

United Kingdom Minority Ethnic (UKME) Mental Health Study 2016

(The term UKME is preferred to BME or BAME throughout this study, reflecting the variance in UK and global ethnography)

Purpose

The purpose of this initial study is to raise issues that need to be addressed in a proposed Church of England UKME Mental Health Toolkit. While this toolkit will not be a training resource aimed at the attainment of new competencies, it is hoped that it will contribute significantly to the development of existing pastoral ministries.

The Issues

(This section has been adapted from ‘*Better practice in mental health for black and minority ethnic communities*’, Mental Health Providers Forum/Race Equality Foundation, May 2015)

Exploring the evidence and assessing the policy background

There has been a wealth of evidence produced over the last 30 years to examine the poorer mental health outcomes experienced by UKME communities, as well as a number of programmes to tackle these inequalities. Whilst reviewing all of the evidence is impracticable, some of the key issues are summarised below.

Rates of mental health issues amongst UKME communities

There is evidence to suggest that individuals from UKME communities may be more likely than their White British counterparts to experience some mental health issues.

For example, African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia, in spite of lower rates of diagnosis for other common mental disorders (Mental Health Foundation, 2015).

It has been suggested these higher rates may be due to a tendency amongst psychiatrists to diagnose schizophrenia when dealing with black males, which has in turn been attributed to explicit or institutional racism, or to a racialised definition of the traits which define schizophrenia (Jonathan Metzger in Lane, 2010). However, an in-depth study into ethnicity and

psychosis, the Aetiology and Ethnicity in Schizophrenia and Other Psychoses [AESOP] study, (Morgan et al., 2006) suggested that rates of diagnosis may also be attributable to socio-economic and geographical differences. With a higher incidence of psychosis in south-east London than Nottingham or Bristol, the authors suggest that ‘urbanicity is a risk factor or indicator for psychosis’ and that subsequently the concentration of black populations in urban areas may explain higher rates of diagnosis (Morgan et al., 2006).

Mental health issues amongst Asian communities appear to be influenced by factors including age and gender. A study from Weich et al. found that middle-aged Pakistani men and older Indian and Pakistani women had significantly higher rates of common mental disorders such as anxiety and depression, whilst Bangladeshi women had a very low prevalence of common mental disorders (Weich et al., 2004). Another study identified that, as a group, South Asian women had much higher rates of common mental disorders compared to white and black women (Bebbington et al., 2009). Indian men are also reported to have high rates of alcohol-related problems (Mental Health Foundation, 2015).

During the 1980s and 1990s evidence emerged to show that Asian women between the ages of 15 and 35 were more vulnerable to suicide and self-harm than their non-Asian counterparts. They were seen as being two to three times more likely to self-harm (Soni-Raleigh, 1996, in Bhardwaj, 2001). This was often attributed to cultural issues such as ‘izzat’ (honour) and ‘sharam’ (shame), issues which were often heightened for second generation migrants by the challenge of reconciling traditional or religious beliefs with the expectations associated with growing up in the UK (Bhardwaj, 2001).

In recent years, there has been a shift and a study from Cooper et al. (2010) suggests that self-harm may now be more common amongst young black women. Although the researchers did not seek to explore the reasons for this in depth, they suggest that ‘young Black females who self-harm may be experiencing greater social adversity, as in our cohort they were more likely to be unemployed and report housing problems’. Furthermore they found that, despite higher rates of self-harm, fewer young black females were receiving psychiatric care than other ethnic groups (Cooper et al., 2010).

Evidence around the prevalence of mental health conditions in Chinese communities tends to be limited, although a 2008 report produced as part of the Delivering Race Equality programme highlighted the importance of cultural concepts of mental health, stating that ‘Chinese older people were unlikely to recognise the symptoms of mental ill health and also unlikely to perceive mental health problems as ailments that required medical attention’ (Tran et al., 2008, p.5). Other resources have emphasised the role of strong community support and an emphasis on holistic and non-statutory approaches to treatment as factors leading to the underrepresentation of Chinese communities in mental health services (Mental Health Foundation, 2015). However, the risk of stigma surrounding mental health means that people from Chinese communities may also be reluctant to seek help. According to the Mental Health Foundation, Irish people living in the UK have much higher hospital admission rates for mental health problems than other ethnic groups, and in particular, are at greater risk of suicide, have higher rates of depression and are more likely to have alcohol problems (Mental Health Foundation, 2015). Ryan et al. (2006) suggest that the relative ease of migrating to England from Ireland, due to geographical proximity and a shared language, may ‘contribute to conflicts with regard to identity and settlement’ since migration is perceived as being only temporary.

Most refugees and asylum seekers will, through the very nature of their position, have experienced trauma in their lives which is likely to have a significant impact on their mental health. Most will have experienced extreme violence or the risk of violence (including war, rape or torture and ‘gender-specific forms of persecution such as sexual violence, marital rape, domestic violence, female genital mutilation, forced abortion or sterilisation’ (ICAR, 2007)) as well as uncertainty during their passage to the UK. Dealing with such experiences will be compounded for most by their experiences on reaching the UK, as well as racism and an alien political system: ‘Those who claim asylum must deal not only with an, at times, baffling and bureaucratic system, but also with the practical and psychological challenges of restarting a new life in a new country, living in a new culture, adapting to new systems and sometimes having to learn a new language’ (Latif, 2014). For young unaccompanied asylum seekers, there is a lack of support and stability coupled with concerns about their immigration status on turning 18.

Although research on dementia is fairly limited, there appears to be evidence that African-Caribbean, South Asian and Gypsy-Traveller communities are more likely to experience early onset dementia, whilst individuals from African-Caribbean backgrounds have a higher risk of vascular dementia (Truswell, 2013). Research into the mental health of children and young people from UKME communities is limited. However, although small sample sizes make it difficult to draw reliable conclusions (Dogra et al., 2012), there is some evidence to suggest that young people from different minority ethnic backgrounds may have different rates of mental ill health. Green et al. (2005) found that amongst children aged 5-16 years, 9.2% of children from black backgrounds, 7.8% of children from Pakistani and Bangladeshi backgrounds, and 2.6% of children from Indian backgrounds had a mental disorder compared to 10.1% of children from white backgrounds. The research also found some differences in outcomes for girls and boys, with black boys in particular experiencing high rates of diagnosis for conduct disorder.

In a recent briefing, Lavis (2014) highlighted a number of factors which may influence the prevalence of poor mental health amongst children and young people, including family breakdown, parental illness, bereavement, poverty, exposure to racism, low IQ, genetic factors, abuse and exposure to gang culture. Although emphasising that ‘a single risk factor, such as low IQ may not cause any particular problems’ she suggests that the ‘more risk factors a person experiences, the greater the probability that they will develop mental health problems’ (Lavis, 2014).

There is also evidence to suggest that mainstream services are failing to meet the mental health needs of UKME children and young people (Street et al., 2005; Malek, 2011). However, whilst Malek and Joughin (2004) found that children and young people from UKME communities were under-represented in child and adolescent mental health services (CAMHS), these communities also appeared to be over-represented in adult mental health inpatient services. Lavis (2014) attributes this to a failure to provide timely support: whilst most mental health problems start in childhood and adolescence, early support can ‘help build resilience, address underlying problems and prevent the development of more serious mental health problems’. Combined with the increasing number of black and minority ethnic children and young people, in particular, from Eastern European (Lavis, 2014) and mixed heritage backgrounds (Morley

and Street, 2014), it appears that the case for early intervention with minority ethnic children and young people becomes imperative.

The relationship between “cultural” and socio-economic issues and mental health

There are also a number of issues which may affect the mental health of UKME groups which are unlikely to affect the general population, including forced marriage, Female Genital Mutilation (FGM), honour-based violence and abuse relating to spirit possession. It is important that such issues are neither seen as widespread in UKME communities nor as accepted in or by certain cultures. Forced marriage, FGM and violence and abuse of any kind are illegal under UK law and are condemned as such by most minority ethnic communities. However, for those individuals who do experience these forms of abuse, there are likely to be severe effects in terms of physical and mental health, as well as difficulties when engaging with health services who may be unfamiliar or ill-prepared to deal with the specific challenges associated with these issues (Bignall, 2015; Philips and Dutt, unpublished for NSPCC).

UKME individuals may also be more likely to experience socio-economic factors which contribute to poorer mental health (Marmot Review, 2010). The Marmot Review found a strong relationship between social gradient and common mental health problems, with a two-fold variation between the highest and lowest quintiles. Factors including deprivation, unemployment and poor housing may all influence mental health outcomes. There is evidence that UKME families are more likely to reside in low-income and workless households; live in overcrowded conditions; with poorer pre-1919 housing (Beasor, 2011; Garrett et al., 2014).

There is evidence that UKME individuals are 40% more likely than white Britons to come into contact with mental health services through the criminal justice system, rather than through referral from GPs or talking therapies (Kane, 2014). There have been a number of explanations for these differences, whether due to limited awareness of, or a reluctance to engage with, statutory services at an early stage of illness (possibly due to previous poor experiences or the belief that services are not “culturally appropriate”) or the stigma around mental health in some communities. Cultural differences in the way that mental health is perceived may also decrease the likelihood of individuals seeking care before reaching crisis point. This can include

‘different understandings of what constitutes a mental health problem, different cultural expressions of distress including the way symptoms are expressed, and differing expectations of services’ (Kane, 2014).

In a paper looking at the mental health of migrant mothers, Latif (2014) stated that ‘women from non-Western cultures are more likely to present somatic symptoms of depression’, that is physical symptoms resulting from untreated mental or psychological distress. Highlighting the role of stigma in preventing women from seeking treatment, she also argues that ‘in cultures where there is little understanding and awareness of maternal mental health related symptoms, women may not be able to easily identify symptoms or, in other cases, women may understand symptoms but be unable to recognise them or express them’. Latif links this to difficulties surrounding the use of Western models of diagnosis and treatment with UKME communities, for example, where treatment depends on individuals self-reporting their concerns (Latif, 2014).

Differences in treatment for individuals experiencing mental health issues have also been attributed to ‘cultural difference on the part of the onlooker (the person witnessing distress or distressed behaviour)’ (Kane, 2014), in particular in relation to a number of high profile cases involving African-Caribbean men (for example, David “Rocky” Bennett). Blame often comes from racialised views of black men as being more aggressive or out of control; such views have been described as at best ‘a failure to understand culture’ and, at worst, a reflection of ‘racist views’ (Kane, 2014; see also, Rogers and Pilgrim, 2010; Nazroo and Iley, 2011).

Conclusions

From the brief summary above, the evidence shows that some mental health conditions are more prevalent among ethnic minorities and that this may be due to a range of factors including lifestyle factors, experiences of racism and culturally specific traumas. The evidence also demonstrates that people from black and minority ethnic communities are less likely to seek help at an early stage of illness, due to a combination of lack of knowledge, stigma, inappropriate models of diagnosis and poor experience of mental health services. UKME

people also have poorer experiences once in the mental health system and are more likely to be medicated and restrained or risk death in detention.

Organisations working with UKME communities around mental health have recognised, and responded to, many of these issues. Understanding their work and highlighting best practice is crucial to continued work on tackling poor mental health outcomes in black and minority ethnic communities.

Personal Experiences

(This section has been adapted from ‘*Mental health crisis review – experiences of black and minority ethnic communities*’ Race Equality Foundation, May 2015, based on a series of community consultations across England)

Case study from Ealing

Paul is an older man.

‘All I wanted was someone to be there, to be with me.’

Paul has been in and out of the mental health system for decades. On one occasion he was held in a Police cell because there were not any beds available in the local hospital. He felt that the Police officers avoided him when he was in the cell because he was mentally ill. The experience of being in crisis in a cell was a major trauma in itself for Paul.

‘I’m in total chaos, I have just tried to kill myself. I’m in a prison cell. I’ve no belt, no shoelaces, no shoes, because they wouldn’t let me have them.’

He feels that it is not just the Police that lack empathy when dealing with people in crisis. The problem extends to professionals.

‘The sort of people you need in crisis is an empathetic person.’

Key Points raised at Ealing consultation

People do not have the confidence to complain about poor service. Several of the participants said that they felt unable to speak up for themselves. *‘I’m frightened of kicking up a fuss...I*

don't know how to stand up for myself.' Many participants felt complaining would not change anything, 'I wouldn't bother, because nothing ever bloody happens.'

An advocate described staff as often being hostile to him and his presence. He said that he often felt service-users were being treated more like prisoners. He also recounted an incident where he had gone to see one of his clients, and spotted a man who was confined to bed and had no food at dinner time. On following this up with the staff it transpired that he had been forgotten because he had special dietary requirements (Halal). The advocate was convinced that this man would not have eaten were it not for their intervention. The advocate and a colleague were also approached by someone who said that staff at the hospital would use condescending language such as announcing medication as 'smartie time'.

Case study from Northampton

Gina is an African Caribbean woman born in the UK.

'They don't take into account faith or culture.'

Gina is a woman who has moved on from supported housing, but still regularly accesses mental health services through a psychiatrist. Gina personally did not have any experience of the mental health system before her first crisis. She did not realise she was mentally ill, but other experiences of mental illness within the family meant her mother recognised the symptoms. This was when Gina was first sectioned.

'Every time God talked to me they locked me up'.

She is a devout Christian, but feels that her faith is often treated by mental health professionals as a symptom of her illness rather than a source of strength for her recovery. Other doctors had handled her faith in a much better way, but they had changed and the new doctor was not as sympathetic.

Key points raised at Northampton consultation

Hospital and police services are not joined up. Several participants talked about being picked up by the Police, but not being taken to a mental health unit or hospital, and instead being kept in cells and released after a while. Another interviewee talked about seeking help from the Police earlier, but their issues were not recognised. They said that the hospital and Police do

not know enough about the services in the community that could help people going through crisis or post-crisis.

There is a lack of understanding of faith in the mental health system. This issue covers both actively asking about faith, and the treatment of faith for someone who outwardly expresses it. One person said there was no understanding or appreciation of his faith in services, he was never asked about his faith. Another participant said her psychiatrist saw her faith as part of her illness – especially when she interpreted her symptoms through a religious perspective. She said this made seeing the psychiatrist difficult, and meant that she suppressed her faith.

Care in prisons is poor. One participant talked about receiving poor care in prison. Medication was forced on him and when he was given pills at discharge, they did not work. He was later admitted to a mental health unit where they started injections. This participant reported that this medication helped, but he felt it was not timely. He further suggested that while in prison he received medication in the mornings and evenings, but had no support in between and had to ‘cope’.

Case studies from Sandwell

Charlie is a British-born African Caribbean man

‘I wouldn’t have gone through so much pain if I had known what to do about my illness, and who to go to, where I could get support. Maybe then I could have stayed in work’.

Charlie lives in supported housing and describes himself as having ‘a routine’ in that he knows his illness and, despite ups and downs, is able to manage it. However, when he first developed symptoms, Charlie did not know what was happening. It was ‘very frightening’. He went without treatment for years before going to hospital. Following a difficult path of through diagnosis and finding the right medication, Charlie now feels able to manage his condition. However, he feels that this could have been different if the information had been there at the start.

Tanya is from a mixed Caribbean and Irish heritage. She is also a wheelchair user.

‘He looked at me as if to say “she’s just another scum on the street” and he wasn’t listening to what I was telling him.’

Tanya feels that whenever she goes to a meeting or appointment, she has to prove she is a 'person' because people make assumptions based on her ethnic appearance. *'I am not the same. We're not the same.'*

She has experienced discrimination inside the mental health system, and in support and wellbeing services outside of the NHS. She also feels that people with a mental illness often have their physical illnesses ignored by medical staff.

Key points raised at Sandwell consultation

Participants felt crisis services were poorly run. One person had been told it was 'out of hours' at 4pm, and on another occasion that there were other calls waiting. Another person said the number was often engaged and that staff tried to 'fob you off' when you got through – she had called the team a few weeks earlier after having self-harmed and described them as unhelpful and rude.

A third said they called up the crisis team on behalf of someone else who had been self-harming and threatening to end their life. She was told that this is not what the crisis team would count as a 'crisis'. When asked what they would define as a crisis, they gave the example of it being "when someone is about to jump off a bridge". Someone else had sought help from both the Police and the hospital without success.

'I knew something was terribly wrong, and I phoned the hospital and said "you had better come and fetch me cos I'm in serious problems here" and all they did was refer me to my GP. But you can't wait. It is not a thing that can wait. I turned up at the Police Station and said "something is wrong here. I got to get treatment." They just said you got to go and see your GP.'

Family and friends can be supportive or part of the problem. One interviewee found that due to the nature of his illness, and the general stigma around mental illness in his community, family and friends are actively contributing to his mental illness. He spoke about a former friend who would 'warn' other people about him, and thus leave him isolated. Similarly, after arriving in the UK he stayed with an uncle who threw him out due to behaviour connected to his illness. For another person, it took time for his family to understand, 'At first my family didn't. They buried their heads in the sand'. Eventually, especially when the medication started to work, the family came on board. They came to understand that regular medication would 'bring me back', and that with support he could manage his illness.

Theological and Ethical Pointers

(This section has been adapted from *‘Medical Ethics: a Christian Perspective’*, Mission and Public Affairs Council position paper, May 2016)

Salient theological themes informing Christian approaches to healthcare

God the life-giver: the creation of the universe is a free act of God as a result of which the gift of life is given to human beings. While human beings share the gift of life with many other creatures on Earth, we are unique in that we alone are made in God’s image. This means that humans have a unique status within earthly creation and that our innate dignity comes from being bearers of God’s image, enabling us to relate to God and to one another in a manner that reflects God’s own being.

God as Trinity: God is a single personal being but God cannot be understood in human personal terms; God is not a ‘bigger’ version of us. Our concept of what it means to be a person ought to come from an understanding of God; not the other way round. The Christian belief in the compound unity of the Trinity, in which complete mutual love and knowledge are infinitely shared, indicates that relationship is at the very centre of God and hence, relationship is intrinsic to the very concept of being a person.

God Incarnate: In becoming one with humanity through the incarnation in Jesus, God demonstrates his selfless love, care and responsibility for humans. The incarnation also indicates that the physical and the spiritual are not two separate unbridgeable realms, but that they are part of a continuum that reflects the reality of God. Creation is not something that exists ‘apart’ from God, but it is sustained and infused by God’s presence.

God the redeemer: in the Christian belief of the atonement, God takes responsibility for humanity and its sinfulness. God freely offers eternal life through Jesus’ identification with sinful humanity, demonstrated ultimately in his death on the cross. Grace, by which humans are freely given what they do not and cannot deserve: eternal life, is the hallmark of God’s relationship with us and hence ought to be the hallmark of our relationships with one another.

God and justice: Jesus taught that our treatment of the poor, the oppressed and the vulnerable has a greater importance than we may realise: as well as being significant in its own right, our treatment of the vulnerable is viewed by Jesus as our treatment of him. His identification with the vulnerable and the oppressed provides the backcloth for Christian social action.

God and community: the Trinitarian understanding of God indicates that relationship is at the heart of what it means to be a person. This is reflected in the New Testament concept that followers of Jesus are bound together in community. The Church is the Body of Christ, joined to him in spiritual union with its members joined to one another through him.

Guiding ethical principles

There are four leading principles, relevant to healthcare and medical ethics that emerge from the core Christian beliefs outlined above. These principles complement one another, displaying an order of precedence with the effects of each principle ‘cascading’ to succeeding principles. The principles, in order are: affirming life, caring for the vulnerable, building community and respecting the individual.

Affirming Life: The right to life and protection of life form the foundations both for human rights and for much of our criminal code. Affirming life includes both of these concepts, but it goes further. To affirm life is to argue that each individual life has purpose, value and meaning, even if some individuals may doubt that for themselves and their own lives. It also means that we wish to see everyone attain the highest quality of life possible in whatever circumstances they may find themselves. Affirming life takes precedence over other principles because it is fundamentally the most important and most basic guarantee that society can offer its members. Other principles are undergirded and set in a positive context by the principle of affirming life.

Caring for the Vulnerable: A civilised society is one that fundamentally affirms life and that ensures that this and other benefits and protection are fairly experienced by all of its members. In practice, this means that particular attention must be given to vulnerable individuals and groups. History indicates that the powerful will often neglect or abuse the vulnerable unless strong and specific action is taken to protect them. Caring for the vulnerable, however, goes

beyond issues of protection: it includes ensuring that vulnerable people are supported, cared for and enabled to live fulfilled lives, being afforded the same respect as other members of society.

Building a Caring and cohesive Society: Relationship is at the heart of what it means to be human and this ought to be reflected in the way that society organises itself. While totalitarian regimes are unacceptable in that they demand too much sway over the lives of their citizens, an individualistic ‘free for all’ will mean that the principles of affirming life and caring for the vulnerable are unlikely to be upheld. Individual autonomy and freedom are important, but these can only be pursued within a society that places limits on them. Building a cohesive and humane society provides the best environment for individual freedom, ensuring that every individual’s life is affirmed and that the vulnerable are cared for. Carefully gauged limitations on individual freedom that enable the building of a truly humane society ought to be welcomed by all.

Respect for Individuals: Within the context of building a cohesive and humane society in which life is affirmed and the vulnerable cared for, maximum individual freedom of choice and opportunity ought to be given. It has been too easy for societies to marginalise, victimise and to persecute individuals and groups on the basis of sex, race, religion, age, disability, sexual orientation and a host of other characteristics, chosen by the powerful as indicators for discrimination. Wherever possible, in keeping with the principles already advocated, maximum individual freedom of choice ought to be underwritten by society to ensure that individuals are enabled to live their lives in the manner of their choosing.

In Practice

**(This section has been adapted from ‘Ethnic Minorities Mental Health Toolkit
-A Guide for Practitioners, HSC and Aware Defeat Depression, October 2014)**

Cultural competence in Mental Health

Cultural competence is important for individuals as well as for services and organisations. For individuals, it is usually understood as knowledge, attitudes and skills that allow them to understand and appreciate cultural differences, enabling them to provide effective health care which takes into account people's cultural beliefs, behaviours, needs and values.

Culture can have an impact on mental health in a number of ways, including:

- People from UKME backgrounds may have a different way of displaying distress or symptoms from the majority white population
- They may come from a culture where they are not used to seeking help or have different seeking help patterns
- They may have different beliefs with regard to the causes or treatment of illness
- Their way of displaying symptoms may have an impact on diagnosis and treatment.

In order to come alongside people from UKME backgrounds who might have mental health problems, it is necessary to develop **cultural competence**.

The first stage in this is to develop **cultural awareness**, starting with an examination of one's own personal value base and beliefs.

Cultural knowledge (the second stage) can be gained in a number of ways, for example, through pursuing a better understanding of health beliefs and behaviours and the issues they raise. Meaningful contact with people from different UKME groups is essential in gaining such knowledge.

An important element in achieving **cultural sensitivity** (the third stage), is how professionals view people in their care or with whom they come into contact. Those who receive pastoral or health-related care ought to be treated as equal partners. This involves demonstrating trust, acceptance and respect.

The achievement of the fourth stage, **cultural competence**, requires the synthesis and application of previously gained awareness, knowledge and sensitivity. Being culturally competent is more than being culturally aware and culturally sensitive. It is not simply a process of learning a list of facts about other cultures. It is about understanding how best to relate with individuals and groups from other cultural and social backgrounds. Wherever possible, we ought to ensure UKME representation in our own structures as well as in engagement initiatives.

A key part of this is learning to be reflective about how our own culture influences the way we work. In order to work in a culturally competent way we might need to:

- Spend some time before becoming actively involved in extending care to an individual to find out pertinent information about the country of origin (if applicable) and the heritage of that person. We need to remember, however, that cultural influences vary from person to person; we should not make assumptions about individuals.
- Examine our own cultural influences and values
- Try to establish why the person is thought to have a mental health problem, how they see their condition and what it means for them. How might this issue be viewed in their culture and where might they go for help?
- Find out whether, in their own culture, they would expect medication or some other kind of help
- Be aware that UKME individuals might already have had negative experiences of mental healthcare, possibly involving the police or the criminal justice system
- Seek advice from local UKME community groups
- Attend equality, cultural diversity/awareness, anti-racism and other relevant training to acquire skills, attitudes and knowledge to work more effectively UKME individuals and groups.

What Can The Church Do?

(This section is adapted from ‘UKME Mental Health Project: ‘Breaking the Circle of Fear’, Mission and Public Affairs Council report, May 2015)

In addition to Church leaders, church workers and chaplains becoming more fully aware of UKME mental health issues it is essential that cultural competence is displayed by all those ministering to UKME individuals with mental health problems.

Two listening exercises involving representatives from mental health charities and Church and community activists were conducted by MPA officers during 2014. Participants emphasised the following roles that the Church could play at all levels of its organisation:

The Church is an independent body with access to local and national government through various mechanisms; it has the potential to be ‘an honest broker’.

The Church has a ready-made network of communities, buildings and pastoral contacts that can be utilised in helping to design and deliver culturally appropriate and accessible services in collaboration with local communities.

By being embedded in communities, the Church can play a leading role in helping to educate both communities and health professionals with regard to mental health issues.

At all levels, the Church can be ‘a voice for the voiceless’, helping to reduce the stigma often associated with mental illness (but see below).

A coherent strategy for developing UKME mental health services is needed, not simply more detailed planning of services. The Church of England should champion this initiative.

Best practice in local situations ought to be identified and information disseminated using the Church’s network of dioceses and parishes.

The Church ought to address UKME inequality issues within its own structures and confront racism within its own membership.

The Church should take a lead in exploring the continuing legacy of slavery with regard to UKME mental health.

The Church should raise mental health awareness among its congregations, helping to minimise stigma attached to mental illness.

Brendan McCarthy 12th November 2016