healthwatch Southwark

Towards Inclusive Healthcare: Rethinking mental health services for Black African and Caribbean communities

Healthwatch Southwark

January 2025

Acknowledgements

We are deeply grateful to everyone who contributed to this project, in particular, the participants who generously shared their time, insights, and lived experiences with us. Thank you for your openness and trust.

We are thankful to our steering group members for their guidance and commitment. We are also grateful to our volunteers and Community Health Ambassadors, whose efforts in supporting data collection and reviewing this work have been invaluable.

Finally, we would like to thank staff and volunteers of the incredible VCS organisations who facilitated engagement for this project, namely Holistic Well Woman, RJ4ALL, The Redeemed Assemblies Food Bank, Paxton Green Time Bank, and Change Grow Live.

If you have any questions or comments on the report, please contact Ruman Kallar (Research & Projects Officer) at ruman@healthwatchsouthwark.org

Contents

1. Executive Summary

This project explores how Black African and Caribbean communities in Southwark perceive and experience mental health services. It is prompted by evidence of persistent inequalities in access, experiences of care, and treatment outcomes for these communities (Department of Health and Social Care 2018).

The research involved two phases: a survey and focus groups capturing general perspectives on mental health services, followed by additional focus groups and interviews focusing on Black men's views on non-clinical mental health support. A total of 79 individuals participated.

Findings reveal significant barriers to accessing mental health support, including stigma, distrust of public services, and limited awareness of available resources, particularly for early intervention and preventive care. Many participants associated mental health services with negative experiences, including being medicated or detained, leading to fear and avoidance. These challenges disproportionately affect Black men.

Isolation was identified as the most significant contributor to poor mental health among Black men. Most male participants described that they currently rely on informal coping strategies like socialising and exercising, rather than using mental health services. Participants, including men and women, expressed interest in non-clinical support, such as peer groups, exercise, and creative activities, but noted a lack of information about how to access such services.

Community-based services were seen as vital for providing accessible, culturally appropriate care. Participants highlighted the role of voluntary and community sector (VCS) groups, community leaders, and faith leaders in addressing stigma and building trust. Suggestions for improvement included long-term funding, integrated activities, accessible locations, and collaboration with mainstream services to ensure appropriate care.

The findings inform recommendations for improving mental health care for these communities, detailed in section 4 of the report.

1.1. Summary of Recommendations

This research provides targeted recommendations to enhance access to mental health services for Black African and Caribbean communities. Several recommendations also have the potential to drive broader improvements across mental health services, ultimately benefiting all patients.

1. Establish **long-term funding** for community-based mental health services.
2. Utilise the current Creative Health programme hosted by South East London Integrated Care Board to **implement targeted projects for Black Men**.
3. Provide **training and support** for VCS groups and community leaders.
4. Facilitate **cross-sector collaboration**.
5. **Embed the Patient and Carer Race Equality Framework** (PCREF) across all mental health services.
6. **Commission a 'Taster Day'** event for community-based mental health services and use learnings to support the implementation of Recommendation 2.
7. Consultation with non-clinical and community-based mental health services to **identify needs and establish good practice models**.
8. Implement a **targeted mental health awareness campaign** for Black men.

The complete set of recommendations is contained in section 4 of this report.

2. Introduction

Black African and Caribbean communities are known to face inequalities in accessing mental health care, as well as in their experiences of care and the quality of treatment outcomes (Department of Health and Social Care 2018). They are more likely to access treatment at crisis point, be subjected to coercive care, and arrive at mental health services through adverse pathways, such as the criminal justice system (Ibid; CQC 2024).

In recognition of this, improving mental health services for Black African and Caribbean communities has been identified as a priority area at national and local levels (Department of Health and Social Care 2018; CQC 2024; South London and Maudsley NHS Foundation Trust 2024a). Southwark-based South London and Maudsley NHS Foundation Trust became the pilot site for the Patient Care Race Equality Framework (PCREF) in 2020, an initiative designed to tackle mental health inequalities for ethnic minority groups (South London and Maudsley NHS Foundation Trust 2021).

This project aims to contribute to this work by gathering direct feedback from Black African and Caribbean residents who have experienced poor mental health, to understand their perspectives and experiences of mental health services in Southwark. As a result of data collected in the early phases of this research, we shifted our focus to investigate Black men's preferences for non-clinical mental health services, aiming to identify ways these services can promote access to inclusive and culturally appropriate care.

2.1. Background Research

Underuse and Access Inequality in Mental Health Services

Research indicates that Black African and Caribbean communities consistently underuse mental health services, despite higher reported mental health needs. For example, Black women experience higher rates of common mental disorders than women from other ethnicities (Birmingham City Council 2022), and in Southwark, severe mental illnesses including psychotic conditions such as schizophrenia and bipolar disorder, disproportionately affect individuals from Black ethnic groups

(Southwark Council 2017).[1] Despite this, Black adults have the lowest treatment rate (6.5%) for emotional and mental health issues among all ethnic groups (Ahmed et. al 2021). This study (Ibid) indicates that inequalities in access to treatment for anxiety and depression are increasing among Black communities.

Barriers to Accessing Suitable Treatment

Studies indicate disparities in the types of mental health treatments offered to Black communities, and in how these treatments are accessed. Black African and Caribbean individuals are less frequently offered psychological treatments such as Improving Access to Psychological Therapies (IAPT), and when they are, they are more likely to drop out before completing treatment (Birmingham City Council 2022). In Southwark, referrals analysis suggests that GPs can be a barrier to IAPT, supporting the finding by Brown et. al (2014) that GPs are particularly poor at detecting the mental health needs of Black Caribbean groups.

This trend is coupled with a tendency for medication to be offered over preferred options like talking therapies, negatively affecting treatment outcomes (Ahmad et al., Raleigh 2023; Savage et. al 2016). To address these inequalities, South London and Maudsley NHS Foundation Trust's Southwark Directorate has an ongoing project to improve access to psychological therapies for Black males within Southwark Community Mental Health teams, though outcomes from this work are not yet known (South London and Maudsley NHS Foundation Trust 2024a).

Over-representation in Coercive Care

The over-representation of Black men in coercive mental health care has been highlighted as an urgent issue in the Care Quality Commission (CQC) State of Care report (2024) and the Modernising Mental Health Act report (Department of Health and Social Care 2018). Black men are over four times more likely to be detained under the Mental Health Act and face restrictive interventions, such as physical restraint or isolation whilst in hospital, than white men (NHS Digital, 2021). Black men also experience longer hospital stays and are more than ten times as likely to receive Community Treatment Orders, meaning that they are kept under supervised care for longer periods of time than men from other ethnic groups

[1] However, diagnostic figures require careful scrutiny, as Black men are disproportionately over-diagnosed with conditions such as schizophrenia (Fearon et al., 2006 cited in Myrie et al.).

(CQC 2024; NHS Digital 2021). Additionally, Chui et al. (2021) report that Black individuals, especially those from Black African backgrounds, are often referred to mental health services through social and criminal justice systems, bypassing early preventive care.

Southwark's rate of mental health hospital admissions and detentions under the Mental Health Act are substantially higher than the national average (Southwark Council 2017). Southwark Council's (2017) "Mental Health Joint Strategic Needs Assessment" notes that higher levels of hospitalisation in Southwark may reflect the ethnic diversity of our local population, as according to national figures, individuals from Black ethnic groups are twice as likely to be hospitalised for mental health than those from white ethnic groups.

Low Engagement with Services

Brown et. al's (2014) study of South East London Community Health finds that 60% of people with mental health problems do not seek help from professionals. Instead, they are more likely to pursue "informal" support, such as speaking to friends or family. Reluctance to engage with mental health services stems from previous negative interactions with healthcare providers, cultural and social norms emphasising resilience shaped by ideas that lead to hyper-masculinity, and stigmatisation of mental health issues (Ibid; Memon et al. 2016; Myrie et al. 2013). These issues are particularly pronounced among men, who may feel less inclined to discuss psychological stress or seek help (Memon et al. 2016; Myrie et. al 2013).

Many Black individuals fear racial discrimination leading to coercive treatment and surveillance by social services, further discouraging engagement (McLean et al. 2003 cited in Myrie et al.; Department of Health and Social Care 2018). Barriers such as language differences, long wait times, poor communication, and a perceived lack of culturally appropriate care compound these challenges (Memon et al. 2016; CQC. 2024).

Recommendations

Several studies advocate for a shift toward community-based services, reducing the reliance on acute services and coercive care (Birmingham City Council 2022, Mind 2019, Department of Health and Social Care 2018, NHS Foundation Trust 2023). This reflects a broader "public health approach," which prioritises prevention and a shift in resources and power to strengthen community services (Department of

Health and Social Care 2010). This is also emphasised in the recommendations from Lord Darzi's NHS review, and Change NHS project to set a new 10 Year Health Plan for England (Department of Health and Social Care 2024; Change NHS N.D).

The Patient and Carer Race Equality Framework (PCREF) seeks to reduce racialised mental health inequalities by establishing a mechanism to hold providers to account and incorporate patient and carer input into service design (NHS Foundation Trust 2023). Recommendations set out in the PCREF include increasing Black male staff, implementing anti-racist training, and leveraging community spaces like barber shops and places of worship to build trust with Black communities.

2.2. Aims

This project was carried out in two parts. Mental health inequalities for Black African and Caribbean communities was identified as a key issue in our Priorities Survey 2022/3, forming part of our broader work on health inequalities for minority ethnic groups in Southwark. The project initially set out to:

- Develop relationships with residents from Black African and Caribbean communities in Southwark.
- Provide a platform for these groups to voice their views.
- Find out the key issues, needs and priorities of the communities, so that we can share them with decision makers to raise awareness and drive change.

Once we established the main concerns surrounding mental health access in our first cycle of engagement, we used these insights to narrow the project's focus.

In doing so, this project builds upon existing work, which indicates a need to explore the role of non-clinical mental health services for Black African and Caribbean men (Race Equality Foundation 2024; NHS Foundation Trust 2023; Department of Health and Social Care 2018).

Non-clinical mental health services are defined as support services that focus on improving mental well-being without involving diagnosis and medication. These can include peer support, some talking therapies, creative practices, and other community programmes aimed at helping individuals manage stress and build coping skills. These are typically provided by VCS groups and trained peers, and

are designed to be more accessible than clinical services. They are not always a replacement for clinical treatment, and can be used alongside treatment such as medication to improve an individual's overall health and well-being.

Therefore, our final set of aims are to:

- Build relationships with Black African and Caribbean men in Southwark, and provide a platform for them to voice their opinions on mental health services.
- Enhance service providers' understanding of community views on clinical and non-clinical mental health services.
- Co-produce recommendations and share them with decision makers to increase access to both clinical and non-clinical mental health services for Black African and Caribbean men in Southwark.

2.3. Methodology

Research was carried out in two phases. The first phase took place between spring and summer of 2023, during which time we ran an online survey (in total 41 participants) and two focus groups (in total 14 participants).

Insights were used from the first phase to refine the project's focus and research questions, leading to the second phase in autumn 2024. This involved four focus groups and two 1-1 interviews (in total 24 participants).

Overall, we engaged with 79 participants.

Survey

The survey included a mix of closed and open questions to gather detailed personal experiences (Appendix 3). It was distributed online and promoted by voluntary and community sector (VCS) groups working with Black communities, Southwark Council and Partnership Southwark. We also circulated physical copies at Community Mental Health Teams locations. This yielded both quantitative and qualitative data. While this study relies predominantly on qualitative analysis for narrative capture, quantitative data is useful for identifying service usage patterns and feedback trends.

Focus Groups

This study employs qualitative research methods to enable participants to contribute in their own words, creating greater potential for original explanations (Savage et al 2016).

We opted for semi-structured focus groups to allow for dynamic group interactions, where participants can build upon or challenge each other's ideas, uncovering shared experiences or contrasting viewpoints. This can foster camaraderie between participants, with peers comforting and encouraging each other through sensitive discussions. We used a preset question guide to steer discussion, but maintained flexibility to explore unexpected emergent themes based on the group's responses (Appendix 4). Participants were also given pencils and paper, and the option to speak with the researcher discreetly after the session, to enable them to share privately.

The first phase of focus groups was hosted at Peckham Levels and led by local VCS group, Holistic Well Woman, which had previously led community-based research into Black fathers' mental health (Unpublished).

The second phase of focus groups was hosted at several spaces; RJ4ALL, The Redeemed Assemblies, Paxton Green Time Bank, and Change Grow Live. These venues were selected based on their location, as we aimed to cover the expanse of the borough. We also hosted one online focus group using Zoom, in response to demand from participants.

These venues are VCS-led and operate various services such as food banks, time banks and generalised community centres. The Redeemed Assemblies also functions as a church, distinct from its food bank. Change Grow Live specialises in substance misuse and criminal justice interventions. This provides important context to the backgrounds of several participants who use these services, which will be reflected in our findings.

1-1 Interviews

We adapted our methodology to include 1-1 interviews for participants who were unable to participate in focus groups. This option was built into our methodology as a secondary method, as we recognised that group exercises may not be suitable for everyone. We used the focus group question guide in these interviews to ensure data consistency (Appendix 4).

Participant Criteria

To be eligible to participate in the study, individuals had to be aged 18 and above, and self-identify as being from Black African and/or Black Caribbean (including mixed Black) ethnic backgrounds. The first engagement phase was open to individuals of all genders, whilst the second engagement phase required participants to self-identify as men.

Participants were individuals who had experienced mental health challenges. They were not required to have used mental health services.

Focus group participants were offered a £20 gift voucher and a "goodie bag" including information about local mental health services and a national directory of Black-led VCS organisations.

Participant Recruitment

Each focus group venue promoted the focus groups to their service users, approaching individuals who met the participation criteria. We also promoted through other VCS organisations that work with Black men, such as Black Thrive and the Black Men's Consortium; through local mental health services such as Southwark Wellbeing Hub; Healthwatch Southwark, Community Southwark, Partnership Southwark and Southwark Council communications, and by posting flyers on local estates' noticeboards, and at shops, libraries and barber shops.

2.4. Analysis

We used Meridian Artificial Intelligence software to transcribe audio files from focus groups and interviews. We manually validated AI transcription by listening to the audio files.

We used thematic analysis to process our qualitative data, focusing on how people described their experiences and what this revealed about perceptions of mental health and mental health services. We employed an inductive approach to allow the data to shape our themes. These themes were reviewed across the dataset to ensure they provide comprehensive and accurate representations of recurring issues and key ideas. We also used thematic summaries generated by Meridian AI to validate our manual analysis, checking for additional themes we may have missed.

Lastly, we used content analysis to quantify qualitative data generated by the survey. For example, to understand the prevalence of a particular theme, we counted how many times it was mentioned across the dataset.

2.5. Challenges

We recognise that recruiting participants via VCS service user networks may contribute to bias in our findings. This method of recruitment utilised the trusting relationships held between VCS organisations and their service users to encourage individuals to participate in the study. Several individuals explained that this trust was essential to their participation, given the stigmatisation of mental health and widely held scepticism surrounding research involving historically marginalised communities. The role of VCS organisations in recruitment was particularly significant in the second cycle of engagement, which focused on Black men.

Comparatively, public promotion of the focus groups proved less effective. We facilitated widespread engagement beyond VCS networks to mitigate against bias, however, suspicious bot activity prevented genuine individuals from signing up online, contributing to low attendance rates from online signups. It was also difficult to ensure whether online signups met the participation criteria. Recruiting via VCS networks therefore became essential to successful engagement for this project.

Online Engagement

As above, it was difficult to confirm that participants in our online focus group met the participation criteria. We required that online participants had their cameras switched on during the session, but this was difficult to monitor and enforce throughout. This issue affects the 12 participants who took part in online engagement.

Researcher Demographics

This research was conducted by our predominantly Black, female team at Healthwatch Southwark. During the second engagement phase which was aimed at Black men, we received feedback from participants that research should be

conducted by Black men, who could best understand the opinions and experiences shared by participants.

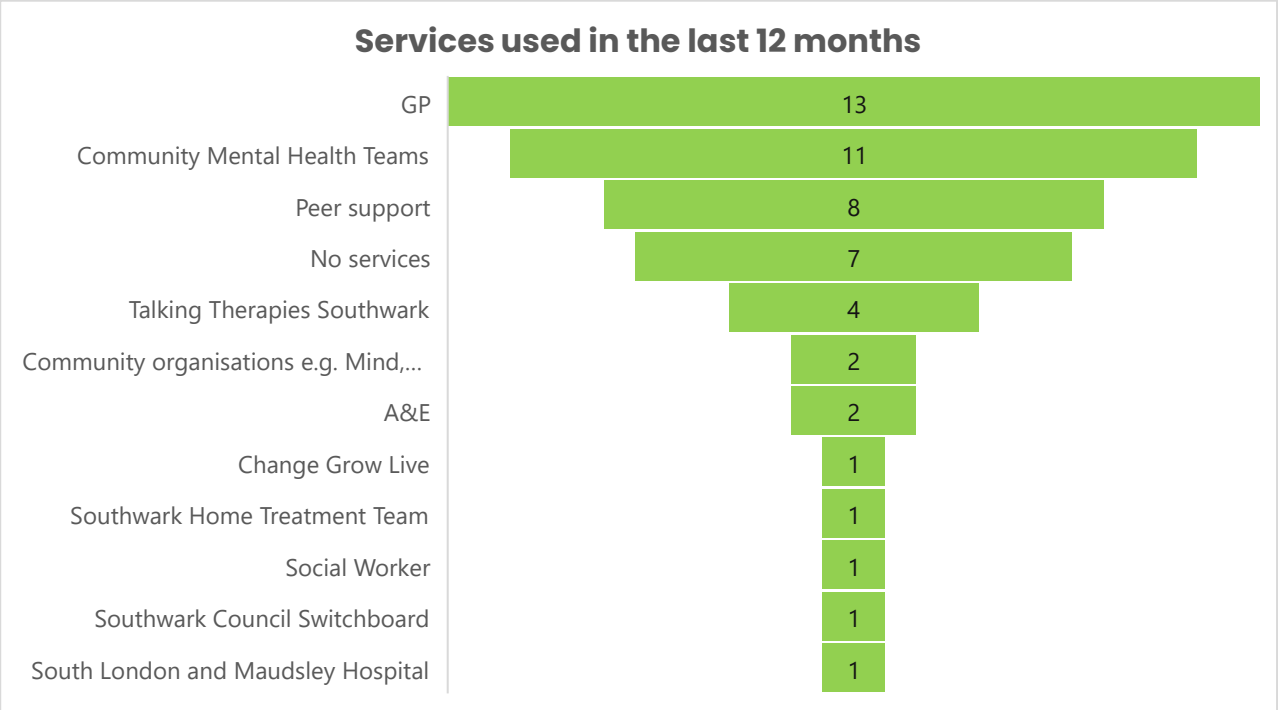
We actioned this feedback by engaging a Community Health Ambassador who identifies as a Black man to lead two focus groups, with the support of Healthwatch researchers. This Ambassador was known to seven participants prior to this study, as they are service users of the VCS organisation he operates. In another focus group, we invited a Black male member of staff from the host VCS organisation to support facilitation. This individual has a staff-client and peer relationship with two participants. The nature of these relationships poses a risk of bias which may be reflected in our findings. However, we felt that this approach was essential to facilitating a safe environment for participants, and is demonstrative of community-informed research practices.

3. Findings

Survey

83% of participants (34 individuals) said they used at least one service to access mental health support in the last year. This includes clinical services such as GPs and A&E, and non-clinical services such as peer support.

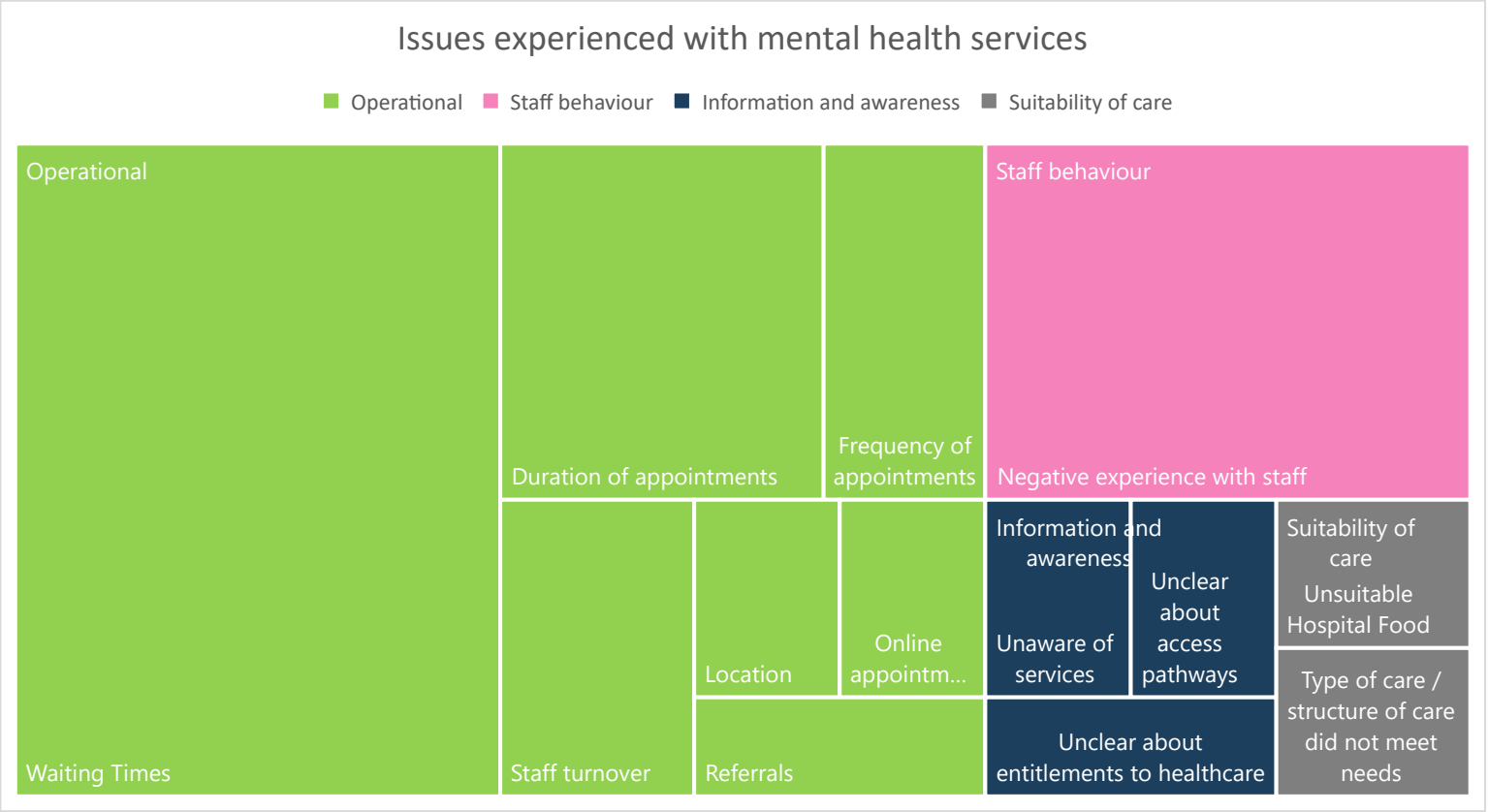
The most used service was GPs (13 individuals), followed by Community Mental Health Teams (11 individuals) and peer support (eight individuals). Seven individuals had not used any mental health services.



3.1. Key Issues

67% of participants who had used a mental health service in the last year (23 individuals) experienced at least one issue with the care they received. These issues related to GPs, Community Mental Health Teams, Talking Therapies, South London and Maudsley Hospital and A&E services.

The issues described can be categorised into four main themes: operational, staff behaviour, information and awareness, and suitability of care.



The graph above shows an overview of the issues described. Each section is proportionate to the number of responses that mention that theme.

Operational Issues

Most feedback was related to operational issues (14 participants), including waiting times, the duration and frequency of appointments, staff turnover, issues with referrals, and lack of face-to-face appointments.

The most common complaint flagged by 11 participants was that waiting times are too long, particularly for GPs and Talking Therapies. Three participants turned to informal support networks as a result.

> "It was difficult to get a timely appointment (for Talking Therapies) and the issues I was (experiencing) required early intervention. I was then forced to talk to family members who I would never have wanted to talk to."

> "I tried looking for an appointment at a time in my life when I felt I wasn't at a good place mentally but had to wait forever until I sought help from my church."

"There was a day when I was overwhelmed with emotions. I didn't really know what was wrong and called to book an appointment. I was told the earliest appointment I would get was in two weeks and I wasn't even given an emergency appointment or referred to another service which could offer help. I called a friend who I knew was trained in mental health awareness. It was she who helped me and even helped me to tweak my diet to help me cope and kept checking on me until I was OK. My GP surgery has up to now not followed up to check on me."

The structure of appointments was also flagged as a key issue. Four participants reported that GP appointments are too short, causing them to feel rushed and unable to communicate fully when seeking help. Two participants felt that extended gaps between appointments for Talking Therapies negatively impacted their experience of treatment.

"Sometimes you feel rushed to complete what you are trying to express, and you only have a few minutes to talk. There doesn't seem to be much personal touch."

Regarding Community Mental Health Teams, two participants experienced disruptions to care due to staff turnover, and one participant flagged that they struggled to complete their treatment as the service relocated to a less accessible site.

Staff Behaviour

Six participants described negative experiences with healthcare professionals, feeling dismissed, and rushed, and that staff lacked "empathy" for their circumstances.

"I found it difficult opening up because my therapist seemed to be in a rush. I felt my concerns were not being taken seriously."

One participant explained that their relative's mental health condition declined to crisis point because their GP did not take them seriously when they presented symptoms. The lack of early intervention care led to police involvement and significant hardship for their family.

"My sister suffered from depression and became suicidal. Her GP didn't take her seriously when she reported that mentally she didn't feel OK. She then (had an incident) where her children called the police."

Information and Awareness

Two participants indicated a lack of awareness about mental health services, and how they could access them, "I know I suffer from depression, but I don't know where to seek help."

Another participant did not access mental health services because they were unsure of their entitlements to use NHS healthcare, given their immigration status.

Suitability of Care

Finally, two participants expressed that the care they received did not meet their needs. For example, one individual received culturally inappropriate food during an in-patient hospital stay, which they felt adversely impacted their recovery.

"My time in Maudsley, the food was not culturally tailored and therefore it made me feel lower."

Another participant was unable to find a service or treatment plan that suited the complex needs of their family.

"My children (have been affected by bereavement) and Southwark did not have provisions to strengthen our family during these difficult times. Each of us would have to access therapy separately. This made the process quite tedious and tiresome…as I'm a lone parent with a limited support network."

3.2. Suggestions for Improvement

We asked survey participants for ideas on how mental health services could be improved to meet their needs.

Suggestions included:

Operational Factors

- Increase early intervention support and provide timely appointments for urgent mental health needs.
- Provide longer appointments and more face-to-face appointments.
- Maintain staff consistency during mental health treatment to enable patients to build relationships with healthcare providers.
- Streamline administrative processes to ensure that referrals are actioned, and patients are kept informed on the status of their care.
- Follow-up with patients who have indicated mental health needs.

Staff Behaviour

- Provide anti-racist, diversity and inclusion training to patient-facing staff.

Information and Awareness

- Advertise mental health services in community spaces and GP surgeries.
- Connect with Black-led organisations and community leaders to promote services, dispel misinformation and de-stigmatise mental health.

"Education should be given about mental health to help reduce the stigma associated with it."

"Assure parents that their kids will not be taken away from them if they seek help for their mental well-being. This is the general perception."

Suitability of Care

- Consult Black-led organisations and community leaders to inform the development of culturally appropriate mental health services.
- Improve access to psychological therapies and non-clinical forms of mental health support.
- Provide extended support programmes to promote long-term recovery and well-being. For example, encourage joined-up working between sectors to provide wrap-around support on topics such as benefits, healthy living and employment advice.
- Fund and equip Black-led organisations to deliver community-based health and well-being programs.

"I would like to see more support given to patients who are suffering or are recovering from mental health issues. An example of this would be home visits to discuss any other life changes, shortage of food, electricity, heating."

"Offer more talking therapy and small community groups, not just medication to Black people. Work with organisations who specialise with Black people to find the right approach."

Focus Groups (2023)

3.3. Key Issues

Whilst our survey findings predominantly highlighted operational issues such as waiting times and appointment structure, our focus group findings emphasised the role of cultural and systemic barriers to accessing mental health support for Black African and Caribbean communities.

Information and awareness

As above, participants expressed a lack of awareness about mental health services and support. Services identified by participants were limited to GPs and South London and Maudsley hospital, whereas community-based services and talking therapies were not mentioned until prompted.

"Maudsley Hospital. That's the only one I know."

"I've never heard of any mental health services in Southwark."

Some participants had little or no understanding of 'mental health' as a term. These individuals explained that they would not approach healthcare services for support, as they would not recognise symptoms of poor mental health as a health condition.

"I think we might not recognise what's happening. We might think things are not quite right, but that it will be okay. You don't know what's normal...You don't realise that you need help."

However, levels of understanding and knowledge did vary between participants, for example one individual indicated a confident understanding of services.

"I feel good about finding services. I would know where to find it, I'm proactive."

Another participant shared a positive example of their GP acknowledging their treatment preferences and referring them to a suitable service.

"I want to say that my GP is a blessing. Because I have a GP and he supports me, when I said I didn't want to be on medication he agreed with me and said I should do talking therapies instead."

Stigma

The impact of stigma on mental health and individuals' ability to access support was emphasised during focus group discussions. Demonstrating how multiple barriers can intersect, participants highlighted how lack of understanding about mental health within some communities can lead to misinformation, preventing individuals from seeking mental health services. For example, participants described that symptoms of mental ill health can be misinterpreted, particularly within faith groups, where these symptoms may be attributed to "witchcraft," "demons," or to lack of faith, which further stigmatises vulnerable individuals.

The effect this has on children and young people was emphasised, as parents can be reluctant to seek help or dissuaded from doing so by family and community leaders such as pastors. One participant highlighted how this contributes to intergenerational trauma within some families and communities, where mental health conditions are unaddressed and met with shame.

The impact of stigma on men was further highlighted, as gendered expectations of "strength" and stoicism make it difficult for men to seek both formal (e.g., NHS services) and informal mental health support (e.g., speaking to a friend or family member) (Brown et al. 2014). The gendered aspect of stigma was raised as a key issue by male and female participants.

> "As a people we shy away from mental health as a culture…because of the stigma we carry."

> "The church misdiagnoses a lot of medical issues as demon possession. They apply so much of the religious part of it that they don't see the person. That there's a real underlying medical thing going on and not so much of a demonic possession. You have a church full of people suffering with mental issues that no one will ever address. Those people are still suffering, their grandchildren. Especially males. In our culture, generally, females will speak. Us men are taught we talk too much. By the time we get

to adulthood, why you not talking? How can you ask me to talk about something I'm not used to? Males in our community are suffering more and even dying at a faster rate. It's a real drastic condition we are facing in our community, life or death."

Institutional racism and distrust of services

Several participants expressed distrust of mental health services due to experience or knowledge of institutional racism in the healthcare system. This related to intergenerational trauma, as participants discussed how their parents' experiences of racism in Britain created longstanding scepticism of public services throughout their families. Others described firsthand experiences of racism from healthcare professionals, particularly receptionists. Participants recognised that Black people, and Black men in particular, are more likely to be medicated for mental health conditions, and more likely to be sectioned and detained.

"It feels like Black Africans / Caribbean they get the end bit. They get sectioned, they don't get the first line care."

"The whole thing around how Africans and Caribbeans were treated in the mental health system, where we were the ones who were going to be sectioned, for little things, so a white woman would get an Indian head massage, and you're getting sectioned. You go in for one little thing and you're locked up for five years."

We can infer a connection between the limited awareness of early intervention and preventive mental health services, and this sense of distrust. As most participants were only familiar with South London and Maudsley Hospital, which is primarily intended to treat acute mental health conditions, their understanding of mental health support was directly linked to coercive care.

"I don't think people are in denial of mental health. I think people think of the worst- Maudsley hospital, medication all that stuff."

Perceived lack of targeted services for men

Two participants suggested that there is a lack of mental health support available for men, particularly early intervention and community-based options. Links were drawn between this perceived lack of non-clinical support and the over-representation of Black men in acute mental health services.

"There are more services for women than men. There's nothing out there for men. There is just barber shop, maybe the pub, parties…when you talk to your friend. It's just 'man up man up', men have nothing there. Men are left alone."

"Men have the barber shop. And you're not getting the right advice there, it's not a professional service."

Lack of Representation

In addition, two participants indicated that a lack of Black representation among mental health professionals further perpetuates the idea that mental health services are "not for us." One participant expressed that the lack of Black representation results in a lack of understanding of Black culture and experiences, meaning that services cannot provide culturally appropriate and effective support.

"Why is it the services that are meant to be run for majority Black people are run by people who don't look like them,"

However, this topic was debated amongst participants, with others expressing concern that Black healthcare professionals could bring cultural stigma into their care,.

"Sometimes they will understand, sometimes they're more dangerous. Sometimes they see you and make all these judgements about you and won't even give you the time."

Most participants indicated that they did not have a preference for the racial or ethnic background of healthcare staff, as long as they were treated equally "I would go with anyone I've got an appointment with. I wouldn't mind."

Socioeconomic Inequalities

Participants expressed that the type of mental health support they want is not available locally. This includes non-clinical services such as support groups and various leisure and well-being activities. Three participants flagged the role of class in access to services, indicating that service provision is inconsistent across neighbourhoods, as well as for different socioeconomic groups within the same neighbourhood.

"Someone who lives in a nice area can come down to Peckham and get Indian head massage but the people who live in the borough who may need that service, not even a second look, they get hand over fist."

"A bunch of young people are sent to a youth centre, they get a little football, they walk around, there's no motivation. A similar group of people, just (elsewhere), the day's planned, mountain-climbing, rock-climbing. The same group of children, same problems, same age, but where the postcode change a little bit there's plans."

3.4. Suggestions for Improvement

When asked how mental health services could be improved for Black African and Caribbean communities, participants made the following suggestions:

- Implement targeted awareness campaigns about mental health, using approachable and non-stigmatising language and representing Black service users.
- Train community members to spread information and awareness about mental health, particularly in faith groups and hairstylists/barber shops.
- Offer a wider range of services for holistic mental health support, including peer support, talking therapies, art therapies, and exercise classes alongside clinical treatment.

"Train staff in the church in mental health first aid. It needs to be someone that understands what's going on in the community."

"I want them to see me as a person. (Medication), okay it prevents an episode. However, whilst I'm trying this, why can't I also try that. Water without flour doesn't make dumpling. Chicken without jerk doesn't make jerk chicken. It's got to work together."

Insights from the first engagement phase indicated that participants were interested in exploring non-clinical mental health support services, and felt that these services would be particularly valuable for Black men. Our

second engagement phase therefore set out to answer the follow research question:

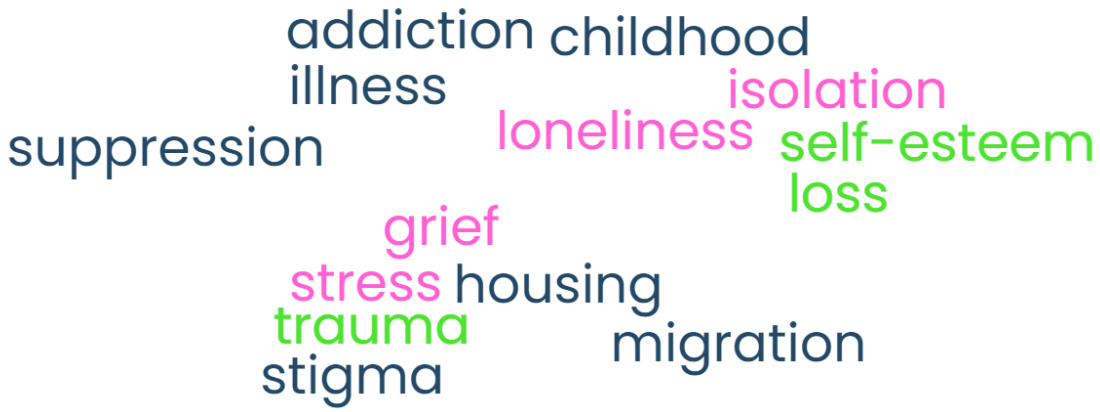
How can non-clinical mental health support be optimised to meet the needs of Black men in Southwark?

Focus Groups (2024)

3.5. Understanding and Awareness

Participants expressed varying levels of understanding about mental health. During discussion, there was frequent mention of common mental health disorders such as depression and anxiety. Otherwise, participants used terms such as "feeling low," "struggling," or "breakdown" to articulate poor mental health.

Factors identified as contributing to poor mental health included: bereavement; relationship breakdown or moving away from social networks; long-term physical health conditions; trauma; emotional suppression; experiencing racism at interpersonal and institutional levels; stress related to housing; migration; and unemployment; and low self-esteem. Isolation was the most common factor indicated.



> "I've been burned by too many people, I don't know how to be intimate with others anymore…I'm crying for connection, making new friends, being in a relationship. In the past I would use a bit of drugs or alcohol to be comfortable, to connect, but I know I can't do that anymore."

> "I've been through grief as well…the loss of my parents was hard for me. It's like you don't even know how to channel this emotion because you've not even been allowed to from a young age."

> "I've suffered corporal punishment since I was a child. And I do suffer trauma from the way my father used to beat my mum physically."

> "I look at myself in the mirror every day and I doubt myself that I'm gonna really find true happiness."

Awareness of mental health services also differed between participants. Some participants had no knowledge of existing services,

> "I didn't think the GP was for mental health issues. I didn't know that there was a support system for anyone going through a mental health change."

> "I would be open to getting help, but I don't know any (services)."

However, most participants had some knowledge of clinical mental health services, including South London and Maudsley Hospital and GPs.

> "In the community, there is no awareness about where you could get some help if you want to do these things without involving friends or family. Apart from Maudsley hospital, which everyone seems to know is a mental health service, but I think people get scared of even mentioning wanting to go there."

There was less awareness of non-clinical services, though some participants mentioned talking therapies, mental health helplines, Southwark Wellbeing Hub, Change Grow Live, and "support groups". All participants who had accessed non-clinical services had been referred to these services through clinical pathways such as GPs, South London and Maudsley Hospital, and A&E. One participant was referred to a non-clinical substance misuse support service through the criminal justice system (probation officer).

3.6. Service User Experience

Participants presented a mixed picture of mental health services when describing their experiences as service users.

> "I personally have gone through therapy, and it really helped me. So, therapy does work, but it's getting the right person and having awareness of what it does."

"Going to hospital (South London and Maudsley) was probably one of the best things for my mental health."

"Services don't understand or relate, they just listen to respond. They're not really helping you."

"I waited for like eight, nine hours in A&E. And I spoke to the guy for like... 25 minutes. And with my GP, I've kind of been dismissed, but he put me to referral to do talking therapy...but the talking therapy made me worse. The GP tried to do his best, but I don't feel that he was mental health trained, so it wasn't good enough."

Some participants indicated knowledge or experience of using acute mental health services, but not of early intervention or preventive support,

"I used to use South London and Maudsley. That's after you get a section. I think there needs to be something before that initial sectioning and before you feel not the same. But I'm not aware of anything that does that."

"I know that within hospitals, there's always somebody on site to deal with you if you're suicidal, but that's very, very far down the line."

Across all focus groups, there was a notable gap in awareness and actual usage of services, where participants were able to name services or, more commonly, types of services such as 'support groups,' but had not made use of them.

"I'm aware of a few like counselling, therapy, and I think support groups, but I haven't had time to try it out."

"I'm aware of some services, I choose not to use them."

We explored possible reasons for this, outlined in the next section.

3.7. Key Issues

Participants were asked to consider challenges that may prevent them from accessing non-clinical mental health support. However, most participants spoke about mental health services more generally. This is likely because participants were not familiar with the term 'non-clinical mental health services,' and most participants had not previously used these services.

Trust and Confidentiality

The main barrier to community-based services was concern regarding trust and confidentiality. Since these services are typically led by peers, many participants worried about sharing sensitive information, feeling that community-based services might be less confidential than mainstream services. This perception stems from assumptions that these services lack professional structures and means of accountability. Concerns about confidentiality were linked to stigma surrounding mental health and gendered expectations, as well as risk factors like migrant status.

> "The peer-led sessions concern me because they're not supervised, so you get abusers. The sessions are good because no one knows more than someone who has been through it. But they are just left to do whatever they want to do."

> "I've heard of social clubs where I could really benefit from, I think they are so much of importance. But I have this kind of biased feelings about those kind of clubs because of interactions and relationships could really go so extreme and delve into more private topics and I'm usually scared of that."

> "When I had anxiety and depression episodes, I felt I needed someone to talk [to], but the trust factor was really taking a hold on me because it would require a whole level of trust for me. To get support requires you to reveal some personal details down to things going on in your household. So I really, I really feared this. I really feared this. And it was really a challenge for me, accessing support services in my community."

Stigma (see also section 3.3 above)

There was consensus that mental health is not widely understood or addressed by Black men, due to stigma surrounding mental health and masculinity. As in the first phase of focus groups, discussions revealed a widely-held perception that poor mental health would be interpreted as "weakness" by others, and that stereotypes attributed to Blackness and masculinity intersect to place additional pressure on Black men to demonstrate emotional strength. Participants agreed that these expectations contribute to the deterioration of Black men's mental health, and their increased likelihood of accessing late stage, acute mental health services.

> "Seeking for mental health services is something that most men generally refrain from until they are at breaking point. As a Black man, you're supposed to be strong. You're not supposed to be weak. We are trained to absorb all of this

until you're completely at breaking point. So, most of the time before (seeking help), you're almost having psychosis."

"If (we) were to cry in front of (our) daughters or wives they would lose respect for (us) so (we) hold it in."

Additionally, one participant described how stigmatisation of queerness within African communities has impacted their mental health, whilst further reducing their ability to seek help,

"Even sexual preference. Coming from an African heritage, that's not something you openly disclose to family. You will have a target on your back."

Perceived Ineffectiveness of Services

Another frequently mentioned barrier to accessing mental health services was the belief that these services were ineffective for Black men. This connects to the earlier issue of representation, where participants felt that a lack of Black service providers limited mental health services' ability to understand and address the unique mental health challenges that Black communities face. This theme became even more prominent in the second phase of focus groups with Black men.

"Sometimes when I'm going to these appointments, I'm seeing my therapist online. Maybe not consciously, but subconsciously, I'm thinking, 'You don't know what I'm going through. You don't understand what it's like to walk at night, worried about being stopped, searched, or even stabbed. You're from a different world, maybe way outside of London."

"As a Black man, I wonder, are they going to understand me? If I speak truthfully about how I feel about society, class, slavery, or the unequal rights for Black people in this country, will they get it?"

The quotes above underline the importance of an intersectional perspective, as participants describe racial, class and place-based identities.

Several participants expressed that their mistrust in mental health services stems from seeing other Black men in the community who visibly struggle with mental health issues, but don't appear to receive effective support. They noted that, despite seeing many men in need, they haven't witnessed success stories of Black men getting adequate help.

"I see so many Black men out here, whether they're dealing with addiction or something else, but it just keeps getting worse. It feels like they're not getting any support or help at all. And instead, people label them as troublemakers or violent-'Stay away from them; they're crazy.' It's really sad to see. I'm definitely not going to end up like that."

"If it was (effective). You wouldn't see so many people walking the streets in a state of despair, and everyone walking past like it's normal."

Some participants further questioned the approach of mental health services, which they felt lacked variety and practical impact. This aligns with the findings of Brown et al. (2014) that Black communities often see mental health issues as rooted in social challenges. Several participants expressed frustration that mental health services "only listen" without addressing the underlying issues, such as unemployment, unsuitable housing, concerns about migrant status and isolation.

"When you get to a certain point, it's like you've talked to everyone. I'm just tired of talking. I want things to change."

"You talk to some Black people, and they'll say, 'What are they going to do for me? Are they going to solve my problem?'"

One participant who is experiencing homelessness critiqued the capacity of community-based, non-clinical services to improve his mental health, "the community can't help me get a place of my own."

Negative Experiences of Public Services

Participants shared that negative past experiences with public services have contributed to their lack of trust in mainstream mental health services. These experiences could involve any public sector service, such as the NHS, job centres, local councils, or public-adjacent providers such as housing associations. When individuals encounter failure in one part of "the system," they often lose confidence in the system's overall ability to meet their needs. These experiences may be personal or involve friends, family, or anecdotes heard through word-of-mouth. Such encounters often reinforce feelings that the state does not prioritise vulnerable people.

"Come on, Southwark Council, how many decades? I've been on this estate for two decades now. There was an elderly couple that lives downstairs from me... I

couldn't believe that 70% of their place was black mould and his wife even died of it. Yet the Council denied any responsibility... When they did work in my house, I got treated very bad. When I say something it's like 'you're a trouble maker, shut up.' I know that being on benefits anytime I used to deal with the dole people they would talk to you like a piece of rubbish. I didn't bother complaining to the council (about my housing association), I've had enough. Because you know what, it's because I'm Black."

Institutional Racism (see also section 3.3 above)

Institutional racism emerged as a central theme in participants' hesitation to engage with mental health services, underlining other concerns, including perceived ineffectiveness, failure to meet cultural need, and fears around medication and coercive care. Many participants shared how personal experiences of racism impacted their mental health and their willingness to seek support. They described incidents of misdiagnosis, as well as culturally insensitive and undignified treatment, rooted in racist stereotypes held by healthcare providers. These experiences reinforced a lack of trust in the system's ability to provide appropriate care for Black patients. As previously discussed, this lack of trust can stem from experiences with other public services, and reflects a broader distrust in "the system."

A participant from a Rastafarian background explained that he felt pressured to cut his dreadlocks by his GP. He shared that the loss of his dreadlocks continues to affect his well-being and self-esteem years later.

"My GP persuaded me to have an operation. I had dreadlocks down to here and I lost them. She was patronising me, so I shaved the locks. And when I went to an appointment after that, she said, you look very well. I was so angry. I said, Why don't you listen to me? If someone asks me, why you lost your dreadlocks? I tell them it's her fault... I just felt like there's no room for Black people when it comes to the hospital, mental health."

"The barrier I face is my presentation as a Black man. They see us as non-educated people who don't have ideas, which is really bad. We have a lot of ideas, and we have a lot of knowledge. We're being pressed down in society."

For some, this sense of alienation was compounded by experiences that felt undignified and dehumanising.

> "When they were (discharging me from hospital), there was like five doctors at the door with the door open and I half had my trousers on, waiting for me to leave. I felt well is it because of the colour of my skin or because I have dreadlocks... I felt (like they were hiding things from me). And it's just really horrible...I find it really difficult to mentally fit into society sometimes as a Black person."

Finally, when asked about current anti-racist initiatives taken by healthcare services, such as equality, diversity, and inclusion (EDI) training, most participants were unfamiliar with these measures but open to their potential. Others, however, felt these initiatives were more symbolic than transformative.

> "Box ticking. It's only learning if people care."

Concerns about Medication

Scepticism towards medication is connected to previous discussions on institutional racism in healthcare. Participants explained that they would be hesitant to seek mental health support, for fear that they would be medicated against their will. Several emphasised a preference for alternatives to medication.

> "I would (prefer) anything that is not going to get me swallowing drugs, taking things that will have to force me to sleep or in order to get into a restful state."
>
> "Medication is overused in the Black community. It's experimentation."

Importantly, two participants discussed how treatment involving medication may not be suitable for those with a dual diagnosis[2]. Prescribed medications can be difficult to self-administer, particularly for those who have previously misused substances to manage their mental health, with the potential to trigger regressive behaviours. Alternative therapies are therefore increasingly crucial for affected individuals.

Capacity of Community-Based Support

Participants recognised that many VCS groups struggle to secure long-term, unrestricted funding and rely on the good will, skills, and flexibility of volunteers. As

[2] Dual diagnosis refers to the co-occurrence of a mental health disorder and a substance use disorder such as alcoholism.

a result, some participants felt reluctant to engage with community-based services, out of concern for the sustainability of these initiatives.

> "Maybe the person (delivering the service) is passing through a lot more than me, or maybe there are more people coming to give problem for solution. So maybe the person is busy, more busy than me. That's the main thing that would disturb me."

> "There are elements of our community which do help. They don't have the resources that they need."

Furthermore, the perception that those offering help may be facing similar challenges added to participants' hesitance to engage with these services.

> "If it's an NGO, charity…The people who are meant to be advising you are also needy, 'I'm having those problems too. I'm trying to apply for those things too.'" This raised concerns about the ability of community-based services to produce outcomes for service users.

Limited Duration of Support

Participants described the limited duration of support provided by mental health services as a significant barrier. In mainstream services, some found the short-term nature of treatment plans unhelpful, feeling that the limited timeframe wouldn't allow them to achieve meaningful progress.

> "I didn't even bother to go there anyway (Mental Health & Substance Misuse Service), because, I (was) referred to them. But when I got there, I was only offered 12 weeks before discharge."

In community-based services, several participants reported experiences where projects that provided valuable support ended unexpectedly.

> "I've been a part of some of these projects and suddenly they don't exist."

Some participants described the adverse impact this abrupt withdrawal of support had on their mental health.

> "There's a charity they help people that has just been discharged, or they might be sitting in service, but there's a place where you can do music…You find a community of people. They try to help you express yourself, so I found that very

good...But then it stopped and that kind of disturbed everything. And that's when I realised not going to these things made me feel a bit lazy, made me smoke more, made me feel depressed."

"I was part of a project where we would go to faith groups and reach out to Black men about their health, it was very good but...most of these projects come to an end...I think there should be a continuity plan for the social clubs."

The lack of sustained support left some participants feeling hesitant to engage with these services, fearing a repeat of previous disappointments.

Treatment Thresholds

Participants highlighted that criteria or thresholds to access mental health services can pose a significant barrier for individuals with a dual diagnosis. These requirements often mandate that individuals be substance-free for a certain period before they can start treatment.

"You cannot have therapy whilst you're still using. The using has to go first and then the therapy after."

Describing their experience with a service offering Dialectical Behaviour Therapy (DBT), "I approached a service for DBT. And they said that the minimum time that they would need to see someone clean from substances, is like three months. This was when I was in a temporary accommodation. I had a good few months, during that time would have been the perfect time for me to have therapy, particularly with the diagnosis of BPD that I was diagnosed with. And I felt let down by that service."

For those experiencing addiction and mental health challenges, these criteria can create barriers to timely support and exacerbate both conditions, particularly when treatment opportunities arise during periods of stability.

3.8. Current Coping Strategies

Most participants relied solely or predominantly on informal coping mechanisms such as exercise, socialising and listening to music to improve and maintain their mental health. This aligns with the findings of Brown et. al's (2014) that 60% of participants in their South East London Community Health study sought informal

help for their mental health, and that men are more reluctant than women to seek formal help. Whilst most participants preferred these strategies to using mental health services, some individuals acknowledged that more severe mental health issues would require clinical interventions.

Participants described a range of activities they use to support their mental health:

- Seeking guidance from community leaders, like advice from a pastor.
- Sports and fitness activities, such as going to the gym or attending exercise classes.
- Socialising with trusted friends or joining groups at church or through hobbies, sometimes discussing mental health, but not always.
- Independent activities like listening to music, writing poetry, cooking, or engaging in self-care.
- Volunteering with local charities.
- Religion and spiritual practices, such as reading religious texts, praying, or meditating.
- Utilising non-clinical services, like talking therapy or recovery groups through organisations such as Change Grow Live.
- Substance use, including alcohol and marijuana, particularly in times of poor mental health.

Participants also spoke about the importance of "safe spaces," defined as local, free public areas where they could socialise and access support if needed.

One participant explained, "A safe space is where you feel that you're listened to, you're respected, you're not threatened. Definitely no judgement." Examples of safe spaces included an open mic poetry forum, and a local church/food bank, offering consistency, practical help, and a community of "genuine people."

"You can see me sometimes, five o'clock in the morning, standing outside (the food bank), waiting for the doors to be opened... The pastors, you can ask them any questions. They can send you to the right place or a telephone number who you can talk to... That's the kind of person that gives me inspiration. He's been a good man to me. If it weren't for them, I would be in these shops stealing."

"The church has really been very fantastic when it comes to this. There are certain groups, where you belong to and on a weekly basis different people sharing their experiences. And for me that has really been very fantastic. So sometimes you're going through painful situations, like there was a time we were talking about migrants coming to the UK, navigating your way... It really helped a lot."

"Sometimes I go to the gym, or I go out with my friends to the café and watch sports together and play games together. And I also listen to music."

"I would go to my friends first, friends I trust. Not just any friends, friends who won't judge me. Friends who are going through what I'm going through."

"My therapy is sitting out there, getting drunk and trying to forget everything else."

"I like all the fitness, the HIIT training stuff and the bootcamp. You're sweating and then when you get home, your muscles are aching. You know what, I miss this. I miss this kind of feeling. I miss that feeling."

"I don't really like to talk to people. I will figure it out to myself."

"It really made me very good to clean my house, to clean myself, to cook my food. I found that therapeutic."

3.9. Suggestions for Improvement

All participants expressed an interest in non-clinical mental health services. Preferences for the type of services varied, as indicated by the range of personal coping strategies above. When asked how non-clinical services could better meet the needs of Black men in Southwark, participants offered the following suggestions:

Community-Based Services

Most participants expressed a preference for community-based, non-clinical mental health services, believing these could better understand and address their needs. Community-based services were seen as valuable for their ability to provide meaningful and accessible support, while fostering lasting connections within the community.

Representation and Shared Experience

Participants emphasised the importance of representation in the design and delivery of non-clinical mental health services. Seeing relatable individuals in support roles was viewed as essential for overcoming stigma, fostering trust, and cultural understanding.

> "The best counsellors that I've seen are the ones that come from the backgrounds of the people that they're helping. So, I think representation is an important thing, definitely. There's a cultural understanding that needs to happen."

> "I feel the best way to get me to share my problems is when I'm sitting around a table with other people who have similar experience like mine, you know, get me kind of motivated and kind of free...and I know I'm not going to be judged."

Additionally, participants wanted to see success stories of Black men who had benefited from mental health services, believing this would encourage others to seek support.

> "I think, if they see a representative. Black men, talking and saying the benefits of using this support. They'll be more aware of it, they'll make use of it a lot more."

Integrated Activities

Participants indicated a preference for holistic approaches to mental health support, involving social and leisure activities such as art therapy and dance, practical guidance such as advocacy and nutritional advice, and more targeted mental health support such as peer support groups. Participants felt that integrating a variety of activities could make mental health services more approachable. For example, exercise classes could be used as a precursor to engage and build trust with service users, which could then encourage openness to discuss their mental health. Moreover, there was an emphasis on the need for practical guidance linking to social determinants of mental health, such as housing and employment.

> "Boot camps keep a lot of them together to work out together, building a brotherhood. And with that brotherhood, you build a bond, and with that bond, they can be more open to discuss their health as well."

"I think they need to be more encouraging for people to come. Sort of like, 'Oh, I want to go there because we're going to do this today'...maybe they encourage you to do a bit of gym...You speak to someone for half an hour, then you do some art work or music."

"Guidance from experienced individuals, advising people how they can focus, how they can start their business or whatever they want to do. And housing support, help finding a good and sustainable place to live."

Governing Framework

One of the key concerns participants had towards community-based mental health services, particularly peer support models, was that they lack formal supervision and an accountability framework. Participants worried that these services may not consistently safeguard vulnerable people, provide accurate information and maintain confidentiality of their service users' information. A proposed solution was to establish a consistent framework for community-based services, which would prevent misinformation and enable service users to report misconduct to an external body, ideally within the VCS or similar. Establishing a consistent framework across community-based services would increase individuals' trust, making them more likely to engage.

"There should be some kind of supervision, not necessarily by a professional."

Training

As participants expressed a preference for community-based services, individuals who deliver these services should receive appropriate training and support, such as mental health first aid and safeguarding information. In addition to VCS organisations, participants highlighted that key figures in the community such as faith leaders, barbers and hairdressers should receive training to support individuals who present with symptoms of poor mental health in everyday contexts.

"Train staff in the church to be mental health first aiders. It needs to be someone who does it that understands what's going on in the community."

Accessible Locations

Most participants preferred non-clinical mental health services to be delivered in-person at consistent, accessible local sites. In-person services are seen as crucial

for fostering healthy socialisation and enabling service providers to monitor individuals' mental and physical well-being. Suggested locations included estate Tenants and Residents' Association (TRA) halls, community centres, and religious spaces. Local transport links and disabled access were noted as essential considerations when choosing premises. Additionally, some participants expressed interest in remote options, such as online groups or 1-1 phone calls with a mentor or counsellor, especially for times when they are experiencing low mental health.

> "People living in estates, they've got community halls and things like that. Easy access for people to go to, whether you suffer with mental health or not. Especially in the wintertime, who wants to come out and go too far and freeze? If there was a gym around here, where people can do yoga, or whatever it is, a little bit of light exercise, it's better."
>
> "I actually prefer a service that is really reachable, has (considered the) accessibility concerns of everyone."

Resources for Sustained Engagement

As discussed, several participants had positive experiences with non-clinical, community-based services that ended abruptly due to lack of sustained funding. Participants emphasised that VCS groups need long-term funding to provide consistent, reliable support. Knowing that services are well-funded and have stable infrastructure would reassure service users that the support they rely on won't suddenly disappear. Furthermore, sustained engagement with individuals builds trust, helping people get the most from available services.

> "It takes me some time before I trust, trust needs to be earned"
>
> "It should find ways to be supported by the government because they could actually give more if they get more (funding)."

Early Intervention Support

Participants identified a critical gap in early intervention support for Black men. Community-based services could either provide preventive and early support directly, or act as a bridge to mainstream mental health services. By offering timely, accessible support or guiding individuals to appropriate resources,

community-based services could help prevent mental health conditions from escalating.

Joined-up Working

Some participants recognised that community-based, non-clinical services may not be best equipped to support individuals with more severe mental health needs. Instead, they recommended that these services collaborate closely with mainstream providers to establish a clear signposting or referral system, ensuring that individuals can access the right level of support.

> "There should be some sort of signposting for people because (community-based, non-clinical services) are more like a preventive approach rather than a curative approach. So, there should be sort of a signposting in case the mental health problem goes beyond non-clinical approaches."

This system should operate in both directions, with mainstream services referring patients to community-based support for supplementary or recuperative care. By working together, community and mainstream services can create a more seamless support network that proactively meets individuals' needs at every stage of their mental health journey.

Inclusivity

Some participants emphasised the importance of inclusivity in community-based services. They considered the needs of various intersections of the community such as LGBTQIA+ groups, as well as various ethnic and religious groups. Some people also said they would feel most comfortable in a diverse setting, with individuals from all backgrounds, as this would indicate that they are being treated equally.

> ""We're only talking about being men, what about trans men? Or gay men?"
>
> "Services should be personally tailored for individuals irrespective of their identity, gender identity, cultural identity, you know, you need to be sensitive enough to this kind of social diversity."
>
> "Making more groups, more space for Black men to come and share their own problems and also bringing both white and Black together and taking them together. So, in a way where you treat a Black man as the same as a white man,

his depression will be reduced. He'll be like, OK, these people take everyone as the same. He won't feel bad."

Information and Awareness

Finally, participants expressed that more should be done to raise awareness about non-clinical mental health support, including mainstream and community-based services. This should involve targeted advertisements that use approachable, non-stigmatising language and represent Black service users. Messaging should be routed through trusted community figures, such as faith groups, barbers and beauticians.

> "The mental health community should start promoting little clips and things that shows everyone from different groups using the services, different people from different communities."

> "Having people out in the community who are of the same faith and community as them, to say just because you're a Christian or a Muslim, doesn't mean these things can't happen to you."

An example of non-clinical mental health services incorporating cultural and personal preferences for managing mental health, such as better promotion of how individuals can access Personal Health Budgets.

Case Study: Community Psychology Model in Tower Hamlets

This case study highlights a culturally responsive, non-clinical mental health initiative delivered by East London NHS Foundation Trust (ELFT) through a community psychology framework, **Gardening for Health**.

1. Gardening for Health

- **Target Group:** Bengali women aged 30-50 experiencing chronic pain, low mood, and isolation.
- **Approach:**

- Shifted from a medicalised model to a biopsychosocial framework, which takes a holistic view of the person and focuses on personal strengths.

- Integrated psychology, physiotherapy, and occupational therapy with gardening activities.
- Activities were designed around interests expressed by participants, such as gardening and recipes, which resonated with their cultural and personal coping strategies.
- Sessions focused on physical activity, social connection, and connecting with nature

- Outcomes:
  - Increased physical activity among participants, and a shift in sense of identity beyond their health challenges.
  - Promoted social bonds, reduced isolation and fostered a sense of purpose.
  - Boosted job satisfaction and well-being among staff.
  - Successfully adapted to virtual formats during COVID-19 disruptions.

Key Lessons and Good Practices:

- Co-production and partnerships with VCS groups were critical for relevance and engagement.
- Safe, trusted environments outside clinical settings promoted accessibility.
- Activities were aligned with service users' existing coping mechanisms or areas of interest, reinforcing cultural relevance and personal empowerment.
- Focusing on strengths rather than deficits empowered participants and encouraged shared learning.

4. Recommendations

Based on feedback from participants, as well as our own analysis of the findings, we have compiled a summary of targeted recommendations set out below. We will share this with local stakeholders and work collaboratively to implement these recommendations.

1. **Establish long-term funding for community-based mental health services.**

Create a dedicated fund to ensure sustainable, long-term financial support for community-based, non-clinical mental health services, in line with the Mental Health Investment Standard. This includes VCS groups delivering activities to promote mental well-being for Black African and Caribbean communities. Funding opportunities should consider the insight and recommendations shared in Community Southwark's (2023) State of the Sector report.

2. **Utilise the current Creative Health programme hosted by South East London Integrated Care Board to implement targeted projects for Black men.**

Allocate funding for targeted projects focusing on prevention and early intervention of mental health issues for Black men. Support the integration of arts-based approaches by developing projects that take a holistic approach to mental health, including practical and emotional support, physical activities, and creative arts and well-being practices. These should be delivered by or in partnership with VCS organisations where possible, following the principles of the South East London VCSE Alliance Charter. The Creative Health Programme should draw on learnings from the National Centre for Creative Health and All-Party Parliamentary Group for Arts, Health and Wellbeing to deliver this work.

3. **Provide training and support for VCS groups and community leaders, and evaluate the effectiveness of these courses for all service providers.**

Collaborate with and provide training opportunities for community leaders and VCS organisations to promote mental health literacy, enabling them to provide informed support in community spaces. Relevant courses could include Culturally Appropriate Peer Support and Advocacy training, Mental Health First Aid, Suicide First Aid, Safeguarding, access to the NHS e-learning for health platform, and additional training requested by recipients that reflect service user and/or organisational needs to address health disparities.

Evaluate the impact of these courses for NHS staff and community-based services. for example, through peer-review, self-assessment and analysing performance data.

4. **Facilitate cross-sector collaboration.**

Enhance collaboration between sectors, including Public Health, Social Care, Local Medical Committee, and VCS organisations. This includes utilising insights to address gaps, improving signposting and referral pathways, and increasing the visibility of non-clinical opportunities in primary care, for example by building communications channels and resources to share opportunities and good practice more easily (Performing Medicine 2024). Southwark Council and South East London Integrated Care Board can demonstrate their commitment to cross-sector, preventative action by becoming signatories of the Prevention Concordat for Better Mental Health.

5. **Embed the Patient and Carer Race Equality Framework (PCREF) across all mental health services.**

Integrate the PCREF in all mental health services, including non-clinical and community-based services, to ensure that equitable, safe, and culturally appropriate care is delivered by all service providers. Inform patients and local communities about the evaluation process for the PCREF and increase promotion of PCREF Network meetings. Share evaluation results to show how PCREF's implementation has brought improvements to service provision and enhanced patient experience.

6. **Commission a 'Taster Day' event for community-based mental health services and use learnings to support the implementation of Recommendation 2.**

Commission a 'Taster Day' event to introduce community members to local mental health services, helping them become familiar with support options. This should be facilitated in an accessible, community-based location with good transport links. Consider financial support for transport and care costs to enable attendees' participation.

7. **Consult with non-clinical and community-based mental health services to identify needs and establish good practice models.**

Identify examples of good practice in community-based services that are currently offering mental health support, to establish and export successful models following Centric's (N.d.) guidance to evaluating Black-led initiatives. Consult with these practitioners to further understand how they can be supported to deliver sustainable services.

This should involve drawing on learnings from South London and Maudsley's upcoming pilot community mental health service in Lewisham (South London and Maudsley 2024b), and rolling out the Culturally Appropriate Peer Support and Advocacy service across South East London Boroughs. Other examples of good practice could include Croydon Health and Wellbeing Space (Mind in Croydon N.D) and South West London's Ethnicity and Mental Health Improvement Project (EMHIP N.D).

8. **Implement a targeted mental health awareness campaign for Black men.**

Review and update communications about mental health services to use approachable, non-stigmatising language and highlight positive stories of Black men who have successfully used mental health support to encourage engagement. Increase awareness of non-clinical and community-based services options by disseminating information through Community Health Ambassadors, VCS organisations, social prescribing services, Public Health

outreach (i.e., Vital 5 checks), faith groups, and venues such as barber shops. NHS North Central London ICB and Islington Council's "Barber's Round Chair Project," aimed at improving mental health outcomes for young Black men, can be used as a model of good practice (Islington Council N.D).

Barrier	Recommendation(s)
Stigma	6,8
Institutional Racism	2,5,8
Trust and Confidentiality	5
Institutional Racism	2,5,7
Perceived Ineffectiveness of Services	2,3,4,6,7,8
Negative Experiences of Public Services	2,4,5,7
Concerns about Medication	1,2,4,8
Capacity of Community-Based Support	1,2.3,4
Limited Duration of Support	1,4
Treatment Thresholds	4

5. Conclusion

In conclusion, this report further examines the challenges faced by Black African and Caribbean communities in accessing mental health services. Our findings align with existing research, emphasising how stigma, lack of information, institutional racism, and distrust in services create significant barriers to mental health support, particularly for Black men.

By examining participants' current coping strategies, this report builds on Brown et al. (2014)'s findings that Black African and Caribbean communities in South London often rely on informal networks for mental health support. We explored participants' interest in non-clinical and community-based mental health services for their potential in providing early intervention and preventive care. This approach helped us identify ways to make mental health services more accessible and culturally appropriate for Black men.

These insights informed our recommendations to strengthen the community sector and foster holistic mental health support for Black African and Caribbean communities in Southwark. We encourage service providers and partners to collaborate in creating actionable plans to address these needs effectively.

5.1. Lessons, Limitations and Opportunities for Further Research

During this research, we identified several principles of good practice that we plan to carry forward to future projects. These include:

- Collaborating with Voluntary and Community Sector (VCS) groups: Partnering with VCS groups already embedded within communities to steer research design and support participation.
- Establishing a timeline for long-term engagement: This involves asking participants how they would like to be informed about the research outcomes and providing clear communication on when updates will be shared.
- Providing tangible resources to participants: Offering practical support, such as signposting to relevant services during the engagement phase and developing a directory of non-clinical mental health services, helps participants access support. This ensures that the research provides direct, immediate benefits to participants.
- Identifying good practice examples: Learning from successful examples across sectors and boroughs demonstrates how recommendations can be effectively implemented.

This research engages with individuals from Black African and Caribbean communities. Future research should disaggregate data on ethnicity, and migrant and refugee status, to explore differences in the perceptions, experiences and needs of different communities within this wider group.

Moreover, targeted engagement with Black men who identify as LGBTQIA+ would help to better understand their specific needs. We recognise that individuals who identify as LGBTQIA+ may not have felt able to participate unreservedly in our focus groups, which may have privileged the experiences of heterosexual, cisgender men. As we did not collect data on sexuality, we cannot ascertain the representativeness of our participant sample in this regard.

5.2. Next Steps

We will share this report with key stakeholders including:

- Partnership Southwark Strategic Board Meeting
- Southwark Council Health and Wellbeing Board
- Southwark Council Health Scrutiny Committee
- Southwark Culture Health & Wellbeing Partnership (SCHWeP)
- Southwark Council and NHS South-East London ICB Integrated Commissioning
- King's College Hospital, Guy's & St Thomas' and South London and Maudsley NHS Foundation Trusts
- Southwark Adult Social Care
- Southwark Primary Care Network
- Southwark Independent Advisory Group
- Impact on Urban Health
- Peter Minet Trust
- Maudsley Charity
- Peckham Settlement
- South East London Mind
- Black Thrive
- Southwark Wellbeing Hub
- London Healthwatch Staff Network
- Healthwatch England Research and Insight Network

Statutory partners will be asked to respond formally to the recommendations made in this report. Responses will be available to view on Healthwatch Southwark's website. We will then carry out reviews with partners six and 12 months after this report's publication, to monitor progress against our recommendations.

We will produce a summary version of this report, as well as a map of VCS organisations offering mental health support for Black African and Caribbean communities in Southwark. These resources will be available on our website and shared directly with participants. We will also provide updates to participants six and 12 months after the report's publication about our impact, and share a one year update on our website and social media.

References

Ahmad, G., McManus, S., Cooper, C., Hatch, S., Das-Munshi, J. 2021. "Prevalence of common mental disorders and treatment receipt for people from ethnic minority backgrounds in England: repeated cross-sectional surveys of the general population in 2007 and 2014." The British Journal of Psychiatry. Pp.1-8.

Birmingham City Council. 2021. "Birmingham and Lewisham African and Caribbean health inequalities review (BLACHIR)." Accessed online 5th November 2024, BLACHIR report | Birmingham City Council

Brown, J.S., Evans-Lacko, S., Aschan, L., Henderson, M., Hatch, S., & Hotopf, M. 2014. "Seeking informal and formal help for mental health problems in the community: a secondary analysis from a psychiatric morbidity survey in South London." BMC Psychiatry 14, 275.

Care Quality Commission (CQC). 2024. "The state of health care and adult social care in England 2023/24." Accessed online 5th November 2024, https://www.cqc.org.uk/publications/major-report/state-care/2023-2024

Centric. N.D. "Who sets the metrics for assessing Black-led initiatives." Accessed online 8th December 2024, Who Sets the Metrics for Assessing Black-Led Initiatives - Literature Review 3

Change NHS. N.D. "Welcome to Change NHS: Help build a health service fit for the future." Accessed online 8th December 2024, Change NHS

Chui, Z., Gazard, B., MacCrimmon, S., Harwood, H., Downs, J., Bakolis, I., Polling, C., Rhead, R., Hatch, SL. 2021. "Inequalities in referral pathways for young people accessing secondary mental health services in southeast London." Eur Child Adolesc Psychiatry 30, pp., 1113–1128.

Community Southwark. 2023. "State of the Southwark voluntary and community sector 2022-2023." Accessed online 8th December 2024, State-of-the-Sector-Research-Research-Findings-and-Call-to-Action.pdf

Department of Health and Social Care. 2018. "Modernising the Mental Health Act increasing choice, reducing compulsion final report of the Independent Review of the Mental Health Act 1983." Accessed online 5th November 2024, Modernising the

Mental Health Act: Final Report of the Independent Review of the Mental Health Act 1983

Department of Health and Social Care. 2010. "Healthy lives, healthy people: our strategy for public health in England." Accessed online 5th November 2024, Healthy Lives, Healthy People: our strategy for public health in England - GOV.UK

Department of Health and Social Care. 2024. "Summary letter from Lord Darzi to the Secretary of State for Health and Social Care." Accessed online 5th November 2024, Summary letter from Lord Darzi to the Secretary of State for Health and Social Care - GOV.UK

East London NHS Foundation Trust. 2023. "Community psychology model." Accessed online 3rd December 2024, Case-study_Comm-Psych-Model_ELFT_CommEng.pdf

EMHIP. N.D. "Ethnicity and mental health improvement project." Accessed online 3rd December 2024, Home - EMHIP

Islington Council. N.D. "Young Black men and mental health programme." Accessed online 2nd December 2024, Young Black Men and Mental Health Programme | Islington Council

Memon A., Taylor K., Mohebati LM., Sundin J., Cooper M., Scanlon T., de Visser R. 2016. "Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England." BMJ Open.

Mind. 2019. "Mind's work with young Black men." Accessed online 5th November 2024, Our work with Young Black Men | Mind - Mind

Mind in Croydon. N.D. "Croydon health and wellbeing space." Accessed online 3rd December 2024, Croydon Health & Wellbeing Space – Mind in Croydon

Myrie, C. and Gannon, K. 2013. "Should I really be here?" Exploring the relationship between Black men's conceptions of wellbeing, subject positions and help-seeking behaviour." Diversity and Equality in Health and Care. 10 (1), pp. 1-22.

NHS Digital. 2021. "Mental Health Act statistics, annual figures 2020-21." Accessed online 5th November 2024, Mental Health Act Statistics, Annual Figures - 2020-21 - NHS England Digital

NHS Foundation Trust. 2023. "Patient and Carer Race Equality Framework Official Local NELFT PCREF Launch." Accessed online 5th November 2024, Patient and Carer Race Equality Framework (PCREF) | NELFT NHS Foundation Trust

Office for Health Improvement & Disparities. 2024. "Prevention Concordat for Better Mental Health." Accessed online 8th December 2024, Prevention Concordat for Better Mental Health - GOV.UK

Performing Medicine. 2024. "Practicing well in primary care." Accessed online 3rd December 2024, PERFORMING-MEDICINE-PRACTISING-WELL-IN-PRIMARY-CARE-REPORT.pdf

Race Equality Foundation. 2024. "Social prescribing, health inequalities and Black, Asian and minoritised ethnic communities." Accessed online 5th November, race equality foundation.pdf

Race Equality Foundation. 2019. "Racial disparities in mental health: Literature and evidence review." Accessed online 3rd December, race disparities in mental health the race foundation.pdf

Raleigh, V. 2023. "The health of people from ethnic minority groups in England." The King's Fund. Accessed online 5th November 2024, The Health Of People From Ethnic Minority Groups In England | The King's Fund

South East London Voluntary, Community and Social Enterprise Strategic Alliance. N.D. "What is the Strategic Alliance?" Accessed online 8th December 2024, South East London VCSE Strategic Alliance

South London and Maudsley NHS Foundation Trust. 2021. "Implementing the PCREF at South London and Maudsley NHS Foundation Trust." Accessed online 5th November 2024, https://www.transformationpartners.nhs.uk/londonpartnership/wp-content/uploads/sites/2/2023/12/PCREF-Anti-Racism-Plan-summary-introduction-Nov23FINAL2.pdf

South London and Maudsley NHS Foundation Trust. 2024a. "Meeting the public sector equality duty and South London and Maudsley Foundation Trust." Accessed online 5th November 2024, 2023-24 Southwark Ethnicity Information Final.pdf

South London and Maudsley NHS Foundation Trust. 2024b. "South London and Maudsley awarded funding for a pilot 24/7 community mental health service in

Lewisham." Accessed 3rd December 2024, South London and Maudsley awarded funding for a pilot 24/7 community mental health service in Lewisham | Press releases - South London and Maudsley

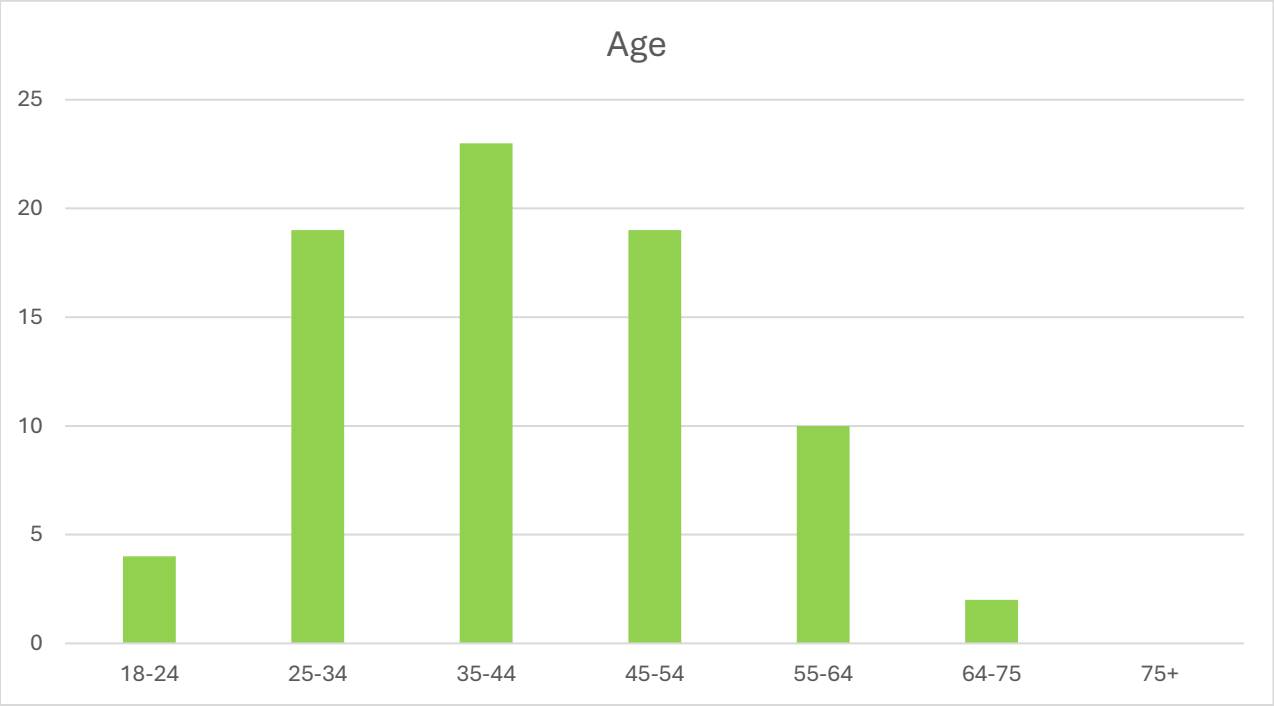
Southwark Council. 2017. "Mental health in Southwark: An overview of health needs and service provision. Southwark's joint strategic needs assessment." People & Health Intelligence Section Southwark Public Health. Accessed online 2nd December 2024, MENTAL HEALTH NEEDS AND SERVICES OVERVIEW

Greater London Authority. 2024. "Understanding creative health in London: the scale, character and maturity of the sector." Accessed online 2nd December 2024, London's Creative Health Sector | London City Hall

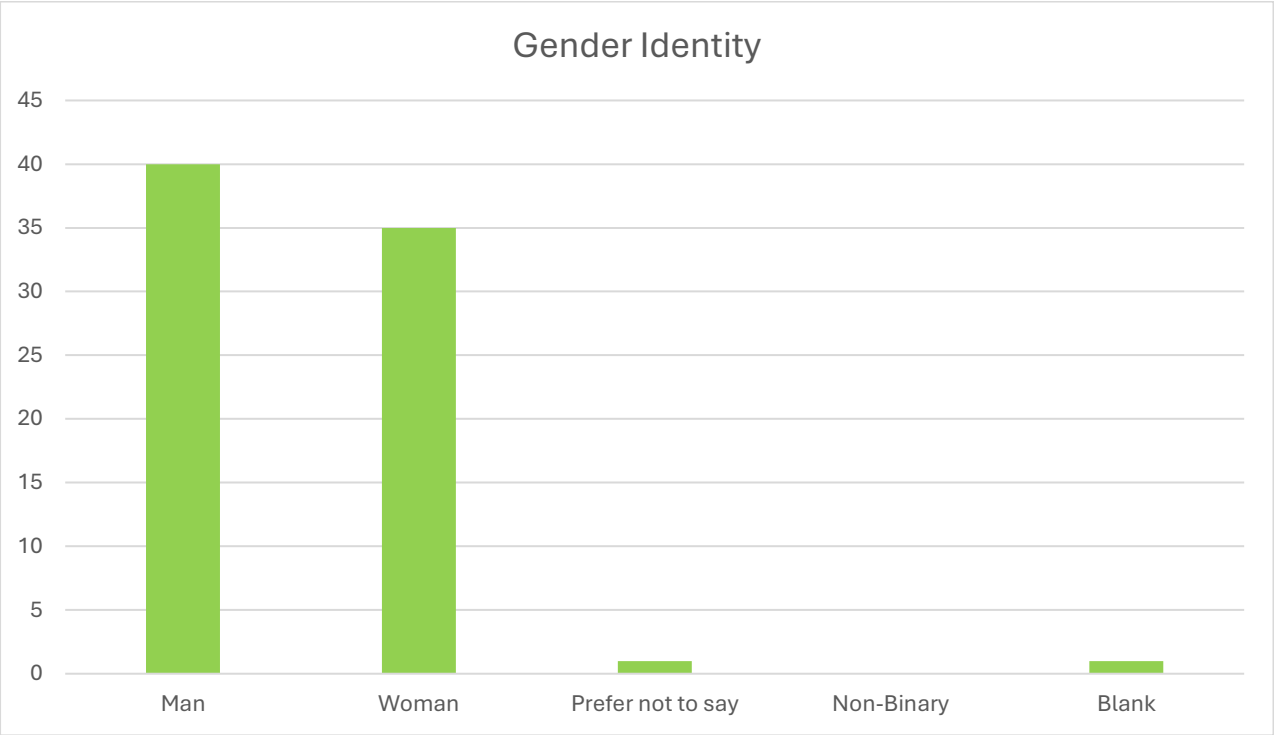
Appendices

Appendix 1- Equalities Data

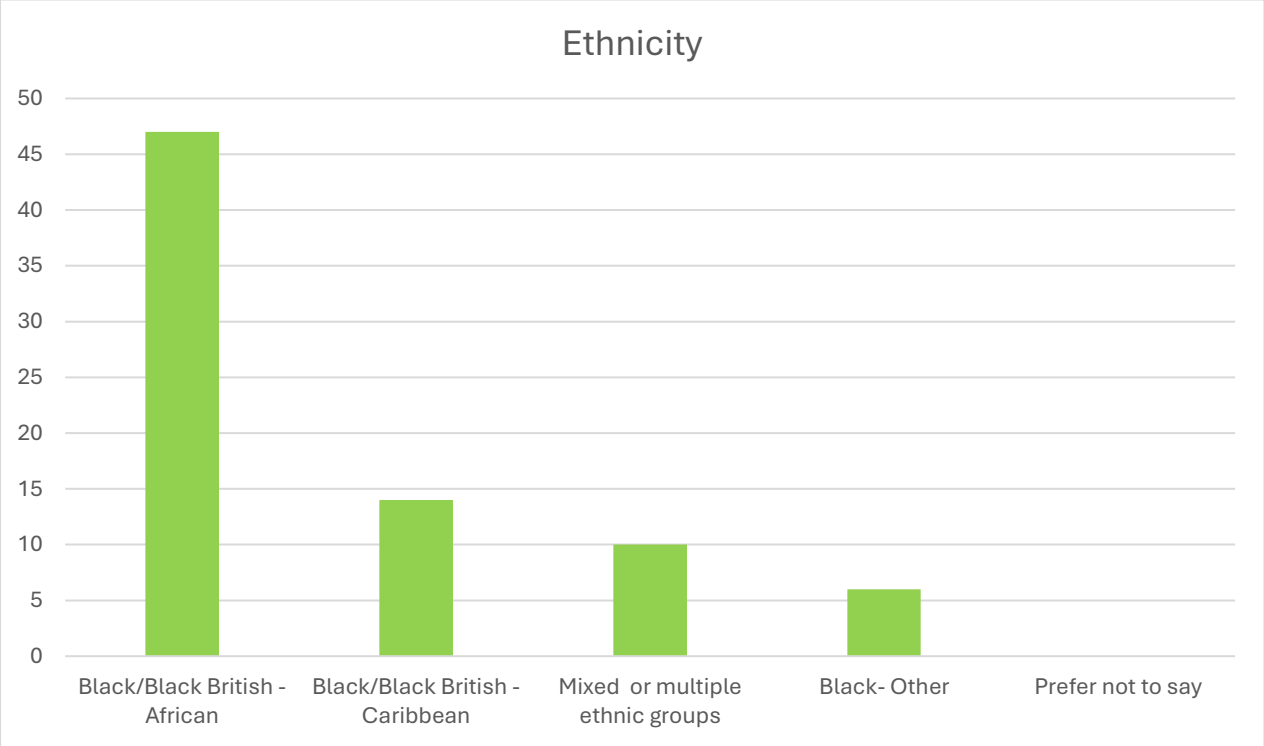
Age



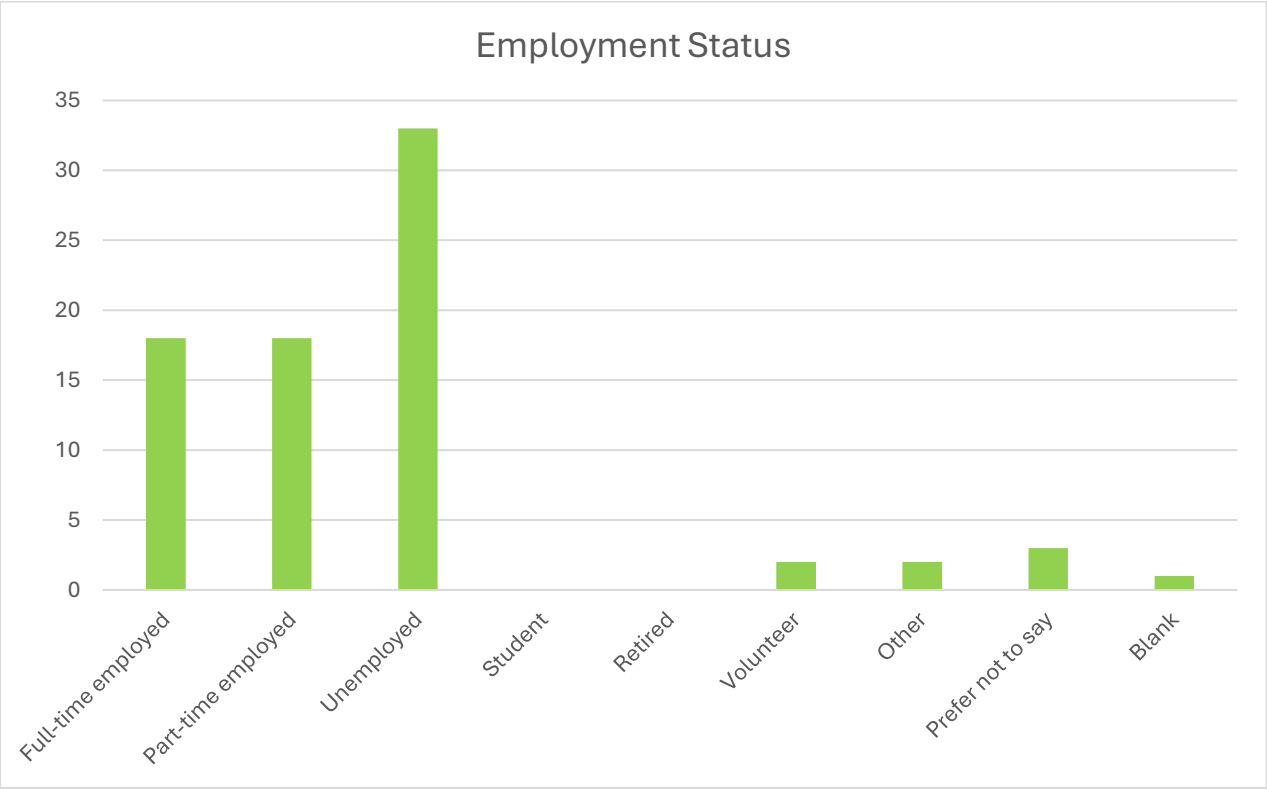
Gender Identity



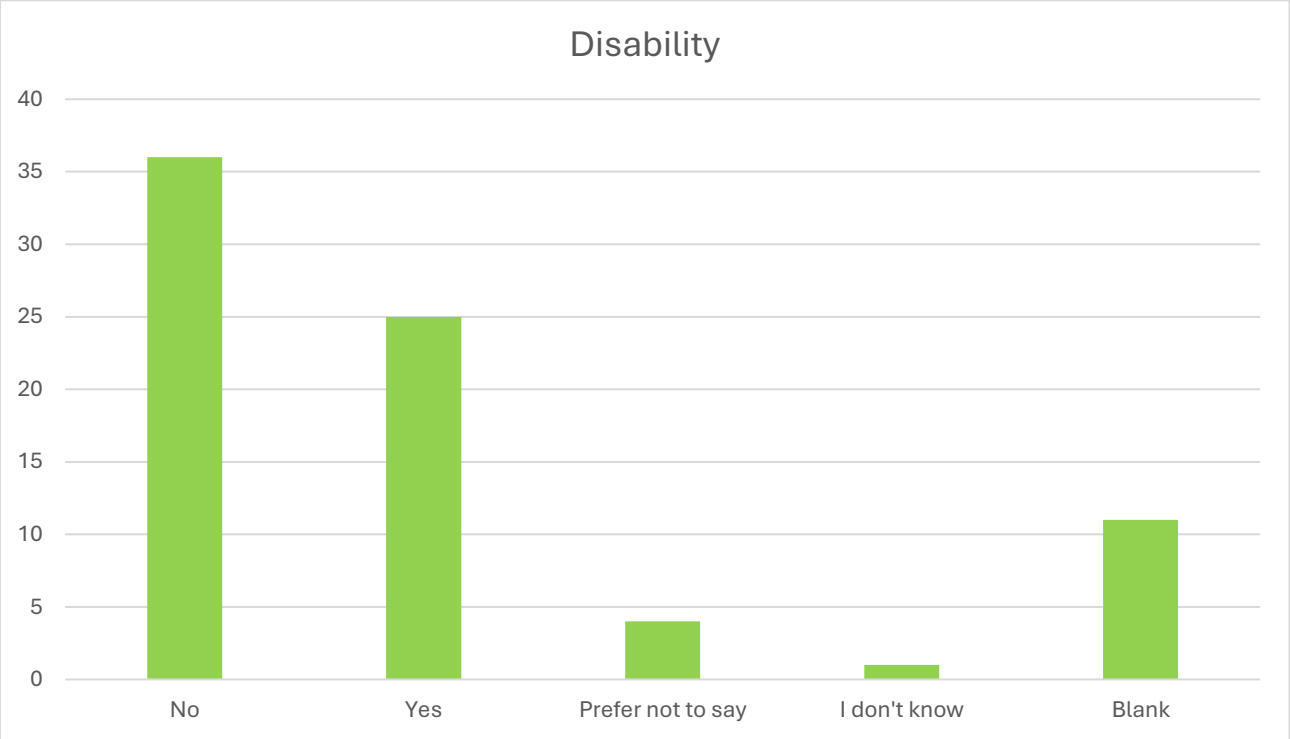
Ethnicity



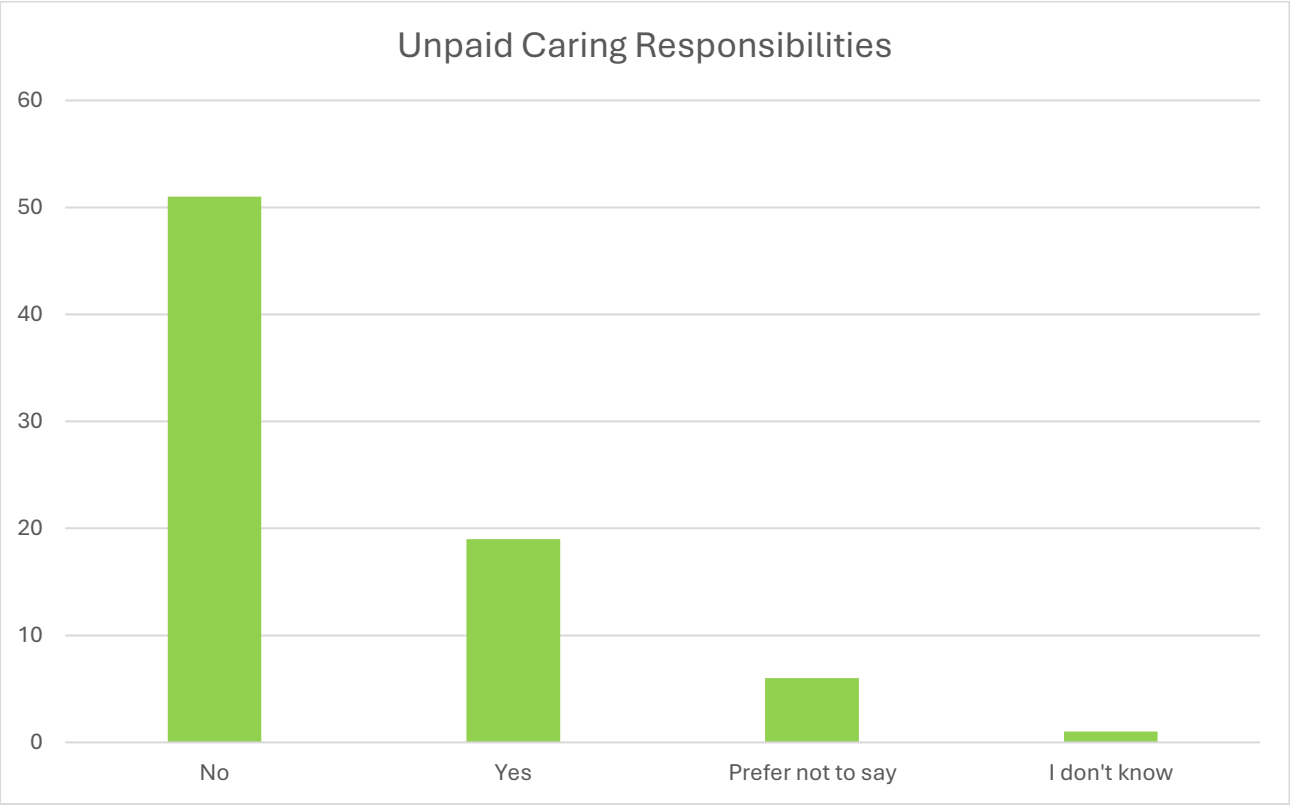
Employment Status



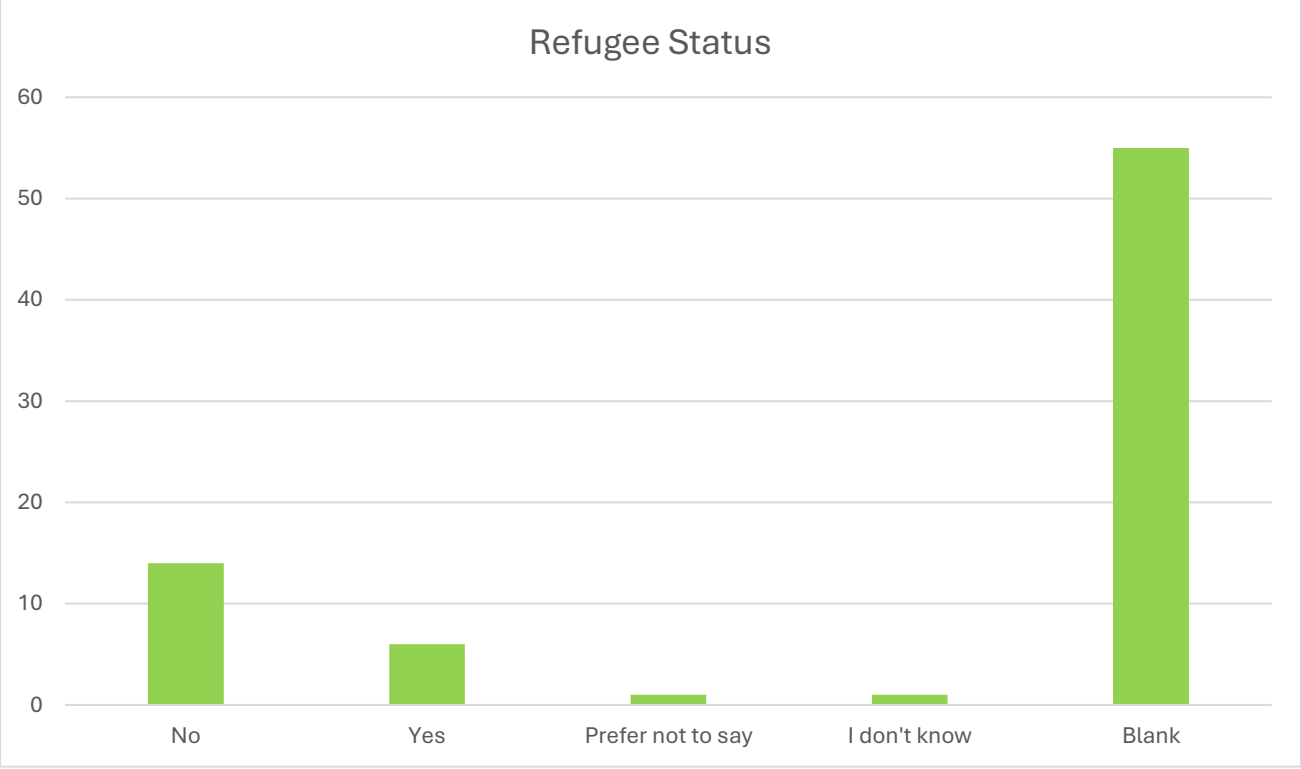
Disability



Unpaid Caring Responsibilities



Refugee Status



*The Equalities, Diversity and Inclusion monitoring form used by Healthwatch Southwark in the first engagement cycle (representing 55 participants), did not ask participants about their refugee status. Therefore, we only have this data for participants in the second engagement cycle (24 participants).

Appendix 2- Survey

Survey

Healthwatch Southwark is your independent health and social care champion. We listen to local people about what matters to them and ensure that NHS leaders and decision-makers take this on board to drive improvements. More information about Healthwatch Southwark and our work can be found here.

Resident feedback has suggested that Southwark's Black/African/Caribbean communities face challenges/issues with accessing mental health services. As a result of this initial feedback, Healthwatch Southwark has prioritised exploring the problems/challenges further and has decided to engage with the wider Black/African/Caribbean community to hear your experiences and gather your suggestions for improving services/access.

This survey will be open from the 7th of December and close 30th of April 2023 at 5 pm.

We want to highlight that we treat your data as confidential and protect it accordingly. We will always make sure that your data is protected and treated securely. Please read our complete Privacy Statement here.
If you have any questions about the survey or would like support completing the study, please get in touch with us via email: at info@healthwatchsouthwark.org or phone: at 02038486546

* 1. Please tell us where you have tried to get help for your mental wellbeing over the last 12 months. Please mark all that apply.

- [ ] **Talking Therapies Southwark (provided by South London & Maudsley)**- |A service providing cognitive behavioural therapy (CBT), online CBT and workshops for common (and milder) mental health conditions depression, anxiety, stress, insomnia and post-traumatic stress disorder (PTSD).
- [ ] **Integrated Psychological Therapy Team (IPTT)**- This is a specialist psychological therapy service (secondary care) that provides assessment, care and treatment including talking therapies for people aged 18-65 who have a severe mental illness and live in the London borough of Southwark. Referrals are accepted by mental health professionals from IAPT and Community Mental Health Teams (CMHT's).
- [ ] **Community Mental Health Teams (CMHT)** – Used by SLaM to cover all the other services including community mental health teams, IPTT, psychosis, psychiatric assessment and liaison, crisis line – these are all being merged into one 'stepped care' model
- [ ] **Mental health assessment** at the Emergency Department at Kings/St Thomas hospitals
- [ ] **Drug and Alcohol Service**- by Change Grow Live
- [ ] **Mental Health Team for older adults** (Southwark) provides community-based assessment, treatment and care for people aged over 65 who have mental health problems and younger people with a diagnosis of dementia.
- [ ] **Southwark Home Treatment Team**- A way of helping people at home rather than in hospital.
- [ ] **Crisis Line/ Crisis Assessment**- Offers a range of different crisis support services tailored to individual needs.
- [ ] **Inpatient Care (Acute Ward or Intensive Care Unit)** – Provides care to patients admitted to the acute ward or Intensive Care Unit with ongoing needs.
- [ ] **Emergency department for mental health**- Provides emergency care to patients with acute mental health needs.
- [ ] **Specialist mental health services** such as eating disorders, perinatal, memory service, learning disabilities – please state
- [ ] **Community Mental Health Support** (community organisations like Lambeth and Southwark Mind and Southwark Wellbeing Hub, Others-please specify below)
- [ ] **Local general practitioner** (GP) or other health professional at your GP practice
- [ ] **Peer Support**
- [ ] **I could not access any mental health services**
- [ ] Other (please specify)

* 2. Please tell us about the challenges/ issues you experienced. (examples: what made it difficult to access services? translation issues, inability to get a timely appointment, staff behaviour etc. Provide as much details as possible, letting us know which service/s you are talking about)

Challenge/Issue 1

Challenge/Issue 2

Challenge/Issue 3

* 3. What improvements would you like to see to make your experience better (your suggestions for improving the services you used)?

4. What additional support can the NHS provide to help people struggling with mental health access?

Appendix 3- Participant Information Sheet

We are excited to invite you to participate in our upcoming research study. Your involvement will provide valuable insights and contribute significantly to advancing knowledge in our field. We assure you that your participation is entirely voluntary, and all information collected will be kept confidential. Your informed consent and ethical treatment are our top priorities.

The focus of this project will be on non-clinical and community-based mental health interventions, as these services can prevent people from reaching crisis point, alleviate stigma and hesitancy surrounding mental health support, and can provide culturally appropriate support.

What is the purpose of the study?

Project aims:

- To develop relationships and partnerships with residents from Black African and Caribbean communities in Southwark,
- To provide a platform for these groups to voice their views and represent their own voice,
- To find out the key issues, needs and priorities of the community so that we can share them with decision makers (services providers/ stakeholders/ commissioners) to raise awareness and drive change,
- To help them develop direct links with these senior representatives, empowering them to influence services on their own terms.

Why have I been invited?

We are particularly to keen engage with **men from Black African and Caribbean backgrounds**.

Do I have to take part?

The answer is 'No', taking part is entirely voluntary.

Participant can withdraw if they later change their mind, without giving a reason;

Withdrawal will not affect accessing any use of services.

What will happen to me if I decide to take part?

You will be joining a focus group, sharing your experiences of mental health services and ways to improve them. The sessions will last an hour and you will be provided with refreshments during the sessions. Each session will be recorded to ensure an accurate reflection of the discussion is written up.

Will my General Practitioner/family doctor (GP) be informed of my participation?

No.

Will my taking part in the study be kept confidential?

We will ensure that information is kept secure and that participants will not be identified by study report. We will keep identifiable data should participants wish to withdraw their data; we can easily remove the information provided.

What if something unexpected happens or I feel uncomfortable?

We have trained and qualified mental health first aiders on hand for you to speak to if you need additional support during the session. You will receive a goody bag of signposting services and self-help information to support your wellbeing.

Will I be reimbursed for taking part?

You will be compensated for your time, £20 Love2Shop vouchers will be issued at the end of each session electronically or by your preferred method

What happens at the end of the study?

Once we have completed all engagement, we will analyse the information provided to compile a report. Participants will not be identified from any report or publication placed in the public domain (for instance, with images of faces). Reports will be published on our website as well as provided to stakeholders who will respond to the outcome recommendations of our study.

o Publishing research findings;

o Presenting your findings at conferences, in health and social care decision maker meetings.

o Feeding back findings to participants themselves.

What if there is a problem?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you should contact Ruman Kallar via email: ruman@healthwatchsouthwark.org or call on 07599653479

Participation in future research:

If you have provided personal details for this study such as your email address and phone number, you will be added to our email list database to be kept up to date with the work of Healthwatch Southwark. Please note this does not oblige you to take part in future research.

Further information and contact details:

Please contact Healthwatch Southwark

Main Office Number: 020 3848 6546 / 020 3848 6540

11 Market Place, Bermondsey, SE16 3UQ

Web: www.healthwatchsouthwark.org

General Email: info@healthwatchsouthwark.org

Appendix 4- Participant Consent Form

Name of Research:

If you agree, please initial box

1. I confirm that I have read the information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I understand that relevant sections of my data collected during the study may be looked at by individuals where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐

5. I agree to audio recording and the use of anonymised quotes in research reports and publications.

☐

6. I agree to take part in this study.

☐

_____ _____ _____

Name of Participant Date Signature

_____ _____ _____

Name of Person taking consent Date Signature

Appendix 5- Focus Group Guide (2023)

1.a) What do you think about using mental health services?

1.b) How is using mental health services viewed in your community?

2.a) Who is the first person you turn to if you are struggling with your mental health?

2.b) Have you used any mental health services if so which ones?

3. How was your experience using the service?

4. Are mental health services culturally appropriate to your needs?

5. Did you experience any challenges/ barriers to accessing and or using the services? If so, can you describe them?

6. Are there any improvements you would like to see made to these services? If so, can you describe them?

Appendix 6- Focus Group Guide (2024)

Research Question:

How can non-clinical mental health support be optimised to meet the needs of Black men in Southwark?

Understanding and Awareness

1. What kind of mental health support services are you aware of?

If no non-clinical services are mentioned, ask follow up:

2. Are you aware of any support services for mental health that do not involve diagnosis and medication?

Preferences and Experiences

3. Have you or anyone you know relied on activities within your community to support your mental health? (for example, faith groups, a sports group, arts and music groups)

Prompt 1: If so, what was the experience like?

Prompt 2: If no, what do you do, if anything, to support your wellbeing?

4. Would you be interested in using a non-clinical mental health service?

Prompt: If yes, what type of services would you like to use? (e.g. peer support groups, art sessions, talking therapies, exercise)?

Access and Barriers

5. As a Black man, have you experienced challenges in finding and using non-clinical mental health support?

Prompt: If so, can you explain those challenges?

Engagement and Impact

6. How effective do you think services are at improving Black men's mental wellbeing?

Prompt: In your opinion, what should be done to make them more effective?

7. Do you think that non-clinical mental health services meet the cultural needs of Black men in Southwark?

Prompt 1: How so? / Can you tell us more about why you think that?

Prompt 2: What do you think needs to be done so that non-clinical mental health services better meet the needs of Black men in Southwark?'

8. Some non-clinical mental health services are trying to become more accessible to Black men. For example, they might provide Anti-Discrimination and Race Equality training to staff or run specific talking groups for Black people.

    1. What do you think about these sorts of anti-discrimination activities?
    2. What else could services do to become more accessible and inviting for Black men in Southwark?

9. How would you like Healthwatch to keep you informed about the outcomes of this project?