews, focus groups and interactive workshops. A series of workshops and discussions to refine the findings and recommendations was attended by 81 people in total.

KEY FINDINGS

Bradford District and Craven's population is changing – there are established communities whose needs have changed over time, as well as newly arrived communities, such as Eastern Europeans. The Covid-19 pandemic, and the cost-of-living crisis, have had disproportionately negative impacts on people with mental health difficulties from racialised communities.

With an overall population of 657,579 people, Bradford District and Craven is a district with diverse cultures and communities. According to census data, in 2021, 61.1% of the population in Bradford identified as white (including Other White communities), 32.1% of the population identified as Asian, 2.0% identified as Black, 2.7% identified as Mixed or Multiple Ethnic background, and 2.0% identified as Other ethnic group (Office for National Statistics, 2023). Bradford also has a growing percentage of young people.

Race – and racism – intersect with other social factors, notably poverty and deprivation across urban and rural areas. Economic disparities and systemic inequalities in access to quality health care, housing and transport also create additional challenges for people with poor mental health.

The people from Bradford who we met as part of the research spoke with pride about their city; they drew strength from their friends and families as well as their faith and cultural identities; they wanted the best for their communities, and had clear ideas and strong views about how to improve services.



RACISM AND MENTAL HEALTH

Participants described how racism causes poor mental health, stops people from accessing services, affects people's experiences of treatment, and hinders their recovery.

Participants acknowledged the impacts of exclusion and discrimination on their health and wellbeing and the challenges in seeking help. They described how experiencing or witnessing violence and discrimination – such as persecution, war, trafficking, domestic and sexual violence – can lead to symptoms of post-traumatic stress disorder (PTSD), anxiety, depression, and other mental health problems.

Historic and systemic issues, including institutionalised racism, may have eroded trust in health care systems among people from racialised communities. Despite a local history of innovation in psychiatry and therapeutic approaches, finding services that can help in culturally appropriate and affirming ways can be difficult.

IMPROVING SERVICE ACCESS

The inaccessibility of services – rooted in several factors, including discriminatory practices, poor understanding of cultural differences, and lack of information about what they offer – leads people from racialised communities to be excluded from adequate support and treatment. These experiences are shared and discourage engagement for other people in need. They often become known to services only in times of crisis.

Barriers to accessing services include:

- ⊙ Language barriers, especially for older people and asylum seekers and refugees
- ⊙ Different beliefs about, and ways of describing, poor mental health, coping strategies, and help-seeking behaviours
- ⊙ Stigma surrounding mental health issues from within communities which can deter individuals from seeking help, leading to delayed or inadequate support and treatment.

Voluntary and community sector organisations can be easy to access because they understand cultural differences, speak community languages, and create a safe environment.

Sometimes, the anonymity and confidentiality offered by a generic GP appointment (rather than a mental health service) enables people to access services without fear of reprisals or shame.

THE ROLE OF THE VOLUNTARY AND COMMUNITY SECTOR

Analysis of service data from the voluntary and community sector services showed that, overall, the proportions of people from different communities matched the population. This is positive. However, given that we know mental health need is not equally distributed across the city, we might have reasonably expected an overrepresentation of some communities in the data, notwithstanding the difficulties that they can face in accessing help.

The voluntary and community sector in Bradford District is large, with almost 5,000 organisations in total. There are networks of key figures, activists, and advocates who share a deep passion for social justice and mental health, knowledge about the communities they serve, and experience in effecting change. These are often associated with long-established voluntary sector organisations that listen closely to communities and have an in-depth understanding of their needs and assets.

There are also numerous challenges in the system. Voluntary sector organisations working in the mental health space in Bradford rely on limited resources, such as funding and grants. Historically, the competition that commissioning processes have encouraged between providers has been significant and has, on occasion, strained relationships. There are also tensions between organisations as they take different approaches to working with, and within, communities, build their organisations' profiles, and take a cautious approach to collaboration.

Practical constraints also inhibit progress, such as a lack of regular opportunities for dialogue and coproduction. A forum where organisations could meet, hear about opportunities, influence priorities, and share best practice could foster stronger networks.

RECOMMENDATIONS

Based on our research, we have made the following recommendations to the Bradford District and Craven Health and Care Partnership and its stakeholders.

LEADERSHIP AND CONNECTIVITY


1. Engage and facilitate system-wide collaboration and provide a framework to build trust between key stakeholders, including voluntary and community sector service providers, reflecting the diversity of the communities.
2. Build on opportunities across West Yorkshire and within the local Compact to bring leadership and influence to the system, including priorities and decisions outside of the mental health domain but which impact upon it, including the social determinants of mental health.
3. Resource and develop mental health service providers to collaborate and bring leadership to the wider system, including priorities and decisions outside of the mental health domain but which impact upon it, to offer mutual support, and find effective solutions for people with mental health difficulties from racialised communities. Ensure there are clear expectations and lines of accountability to influence decisions and be a conduit for investment as well as taking responsibility for delivery.
4. Coproduce decisions and co-design services with people from racialised communities, using established channels and structures, routinely checking that all communities are engaged and that organisational interests do not overshadow community needs.

COMMUNICATIONS

5. Provide information about services through diverse media and in different community languages such as Bangla, Urdu and Punjabi. This will encompass strengthening the 'Our Healthy Minds' initiative.
6. Improve the promotion of mental health services within community settings and other settings such as GPs, schools, and social media. Co-designing with people from racialised communities and people with experience of poor mental health will make it relevant and more likely to be effective.

ACCESS AND REACH

7. Acknowledge generational, gender, ethnic, cultural, and age-related differences amongst service providers and raise awareness about the needs of intersectional identities, such as young Muslim people who identify as LGBTQ+.
8. Understand and remove physical barriers to services.

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9. Explore how Personalised Budgets can support improvements in service access.
 10. Resource a community-led campaign (co-designed with people from racialised communities) to challenge deeply held cultural beliefs which create stigma, shame and denial, and inhibit people in need from seeking help. A particular focus might be working with South Asian men to raise awareness and service engagement.
 11. Co-design and develop a directory of services that is accessible, comprehensive and up to date to increase awareness and use of preventative and support services in the community – this could also be used as a basis for signposting and social prescribing for individuals and their families. This would build on learning from the Healthy Minds directory.

SERVICE DEVELOPMENT

12. Expand the data and intelligence that is collected to include wider system data, for example relating to how well refugees, asylum seekers, and people from other minoritised communities (including African and Caribbean people and people from Eastern Europe) are reached, and analyse service data from statutory mental health organisations.
13. Develop the current model of promoting cultural competence amongst commissioners and service providers to one which acknowledges the effects of racism on mental health, identifies their active responsibilities in ending it, and gives them tools to challenge racism and the legacies of colonialism – for example by signing up to, and implementing, Root Out Racism. Commissioners can set standards in their contracts.
14. Ensure services take into consideration the religious practices of service users, for instance by holding events at venues that do not serve alcohol, having women only groups, and holding events outside of Ramadan.
15. Promote greater understanding amongst service providers of the impact of trauma on people from racialised communities – including refugees and asylum seekers – and integrate trauma-informed approaches. For example, review and roll out the Bradford District Care Trust cultural change programme to embed trauma-informed approaches, ensuring that it encompasses tackling racism as a key pillar of the work.
16. Provide interpreters to support communication between providers and service users and their families. Resource service providers to work with the Interpretation Service.

TOOLS, RESOURCES AND INVESTMENT

17. Ensure data and insights are collected, and develop a dashboard that can be used to assess the potential impact of services and their reach. This dashboard should be used to inform system decisions on the provision of mental health services, including preventative measures, for people from minoritised communities.
18. Recruit and retain staff (including health care professionals) who speak community languages and have lived experience of poor mental health – value their contribution, ensure that they are appropriately trained and supported, and actively address racism in the workplace.

INTRODUCTION

In early 2023, Bradford District and Craven Health and Care Partnership commissioned Centre for Mental Health to help design their approach to understanding, engaging, and supporting adults with mental health needs from racialised communities, with particular focus on the role of commissioned voluntary and community sector services. In this context, and understanding that poor mental health encompasses a wide spectrum of challenges and conditions, the main objectives of the research were to:

- ⦿ Understand the mental health needs of people from racialised communities
- ⦿ Identify strengths, barriers, and key outcomes for people from racialised communities using mental health services
- ⦿ Draw up recommendations for the Partnership Board to action that remove barriers and improve services, including the voluntary and community sector.

HOW WE DID THE RESEARCH

To give us as many insights as possible within the time available, a mixed method approach was taken with the following elements:

- ⦿ A rapid literature review which provided insights about Bradford, its population health and the issues faced in delivering services to people with mental health needs from racialised communities
- ⦿ Analysis of performance data collected by the Integrated Care Board from services commissioned in the voluntary and community sector: Cellar Trust, Girdlington Community Centre, Mind in Bradford, Naye Subah, Roshni Ghar, and Sharing Voices
- ⦿ In-person and online focus groups, one to one interviews, and workshops with key stakeholders including commissioners, service managers and front-line staff. There were 51 participants in total in this tranche
- ⦿ In-person and online focus groups and interviews with service users¹. We spoke to a total of 37 service users, of which 78.4% identified as women, 94.6% were from Asian communities, and 5.4% were from Black African and Caribbean communities. Our largest group of service users were from Pakistani or British Pakistani communities, making up 67.6% of the sample. Additionally, 75.7% of the sample were Muslim
- ⦿ A second round of workshops and discussions open to all research participants and others to test and refine the findings, conclusions and recommendations. More than 85 people were engaged in this tranche.

¹ We reached out to service users and service providers from: African Caribbean Achievement Project; Black Health Forum; Bradford African Community; Bradford Ukrainian Cultural Centre (AUGB); Connecting Roma; Girdlington Community Centre; Inspired Neighbourhoods; Keighley Polish and Slavic Groups; Roshni Ghar; Sharing Voices; Women Zone; Young Dynamos

We offered remuneration to every service user who took part. We relied on the support of translators when hearing from service users who did not speak English.

The sample of service users had too few Black African and Caribbean people in it and no one from Eastern European or Roma communities. There were also no service users who identified as LGBTQ+. This was a limitation of the research and future efforts should be directed at engaging with people from those communities.



BRADFORD IS A DYNAMIC CITY

Bradford District is the fifth-largest metropolitan district in England and has a population of 657,579 people, including around 50,000 in Craven. Younger people make up a large proportion of the Bradford population, and the city has the third-highest population percentage for people aged under 16 in England.

Bradford District ranks as the 13th most deprived local authority in England and second-most deprived in Yorkshire and Humber (after the city of Kingston upon Hull).

Almost 120,000 people are thought to be income deprived (the fourth largest figure in England), and more than one in three people of working age were out of work in 2011. Furthermore, in a recent survey on Bradford's housing, just over 40% of housing in the private sector was classed as 'not decent'.

One of the challenges identified is the predicted increase in the number of children with mental health problems over the coming years, in part due to an increase in the child population, particularly in deprived areas.

Severe mental illness data in Bradford District and Craven in October 2023 showed an overrepresentation of patients from racialised communities compared to the city's general population.

Bradford is a district with a mix of diverse cultures and ethnic groups. According to census data, in 2021, 61.1% of the population in Bradford identified as White, including Other White communities, 32.1% of the population identified as Asian, 2.0% identified as Black, 2.7% identified as Mixed or Multiple Ethnic background, and 2.0% identified as Other Ethnic group (Office for National Statistics, 2023).

There are several established racialised communities in the city, including several generations of people of South Asian and African Caribbean origin, whose experiences of racism remain significant yet whose health needs have changed over time. There are also several newly arrived communities, for example from Eastern Europe, including Roma people, although less is currently known about their needs. The city welcomes refugees and asylum seekers from around the world. They face many challenges in settling in a place that is unfamiliar to them and often experience acute trauma from having fled war and conflict, leaving their homes, families and friends, often in distress. Undocumented people face difficulties in finding and accessing services.

UNDERSTANDING CURRENT VOLUNTARY AND COMMUNITY SECTOR PROVISION

Bradford District and Craven Health and Care Partnership provided the research team with beneficiary data from six of their organisations recorded between April 2019 and September 2022. These organisations were Cellar Trust, Girlington Community Centre, Mind in Bradford, Naye Subah, Roshni Ghar, and Sharing Voices.

Analysis showed that the number of people accessing these services each year increased from an average of 2,236 people between April 2019 and March 2020 to an average of 2,509 people between April 2020 and March 2021. This increased demand could be the result of the Covid-19 pandemic. The average number of people accessing these services decreased to 1,721 between April 2021 and March 2022, and increased again to an average of 1,948 people between April 2022 and September 2022.

When comparing reach by ethnic groups, we found that, on average, more than 50% of people using these services were White British and Irish. This was the case across each year between April 2019 and September 2022.

Service users from Asian communities, including Bangladeshi or British Bangladeshi, Chinese or British Chinese, Indian or British Indian, Pakistani or British Pakistani, and Other Asian communities, were, on average, the second largest service user group.

Furthermore, service users from Other White communities, including Romani or Irish Traveller, Central and Eastern European, made up less than 5% of the cohort on average. Also, service users from Black communities, including Black African, Black Caribbean, and Other Black communities, made up less than 3% on average.

Analysis of the data suggested that overall, the proportions of service users by ethnicity reflects the population. This is positive. However, given the unequal distribution of poor mental health across Bradford, with some communities carrying a disproportionately high burden, it appears that there remain challenges in engaging the right people.

We should, however, exercise caution with the data. It should be noted that the ethnicities of 3,696 service users were unknown over the period. And data from a further 993 service users was omitted due to inconsistent data recording. This may have impacted on the proportions of service users overall and the margin could tip the findings decisively into different conclusions if they were radically different from the rest of the data. We do not know what proportion of people from other White communities made up 'White' in the census data, therefore we cannot compare this group individually.

WHAT THE LITERATURE TELLS US

People from racialised communities in Bradford face a heightened risk of mental health issues. Racism, discrimination, trauma, language barriers, cultural differences and financial hardship contribute to their vulnerability. Addressing disparities in mental health for people from racialised communities requires a systems-wide, multi-pronged approach.

In turning to primary services, public institutions or voluntary organisations to access help, people encounter many cultural, religious, linguistic, and practical barriers. From a clinical perspective, the literature shows that racism is a key driver of poor mental health for people from racialised communities.

Simply put, racism causes poor mental health, prevents people from accessing services, affects people's experiences of treatment, and hinders their recovery.

Trauma remains poorly understood, and yet it is a recurring challenge for people from racialised communities including refugees and asylum seekers, who have experienced adverse events and repeated psychological distress. Racism causes trauma, and engagement with systems that do not acknowledge it or understand its effects can trigger poor mental health and exacerbate existing mental health difficulties.

The Covid-19 pandemic hit families from racialised communities hard. They faced a higher risk of contracting and succumbing to the virus due to a range of factors, including overcrowded living conditions. Furthermore, financial hardship and reduced access to mental health services exacerbated the challenges faced.

In addition to improving mental health services and integrating voluntary and community sector provision with statutory services, efforts to include equitable improvements in housing and homelessness, transport, employment, and education are also crucial. Solutions are more likely to be sustainable if they are coproduced with residents, service users and their families.

SOCIAL INEQUALITIES AND MENTAL HEALTH

Economic disparities and systemic inequalities in access to quality health care, housing and transport create additional challenges for people with poor mental health from racialised communities.

For example, participants told us that transport is prohibitively expensive, impeding their access to services. Bus fares are a key consideration for people who live in rural areas in Craven or even in urban places like Keighley and yet are required to travel to Bradford for services.



"...my parents have obviously lost a lot of people during Covid, my mom **doesn't speak English**, not that well anyway, and the rest of the family all got bereavement counselling offered to them by doctors, but my mum hasn't, and every time anyone mentions her nephew... just at the slightest [thing] my mum bursts out crying because there is **no bereavement support in her own language.**"

(Service user)



The Covid pandemic had a disproportionately negative impact on people from racialised communities, which was likely to be even more acute for people with existing mental health needs. They variously experienced intense isolation, anxiety about personal financial matters, uncertainty, and grief. These challenges are still present in the aftermath of the pandemic and the mental health impacts continue to be felt.

Race intersects with other social factors such as gender, age, sexuality and socioeconomic status – notably poverty, which is geographically distributed in the city with pockets of deprivation across both inner-city urban and rural areas. Participants shared personal perspectives on the complexity of their identities. Some women spoke about the misogyny they encountered whilst working in the voluntary and community sector. A participant told us about a young Muslim LGBTQ+ person who spoke to them about the racism they encountered in queer spaces and the homophobia they experienced in their communities.

The cost-of-living crisis has made matters worse and has significantly affected people who have poor mental health, exacerbating long-standing challenges. Families are worried about not being able to pay rent and bills or buy food and clothes. Uncertainty about securing the basics creates additional anxiety and leaves people with poor mental health, and their family and carers, feeling exposed.

RACISM AND MENTAL HEALTH

Racism has direct and indirect impacts on mental health. Participants described how it flows through Bradford's communities, including through the multiple agencies that are tasked to serve them such as health and social care, education, housing, homelessness services, and the police. As a result, trust has been undermined.

The media has fuelled racism over many years, for instance in the systematic dehumanisation of Muslim men, the demonisation of refugees and asylum seekers, and the vilification of people seeking sanctuary on small boats.

People from racialised communities, including asylum seekers and refugees, face significant challenges as they go about their everyday lives, such as blocks to accessing health and social care services. These include language barriers and experiences of cultural stigma – where individuals, in a state of distress and anxiety, stay away from services because they are fearful that they will not be taken seriously or that services will be insensitive to, or dismissive of, their cultural differences.



"[T]here's stigma attached to **accessing support**, I think that's a big barrier for a lot of folk...it's very hush hush. When I accessed this, no one knew...it's not something that I shared with anybody and the few people that did know, you get raised eyebrows... because you're supposed to just deal with it... 'you've got religion to turn to, why are you needing mental health?'... especially for the male counterparts because if they access mental health it's that **sign of weakness**..."

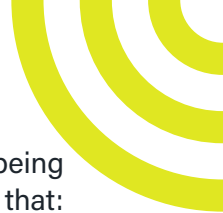
(Female service user)



Participants told us that poor access for people from racialised communities has often resulted in them being excluded from support and treatment. In addition, when left unchallenged and unexamined, routine practices can exclude people from racialised communities and compound trauma. Examples include:

- ⦿ The complexity of completing forms to access talking therapies for people whose first language is not English
- ⦿ The provision of culturally inappropriate food
- ⦿ The lack of acknowledgement of the impact of Ramadan and people's routines.

Racism – and its associated forces of eurocentrism and colonialism – is at play within the organisations and agencies that are tasked with tackling it, or at least, alleviating its impact. The challenge for those services is twofold: they are responsible for supporting victims of racism as well as stopping the racism that they themselves perpetuate.



Participants acknowledged the impacts of exclusion and discrimination on the health and wellbeing of people from racialised communities, including refugees and asylum seekers. They explained that:

- ⊙ Trauma from experiencing or witnessing racist violence and discrimination can lead to symptoms of post-traumatic stress disorder (PTSD), anxiety, depression, and other mental health conditions
- ⊙ For women from racialised communities, trauma can be a response to adverse events leading to their arrival in the UK, such as trafficking, domestic and sexual violence, as well as racism and racial injustice
- ⊙ Chronic stress is a response to repeated exposure to racism and discrimination which can lead to anxiety disorders, depression and substance misuse
- ⊙ Loneliness and pervasive feelings of not belonging, of not being valued, and of not being entitled to support can, in turn, affect mental health
- ⊙ Trauma responses rooted in previous adverse experiences of racism, which can be carried by families for generations, can be triggered by relatively minor incidents as the abuse is re-enacted and memories return
- ⊙ The option of seeking support from voluntary and community organisations that understood their language, culture and religion and spiritual needs was often appealing – and seen as a lifeline in times of crisis.



"I grew up in a household where there was sexual abuse and domestic violence... it was six or seven months after moving... **that's when my mental health severely deteriorated...**"

(Female service user)



[translated] "...they said that if there's men there, they wouldn't feel comfortable talking about the personal issues to a man. This is a cultural thing... there are certain aspects in the South Asian culture where you **do not openly talk about...** women's issues and women would not feel comfortable talking about some of those issues in front of men... so that's where the cultural sensitivity needs to come in."

(Service user)



ISSUES FACING SOUTH ASIAN RESIDENTS AND THEIR FAMILIES

Participants said that for people whose families came from South Asia – including India, Pakistan and Bangladesh – there are community-specific issues to bear in mind, including:

1. The stigma surrounding mental health in South Asian communities can prevent individuals from seeking help and receiving support.
2. Gender is a key factor when working with Muslim communities. Safe, dedicated spaces are critical when designing and delivering services for women, including those seeking to promote wellbeing and offer mental health support.
3. Mental health issues may be perceived as a source of shame, leading individuals to avoid seeking help or discussing their struggles openly.
4. A lack of awareness can contribute to misconceptions and contested definitions, such as viewing mental illness as a sign of weakness, possession by evil spirits, or a punishment from God. It was noted that the prevalence of such ideas is lessening as time goes on.
5. Individuals may believe that prayer and faith alone can cure mental health problems, leading to a reliance on spiritual remedies, which do not have an established evidence base.
6. Concerns about how mental health problems may affect marriage prospects, career prospects, or familial relationships can further perpetuate the stigma.
7. Family can be a source of support and care for people with poor mental health and the role of family carers for Pakistani families is key, for example, yet help is not routinely offered to them.

IMPROVING SERVICE ACCESS

Service users described what stops them and others from accessing mainstream mental health and other social services.

Waiting lists and the impact of trying to access help from a service under immense pressure – which meant that they could not be seen quickly – were cited as reasons, as was basic lack of knowledge of what services exist, what they deliver, who they work with, how patients can be referred, and where they are located.

Information was not easily found in community languages or in places that would maintain the privacy of the person seeking help. They suggested that having an accessible directory of services would be useful, as would promoting services through mosques, restaurants, cafes or in primary care settings, and using social media and community broadcasting. There were generational differences in this regard. Younger adults were happy for information to be in English. Older people wanted it conveyed in their own languages.

Language barriers and lack of understanding about different cultures create significant challenges for individuals seeking mental health support, especially for older people and newly arrived refugees and asylum seekers. These barriers are also significant in undertaking coproduction and co-design work. Where services communicate in community languages, service users report greater satisfaction, better experiences and better outcomes.

Culture and religion play significant roles in shaping how individuals understand and experience mental health. Different racialised groups may have distinct definitions, shared beliefs, ways of describing poor mental health, coping strategies, and help-seeking behaviours. Services that do not understand these aspects struggle to give effective support to individuals and their families. This can, in turn, prevent people from accessing services; it can also result in an unsatisfactory experience of services once they have been accessed.

Stigma surrounding mental health issues and a fear of being judged persist and can deter people from seeking help, leading to delayed or inadequate support and treatment. As an example, one participant sought help for their child in a different city to avoid any misunderstanding amongst neighbours and other members of their community, including people with whom they worshipped. This demonstrates that stigma relating to poor mental health affects how people use services. Participants explained that primary care is critical in this regard: someone might legitimately visit a GP for many reasons, and nobody can identify someone's mental health need by their use of those services. This is not always the case for specialist health facilities or for voluntary and community sector organisations which are well known and embedded in communities and neighbourhoods.

Historic and systemic issues may have eroded trust in health care systems among people from racialised communities. For example, mental health services are not always sufficiently culturally competent to effectively meet the needs of the city's diverse communities. This can deter help-seeking by people in need of support. Several service users spoke of the relief of accessing services in voluntary and community organisations staffed by people who looked like them, who spoke their language, who understood cultural mores and rituals, and who could empathise and offer meaningful support.



"[T]he problem I had was the woman that was my therapist... I am from a South Asian background, and she was white, **she's not going to understand the bigger stuff around abuse in my culture...**"
(Service user)



"...there was nothing [asked] around culture, religion... you don't get asked anything like that. Even like support networks, obviously in our culture support networks are very different, it was never picked up on. We spoke about the issue, but it was never extended to anything on the outside... I think if the counsellor had a bit of understanding of different backgrounds, I think the questions they asked might have been more different. **I thought the questions were very 'textbook-y'**... they had a script, it's very much stick to the script."
(Service user)



Of interest were participants' reflections on the effects that Covid had on service delivery. The move to remote engagement, though challenging at first, was beneficial because it meant that services could be accessed without having to travel. While this raised safeguarding concerns for some patients, they welcomed the change. As services return to in-person interventions, some service users are pleased to be working face to face, but for others, the problems associated with leaving the home and funding transport have resumed.

THE ROLE OF THE VOLUNTARY AND COMMUNITY SECTOR

Voluntary and community sector organisations provide shelter from the challenges people from racialised communities routinely face. They are led by people who have a deep commitment to promoting fairness and social justice and have extensive knowledge of the communities they serve and often respond quickly to service user needs. At their best, these organisations are key assets to Bradford: they champion service user needs; advocate on their behalf; and bring about systems-wide change through their lobbying. They also focus on building relationships and celebrating diverse cultures. The leaders of these organisations are prepared to speak out, point out the historic failings of mainstream services, and identify ways forward.

Each community in Bradford has its own histories, experiences, and relationships. Historical tensions, cultural misunderstandings, different ideas about family and gender roles, and, on occasion, associated factors of homophobia and misogyny, as well as unresolved conflicts within and between communities, can spill over into the voluntary sector organisations.

For example, in established communities, the confidence, shared identities, and aspirations of younger people can be different to those of older generations. These differences can, in turn, have an impact on how they think about mental health and wellbeing, influence what they want from services, and inform how they wish to access them. They are, on occasion, creating tensions and making collaboration between different voluntary and community sector organisations difficult. In the absence of shared spaces in which safe conversations can be undertaken, it is unlikely that rifts will heal. This brings questions of sector leadership to the fore and underscores the importance of finding a shared vision for it to face the future.

CHALLENGES FACING THE VOLUNTARY AND COMMUNITY SECTOR

Stakeholders described how voluntary and community organisations are overwhelmed with demand as they pick up the pieces for a health care system that is struggling to keep going in the face of low staffing and an escalation in need after the pandemic.

Voluntary sector organisations working in mental health in Bradford rely on limited resources, such as funding and grants from multiple and diverse sources, each with different conditions and reporting mechanisms. Their purpose and availability change relatively quickly which makes planning a challenge, notably in relation to workforce development and capital investments, such as buildings.

Historically, the competition that commissioning processes have encouraged between providers has been challenging and has, on occasion, strained relationships. There are signs of tension as different voluntary sector organisations understandably compete for funding, and seek to increase their influence system-wide as a means of survival in a constrained environment where need is escalating and resources are not keeping up. The long-term sustainability of the sector demands a more strategic approach to its resourcing and development, and a determined approach to limit fragmentation and duplication of roles. It is recommended that commissioners and providers work in partnership to understand and agree the targets, metrics and outcomes to support population need.

There were tensions in the relationships between statutory and voluntary sector organisations. Some participants from voluntary and community sector organisations said that they had been marginalised, underrepresented and excluded from statutory decision-making processes. Other stakeholders disagreed, saying that all decisions are transparent, and processes are scrutinised and fair, but offers of engagement are not picked up. During these discussions, the goals of collaboration and cooperation felt a long way off.

Power imbalances – perceived or real – within the system, as well as within the voluntary sector itself, contribute to tensions which, on occasion, result in distrust and suspicion of motives and alliances. There are also practical constraints, like limited opportunities for meaningful and safe dialogue and coproduction. Participants said that creating regular and inclusive opportunities to connect workers from different organisations, to discuss ideas and share evidence of successful projects and interventions, would be a welcome development.

Issues relating to workforce – including the recruitment of staff from racialised communities at all levels of seniority, retention and training – were strong in the fieldwork. Voluntary sector colleagues were frustrated that they could not offer similar reward, training opportunities, or conditions to statutory sector agencies. In addition, there was concern that untrained but enthusiastic candidates came to the voluntary sector to gain experience and then left to work in the public sector once their skills and confidence had grown, which left a vacuum in the voluntary sector workforce. An alternative view was that the voluntary sector provides routes into employment for people who otherwise would not have opportunities to contribute, and that function – of building skills and experience – needs to be acknowledged and resourced. The issue of pay needs to be addressed



by commissioners to achieve parity and to attract high quality candidates to voluntary sector roles, otherwise capacity issues will affect performance and the overall sustainability of the sector.

Participants from the voluntary and community sector expressed frustration at having to collect service-related data for commissioners when it was not clear why it was collected or how it was used. They also noted that the needs of racialised communities had been repeatedly researched, profiled and measured, and yet it was not clear what the tangible results were of providing information and spending time building knowledge. Future efforts must focus on generating actionable insights.

It was suggested that pooling data from across the system – from all relevant providers – would draw together useful information for targeting resources quickly and effectively and ensuring equity. Potential measures include access data; measures of patient experience; outcomes for individuals; and prevalence and demographics, including intersectionality. This could be broken down as appropriate by service or place.

The point was repeatedly made that people become known to services too late. Earlier support would be beneficial for them and their families, and potentially reduce the burden on crisis services overall.

LEADERSHIP AND REPRESENTATION

Issues of system-wide leadership and representation were discussed. Challenging a system from within is a huge task which demands determination and commitment. There were a number of people – found across communities and organisations – who spoke from the heart about their deep desire to improve the lives of people with mental health problems in Bradford. However, being a leader in a complex system is not easy.

The legitimacy of people who speak on behalf of communities was a complex and prominent issue that recurred throughout the fieldwork. Participants made the following observations:

- ⊙ There are a number of individuals working tirelessly in Bradford, across all sectors, who use their positions of authority to advocate for the mental health of local people, developing local services close to home. They routinely identify opportunities to challenge racism, alleviate its effects, and secure equity for people from racialised communities
- ⊙ It is not always clear to participants how people in positions of authority are given the mandate to speak on behalf of communities or the voluntary sector. Greater transparency would help allay concerns
- ⊙ Individuals speaking on behalf of communities and other organisations should ideally have a connection to, and understanding of, the communities they are representing, including ongoing engagement and accountability to community members. They should be open to regular feedback and critique about the impact of their approaches and behaviour. They should make efforts to uplift and amplify marginalised voices, not to put their own views first.
- ⊙ No one individual can fully represent the diverse perspectives and experiences within racialised communities in Bradford or the voluntary sector. It is wrong to assume they should, or indeed would, seek to. Coproducing decisions and co-designing solutions are ways of dispersing the opportunities to influence change, make decisions more democratic, and hold authorities to account
- ⊙ Participants inevitably held different points of view, and it was considered important to incorporate a range of voices and perspectives to avoid tokenism or exclusion. This is especially the case in Bradford where the population is changing and the sector is dynamic. Black African and Caribbean voices are not featured, for example
- ⊙ There were participants who questioned the legitimacy of people who saw themselves as community and sector leaders, including elected members and activists, asking whether they were motivated by self-interest: did they actively listen, show empathy and a willingness to learn from community members, or did they use their positions of authority to further their own political and services-related interests?
- ⊙ Creating opportunities for the sector to come together with a shared set of objectives and rallying behind leaders who spoke on behalf of the sector would give it significant power, participants noted.

WAYS FORWARD

All the participants were united in wanting to work productively to secure the best outcomes for people with mental health needs from racialised communities. Suggestions varied, but it was agreed that the voluntary and community sector had key roles in driving system-wide change. The proposed facets of their engagement included:

- ⊙ Influencing key statutory organisations in addressing issues relating to the 'big picture' determinants of mental health – poverty, institutional racism, housing, and transport
- ⊙ Uniting to find a shared vision for its delivery of services as a critical element of the wider transformation of the mental health system in Bradford
- ⊙ Better connectivity between specialist, community-driven services in neighbourhoods, services in primary care, and hospital settings, with the longer-term objective of agreeing established pathways and integrated provision
- ⊙ Developing and building partnerships between communities, providers, and commissioners to improve outcomes for the population
- ⊙ Engaging with communities in all their diversity – harnessing technology to make it as easy as possible – to constantly refresh what is known about the needs of the communities they serve, and to listen to their ideas about how services could be better delivered
- ⊙ Challenging the mental health stigma and misinformation that exist within communities, as well as the stereotypes and assumptions that are made outside of them
- ⊙ Communicating with their service users and wider communities about what services are available and how they can be accessed
- ⊙ Joining up with other providers to ensure that the system, as a whole, is trauma-informed, understands the connections between racism and trauma, and takes aligned steps to address both with determination and urgency
- ⊙ Supporting mainstream 'anchor' organisations and others to realise their potential as employers and influencers of change, to improve their cultural competence, reduce unconscious bias, and fundamentally challenge racism in their policies and procedures, ways of working, recruitment and management, as well as build their capability to meet the needs of all their service users. This entails going beyond the administrative tasks of Equality, Diversity and Inclusion checklists and activating deep cultural change in organisations, as advocated by Root Out Racism and other anti-racism programmes
- ⊙ Celebrating successes and innovation – such as the positive impacts of culturally-adapted therapies – and focusing on highlighting the resilience and creativity of the communities with whom they work
- ⊙ Future-proofing plans to ensure the sector's sustainability and ability to adapt to emergent mental health challenges and opportunities within society, such as technological advances and AI.

For these aspirations to be met, there must be effective and inclusive strategic and operational alliances in place, and multi-agency sign up. It was noted that these actions will not be implemented without funding and sustained commitment from the commissioning partners.

RECOMMENDATIONS

Based on our research, we have made the following recommendations to the Bradford District and Craven Health and Care Partnership and its stakeholders.

LEADERSHIP AND CONNECTIVITY

1. Engage and facilitate system-wide collaboration and provide a framework to build trust between key stakeholders, including voluntary and community sector service providers, reflecting the diversity of the communities.
2. Build on opportunities across West Yorkshire and within the local Compact to bring leadership and influence to the system, including priorities and decisions outside of the mental health domain but which impact upon it, including the social determinants of mental health.
3. Resource and develop mental health service providers to collaborate and bring leadership to the wider system, including priorities and decisions outside of the mental health domain but which impact upon it, to offer mutual support, and find effective solutions for people with mental health difficulties from racialised communities. Ensure there are clear expectations and lines of accountability to influence decisions and be a conduit for investment as well as taking responsibility for delivery.
4. Coproduce decisions and co-design services with people from racialised communities, using established channels and structures, routinely checking that all communities are engaged and that organisational interests do not overshadow community needs.

COMMUNICATIONS

5. Provide information about services through diverse media and in different community languages such as Bangla, Urdu and Punjabi. This will encompass strengthening the 'Our Healthy Minds' initiative.
6. Improve the promotion of mental health services within community settings and other settings such as GPs, schools, and social media. Co-designing with people from racialised communities and people with experience of poor mental health will make it relevant and more likely to be effective.

ACCESS AND REACH

7. Acknowledge generational, gender, ethnic, cultural, and age-related differences amongst service providers and raise awareness about the needs of intersectional identities, such as young Muslim people who identify as LGBTQ+.
8. Understand and remove physical barriers to services.
9. Explore how Personalised Budgets can support improvements in service access.

10. Resource a community-led campaign (co-designed with people from racialised communities) to challenge deeply held cultural beliefs which create stigma, shame and denial, and inhibit people in need from seeking help. A particular focus might be working with South Asian men to raise awareness and service engagement.
11. Co-design and develop a directory of services that is accessible, comprehensive and up to date to increase awareness and use of preventative and support services in the community – this could also be used as a basis for signposting and social prescribing for individuals and their families. This would build on learning from the Healthy Minds directory.

SERVICE DEVELOPMENT

12. Expand the data and intelligence that is collected to include wider system data, for example relating to how well refugees, asylum seekers, and people from other minoritised communities (including African and Caribbean people and people from Eastern Europe) are reached, and analyse service data from statutory mental health organisations.
13. Develop the current model of promoting cultural competence amongst commissioners and service providers to one which acknowledges the effects of racism on mental health, identifies their active responsibilities in ending it, and gives them tools to challenge racism and the legacies of colonialism – for example by signing up to, and implementing, Root Out Racism. Commissioners can set standards in their contracts.
14. Ensure services take into consideration the religious practices of service users, for instance by holding events at venues that do not serve alcohol, having women only groups, and holding events outside of Ramadan.
15. Promote greater understanding amongst service providers of the impact of trauma on people from racialised communities – including refugees and asylum seekers – and integrate trauma-informed approaches. For example, review and roll out the Bradford District Care Trust cultural change programme to embed trauma-informed approaches, ensuring that it encompasses tackling racism as a key pillar of the work.
16. Provide interpreters to support communication between providers and service users and their families. Resource service providers to work with the Interpretation Service.

TOOLS, RESOURCES AND INVESTMENT

17. Ensure data and insights are collected, and develop a dashboard that can be used to assess the potential impact of services and their reach. This dashboard should be used to inform system decisions on the provision of mental health services, including preventative measures, for people from minoritised communities.
18. Recruit and retain staff (including health care professionals) who speak community languages and have lived experience of poor mental health – value their contribution, ensure that they are appropriately trained and supported, and actively address racism in the workplace.

CENTRE FOR MENTAL HEALTH



PURSuing RACIAL JUSTICE IN MENTAL HEALTH

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