CENTRE FOR MENTAL HEALTH

Thrive LDN

SHIFTING POWER

The role of population-level, anti-racist interventions in addressing inequities in mental health

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EXECUTIVE SUMMARY

KEY MESSAGE

Population-level interventions, defined as programmes or policies that aim to prevent disease or promote health across an entire population or a significant subgroup of the population are essential to tackle racism's impact on mental health. They move beyond individual clinical care towards prevention, addressing the social determinants of health and embedding community-led approaches. Designing and delivering culturally competent, collaborative interventions reduce racial health inequalities across the life course.

SUMMARY

The report was commissioned by London Anti-Racism Collaboration for Health (LARCH), which is delivered by the Race Equality Foundation and Thrive LDN both of which aim to reduce mental health inequalities in London. It examines the relationship between racism and mental health in the UK, with a particular focus on the capital. The report draws on a literature review, a mapping of interventions and three workshops with people with lived experience and other stakeholders. It asks how health systems and services can stop harming racialised communities, how population-level interventions can address the impacts of racism, and what leaders, staff and communities must do now.

KEY FINDINGS FROM THE LITERATURE

This section sets out the core issues that shape anti-racism in population-level work. Racism is not only a matter of personal prejudice. It is built into systems and institutions that shape daily life. Structural racism influences social, economic and political conditions. These include poverty, insecure work, poor housing and limited access to green space and community resources. These pressures shape mental health across the life course and across generations. They show why public health must focus on systems rather than only on individual behaviour.

Institutional racism in health care, education and the justice system reinforces these pressures. It intersects with poverty, gender, disability and sexuality. Intersectionality helps to explain how these forms of disadvantage combine and deepen harm. For many racialised communities, racism and poverty are linked forces that shape experience and limit access to support.

Racialised communities face poorer engagement with mental health services, worse outcomes and higher levels of coercion. Black people are more likely to be detained under the Mental Health Act and to face compulsory treatment. Racial trauma, including childhood and intergenerational trauma, causes harm across time. Trauma-informed and anti-racist care is needed to prevent retraumatisation in settings where restraint and seclusion are common.

Anti-racist action must take place at a population level because the forces that drive unequal outcomes sit within systems, not only within individuals. Structural racism shapes the conditions in which people live, work and seek care. These conditions influence risk, access and outcomes long before a person reaches a service. Population-level action can shift power, change the rules that govern institutions and create fairer conditions across whole communities. It links individual experience with wider social and historical forces and supports long-term change rather than short-term fixes.

LEGISLATIVE AND POLICY CONTEXT

There are numerous legislative levers for tackling racism to support long-term change in mental health (see page 14). They set clear duties for public bodies and give a structure for action on unequal outcomes. Yet they sit within a system where enforcement is often weak and progress depends on local will, resources and leadership. Duties that should guide decisions across services often become routine reporting tasks with little influence on practice. Strategies aim to reduce unequal outcomes but do not always lead to change, and many actions rely on short-term projects that do not shift the conditions that cause harm. This creates a gap between what legislation promises and what communities experience. For population-level anti-racist mental health work, this gap has real effects. Weak enforcement allows racism in systems and institutions to continue without challenge. Uneven progress makes it hard to build shared approaches across regions. A lack of clear accountability limits the ability to track change or respond to harm. Stronger and more consistent use of these duties is needed if London is to address the conditions that shape mental health across the life course and across communities.

POPULATION-LEVEL INTERVENTIONS

A life course view shows how racism shapes health through linked events, pressures and losses that build over time. It makes clear that harm does not begin with a single moment or a single choice. It begins in the conditions that shape childhood, family life, school, work and ageing. These conditions include poverty, insecure work, poor housing and limited access to green space and community resources. They are shaped by structural racism within systems and institutions. A life course view shows that these forces act long before a person reaches a service and continue to shape outcomes across generations. It also shows why work that focuses only on individual behaviour cannot address the scale of the problem.

Traditional approaches to mental health have focused on clinical services for individuals. Population-level interventions aim to prevent illness and promote health across communities. They draw on prevention, attention to social determinants, engagement with communities and collaboration across sectors. The life course view strengthens these principles by showing how racism affects health at each stage of life. It also supports the population intervention triangle (see page 20), which sets out civic-level, service-based and community-centred action. Together these approaches help to guide work that shifts power within systems and improves conditions for whole communities.

Community leadership and engagement are central to effective interventions. Without them, trust is undermined and outcomes are poor. Voluntary, community, faith and social enterprise organisations play a vital role in delivering culturally competent services.

MAPPING OF INTERVENTIONS

The report maps 23 population-level interventions across the UK. A third focused on racialised people in general, a third on Black communities, and a third on other ethnic identities. Many projects targeted young people, while others focused on women or asylum seekers. Half provided mental health information and advice, a quarter supported wellbeing and skills, and others offered linguistic support, peer mentoring, service improvement or campaigning. Gaps were identified in early intervention, advocacy during NHS referrals, links to housing and employment, as well as campaigns to challenge stigma.

FINDINGS FROM WORKSHOPS

Three workshops with more than forty participants revealed that racism is a daily stress that harms mental health. This stress is intensified by the current political climate, which includes cuts to public services, rising unemployment, a hostile policy environment towards migrants, and the rise of far right activism targeting immigrants and racialised communities. Participants described how these forces create fear, isolation and a sense of being under constant threat.

IMPLICATIONS FOR POLICY

Data systems fail to show the full picture of need. Gaps in ethnicity data hide whole communities and weaken efforts to track harm or measure progress. Policy delivery is uneven and many frameworks do not match the scale of structural racism. This limits the ability of local areas to plan, act and learn. Primary care plays a central role but needs stronger training on racism, trauma and the social determinants of health, as well as closer work with community groups that hold trust and insight.

Participants called for a clear move away from models that rely on medical labels and coercive practice. These models do not address the conditions that shape health across the life course. Prevention and population-level action offer a stronger route to fair outcomes because they focus on the systems that produce harm. Real collaboration with communities is essential. It is often limited to consultation and does not shift power or shape decisions. Participants stressed the need for reparative approaches, cultural competence and clear accountability so that institutions act on evidence and lived experience rather than repeat past patterns.

CONCLUSIONS

The evidence is clear that racism is embedded in systems and institutions and that it damages mental health across the life course. These harms are intensified by poverty, insecure living conditions and a political climate that emboldens hostility towards immigrants and racialised communities. Legislative duties exist but are often weakly enforced. Policy frameworks provide commitments but delivery is inconsistent. Population-level interventions, particularly those led by communities, offer promise in promoting resistance and preventing harm. However, gaps remain in early intervention, advocacy and links to other social determinants of health such as housing and employment. Policymakers must act now to recognise racial trauma, fund community organisations, reform data systems and embed race equity monitoring. Only by addressing the wider structural conditions that shape mental health can systems begin to deliver justice and resilience for racialised communities.

RECOMMENDATIONS

1. Make racial trauma a central public health concern

London can place racial trauma at the centre of its public health work, with clear lines of accountability for progress. Anti-racist, trauma-informed and culturally competent care can shape routine practice across services, supported by safe spaces led by racialised communities. The Greater London Authority can set the direction, health bodies can show how commissioning meets this aim, VCSE organisations can lead community-based support, and primary care can bring trauma-informed practice into everyday care. Each part of the system should report on its role and the outcomes it achieves.

2. Build services that offer choice, safety and cultural competence

Services can move toward models that reduce coercion and offer early support through community hubs, crisis cafes, peer networks and creative health programmes. Regional NHS bodies can set expectations for this shift and show how they are met. Borough commissioners can invest in community options and report on reach and impact. VCSE partners can shape and deliver these models, and primary care can guide people toward early help. Clear measures of safety, access and experience can support accountability across the pathway.

3. Strengthen community-led organisations through stable investment

VCSE organisations need secure funding so they can plan, grow and support their workforce. Multi-year investment can improve access to culturally safe support and strengthen local systems. City and borough leaders can embed VCSE partners in commissioning cycles and show how funding decisions support equity. VCSE organisations can codesign services that reflect lived experience, and primary care networks can build clear referral routes. Shared reporting can show how investment leads to change.

4. Share power through meaningful engagement

Communities should shape decisions from design to evaluation, with clear accountability for how their insight is used. Paid lived experience roles and shared boards can support this shift and build trust across systems. Local health and council leaders can make meaningful engagement a core expectation and show how it influences decisions. VCSE partners can hold space for community insight, Healthwatch can offer independent oversight, and primary care can take part in shared governance. Public reporting can show where engagement has led to change.

5. Make equity visible and measurable

Better ethnicity data and open reporting can show where exclusion takes place and guide action. Mixed evidence, including community insight, should shape decisions across systems. Health bodies can lead improvements in data quality and show how data informs planning. Borough public health teams can monitor patterns and report on progress. VCSE partners can contribute participatory data, and primary care can improve recording and share insight on access. Clear measures and regular reporting can support accountability for change.

6. Build a workforce that can deliver anti-racist, trauma-informed and culturally competent care

Staff across the system need support to develop the skills, confidence and insight needed for anti-racist, trauma-informed and culturally competent care. This includes space for reflection, supervision shaped by community knowledge and clear routes for racialised staff to move into leadership. Workforce leaders can shape training and show how it improves practice. Primary care networks can support learning across teams, and VCSE partners can codeliver programmes that draw on lived experience. Regular review of workforce data and outcomes can support accountability for progress.

FOREWORD

A report of this kind arrives at an important moment for London and for the communities that shape it. LARCH stands as a collective programme with a clear purpose, a shared commitment and a practical route for health and care organisations that want to embed anti-racist practice. Its focus on population-level mental health interventions reflects the scale of the challenge and the scale of the opportunity.

London is one of the most ethnically diverse cities in the world. Many of the people who rely on its services also work within them. Yet racial health inequalities remain widespread and avoidable. Anti-racist action is a legal and public duty. And it requires institutional accountability and sustained resourcing.

The wider climate brings pressure on systems and strain on public services. It also brings political shifts that place equality and human rights at risk. Racism continues to operate as a system that shapes outcomes across communities and across generations. It is not a series of isolated incidents but a structure that demands sustained effort and clear intent to dismantle. This makes the work set out in the report ever more urgent.

The report offers evidence-based analysis, collaborative insight, and actionable recommendations. It points toward measurable change and a fairer future. It also calls for clear ownership and determination so that progress can be tracked and success can be measured. I welcome it with concern for the present and hope for what can follow.

Dame Marie Gabriel, Chair, London Anti-Racism Collaboration for Health (LARCH)

INTRODUCTION

This report explores the relationship between racism and mental health, including the questions of structural and institutional racism, and asks how we can stop health and other systems and services in the UK from harming racialised communities. It explores the traumatic effects of racism, how it manifests across the life course, and how racism intersects with other forms of discrimination and structural disadvantage. In particular, the report explores how population-based actions or interventions can address the impacts of racism on mental health, especially interventions that employ community-informed methods. It reviews the evidence and best practice on such interventions, highlighting key themes and trends, as well as pointing to gaps in knowledge. Finally, we ask what policymakers must do now, and what leaders, staff and communities must demand, to end racial inequity in mental health.

The report has been commissioned by London Anti-Racism Collaboration for Health (LARCH), delivered by the Race Equality Foundation and Thrive LDN. The mission of both organisations is to address health inequalities in the capital. LARCH is a combined programme of work to empower health and care organisations to adopt an anti-racist approach and to address the health inequalities that racialised Londoners experience. Thrive LDN is a citywide public mental health partnership, working towards the shared mission of a city where every individual has equal opportunity for good mental health and wellbeing.

We have drawn on the analysis of two previous reports, one by the Institute of Health Equity on structural racism, ethnicity and health inequalities in London (Marmot *et al*., 2024); and another by the Race Equality Foundation on recommendations to address structural racism and health inequalities in the city (Race Equality Foundation, 2025).

The report is made up of three sections. First, a rapid literature review, drawing on reports, journal articles and unpublished research, and looking at concepts such as structural racism and racial trauma. Next, a mapping exercise, looking at existing interventions across the UK but with a focus on London, reflecting the interests of the report's commissioners. Finally, we summarise three online workshops in which we spoke to more than forty participants – people with lived experience, policymakers, clinicians, practitioners, researchers and others – to gather their opinions on our preliminary findings. Analysis was iterative, building themes through dialogue, and our findings were shaped by lived experience and collective debate.

A note on language

When describing ethnicity in this report we have been specific wherever possible. When referring to multiple communities who experience racial inequality the term 'racialised communities' has been used rather than the acronyms 'BME' or 'BAME' ('black and minority ethnic'). The term 'racialised' underscores 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. The term 'ethnic minorities' has been avoided, 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.

WHAT THE LITERATURE TOLD US

RACE, RACISM AND INTERSECTIONALITY

Racism is a system of disadvantaging people and communities by structuring opportunity and assigning value based on the social interpretation of race, including physical looks, culture and other symbolic differences. Racism works by excluding, marginalising and inferiorising communities who are racialised (Nazroo *et al*., 2020). Racism consists of components that are structural (social, political and economic) and ideological (ideas about race, power and hierarchy).

FORMS OF RACISM

There are multiple forms of racism, including interpersonal, internalised, systemic and institutional racism – each of which is described below.

- **Interpersonal racism** – Refers to racial discrimination, bias, abuse and bigotry shown by individuals. This can be manifested in many ways, from covert to overt acts, from microaggressions to deadly hate crimes.
- **Internalised racism** – Refers to members of an oppressed racialised group adopting racist behaviour, ideology, prejudices and beliefs of racial hierarchy. This leads to oppressed people adopting negative messages about their own identity and self-worth.
- **Structural racism** – Refers to racism embedded across a society. It is a feature of the large-scale social, economic and political systems in which all members of society exist – acting to privilege some groups and disadvantage others.
- **Institutional racism** – Refers to racism embedded within organisations and institutions such as government, education, health care and legal systems.

Given this report's focus on population-based interventions, it is structural and institutional racism that are particularly relevant here. The Institute of Health Equity (Marmot *et al*., 2024) further describes structural racism as:

"The forces underlying structural racism are so embedded in daily life that they are seen as the inevitable order of things. White privilege is one of the ways structural racism is experienced and perpetuated in daily life and refers to the many advantages that White individuals experience, which they may not be aware of. White privilege is a result of a system that takes Whiteness as the norm and perpetuates this through the institutions, allocation of resources, systems and societal norms."

Link and Garcia (2021) argue that focus is lost when research "ignores, underplays, or excuses the actions of more advantaged individuals and groups for the part they play in producing health inequalities."

Moreover, an Institute of Health Equity report outlines the ways in which structural racism informs institutions, as well as our shared duty and ability to address it (Marmot *et al.*, 2024):

"The effects of structural racism are evident in ethnic inequalities in experiences in education, rates of poverty, employment, pay, career progression, experience of the criminal justice system, housing and health care services, particularly maternity and mental health services, as well as in experiences of racism between people. Institutions, communities, systems and leaders in London have the ability to influence those structures which embed racism; through representation, advocacy, leadership and supporting changes to legal systems, investment decisions, economic policies and shaping cultures and discourse."

An additional concept discussed in this report is intersectionality. This is an approach developed by American lawyer Kimberlé Crenshaw when she took the case of someone who was being discriminated against because of both her race and gender. At the time, people looked at gender discrimination and race discrimination separately. Crenshaw said one needs to look at how these characteristics can combine and make life harder for people facing intersecting oppressions (Crenshaw, 2013). When addressing structural racism, it should be acknowledged that oppression can and does come from intersecting forms of discrimination, including those relating to race but also other factors that include gender, disability, sexuality and gender identity, as well as socioeconomic status. In particular, the link between racialisation and poverty cannot be understated. Intersectionality can also further our understanding of how social advantage and disadvantage can exist simultaneously. This demonstrates its potential as a theory that helps to analyse how power operates, in addition to, how different forms of oppression intersect (Winer, 2021).

Racism should be understood as a system, rather than as a series of individual events and outcomes (Jones et al., 2024). Concepts such as structural racism and intersectionality can help us to understand this system. Nevertheless, any term can become problematic if it is used without sufficient reflection. For example, terms can become empty if they are repeated without attention to the lived realities they describe. Words such as "structural" or "systemic" can be used as labels rather than prompts for action, allowing organisations to name racism without changing the conditions that produce it. There is also a risk that language becomes a shield, where institutions adopt the right vocabulary while continuing practices that harm racialised communities. Without care, terms that were created to expose injustice can be absorbed into routine policy language and lose their force.

Moreover, the concept of anti-racism is itself an elusive one. It is certainly not a single set of practices but more a set of principles that guide how organisations and systems should act. Anti-racism requires a commitment to change the structures that create unequal outcomes, not only to challenge individual prejudice. It involves a willingness to confront power, to redistribute resources, and to accept that progress will be uncomfortable for institutions that have benefited from the status quo. Anti-racism also demands accountability. It is not enough to state support for racial justice; organisations must show how decisions, budgets and leadership choices reflect that commitment.

At its heart, anti-racism is a collective responsibility. It asks systems to recognise that harm to one racialised person is felt across whole communities, and that meaningful action must address the wider social and economic conditions that shape people's lives.

"The social determinants of equity determine the range of contexts in our society as well as which groups are over – or underrepresented in each of the different contexts. The social determinants of equity are systems of power that differentially distribute resources and assign societal value. They operate at the most basic level through determining who is at the decision-making table and who is not, as well as what is on the agenda and what is not" (Jones *et al*., 2024).

HEALTH INEQUALITIES AMONG RACIALISED COMMUNITIES

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. These differing health outcomes reflect deep-rooted inequalities in the social determinants of health – the conditions in which people are born, grow, live, work and age, and the distribution of power, money and resources which shape the conditions of daily life. Racism and discrimination are important parts of these social determinants.

In 2022, the NHS Race and Health Observatory (RHO) published a review of evidence of ethnic inequalities in health care and the reasons for them (Kapadia *et al*., 2022). The evidence indicates that mental health services engage poorly with people from racialised communities, leading to underutilisation of such services and lower rates of retention of treatment. This is attributed to several factors including discrimination and prejudice, unequal access to care and lack of resources to fund health services.

Given the above background, it is very likely that people from racialised communities become reluctant to ask for help from mental health services and are more likely to delay presenting to services until they are in crisis. In fact, it has been shown that there are disproportionate rates of admission of people from racialised communities to the UK psychiatric inpatient units, as well as higher levels of compulsory detention in inpatient units (Department of Health, 2005). Further reports indicate that poor relationships exist between psychiatric services and Black groups (Black Caribbean, Black African and Black British). People from these groups are four times more likely to be detained under the Mental Health Act, and thus forcibly treated, than people from white groups (NHS Digital, 2019).

An important driver of poor mental health among racialised communities is racial trauma (Hassan *et al*., 2026). Trauma is an emotional response to a terrible event, or series of events, that can be experienced in childhood and/or adulthood (Hopper *et al*., 2010). Sources of trauma include adverse childhood experiences (ACEs), which refer to a wide range of traumatic or stressful experiences that children and young people can be exposed to while growing up, including racism (NHS Highland, 2018). In the UK, about half of the population have at least one ACE, and research has found that people who have acquired trauma from ACEs are more likely to have mental health issues in adulthood and to use health care services more frequently. Finally, the effects of racism can also manifest through historical and intergenerational trauma (Conner, 2020).

A supplementary concept that has emerged in recent years is trauma-informed care. This is a framework that aims to identify and understand the impact of trauma, including racial trauma. The framework aims to create a safe environment for patients and providers, and to prevent the former's re-traumatisation. Re-traumatisation might occur in mental health care settings if an individual is triggered by certain procedures or actions – such as restraint, round the clock observation, body searches, seclusion, forced medication and other coercive practices by health care professionals (Sweeney *et al*., 2018). The negative impact of re-traumatisation reinforces the need for trauma-informed approaches in health care settings (Dawson *et al*., 2021).

It should also be noted that within different ethnic groups are different age profiles, migration histories and social class profiles, all of which influence people's experiences of racism and discrimination and which can therefore impact on health and the social determinants of health. For example, whether this is attributable to racism or other factors, it is notable that severe mental illness diagnosis is particularly pronounced among Black groups, with research showing that people from Black communities are at a higher risk of psychotic disorders and non-affective disorders than majority ethnic groups in a given setting (Jongsma *et al*., 2019).

In addition, young people from racialised backgrounds are also treated unequally in mental health settings, with research showing that racism results in discrimination in referral routes to mental health services and disproportionate rates of criminalisation. For example, Black children are ten times more likely to be referred to NHS children and young people's mental health services via social services and youth justice teams than through the GP or other voluntary routes, compared with white British children (NHS Race and Health Observatory, 2022).

Furthermore, the Howard League reports how institutional racism at every level of the criminal justice system results in the overrepresentation of people from racialised backgrounds in prisons, where poorly funded regimes and limited mental health support make release and return to prison a 'revolving door' (Howard League for Penal Reform, 2023). Finally, people from racialised communities who are part of the lesbian, gay, bisexual, transgender and queer (LGBTQ) community are at a higher risk of experiencing trauma and social disadvantages, due to intersectional oppression, and face barriers such as limited access to health care services (Salerno *et al*., 2020).

DATA CHALLENGES

Debates about ethnicity data in the UK reflect deep ethical, conceptual, practical and political tensions. Ethically, many people question how the state uses categories that have been shaped by racism and colonial history. Some fear misuse, surveillance or further stigmatisation. Conceptually, ethnicity is fluid and relational, yet official systems treat it as fixed. Categories often fail to reflect lived identities or the diversity within broad groups. Practically, data collection is uneven across services, with missing records, inconsistent coding and limited staff training. Politically, ethnicity data sits within wider disputes about racism, inequality and the role of the state. Some organisations resist naming racism as a structural force, which leads to weak investment in data systems and reluctance to publish patterns that show unequal outcomes.

These problems appear in gaps in routine records, unclear categories, low confidence among staff and limited engagement with communities about how data is used. The result is a system that cannot see the full picture of harm or track progress. For population-level, anti-racist mental health work, this is a major barrier. Without reliable data, it is difficult to understand need, design fair interventions or hold institutions to account. It also limits the ability to link personal experience with wider structural forces and to plan long-term change

LEGISLATIVE, POLICY AND INSTITUTIONAL CONTEXT

The work of the London Anti-Racism Collaboration for Health (LARCH) and Thrive LDN has been shaped by London Mayoral Mandates to reduce health inequalities.

In the UK, the 2010 Equality Act is designed to protect individuals from discrimination and race is one of the 'protected characteristics' that it relates to (the others are age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, religion or belief, sex and sexual orientation).

The Act is intended to protect individuals with these characteristics against four types of discrimination that it identifies: direct discrimination, indirect discrimination, harassment and victimisation.

Under the Equality Act, individuals are protected from discrimination in several domains of life, including when using public services or when in contact with public bodies. The duties of public bodies are set out in the Public Sector Equality Duty (PSED), which charges such organisations with eliminating unlawful discrimination against people with protected characteristics and advancing their equality of opportunity. In the context of this report, the Public Sector Equality Duty obligations of the NHS, when dealing with people from racialised communities, are particularly relevant.

Another important piece of legislation is the Health and Care Acts 2012 and 2022. This introduced a Health Inequalities Duty, which places a legal obligation on NHS bodies, particularly NHS England and Integrated care boards (ICBs), to actively reduce unfair differences in people's access to care and in their health outcomes. There is also a requirement to publish data in relation to these duties. Nevertheless, while the duties have led to a stronger focus on health inequalities within organisations in the NHS, there is currently a very limited amount of testing of these duties.

In addition to these duties mandated by legislation, other policy frameworks address structural inequities within the activities of NHS England. The principal strategy document of the NHS is the Long Term Plan (2019-29), which includes a focus on tackling health inequalities, as well as recommendations for trauma-informed care. Additional initiatives include Core20PLUS5 (2021), a scheme designed to support the reduction of health inequalities, including among racialised communities, by defining target populations and identifying clinical areas requiring accelerated improvement. Finally, Public Health England developed place based approaches to reducing health inequalities (2021), which consists of guidance on population-level interventions, at the core of which is an online suite of resources available for all local health systems to access, to enable leadership and action to address health inequalities.

In the area of mental health legislation and policy, a key milestone was the Independent Review of the Mental Health Act (2018), part of which addressed how the structure of mental health services can lead to racial inequalities. One response by the NHS was the Advancing Mental Health Equalities Strategy (2020), which aims to improve access, experience and outcomes for racialised communities, among others. A second response was the development of the Patient and Carer Race Equality Framework (PCREF) (2023), which makes NHS trusts and other providers responsible for co-producing and implementing concrete actions to reduce racial inequalities within their services. Centre for Mental Health was part of the working group for the Independent Review and has supported the creation and implementation of the PCREF.

In London, health and equalities policy for the city is championed by the Greater London Authority (GLA). One important policy document is the Health Inequalities Strategy (2018-28). This sets out a shared ambition, agreed between the GLA and the leaders of the city's health and care providers, to make London a healthier, fairer city, including by tackling ethnic inequalities and structural racism. This is supported by Building a Fairer City (2022), which focuses on improvements for the groups of Londoners that were disproportionately impacted by the pandemic, including racialised communities.

Finally, the GLA has supported A Strategic Framework to Tackling Ethnic Health Inequalities through an Anti-Racist Approach (2023), which charges health and care organisations to make progress on several strategic commitments, including ones relating to leadership, workforce and health equity programmes. In the latter areas, it calls for programmes that will "prioritise and deliver evidence-informed, culturally competent interventions to narrow the gap, by reducing inequities people from ethnic minority groups face in access, uptake, experiences and outcomes of our health and care services."

The legislative, policy, and institutional context demonstrates a legal duty that is supported by political and institutional efforts. However, there has been a lack of strong and/or consistent enforcement to ensure that racism and racial inequities in mental health are addressed effectively. In order for population-level interventions to succeed, we need stronger and more consistent use of these duties to address the conditions that shape mental health across the life course and across communities.

LEGISLATIVE AND POLICY CONTEXT

Equality Act 2010

Aims to protect people from discrimination and promote fair treatment. It sets out protected characteristics, including race, and gives people legal rights when they face unequal treatment. In practice it relies on individuals and communities to raise concerns, and enforcement is often slow and uneven.

Public Sector Equality Duty

Requires public bodies to eliminate discrimination, advance equality and foster good relations. It is meant to shape decisions across services. In practice many bodies treat it as a reporting task rather than a driver of change, and there are few consequences when duties are not met.

Health and Care Acts 2012 and 2022

The Acts introduced a Health Inequalities Duty that requires NHS bodies to reduce unfair differences in access and outcomes. The duty should guide planning and commissioning. In practice it is weakly enforced, and many organisations struggle to show how their work meets the duty.

NHS strategies

The Long Term Plan, Core20PLUS5 and the Advancing Mental Health Equalities Strategy aim to reduce inequalities and improve access for racialised communities. Progress is mixed, and many actions depend on local leadership and resources. The Patient and Carer Race Equality Framework seeks to embed actions shaped with communities, but uptake varies across Trusts.

London wide commitments

The Greater London Authority (GLA) sets out goals in the Health Inequalities Strategy and Building a Fairer City. It has also supported a Strategic Framework for Tackling Ethnic Health Inequalities through an Anti-Racist Approach. These commitments offer direction, but strong and consistent enforcement is still needed across the system.

THEORY OF INTERVENTIONS

Approaches to addressing mental health in society have often focused on the provision of clinical services to individuals. However, although clinical mental health services dramatically improve the lives of many people, there are many reasons why the provision of clinical services in isolation is not the best approach to maximise the mental health of a population. In more recent years there has been an increasing desire to expand the focus, embracing the impact of community and population dynamics in promoting mental health, preventing mental illnesses and fostering recovery.

This report is looking at population-based interventions in the mental health of racialised communities. Population-based interventions are programmes or policies that aim to prevent disease or promote health across an entire population or a significant subgroup of the population. The importance of these interventions lies in their potential to have a broad impact on health outcomes, reducing health inequities and improving the overall quality of life for large numbers of people. Effective population-based interventions are guided by several key principles, including:

- A focus on prevention and health promotion
- A population-level perspective, which considers the social determinants of health
- A clear understanding of the target population, as well as engagement with the community and other stakeholders
- Collaboration across sectors and disciplines.

One key element that has emerged in population-based interventions in mental health is the life course framework, a framework which comes from the World Health Organisation (WHO). The Institute of Health Equity report on structural racism as well as other policy documents that explore the impact of racism have used a six-part structure, as set out in the 2010 and 2020 Marmot Reviews and derived from the life course framework. This explores how racism and the social determinants of health interact at different life stages, and how interventions can be organised (Marmot *et al*., 2024). The six factors are:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention.

Another key principle that has emerged, when considering how population-based interventions may reduce ethnic inequalities in mental health, is community engagement and coproduction. Much can be gained by hearing from individuals and groups who have experienced racism and who understand its impacts on their health. A lack of engagement with communities undermines trust and confidence in the policies, services and interventions that may be produced in their name. Cultural inappropriateness and misalignment with needs are barriers to accessing services, drive poor experiences with services and lead to worse outcomes.

Public Health England launched its own guidance on population-level interventions in 2021, in the form of a suite of tools and resources known as Place Based Approaches to Reducing Health Inequalities. One of the central concepts used in this framework is the Population Intervention Triangle (see Figure 1). This guidance argues that there are three main categories of intervention within the field of place-based working, outlined below.

Civic-level interventions

These interventions include legislation and regulation; policy and strategy development; financial incentives and disincentives; economic development; environmental planning; public information campaigns; and welfare and social care. Such tools can have a powerful and far-reaching impacts on the health and wellbeing of the population as well as on the inequalities that exist in the place in question.

Service-based interventions

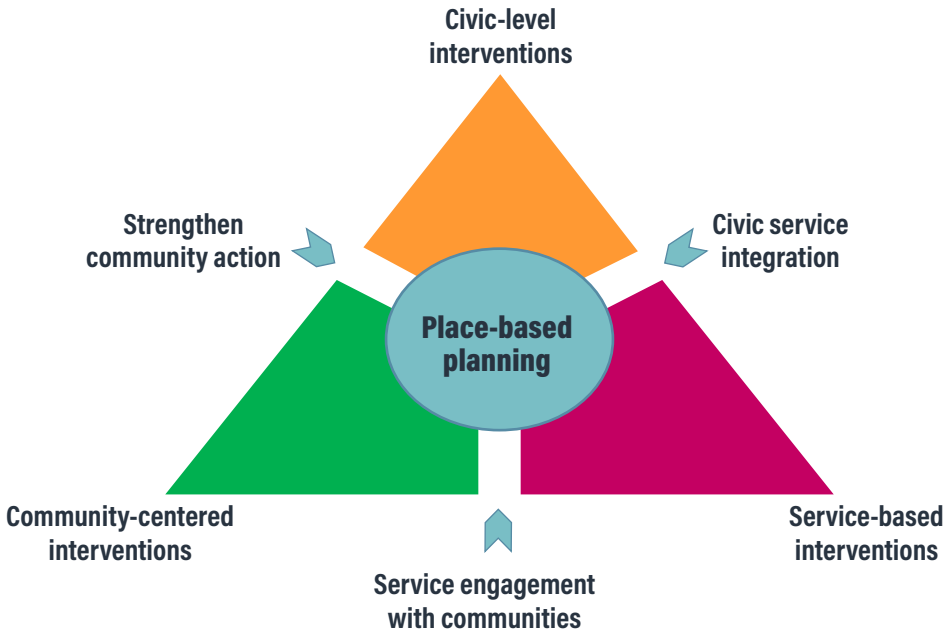
Civic-level interventions may sometimes fail to generate population-level change because of variations in the way that they are implemented and utilised, variations in service quality and delivery, and variations in the way that the population uses those services. Therefore, service-based interventions are designed to give appropriate support to the populations in greatest need and to help these populations to use services to best effect.

Community-centred interventions

These are interventions that promote health and wellbeing, or reduce health inequalities, in a community setting, using non-clinical methods. They employ the principles of community engagement and coproduction outlined above, aiming to increase people's control over their health and lives. These include employing participatory methods where community members are actively involved in design, delivery and evaluation, and building on local community 'assets' in developing and delivering the project.

Two important concepts, when looking at population-based interventions in mental health, are the recovery model and building resilience. Where psychiatry emphasises symptoms and functioning – employing assessments, interviews and rating scales to document and monitor psychopathology – the recovery model views mental illness from a very different perspective. Rather than pursuing symptom resolution and full functioning, it emphasises how individuals can be helped to stay in relative control of their lives, focusing on building the resilience of people with mental illness and supporting those in emotional distress (Jacob, 2015).

Figure 1: Components of the Population Intervention Triangle
(Source: Gov.uk, 2021)



Some cultural knowledge – as well as caution – is required when applying such concepts to the mental health of people in racialised communities. For example, some research has shown that the understanding of resilience varies amongst women from racialised communities (Kalathil, 2011). The concept of resilience for these women varied from a notion of inner strength, to undertaking practical tasks to help them keep well, and drawing on support systems – be it faith, care services or family – in order to maintain their resilience. Moreover, Kalathil argues that the premise of recovery is not as useful to racialised communities if the definition does not take a holistic approach with race equality at its centre.

The terms resilience and recovery sit at the centre of many mental health policies in the UK, yet they raise serious concerns when used to describe the experiences of racialised communities. Both terms place attention on the individual and suggest that distress can be managed through personal strength or a return to a previous state of wellbeing. This framing does not match the realities of people who live with the combined pressures of racism, poverty, insecure work, poor housing and limited access to community resources. These pressures are shaped by systems and institutions, not by personal choices. Intersectionality shows how racism interacts with gender, disability, class and sexuality to produce harm across the life course. When resilience and recovery are used without this context, they risk placing responsibility on people who already carry the weight of structural inequality.

There is no question that racialised communities show great strength and survivorship. These qualities are real and deserve respect. The problem arises when systems use these qualities as a reason to avoid change. Calls for resilience can shift attention away from the conditions that cause distress. Calls for recovery can imply that people must adapt to systems that remain harmful. For population-level anti-racist mental health work, this is a major challenge. The focus must stay on the systems that produce harm, the institutions that hold power and the long history that shapes present outcomes.

In relation to community-centred interventions, in particular, there has been a growing recognition of the importance of voluntary, community, faith and social enterprise groups organisations in delivering a range of services and developing community cohesion and wellbeing. Such organisations have had an important role in supporting people from racialised communities who are affected by mental illness, sometimes filling the void where a statutory service is missing or inadequate. This has been particularly important where there is lack of trust, lack of cultural understanding, or fears related to racism and discrimination – as well as in specific settings such as the prison system (Yap *et al*., 2018).

In focus groups conducted by the Race Equality Foundation in 2018, services users from racialised communities said that they rated such organisations highly when navigating the mental health system and seeking culturally appropriate advice and support (Bignall *et al*., 2019). Moreover, there has been a tendency, in recent years, for the responsibility for interventions to pass from health professionals to lay health workers. This shift may help when overcoming cultural or linguistic barriers, but it may also have disadvantages – if, for example, membership of a faith community means that a lay worker holds beliefs that are more stigmatising than those of most health professionals (Baskin *et al*., 2021).

Whole population mental health approaches can widen inequities when they bring the greatest benefit to groups that already hold social and economic advantage. An equitable approach must place the needs of marginalised groups at the centre and must recognise that population mental health is shaped by unequal access to resources, unequal exposure to risk and unequal protection from harm. This requires a shift from narrow models toward holistic and multi-dimensional methods that can hold the full complexity of people's lives.

Intersectionality helps to explain why this shift is needed. It shows how forms of discrimination combine and create harm that cannot be understood through single categories. Race, gender, disability, sexuality, gender identity and socioeconomic status interact to shape mental health across the life course. The link between racialisation and poverty is especially strong. Intersectionality also helps us see how advantage and disadvantage can exist at the same time, and how power shapes who is protected and who is exposed to harm.

To understand these patterns, population mental health work needs approaches that can explore lived experience and community knowledge. Participatory, settings based, qualitative and mixed method approaches can support this by drawing on insight held within communities and by placing human perspectives at the centre. These methods can reveal how systems create risk and how structural conditions shape mental health outcomes across populations.

The UKRI funded Population Mental Health Consortium is a partnership between King's College London and Thrive LDN with other organisations and stakeholders across public health, local government and voluntary organisations. The consortium aims to enhance mental health outcomes across the UK by leveraging large-scale datasets to drive population-level improvements. They prioritise research that addresses societal conditions and determinants of inequity which contribute to mental health inequalities, particularly for children and young people, suicide and self-harm prevention, and multiple long-term conditions. Integral to the consortium's approach is also to work closely with people with lived experience of mental distress and adversities which impact mental health. This will allow for the identification and evaluation of population-level interventions which hold the greatest promise for the improvement of mental health and advancing equality. The aim is to build equity through the development of practice-based evidence and concerted knowledge exchange. It is therefore significant to consider how this work, and the learning from the consortium, advance the insights form this report and wider efforts to evaluate population-level mental health interventions.

MAPPING EXISTING INTERVENTIONS

This section looks at examples of population-level interventions designed to improve mental health among racialised communities, examining 23 projects selected from desk-based research (for full descriptions of the projects see Appendix 1). Only interventions in the UK were included, and only ones which occurred within the last ten years or are currently operating (for more information see Appendix 2). Nine projects are nationwide, ten are from London and four are from other cities or regions. This report focuses mainly on community-centred interventions, in accordance with the brief. Nevertheless, some of the projects included could also be characterised as service-based interventions (those described as 'service improvement' programmes, below) or as civic-level interventions (those characterised as 'campaigning' projects, below).

Roughly a third of the interventions are aimed at racialised people in general, another third are aimed at Black people, and the final third are aimed at other racial or ethnic identities (including South Asian and East Asian). As described below, a significant proportion of the projects are aimed at young people, while smaller proportions are aimed at other groupings – including women, as well as former refugees and asylum seekers. Some interventions are time-limited projects, while other interventions are in fact ongoing community organisations.

Some of the projects represent interventions at particular stages in the life course model. Notably, a third of the projects address the needs of children and young people and among those there is a particular focus on the mental health needs of Black children and young people. In addition, a considerable proportion of projects focus on supporting wellbeing or developing skills and thus could be said to strengthen the role and impact of ill health prevention. The life course stages which have less representation among these projects are those focused on employment, standard of living and healthy and sustainable communities.

Finally, only one of the interventions has been peer-reviewed in an academic journal (as far as could be ascertained), and only a relatively small number of projects made any form of evaluation public on their websites. Therefore, what follows is largely descriptive, rather than an evaluation of effectiveness.

INFORMATION AND ADVICE

The interventions surveyed take various approaches to promoting good mental health among racialised people, but a large group of projects – 13 in total – can be characterised as offering mental health information and advice. Previous research has suggested that mental health services that are provided by community organisations and embedded in communities enjoy trust among racialised communities, which in turn promotes awareness of mental health problems and access to mental health services (Weich *et al*., 2004).

One common characteristic of these organisations was offering signposting to other services, including statutory health services. Signposting has been widely adopted in England through social prescribing schemes, although previous research has suggested that many schemes lack cultural specificity (Bickerdike, 2017).

Nevertheless, the interventions under consideration in the current report are predicated on cultural competence, and include projects such as IRIE Mind, a mental health initiative run by and for the Black community in Hackney, East London. In its self-description, IRIE speaks of collaborating with statutory services as well as enabling culturally specific interventions, with an emphasis on prevention rather than crisis intervention.

An additional characteristic of a small number of the projects under review is an emphasis on referrals and advocacy – referring service users to statutory health services and advocating on their behalf within these systems. An example is Al-Hasaniya Moroccan Women's Centre, which offers individual support for Arabic-speaking women who live in Kensington and Chelsea, West London. The organisation describes itself in part as a referral and advocacy service that helps women access NHS services.

A final sub theme is addressing stigma. Mental health problems can be sources of stigma within particular ethnic groups, for cultural reasons that can include traditional ideas of faith or gender. The Young Black Men Programme was a programme run by Mind between 2019 and 2022, that offered locally tailored services for young Black men in London, Coventry and Leeds. One of its aims was to enable the discussion of stigma in mental health, challenging stereotypes of masculinity held both inside and outside the Black community and encouraging young men to access help. Conversely, the organisers suggest that it can be good to avoid framing services solely around mental health, for example by promoting the inclusion of physical activities.

WELLBEING AND SKILLS

Another broad theme among the interventions reviewed, and which was reflected in six of those examined, is the support of wellbeing and the development of skills. In this category the most common organisational offer is wellbeing activities. For example, Enabling ESEA Community Resilience, a project run from 2023 to 2025 and dedicated to empowering the East and Southeast Asian communities in London, included within its activities some that promote health and wellbeing (including dancing, gardening and cooking classes) as well as some based on mind-body practices or holistic therapies (including relaxation techniques and meditation). Other organisations offer 'creative health' activities, such as Poetic Unity, which supports young people of Black and mixed-Black heritage in London, and employs poetry as a form of creative expression and healing.

The Ubele Initiative, the organisers of BAMEStream – a project that offered a range of wellbeing activities to the Black community in London between 2020 and 2021 (as far as can be ascertained) in direct response to the Covid-19 pandemic – argue that the activities conducted as part of the programme helped service users in various ways. These include improved mental health; the development of life skills, enabling people to become more independent and less isolated; improved communication skills; increased capability to shape the delivery of mental health services; and increased confidence, including reduced fear of accessing statutory mental health services.

Some interventions have a particular emphasis on skills development. One is Coffee Afrik, a community organisation which collaborates with women and young people from Black and racialised communities, running community hubs across East London. These hubs focus on particular groups of people and issues (for example, one is focused on problematic drug use) but also have a strong emphasis on work skills. A small number of the interventions under consideration also had an emphasis on employment and/or housing support. One example is Shifting the Dial, a partnership operating from 2018 to 2021 sought to promote the mental health of young Black men in Birmingham.

LANGUAGE SUPPORT

A particular offer among the projects reviewed is linguistic support, an intervention aimed at overcoming language barriers when accessing care which is associated with communities that include a significant proportion of first-generation immigrants. Six of the projects under review included an emphasis on linguistic support. One example is Sahayak, a mental health helpline which offers a culturally sensitive listening and information service for the Asian community in Kent and West Sussex. Calls can be taken in four different South Asian languages – Gujarati, Punjabi, Hindi and Urdu – as well as in English.

PEER SUPPORT AND MENTORING

Some research has suggested that people from racialised communities can find it easier to start conversations on mental health within their own cultural networks rather than with health professionals, with formal mental health services perceived as a last resort (Tabassum, 2000; Sheikh, 2000). Four of the projects under review could be categorised as offering peer support and mentoring. One such is KORI, which works with young people from Black and racialised communities, and has a particular emphasis on mentorship programmes. Another is Sharing Voices, an organisation working racialised communities in Bradford, and which includes befriending among its activities.

SERVICE IMPROVEMENT

Four of the interventions under consideration can be categorised as service improvement programmes. These projects demonstrate various types of interaction with the communities that they seek to help. Some can be categorised as community consultation exercises. This includes the Ethnicity and Mental Health Improvement Project, which was launched in 2019 and is an attempt to reduce ethnic inequalities in access, experience and outcome of mental health care in South West London.

One study, which evaluates interventions that have improved access to community mental health care for Black men, points to a number of challenges for small community organisations. It argues that for most of these organisations, the major challenge that they face is funding, but it also notes that they can find monitoring and evaluation a significant administrative burden (Stockwell *et al*., 2025). Such findings were echoed in the project evaluations for the interventions in this report. For example, The Ubele Initiative, the organisers of BAMEStream, note that community service providers need capacity building and infrastructure support, including to help them move online.

CAMPAIGNING

A final category in the interventions under review are those that are focused on campaigning. Two such projects were reviewed, including Young Changemakers. This programme, which ran from 2021 to 2024 and was a collaboration between UK Youth, The Diana Award and Centre for Mental Health, sought to support Black and Black mixed-heritage young people to develop social action projects addressing mental health inequalities.

EVALUATION AND CAPACITY BUILDING

Evaluation and capacity building are central to population-level anti-racist work because they shape how learning takes place and how communities gain the support they need. Many projects now include elements of organisational development, often through re-granting models that aim to strengthen local groups rather than only fund short-term activity. Right to Thrive, a grants programme run by Thrive LDN between 2018 and 2024, is one example. It supported community organisations that work with Londoners at high risk of poor mental health, including people from racialised communities. This kind of support helps groups build skills, improve governance and create stable roles. It also helps systems understand what works in practice and how community insight can guide long-term change. Strong evaluation can show how racism, poverty and other pressures shape outcomes across the life course. It can also show where systems need to change rather than place responsibility on individuals. Without this focus, population-level interventions risk repeating patterns of exclusion or failing to reach the communities most affected by structural harm.

WHAT WE LEARNT FROM THE INTERVENTIONS

1. **Community embedded mental health information and advice builds trust**

   Many interventions succeed because they are delivered by organisations rooted in racialised communities. Trust is a major barrier to statutory mental health services, and community-based information and advice can bridge this gap. This reinforces the need for long-term investment in community infrastructure rather than short-term project funding.

2. **Cultural competence is essential for effective signposting and social prescribing**

   Signposting is common across interventions, but previous research shows that mainstream social prescribing often lacks cultural relevance. The projects in this review demonstrate that culturally competent signposting improves access and engagement. Policymakers should ensure that social prescribing models are redesigned with cultural specificity at their core.

3. **Advocacy and referral support are vital for navigating statutory systems**

   Some organisations provide direct advocacy to help people access NHS services. This reflects a wider structural issue: statutory services remain difficult to navigate, especially for people facing language, cultural or bureaucratic barriers. Advocacy should be recognised as a core component of equitable mental health pathways.

4. **Stigma remains a major barrier, especially for young men**

   Several interventions address stigma linked to masculinity, faith or cultural norms. This suggests that mental health promotion must be tailored to specific groups and identities. Policymakers should support targeted anti-stigma work that is codesigned with communities.

5. **Wellbeing and creative health activities support mental health and build confidence**

   Projects offering activities such as gardening, cooking, dance, poetry and meditation show benefits beyond mental health improvement. They help people build life skills, reduce isolation, and increase confidence in engaging with statutory services. This highlights the value of non-clinical, asset-based approaches.

6. **Skills development and employment support are important but underused**

   Only a small number of interventions focus on employment or housing, despite strong evidence that these are important factors in mental health. Policymakers should integrate mental health with employment, housing and skills programmes to address root causes of distress.

7. Language support is a critical but overlooked need

Six projects provide linguistic support, showing that language barriers remain a major obstacle to accessing care. Policymakers should ensure that interpretation and translation are funded, high quality and culturally sensitive across all mental health pathways.

8. Peer support and mentoring are powerful tools for engagement

Peer-led models help people feel understood and reduce fear of statutory services. They are especially effective for young people. Policymakers should expand peer support roles and ensure they are properly funded, trained and integrated into care pathways.

9. Community organisations face structural barriers: funding, capacity and evaluation

Many organisations struggle with insecure funding, limited capacity and the administrative burden of monitoring and evaluation. These pressures undermine sustainability. Policymakers should simplify reporting requirements, provide core funding and invest in capacity building for community organisations.

10. Campaigning and youth led social action can shift narratives and challenge stigma

Campaign-based interventions, such as Young Changemakers, show that young people can lead powerful work on mental health inequalities. Policymakers should recognise campaigning as a legitimate form of mental health intervention and support youth led social action.

WHAT WE LEARNT FROM THE WORKSHOPS

We organised three workshops in September and October 2025 to gather opinion on how population-level actions can promote anti-racism and cultural change in mental health. There were 40 participants overall, including people with lived experience as well as colleagues from charities, councils, universities, and community groups, discussing issues such as racial trauma, inequality, missing data, leadership, joint working and service redesign. The discussion was shaped by recent protests, sector restructuring and worsening mental health outcomes for racialised communities.

In this section we set out seven themes that we drew from the workshops. Participants called for major changes across systems and stressed the need for care that respects diversity, ideas coproduced with people with lived experiences, as well as stable funding for community groups. Quotes from the workshops show how urgent this work is, and we hope that they will guide decision makers to include anti-racist practice in mental health systems, and focus on prevention, fairness and wellbeing. All quotes in this section are from workshop participants.

STRUCTURAL RACISM AND RACIAL INJUSTICE

Racial trauma and chronic stress

Racism was described not only as a social injustice but as a chronic stressor with far reaching mental health consequences. Participants said that racial trauma builds up over time, is often overlooked, and happens in everyday interactions with services.

> **"Racism shows up in every part of the system... it creates poor mental health, blocks access, delays discharge and undermines recovery."**

This trauma is shaped by histories of exclusion, surveillance and violence. It influences how distress is experienced, expressed and responded to within mainstream services.

Racial trauma isn't just about personal experiences. It is made worse by wider issues like housing problems, policing, immigration rules and cuts to services. These factors affect mental health but are often overlooked in clinical care.

> **"We're witnessing a scale and mobilisation of racist activity... the mental health data shows things are getting worse, not better."**

Systemic disparities and hostile climate

Participants pointed out ongoing inequalities in mental health care: Black people are detained more often under the Mental Health Act, and racialised communities have worse outcomes, less access to culturally appropriate care and more coercion.

> **"The likelihood of being sectioned for Black people is even greater than it was before."**

Participants also noted that discrimination is often intersectional, overlapping across race, class, LGBTQIA+ identity and disability. They wanted approaches that respect differences within and between racialised communities, rather than treating them all the same.

Many participants noted the increasingly hostile climate in which anti-racist work takes place. They described a political environment shaped by the rise of right wing narratives, public protests that target immigrants, and organised street movements that direct anger towards racialised communities. These developments sit alongside longstanding institutional discrimination. Together they create conditions in which racialised people feel less safe and more exposed to harm.

"Language matters as does trust… 'hard to reach' is derogatory and exacerbates disparities."

Participants stressed that this climate affects daily life. It shapes public attitudes and influences how communities understand their place in society. It also places pressure on community organisations, which are expected to offer safety and support while working with limited resources.

In this context, anti-racist work becomes more urgent because the harms are increasing. It also becomes more difficult because the systems that should protect racialised communities are influenced by the same political forces. Public debate often resists open discussion of racism and structural inequality, which limits the space for honest work on these issues.

"An attack on one racialised person is felt by every racialised person."

One participant from a local authority expressed this clearly, saying that an attack on one racialised person is felt by every racialised person. The harm is collective, and the response must address the wider conditions that allow racism to grow. This includes action on poverty, housing, employment, education and community safety, as well as a commitment to challenge discriminatory practices in services and institutions.

DATA, POLICY AND GOVERNANCE

Inadequate and inaccurate data

Ethnicity data is often inaccurate or incomplete. It misses undocumented workers, temporary migrants, and groups such as East and Southeast Asian communities. Data usually reflects only people using services, leaving out whole communities. Lived experience and qualitative insights are rarely included.

"What's not counted doesn't count."

Policy frameworks

Despite widespread acknowledgment of racial inequities, policy delivery remains inconsistent. Participants stressed the need to embed race equity monitoring across NHS systems.

Frameworks such as the Patient and Carer Race Equality Framework (PCREF) were acknowledged, and on occasion praised, but also criticised for superficial uptake. Participants called for more detailed and transparent metrics that reflect community realities.

"Equality frameworks are often outdated or used to avoid naming racism directly."

"Deficit-based metrics focus on individual shortcomings rather than systemic failures."

Governance gaps

There was a strong call for robust governance mechanisms and local oversight. Tools that measure health equity must be embedded across system, not treated as optional or symbolic. An example of a successful initiative was the roll out of a Heath Equity Toolkit in Newham (see here).

"Progress depends on bridging the gap between policy intent and delivery."

Local mechanisms for oversight and action were seen as essential. Without accountability, policies risk becoming performative or disconnected from reality.

SERVICE DESIGN AND COMMUNITY INFRASTRUCTURE

Primary care

Participants had many insights into how and why the existing health services are failing racialised communities. They emphasised the importance of primary care in the support of mental illness, but noted that primary care staff often struggle to build strong relationships with racialised communities. To fix this, they argued for better workforce training, more cultural awareness and stronger community partnerships.

"Primary care is where people first show up… but it's not always equipped to respond."

Community-based interventions

Participants also called for a shift away from over-medicalised models and coercive approaches towards population-level interventions that focus on prevention, not just treatment which address the social determinants of health.

"Mental health services treat racialised communities as homogenous… ignoring diversity of experience."

They emphasised community-based interventions, ones that can reflect cultural realities, prioritise early intervention and youth provision, and offer non-clinical support. Participants called for integrated models that connect primary and specialist care with community organisations, ensuring continuity, responsiveness and equity.

Lived experience and coproduction

Lived experience was described as central, but participants warned against coproduction that manifests in name only. True coproduction requires time, skill and resource. Participants said that services should embed lived experience and community input in their design and review. Working together builds trust over time.

"Sometimes what we call coproduction is little more than consultation."

Community-led innovation

Participants want models of community-led care that can learn and evolve, while maintaining their key principles. These models are not like traditional, western influenced care, but instead offer a variety of culturally suitable options. Examples of promising practice included Black Thrive Lambeth and Taraki.

Participants also argued that funding models must reward equity-driven innovation and support organisations led by and for racialised communities. Sustainability is key to building trust and achieving long-term impact.

"None of this can be done on short-term funding... there are no quick fixes."

LEADERSHIP, WORKFORCE AND CULTURE

Leadership as a catalyst

Change was seen to occur when leaders act with honesty and care, often at personal risk. However, such leadership is fragile without systemic support.

"Change happens when leaders show up and speak truth to power... but the cost to individuals can be significant."

Participants want leadership training that focuses on fairness, ethics and long-term impact. Leadership should be shared, well supported and responsible, and not dependent on one person.

Workforce support and cultural competence

Staff from racialised communities often face extra emotional strain. Participants asked for training, supervision and opportunities for all staff to learn about, and deal with, racism and its impacts.

Organisational culture should make staff and service users feel safe, seen and valued. Cultural competence is not just a checklist. It needs real relationships and ongoing learning. It is a long-term commitment.

"Staff need support to reflect the communities they serve... and to understand their role in perpetuating or challenging inequity."

TRUST, LANGUAGE AND ACCESSIBILITY

Rebuilding trust

Historical and ongoing racism has eroded trust in mental health services. Reparative approaches – which acknowledge historic harms – and transparent communication were seen as vital.

"People need to feel safe, seen and valued."

Participants stressed the importance of relational care and culturally competent practice. Trust cannot be assumed. It must be earned through consistent, accountable action.

Language and stigma

Language was identified as a barrier to access. Terms like 'hard to reach' were criticised for reinforcing exclusion. Translation gaps and stigma can prevent people from seeking help before they reach crisis.

Participants called for investment in translation, outreach and culturally competent communication. Accessibility must be built into every layer of service design.

CONCLUSIONS

The literature review that we conducted for this report emphasised the importance of understanding racism as a system for which we are jointly responsible as a society rather than as a series of individual events and outcomes. Racism is a force embedded across society and within its systems and institutions, including the health system. This is what is meant by structural racism. When we talk of racism within organisations and institutions the narrower term institutional racism is also appropriate. In addition, discrimination is often intersectional – it is made up of overlapping factors. This explains, for instance, how the disadvantage of being racialised may be compounded by other factors that include gender, disability, sexuality and gender identity, as well as socioeconomic status.

Health inequities result from a failure to address inequalities in the social determinants of health, and discrimination is an important part of these social determinants. Mental health services have poor engagement with people from racialised communities. As a result, people from racialised communities are more likely to delay presenting to services until they are in crisis, are more likely to experience compulsory detention, and are less likely to achieve good outcomes. Discrimination is woven into this pattern of events at every point.

The health inequalities experienced by racialised communities reflect several important factors. Notably, the lifetime experience of racial trauma as well as exposure to historic and intergenerational trauma. One response to this is trauma-informed care, a framework that aims to identify and understand the impact of trauma. In addition, young people from racialised backgrounds are treated unequally in mental health settings, with research showing that racism results in discrimination in referral routes to mental health services and disproportionate rates of criminalisation. However, within different ethnic groups are different age profiles, migration histories and social class profiles, all of which influence peoples' experiences of racism and discrimination.

The duties of public bodies, such as the NHS and GLA, to combat racism are mandated by legislation. However, there is currently a limited amount of testing of these duties. Moreover, a persistent problem is gaps in data on ethnicity, and "statistical invisibility" in many of the domains of public health, which hampers the measurement of the prevalence and impact of structural and institutional racism within the public health system. This undermines efforts towards anti-racism and structural accountability.

Population-based interventions are programmes or policies that aim to prevent disease or promote health across an entire population or a significant subgroup of the population. They can happen in one of three domains: civic-level interventions; service-based interventions; and community-centred interventions. Elements within population-based interventions commonly include:

- A focus on the social determinants of health, including at different life stages
- A focus on building community leadership and promoting system-wide prevention measures, rather than finding cures
- Community engagement and coproduction.

As part of this report we conducted a mapping exercise, looking at current or recent population-based interventions across the UK that address racism and mental health. 23 projects were selected, including nine that are nationwide, ten from London and four are from other cities or regions. The focus was mainly on community-centred interventions, in accordance with the brief of this report, however, some of the projects were civic-level or service-based interventions. A third of the interventions are aimed at racialised people in general, another third are aimed at Black people, and the final third were aimed at other racial or ethnic identities. A significant proportion of the projects are aimed at young people, while smaller proportions are aimed at other groupings – including women, and asylum seekers.

The population-based interventions we examined revealed some interesting features. Half of the projects can be characterised as offering mental health information and advice. This included:

- Signposting
- Referrals and advocacy
- Addressing stigma.

A quarter of the projects are focused on the support of wellbeing and the development of skills. This included:

- Wellbeing activities
- Skills development
- Employment and/or housing support.

Other groups of projects focus on:

- Linguistic support
- Peer support and mentoring
- Service improvement
- Campaigning.

In addition, we conducted three workshops with people with lived experience, to ask for their input. Many of the participants spoke about their experience of racial trauma and chronic stress. Racism was described not only as a social injustice but as a chronic stressor, with effects that build over time. In addition, participants attested to how racism contributes to ongoing inequalities in mental health care, and said that clinical services often neglect the impact of racism as well as the social determinants of health more widely. Finally, some participants noted the importance of an intersectional approach to disadvantage, while many emphasised the added stress of the increasingly hostile political climate.

One set of insights from the workshops was around data, policy and governance. It was noted that ethnicity data is often inaccurate and incomplete. Moreover, participants argued that policy delivery remains inconsistent and that existing policy frameworks are inadequate. Frameworks should be reworked to make them more detailed, more transparent, and more reflective of community realities. Finally, better governance and much higher accountability is required.

Participants in the workshops also addressed service design and community infrastructure. Primary care was viewed as essential in the support of mental illness – but better workforce training and stronger community partnerships are required. In general, participants called for a shift away from over-medicalised models and coercive approaches towards population-level interventions which address the social determinants of health – with a focus on prevention, not just treatment.

They emphasised community-based interventions, ones that are culturally competent, that can learn and evolve, and that prioritise early intervention, youth provision and non-clinical support. Finally, they said that proper coproduction is essential – but that it requires time and commitment.

Additional topics addressed in the workshops included leadership, workforce and culture. Participants argued that good leadership is key but requires significant support and training. Moreover, they said that staff from racialised communities often face extra stress, require support and training, and that organisational culture should make both staff and service users feel safe, seen and valued. Finally, participants addressed trust, language and accessibility. Many people pointed out how racism has eroded trust in mental health services, and that language and stigma still create barriers to accessing support. Reparative approaches, culturally competent practice and accountability are all vital.

Racism affects mental health at every stage. It harms access, outcomes and trust. Moreover, although policies to tackle racial inequities in mental health exist, they lack community competence and have low levels of enforcement, while poor data and weak leadership slow progress. Major changes in public policy and strategy are needed so that we can truly move beyond treating individuals and towards tackling systemic issues. Moreover, these policy changes need to support real community involvement and provide sustainable funding for community partners. Population-based interventions – and especially community-led interventions – have a very important role to play in addressing racial trauma, reflecting cultural competence and redesigning services to fit community need. Finally, this project will not succeed unless it is built on trust, fairness and accountability.

RECOMMENDATIONS

1. Make racial trauma a central public health concern

London can place racial trauma at the centre of its public health work, with clear lines of accountability for progress. Anti-racist, trauma-informed and culturally competent care can shape routine practice across services, supported by safe spaces led by racialised communities. The Greater London Authority should set the direction, health bodies should show how commissioning meets this aim, VCSE organisations should lead community based support, and primary care should bring trauma-informed practice into everyday care. Each part of the system should report on its role and the outcomes it achieves.

2. Build services that offer choice, safety and cultural competence

Services can move toward models that reduce coercion and offer early support through community hubs, crisis cafes, peer networks and creative health programmes. Regional NHS bodies should set expectations for this shift and show how they are met. Borough commissioners should invest in community options and report on reach and impact. VCSE partners should shape and deliver these models, and primary care should guide people toward early help. Clear measures of safety, access and experience can support accountability across the pathway.

3. Strengthen community-led organisations through stable investment

VCSE organisations need secure funding so they can plan, grow and support their workforce. Multi-year investment can improve access to culturally safe support and strengthen local systems. City and borough leaders should embed VCSE partners in commissioning cycles and show how funding decisions support equity. VCSE organisations should codesign services that reflect lived experience, and primary care networks should build clear referral routes. Shared reporting can show how investment leads to change.

4. Share power through meaningful engagement

Communities should shape decisions from design to evaluation, with clear accountability for how their insight is used. Paid lived experience roles and shared boards can support this shift and build trust across systems. Local health and council leaders should make meaningful engagement a core expectation and show how it influences decisions. VCSE partners should hold space for community insight, Healthwatch should offer independent oversight, and primary care should take part in shared governance. Public reporting can show where engagement has led to change.

5. Make equity visible and measurable

Better ethnicity data and open reporting can show where exclusion takes place and guide action. Mixed evidence, including community insight, should shape decisions across systems. Health bodies should lead improvements in data quality and show how data informs planning. Borough public health teams should monitor patterns and report on progress. VCSE partners should contribute participatory data, and primary care should improve recording and share insight on access. Clear measures and regular reporting can support accountability for change.

6. Build a workforce that can deliver anti-racist, trauma-informed and culturally competent care

Staff across the system need support to develop the skills, confidence and insight needed for anti-racist, trauma-informed and culturally competent care. This includes space for reflection, supervision shaped by community knowledge and clear routes for racialised staff to move into leadership. Workforce leaders should shape training and show how it improves practice. Primary care networks should support learning across teams, and VCSE partners should codeliver programmes that draw on lived experience. Regular review of workforce data and outcomes can support accountability for progress.

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APPENDIX ONE: INTERVENTIONS

Full details of the 23 projects selected from desk-based research. These are all population-based interventions across the UK that address racism and mental health. The themes are those identifed in the report.

ACTIVE LIVES, HEALTHY MINDS

Themes

Mental health information and advice

Date: 2016-19

Geographical range: London (West London)

Target demographic: Nepalese, Somali and Tamil

Organisers: Race on the Agenda

Partners: Equals CIC, Helplink and Tamil Community Centre

Funded by: Reaching Communities – the Big Lottery Fund

Evaluation: conference

A mental health and wellbeing project that is being implemented in West London focusing on the Eritrean, Nepalese, Somali and Tamil communities. The project aims to improve mental health and the wellbeing of members of the communities, supporting them to increase participation in the development and implementation of relevant mental health and health services in the area.

Members of the Eritrean, Nepalese, Somali and Tamil communities have experienced severe loss and disruption of their lives due to war, civil unrest and natural disaster in their countries of origin, followed by the traumatic experience of flight and then the stress caused by the asylum process and difficulties adapting to new language and cultural settings. The project will assist community groups in developing activities to support the mental health and wellbeing in a culturally sensitive and non-stigmatising way.

Active Lives, Healthy Minds (ALHM) follows on from a previous three year ROTA project called Healthy Mobilised and BAME (2012-15) which worked from a baseline whereby service users were engaged and made aware of mental health issues in year one, to building skills and development through year one, two and three to a position where they were more content with their life from their own perspective. The lessons from Healthy Mobilised and BAME formed the basis of ALHM.

More information:

https://rota.org.uk/our-work/previous-work/active-lives-healthy-minds-project/

https://rota.org.uk/wp-content/uploads/2019/06/events_ALHM-Hardly-Hard-to-Reach-Report-MH-26062019-Final.pdf

AL-HASANIYA MOROCCAN WOMEN'S CENTRE

Themes

Mental health information and advice:

- Signposting
- Referrals and advocacy
- Addressing stigma
- Linguistic support

Date: unknown (current)

Geographical range: London (West London)

Target demographic: Arab women

Organisers: NA

Funded by: unknown

Evaluation: unknown

The Mental Health project offers individual support for Arabic-speaking women who suffer from enduring mental health problems and live in the Royal Borough of Kensington and Chelsea, West London.

Women experiencing mental health problems often find their difficulties impact on their daily life. Those from Arabic-speaking communities can also find themselves very isolated, due to the stigma which still exists in the community with regards to mental ill-health.

This can make it particularly difficult for women to ask for help and access the services which can support them. Shame and fear is usually associated with why many of our service users tend not to seek help when needed, we are able to create a space for our service users to feel safe and comfortable and in a non-judgemental environment in order for them to express their worries and concerns to our trusted service.

Our service provides practical and emotional support for both the women and their families. A programme of advice, advocacy and referrals helps the women deal with their practical problems and access mainstream NHS services.

More information: https://www.al-hasaniya.org.uk/mentalhealth

BAMESTREAM

Themes

Mental health information and advice

Wellbeing and skills:

- Wellbeing activities

Date: 2020-21 (?)

Geographical range: London

Target demographic: Black and racialised communities in general

Organisers: The Ubele Initiative

Funded by: unknown

Evaluation: conference

BAMEStream was an alliance of mental health practitioners, therapists, policy specialists, organisations, activists and academics, dedicated to bringing the mental health needs of Black and minoritised communities into the mainstream.

A range of activities were delivered across the project partnership in each of the three locations across London. Over 150 participants have been involved in activities such as English language provision, sewing and tailoring, cookery, exercise and yoga, head massage, relaxation, welfare support and immigration advice, training on personal budgets and training on mental health and equality legislation.

More information:

https://www.bamestream.org.uk/

https://ubele.org/our-work/bamestream

BAYO

Themes

Mental health information and advice:

- Signposting (a directory of services)

Date: Launched 2021

Geographical range: UK

Target demographic: Black

Organisers: Developed by Ubele Initiative (who also run it), Mind, Young Minds and Best Beginnings

Funded by: National Emergencies Trust

Evaluation: unknown

BAYO means 'Joy has found us' in Yoruba and it is a space to find collectives, organisations and services from across the UK -- for the Black community -- to support mental health and wellbeing.

Community organisations and individual that provides mental health and wellbeing services to diverse young people from the black community, are invited to join the BAYO digital platform and become a member of the Network – which provides them with access to free learning packages, peer to peer support, networking and access to a small grant programme.

More information: https://www.bayo.uk/

BLACK MENTAL HEALTH MANIFESTO

Themes

Campaigning

Date: launched 2024

Geographical range: UK

Target demographic: Black and racialised people in general

Organisers: various

Funded by: unknown

Evaluation: unknown

The Black Mental Health Manifesto was born out of the collective efforts of the Black Mental Health and Wellbeing Alliance a coalition made up of individuals and groups, including Black and racialised people with lived experience, caregivers, practitioners, researchers, and representatives from community organisations and national charities. Many organisations have signed up.

Points in the manifesto include:

1. The Government should develop and implement a comprehensive strategy to
2. Eradicate racism from society and appoint a cabinet level minister to oversee this.
3. All NHS Trusts, VCSE and mental health service providers should embed NHS England's Patient and Carer Race Equality Framework (PCREF) by March 2025.
4. Policymakers, academic institutions, and funders should actively invest in and engage with community research conducted by and for Black communities in a meaningful way.

More information: https://www.bmhwa.co.uk/

COFFEE AFRIK

Themes

Mental health information and advice

- Wellbeing and skills:
- Skills development

Date: unknown (current)

Geographical range: London (East London)

Target demographic: women and young people from Black and racialised communities

Organisers: NA

Funded by: unknown

Evaluation: unknown

Coffee Afrik is a community organisation led by lived experience and working across East London. It collaborates with women and young people from Black and racialised communities, running community hubs that provide life-saving services, building knowledge, skills and connections in the pursuit of power.

We currently oversee 28 projects, across seven community-led hubs, including a Youth Hub, two Women's Hubs, a problematic drug use safe space, a research lab, and a systemic litigation space.

Since 2019, we've been commissioned by the East London NHS Foundation Trust to run a culturally sensitive Community Connector Service. We've since supported thousands of clients to access support for housing, employment, mental health care and much more.

More information: https://www.coffeeafrique.co.uk/

COMMUNITY MENTAL HEALTH TRANSFORMATION PROGRAMME

Themes

Service improvement

Date: 2019-24

Geographical range: East London, Bedfordshire and Luton

Target demographic: racialised people in general

Organisers: NHS Foundation Trusts in the relevant areas

Funded by: NHS Long Term Plan

Evaluation: unknown

The Community Mental Health Transformation Programme provided an opportunity to identify and address the unmet mental health needs of people in racialised communities.

This pioneering transformation work – which began in inner London footprint (Tower Hamlets, Newham and City and Hackney) in 2019, before extending to Bedfordshire and Luton in 2021 – was an ambitious programme of change.

It involved lots of conversations with staff from stakeholder organisations, service users and local citizens to design and test new ways of working, and to help reshape community mental health services enabled by new NHS Long Term Plan investment.

Through workshops, focus groups and localised work in newly-formed 'blended teams,' it aimed to coproduce improvements to mental health care based in and around primary care networks.

More information: https://www.elft.nhs.uk/information-about-elft/community-mental-health-transformation-programme

ENABLING ESEA COMMUNITY RESILIENCE

Themes

Wellbeing and skills:

- Wellbeing activities
- Skills development
- Employment support
- Housing support
- Linguistic support

Date: 2023-25

Geographical range: London

Target demographic: Southeast and East Asian people

Organisers: Bahay Kubo Housing Association (BKHA), Kanlungan Filipino Consortium (Kanlungan), and Southeast and East Asian Centre (SEEAC)

Funded by: The National Lottery

Evaluation: unknown

The Enabling ESEA Community Resilience project was dedicated to empowering and strengthening the East and Southeast Asian (ESEA) communities in London.

The mission was to provide support, resources and opportunities to vulnerable ESEA communities and individuals from diverse backgrounds, including Filipino, Vietnamese, Indonesian, Malaysian, Korean, Thai, Japanese and others. This three-year project addressed issues related to employment, housing and mental health, with the ultimate goal of building adaptable and resilient communities capable of overcoming future challenges.

The project offered a range of workshops, such as employment skills training (including job search workshops, certification for job skills qualifications, literacy/numeracy, digital training, and financial literacy), mental health and wellbeing workshops (including intercultural dance classes, meditation, relaxation techniques, gardening, healthy cooking and public health information) and cultural festivals. The services and activities aimed to strengthen intergenerational bonds within the ESEA communities and create connections with the broader British community.

More information: https://www.seeac.org.uk/enabling-esea-community-resilience

ETHNICITY AND MENTAL HEALTH IMPROVEMENT PROJECT (EMHIP)

Themes

Service improvement:

- Consultation exercise

Date: Launched 2019

Geographical range: London (Southwest London)

Target demographic: Black and racialised communities in general

Organisers: South West London and St Georges Mental Health NHS Trust, South West London Clinical Commissioning Group, and Merton & Wandsworth Locality

Funded by: unknown

Evaluation: unknown

The Ethnicity and Mental Health Improvement Project (EMHIP) is an attempt to reduce ethnic inequalities in access, experience and outcome of mental health care in South West London.

EMHIP has been designed to be a practical, locally based, service improvement programme to bring about change for racialised communities in mental health care. The aim of the programme is to reduce inequalities in three specific areas where racialised communities fare worse: in access, experience and outcomes of mental health care.

EMHIP is a collaborative project involving a number of NHS providers in South West London, working with networks of voluntary, faith and community groups, convened by the Wandsworth Community Empowerment Network.

EMHIP has recognised the need for change in the mental health system and the community. The project sets out a clear approach for system-wide change and addresses discriminatory patterns of mental healthcare by creating a programme that was developed and adapted through coproduction with people from racialised communities.

More information: https://emhip.co.uk/

HARAMBEE

Themes

Service improvement:

- Organisational development

Date: Launched 2025

Geographical range: London (South London)

Target demographic: Black children, families, parents and carers

Organisers: Partisan, Milk Honey Bees, Loughborough Community Centre and ParentSkills2Go

Funded by: Impact on Urban Health

Evaluation: unknown

Partisan is a small, Black-led Community Interest Company, centred on a team of diverse, culturally sensitive, forward-thinking team of experienced psychotherapists and clinical psychologists. In Summer 2025 Partisan has announced the launch of a new partnership in Lambeth and Southwark, as part of an initiative to improve mental health disparities for Black children, families, parents, carers and other community members.

In this project - entitled Harambee: Our Say, Our Way - Partisan is joined with three other Black-led organisations, and will be working collectively with the Black community in Lambeth and Southwark to design and invest £150,000 toward initiatives aiming to improve mental health outcomes. They are looking for seven community members between the four partners, who will help direct how the £150,000 pot gets used to design alternative mental health help systems in the community.

Importantly, it will explore these ideas collectively, through a codesign process that aims to give all partners, and the communities served, the power to decide what they want to do and how they want to do it. Additionally, the project partners will be exploring how to grow their own capacity as Black-led organisations, strengthening infrastructure and services together, and building worldview through skills and knowledge sharing.

More information:

https://www.partisanuk.org/

https://www.partisanuk.org/blogs-news/harambee

IRIE MIND

Themes

Mental health information and advice:

- Signposting
- Referrals and advocacy
- Addressing stigma

Date: Launched 2019

Geographical range: London (East London)

Target demographic: Black people

Organisers: Mind (City, Hackney and Waltham Forest)

Funded by: unknown

Evaluation: unknown

IRIE Mind is a mental health initiative run by and for the African-Caribbean community in Hackney. IRIE Mind is an awareness raising group but also runs services for the Black community.

Services include:

- An emergency and crisis centre, including a 24-hour helpline, a support group and a walk-in crisis café
- Peer mentoring for young black men
- Wellbeing activities.

Themes in services:

- Emphasising prevention over crisis intervention
- Enabling culturally specific interventions
- Collaborating with statutory services.

More information: https://iriemind.org/

KORI

Themes

- Peer mentoring and support

Date: Founded 2002

Geographical range: UK

Target demographic: young Black people

Organisers: NA

Funded by: unknown

Evaluation: unknown

KORI is a youth-centred foundation developed by African and Caribbean community artists. It is engaged in supporting hundreds of young people with vulnerabilities in their backgrounds that pose a threat to their futures. Over two decades it has helped thousands of young people transcend negative stereotypes, actively contributing to their development at crucial phases in their lives.

Educational and employment opportunities are not universally accessible. Inequality persists, hindering the potential of countless young minds. As a means of bridging the inequality gap, IRIE strives to break down these barriers, offering educational resources and mentorship programmes to young people from predominantly black and racialised communities, aged 11-25 years. The programmes empower youth with the tools to navigate life's challenges, fostering resilience and well-being.

KORI offers in-house counselling for 18+ used by both young people and parents. Its work is driven by a passion for empowering the next generation. By addressing the barriers that young people face head-on, it strives to create a world where every young person has the opportunity to thrive.

More information: https://kori.org.uk/

POETIC UNITY

Themes

Mental health information and advice

- Wellbeing and skills:
- Wellbeing activities

Date: Founded 2015

Geographical range: London (South London)

Target demographic: young people of Black and mixed-Black heritage

Organisers: Poetic Unity

Funded by: unknown

Evaluation: unknown

Poetic Unity is a Black-led charity that provides spaces for learning, expression and joy through poetry. Based in Brixton, Poetic Unity offers a service by the community, for the community, predominately supporting young people of Black and mixed-Black heritage, aged 10-30.

Its work centres the needs and experiences of the young people it supports, recognising poetry as a therapeutic tool that unites and heals communities, celebrates identity and challenges injustice. Through targeted education, employment, social justice and mental health support, it aims to create safe and friendly environments in which young people can express themselves and feel valued in the community.

More information: https://www.poeticunity.org.uk/

RIGHT TO THRIVE

Themes

Service improvement:

- Organisational development

Date: 2018-24

Geographical range: London

Target demographic: Black and racialised people in general

Organisers: Thrive LDN

Funded by: Mayor of London

Evaluation: unknown

Right to Thrive was a grants programme designed to enable grassroots and community-led organisations to support Londoners at disproportionate risk of poor mental health and wellbeing. It invested more than £500,000 in grassroots and community-led organisations, engaging directly with Londoners at disproportionate risk for poor mental health and wellbeing. Supported projects included ethnic minority organisations.

More information: https://thriveldn.co.uk/about/our-activities/right-to-thrive/

SAHAYAK

Themes

Mental health information and advice:

- Signposting

Date: unknown (current)

Geographical range: Kent and West Sussex

Target race / ethnicity: Asian

Organisers: Rethink

Funded by: unknown

Evaluation: unknown

Sahayak is a mental health helpline offers a culturally sensitive listening and information service for the Asian community in Kent and West Sussex. The service is for anyone affected by mental health issues - whether they are service users, carers or friends and people affected by domestic abuse.

People who call the helpline can expect to be listened to, treated with dignity and respect, given emotional support and signposted to useful sources of information. Calls can be taken in four different Asian languages (Gujarati, Punjabi, Hindu and Urdu) as well as English.

SHARING VOICES

Themes

Mental health information and advice:

- Linguistic support

Peer mentoring and support:

- Befriending

Date: unknown (current)

Geographical range: Bradford (Yorkshire)

Target demographic: Black and racialised people in general

Organisers: NA

Funded by: unknown

Evaluation: unknown

Sharing Voices is a community mental health organisation actively supporting and working with diverse minority communities of Bradford.

It understands that an individual's mental health experience can arise from a combination of issues, including poverty, racism, unemployment, loneliness, family conflicts, relationship difficulties and other socio-economic and personal factors.

Understanding where an individual is, on their journey of recovery, listening to people's own explanation and helping find solutions based on their needs, is a key part of its work.

Services include one-to-one and home visits, group sessions and befriending.

More information: https://sharingvoices.net/

SHIFTING THE DIAL

Themes

Wellbeing and skills:

- Skills development
- Employment support
- Housing support
- Peer mentoring and support

Date: 2018-21

Geographical range: Birmingham

Target demographic: young Black men

Organisers: First Class Foundation, Centre for Mental Health, The Rep, and Birmingham and Solihull Mental Health NHS Foundation Trust

Funded by: unknown

Evaluation: Centre for Mental Health

Shifting the Dial was a three-year partnership that sought to promote the mental health of young Black men aged 16-25 based in Birmingham. The innovative partnership included:

Birmingham Repertory Theatre (The Rep): Hosted the programme and Lightpost Theatre Company, a dedicated theatre group led by and for young Black men.

Centre for Mental Health: Led on the evaluation and facilitated peer-led research.

First Class Foundation: Engaged young Black men through the Dear Youngers project delivering peer to peer support, outreach, forums, mentoring and skill development

Birmingham and Solihull Mental Health NHS Foundation Trust: Led on the development of employment pathways and opportunities for young people including apprenticeships, volunteering and work experience.

The projects worked together collectively to influence system change. The findings in the report are based upon a three-year process and impact evaluation led by Centre for Mental Health in collaboration with a network of young peer researchers.

More information:

https://www.centreformentalhealth.org.uk/publications/shifting-dial/

SIKH YOUR MIND

Themes

Mental health advice and support

Date: Founded 2015

Geographical range: UK

Target demographic: Sikh and Punjabi people

Organisers: NA

Funded by: unknown

Evaluation: unknown

Sikh Your Mind is a Sikh charity which offers professional support to the Sikh and Punjabi community. Its services include a telephone helpline, live chat, virtual women's group, student spaces as well as in-person workshops and presentations. It has also undertaken and published research.

More information: https://sikhyourmind.com/

300 VOICES

Themes

Service improvement:

- Consultation exercise

Date: 2013-16

Geographical range: UK

Target demographic: young Black men

Organisers: Mind, with Time to Change and three NHS Foundation Trusts

Funded by: unknown

Evaluation: Mind

This work focused on reducing the stigma and discrimination in mental health hospitals and the police.

It also looked at helping young Black men to take greater control of their mental health.

The project brought together staff from a range of services. people with experiences of mental health problems and community representatives.

Together, they explored how to improve young Black men's experience of mental health support.

https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/young-black-men/

https://www.berkshirehealthcare.nhs.uk/media/110205634/mha-dp-engagement-report.pdf

UP MY STREET

Themes

Mental health ad-vice and support (street therapy)

Date: 2016

Geographical range: UK

Target demographic: young Black men

Organisers: Mind, with Integrate Movement, Centre for Mental Health and First Class Legacy

Funded by: unknown

Evaluation: Centre for Mental Health

The Up My Street project supported young Black men aged 15 to 25. It helped them build their mental health resilience and talk to each other and their families.

It implemented a street therapy approach, going out to talk with young people on the street, or in a youth centre. This helped young people to get the support they needed in a flexible and informal way.

More information:

https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/young-black-men/
https://www.centreformentalhealth.org.uk/publications/against-odds/

WELLBEING INTERVENTION

Themes

Mental health information and advice:

- Signposting

Wellbeing and skills:

- wellbeing activities

Linguistic support

Date: 2014

Geographical range: Northwest England

Target demographic: South Asian and Somalian women

Organisers: School of Nursing Midwifery and Social Work, Manchester; NIHR School for Primary Care Research, University of Manchester; Institute of Psychology, Health and Society, University of Liverpool

Funded by: National Institute for Health Research (NIHR)

Evaluation: peer-reviewed journal articles

This intervention involved 57 South Asian and Somalian women with moderate depression and/or anxiety in Northwest England. The intention was to improve treatment of depression and anxiety using social and community interventions.

A group of participants received individual or group therapy-style sessions, or usual care. Activities focused on health and wellbeing, as well as signposting to service and education opportunities.

The study provides evidence in favour of social group interventions for short-term improvements of mental health; but no statistically significant findings, and the small sample size and lack of control group limit the generalisability of the findings.

More information:

https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-014-0217-8
https://bmjopen.bmj.com/content/bmjopen/11/4/e041102.full.pdf

YOUNG BLACK MEN PROGRAMME

Themes

Mental health advice and support:

- Challenging stigma
- Peer mentoring and support

Date: 2019-22

Geographical range: UK

Target demographic: young Black men

Organiser: Mind

Funded by: The Matrix Causes Fund, ServiceNow, Terra Firma

Evaluation: Mind

T he programme offered locally tailored services for with young Black men aged 11 to 30 years. The aim of the programme was to learn what works when it comes to supporting the mental health of young Black men, addressing the barriers they face in receiving appropriate, timely support.

The services developed included:

- Peer support to prevent mental health problems
- Content to challenge stigma around mental health
- Support to encourage young men to access help
- Support to address material needs, such as access to housing and employment
- Practical ways to cope with challenging situations.
- Opportunities for creative expression
- Flexible ways to take part, for example being able to access services in person or remotely.

The project worked with five local Minds operations, including three in London as well as others in Coventry and Leeds. There were improvements to the mental wellbeing, self-esteem, and social support of a small number of young men who took part in the evaluation.

More information: https://www.mind.org.uk/about-us/our-policy-work/equality-and-human-rights/young-black-men/

YOUNG CHANGEMAKERS

Themes

Campaigning (youth-led)

Date: 2021-24

Geographical range: UK

Target demo-graphic: Black and Black mixed-heritage young people

Organisers: UK Youth, The Diana Award, and Centre for Mental Health

Funded by: People's Post-code Lottery and Comic Relief

Evaluation: Centre for Mental Health

The Young Changemakers programme represented a pioneering effort to reimagine mental health support for young people from Black communities across England.

The programme sought to support Black and Black mixed-heritage young people to lead and influence mental health support systems. By collaborating with young people aged 14 to 25, together with youth workers, the programme provided the tools and resources needed to develop youth-led social action projects addressing mental health inequalities, with a specific focus on those impacting Black young people.

A total of 92 Young Changemakers were recruited nationwide, and they spearheaded fifteen social action projects designed to improve outcomes for young Black people. These projects advocated for policy and practice changes and sparked important conversations about mental health within their local communities. The programme also worked alongside a total of 26 co-producers and 15 peer researchers across all of the cohorts.

More information:

https://www.centreformentalhealth.org.uk/publications/a-space-to-be-me

APPENDIX TWO: METHODS

Literature search / peer-reviewed literature

- Databases searched: PubMed; PsychINFO; Sociological Abstracts.
- Search terms used:
- ("mental health") AND ("racial" OR "ethnic" OR “racism”) and ("population" AND "intervention") and ("UK" OR "United Kingdom")
- ("mental health") AND (“racism”) and ("population" AND "intervention") and ("UK" OR "United Kingdom")
- Excluded: papers not addressing interventions in the United Kingdom; papers not written in English; papers that did not focus on an interventions, such as systematic reviews, conference papers and commentaries.

Literature search / grey literature

- Organisations, research and policy (general):
- Demos
- Institute of Public Policy
- Joseph Rowntree Foundation
- The King’s Fund
- McPin Foundation
- New Economics Foundation

Organisations, research and policy (health)

- Faculty of Public Health
- General Medical Council
- Health Foundation
- Mental Health Foundation
- Mental Health UK
- Mind
- Nuffield Trust

- Nursing and Midwifery Council
- Rethink
- Royal College of Psychiatrists
- Royal Society for Public Health
- Organisations, racialised communities (general):
- Action for Race Equality
- Institute of Race Relations (IRR)
- Race and Health Observatory
- Race Equality Foundation
- Race on the Agenda
- Runnymede Trust

Organisations, racialised communities (health)

- BAATN (The Black, African and Asian Therapy Network)
- BLAM (Black Learning Achievement and Mental Health)
- Bounce Black
- The Delicate Mind
- Taraki

Workshops

Recruited through Eventbrite, each of the three online workshops started with a summary of what we had found to date and then a discussion followed with the participants. Anonymity in reporting was assured. Experts by experience were offered a high street voucher as a token of thanks.

CENTRE FOR MENTAL HEALTH

SHIFTING POWER

THE ROLE OF POPULATION-LEVEL, ANTI-RACIST INTERVENTIONS IN ADDRESSING INEQUITIES IN MENTAL HEALTH

Published March 2026

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