YOUR VOICE MATTERS!

Improving Access to Mental Health and Learning Disability Services for Asian Communities in Greenwich, Bexley and Bromley

Oxleas community engagement

NHS
Oxleas
NHS Foundation Trust

VOICE 4CHANGE ENGLAND

GREENWICH

BEXLEY

BROMLEY

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1. EXECUTIVE SUMMARY

Voice4Change England in partnership with Oxleas NHS Foundation Trust, held a series of 'Your Voice Matters' engagement events to understand how Asian communities experience, access and use local mental health and learning disability services. The events were conducted in Greenwich, Bexley and Bromley, and combined presentations from Child and Adolescent Mental Health Services (CAMHS) and Adult Learning Disability (ALD) Services with facilitated table discussions. Together, the sessions brought together community members, faith organisations, VCSE organisations, Healthwatch representatives, clinicians and community leaders from across the three boroughs.

The events worked well as a model of engagement. Community members were able to speak directly with clinicians, facilitated table discussions created a safe space for open and honest conversation, and the sessions offered valuable networking opportunities between community and statutory partners. NHS colleagues showed a genuine willingness to listen and engage with community perspectives, which participants noted and valued.

Across the three sessions, discussions converged on a small number of consistent messages. Awareness of services is low, and the gap runs in both directions: communities do not know what is available, and services do not fully understand the communities they are meant to serve. Where awareness exists, stigma, shame, language, and fear of intrusive intervention prevent people from coming forward until a situation has reached a crisis point. Trust is held by faith leaders, family, and people from within the community who share its language and lived experience.

A key learning point from this project is the value of relationship-based engagement and outreach. Much of the engagement that made these sessions possible was achieved through personal conversations, WhatsApp communication, trusted community connectors, faith organisations, VCSE organisations, Healthwatch colleagues, and links with local authority community and equality officers. Voice4Change England supported this process through targeted outreach, relationship-building with trusted community networks, and facilitation of the discussions themselves, bringing community insight together in a form that could inform service development.

Whilst attendance varied across the three events, these trusted relationships brought together participants with valuable lived experience, community knowledge and professional insight, generating rich discussion and demonstrating how this kind of partnership working can reach communities that are often underrepresented in more traditional engagement approaches.

Participants were clear about what would help to change this. Services need to go to the community rather than wait for the community to come to them; they need staff and materials that reflect the languages and cultures of the people they serve; and they need to act on the feedback they collect rather than simply gathering it. The recommendations in this report are drawn directly from what participants said.

1.1. Findings

- **A two-way awareness gap exists.** Communities are largely unaware of services, and services are not sufficiently aware of the communities they serve.

- **Stigma and shame are the dominant barriers**, falling heaviest on men and on women, who often carry the burden of managing a family member's condition alone.

- **Fear of the system delays help-seeking.** Fear of detention, of social services, and of authority means people only come forward in crisis.

- **Trust is personal, not institutional.** Faith leaders, family, community champions and culturally matched staff are trusted; professionals and digital channels are generally not.

- **Digital-only access excludes people,** particularly those with limited digital literacy, no internet access, or language barriers.

- **Long waits after access erodes trust.** Even where people did reach services, waiting times were described as lengthy, and this delay itself was raised as something that undermines trust.

- **Feedback without follow-up erodes trust.** Participants repeatedly asked that engagement be two-way; acted upon and reported back.

2. BACKGROUND AND PURPOSE

The 'Your Voice Matters' events were designed to bring together statutory services and community members in single space. Local NHS services, Greenwich, Bexley and Bromley CAMHS and the Oxleas Adult Learning Disability service, set out what they do and how people reach them, and community members were then invited to respond through facilitated table discussions.

The discussions were structured around five questions, which frame the findings in this report:

1. What do people in your community know about local mental health and learning disability services?
2. What barriers or concerns might prevent Asian individuals and families from accessing support?
3. Who do people trust when seeking information, advice, or support?
4. What would make services feel more welcoming, accessible, and culturally responsive?
5. What could services do differently to better support Asian individuals, families, boys and young men?

The workshops form part of a wider programme of engagement with Asian communities across Bexley, Bromley and Greenwich. Alongside the three Your Voice Matters workshops, Oxleas has been working with the Greenwich Nepalese community through the longstanding Oxleas/Nepalese community engagement steering group and a Healthy Ageing programme delivered in partnership with Community Empowerment and Support Initiatives (CESI), Greenwich Public Health and primary care colleagues. This included a large community event focused on healthy ageing, memory, brain health and prevention, attended by more than 60 members of the local Nepalese community, with subsequent work exploring community champion roles and ongoing health promotion programmes. The programme has also built on earlier engagement led by Greenwich Older People's Mental Health Services and Greenwich Time to Talk, including dementia awareness workshops, co-produced health information resources and partnership working with Nepalese community leaders.

More broadly, Oxleas has strengthened relationships with a range of South Asian communities, and through partnership with Voice4Change England, local VCSE organisations, faith leaders and community champions, the work has created new opportunities for direct dialogue between communities and clinicians, helping to shape a more culturally responsive approach to mental health and learning disability services.

2.1. Aims

To facilitate community engagement events across Greenwich, Bexley and Bromley, surfacing the lived experience of Asian communities in relation to local mental health and learning disability services, and to produce recommendations that support system stakeholders in improving access, awareness and outcomes.

2.2. Objectives

- Facilitate community engagement events in the three boroughs.
- Facilitate table discussions to understand local people's lived experience, structured around the questions mentioned above.
- Analyse findings from the table discussions.
- Produce a report with recommendations for system stakeholders, addressing needs and gaps in services and awareness, to enhance access and use of local services and improve health outcomes.

2.3. Scope

The project is bounded geographically to Greenwich, Bexley and Bromley, and demographically to Asian children, boys and young men engaging with local Child and Adolescent Mental Health Services (CAMHS), and to Asian communities engaging with Adult Learning Disability (ALD) services. It covers community engagement events and facilitated table discussions only; referral monitoring and service-level data sit with Oxleas NHS Foundation Trust rather than within this scope.

BROMLEY SESSION

2.4. Methodology

The events themselves modelled the kind of delivery participants asked for. Sessions were held in local, non-Oxleas venues rather than clinical settings, using organisations already embedded in the community, which also brought a direct benefit to those organisations through the booking and hosting itself. Staff and facilitators were broadly representative of the communities attending, reflecting the languages and backgrounds of participants. Table discussions were facilitated rather than tightly directed, allowing conversation to follow what mattered most to participants rather than a rigid script.

The approach was qualitative, built around community engagement events combining service presentations with facilitated table discussions. Each session was structured around five fixed questions, asked consistently across all three boroughs, to surface participants' lived experience of awareness, barriers, trust, and service design.

Table discussions were facilitated to draw out open, first-hand accounts rather than closed responses, allowing themes to emerge from participants' own language and priorities. Notes from each session were then analysed thematically, both within each borough and across all three, to identify findings common to all sites and those distinct to a particular community or location.

The resulting themes and findings were used to develop recommendations directed at system stakeholders, aimed at closing the awareness and access gaps identified through the discussions.

Given the qualitative nature, findings should be read as indicative of lived experience and recurring themes, not as statistically representative of the wider Asian population in these boroughs.

Participants included:

- Adult representatives from the Asian community across the 3 boroughs
- Representatives from MIND
- Representatives from Healthwatch
- Clinicians
- Representatives from a variety of organisations that work with Asian and other underserved communities

3. UNIQUE FINDINGS FROM 3 SESSIONS

Session 1 — Greenwich (10 June)	Session 2 — Bexley (22 June)	Source 3 — Bromley (29 June)
• Fear of intrusive intervention (e.g. detention) as an active deterrent to help-seeking • A whole cohort potentially undiagnosed / unaware of being neurodivergent • Non-transfer of paperwork, prescriptions and contacts at the child→adult transition boundary • Interpreter confidentiality risk: interpreters personally known to the family • Distrust of social services rooted in prior scandals	• Pride, particularly among older cohorts, as an axis distinct from stigma • Inability to distinguish valid information from misinformation • Low event/service turnout recorded as an observed outcome • “Be Well Hubs” sited in temples as a concrete delivery model • Family-first hub model • Transport as a material access lever (mini-bus provision)	• Two-way knowledge gap stated explicitly: services unaware of their target communities • Health champions recruited from within the target community as designated access points • Outreach into unconventional high-footfall sites: football clubs, tattoo parlours, sports clubs • Geographic targeting to the north of the borough / town centre where population concentrates • Sector mapping for gaps/overlaps; explicit query on whether the underlying data exists

Session 1 — Greenwich (10 June)	Session 2 — Bexley (22 June)	Source 3 — Bromley (29 June)
• Comparison pressure and parental self-positioning as primary problem-solvers • Shame amplified where conditions are perceived as heritable (genetic framing) • “Connect to connectors” — route through existing trust-holders rather than importing professionals • Schools compelled (not merely invited) to engage, especially at 18+ and SEN transitions	• Draw mechanisms: food, celebration, freebies, a deliberately non-clinical “soft approach” • No single trust-building approach fits all — explicitly segmented by age/generation/background • Content authored by the community, instead of just translated for it	• Bromley Parents Voice cited as an existing (non-ethnically-structured) organising node • Young people offered voluntary roles to confer a sense of purpose • Website auto-translation; QR codes; distribution via gyms and supermarkets • Explicit caution against AI-generated translation — human proofreading mandated • Integrated Neighbourhood Teams (INT) named as a coordination vehicle

4. FINDINGS

The findings below are organised around the five discussion questions. They draw together the table notes from all sessions, Greenwich (10th June), Bexley (22nd June) and Bromley (29th June).

4.1. What communities know about local services

The clearest and most consistent message was that awareness is very low. Participants did not know what services exist locally, how the referral pathway works, or how to self-refer. Knowledge of the transition from child to adult services was described as particularly absent, and participants suggested that a whole generation may be undiagnosed and unaware that they are neurodivergent.

Crucially, the awareness gap was described as running in both directions. Just as communities are unaware of services, services are not sufficiently aware of the communities they are meant to serve. By the time someone reaches a GP, participants felt, it may already be too late. The underlying question that came up was simple: do people know about services at the moment they actually need them?

Even where people knew that services existed, their lived experience was that accessing them could feel almost impossible. Some feared that reaching out would trigger extreme intervention, such as being detained, and so held back until their situation had escalated.

4.2. Boys and Young Men: Distinct Needs and Access Barriers

National research supports what participants described locally. South Asian communities in the UK are known to underuse mental health services relative to the wider population and other minority ethnic groups, and where they do access care, engagement tends to happen later and is influenced by cultural factors such as favouring psycho-social-spiritual explanations over biological ones, alongside language barriers, stigma, and unfamiliarity with the healthcare system. Evidence also points to gaps at the point of engagement itself: men from Asian backgrounds have been found to be at higher risk of being referred elsewhere rather than completing treatment, compared with men from non-minority, non-religious background.

This pattern is reflected locally: Oxleas has identified referral and uptake gaps for Asian men into Adult Learning Disability services and Asian boys into Children and Young People's services as significant enough to warrant a dedicated six-month action plan across Bexley, Bromley and Greenwich, with baseline referral data now being tracked through the Equalities Dashboard to measure progress.

Across the three sessions, boys and young men emerged as a distinct group with needs not fully met by the wider findings. Loneliness, isolation and a lack of community connection were noted among young people, while stigma fell especially heavily on men, for whom asking for help conflicts with expectations of strength.

Participants pointed to specific gaps at the child-to-adult transition: paperwork, prescriptions and contacts often failed to transfer at this boundary. Schools were also described to need a push to engage at this stage with special educational needs settings.

Suggested approaches centred on outreach into spaces young men already occupy, such as football clubs, sports clubs and gyms, and on training young men and trusted community leaders to lead conversations with their peers. Offering young people voluntary roles was also raised as a way to give them a sense of purpose and a route into engagement that does not feel clinical or intrusive.

4.3. Barriers and Concerns

4.3.1. Cultural and Attitudinal

- Stigma and shame, felt especially strong by men, for whom asking for help conflicts with expectations of strength.
- Guilt and blame falling on women, who are often left to handle a family member's condition alone. Mothers frequently attend assessments or diagnoses by themselves and do not share the outcome with partners, out of shame.
- Family denial, difficulties minimised, managed quietly within the family, or only acknowledged at crisis point, compounded where conditions are perceived as genetically inherited.
- Loneliness, isolation and lack of community connection among many young people.

- Spiritual frameworks for understanding mental health that can delay engagement with clinical services. Faith was described a both a barrier and a potential entry point.

4.3.2. Systemic and Structural

- Inconsistent referral by GPs and school, sometimes partial, sometimes absent altogether.
- Information and paperwork that do not transfer smoothly at transition points, such as from child to adult services.
- Digital-by-default delivery that excludes those with low digital literacy or no internet access.
- Language barrier, with women often unable to drive, compounding access difficulties; and inaccessible service timings.
- Interpreters who may be personally known to families – raising confidentiality concerns – and whose mental health literacy is often untested.
- Organisations working in silos, with no joined-up coordination; and feedback that is gathered but not acted upon.

4.3.3. Trust Deficits

- Fear of being 'locked up' and distrust of social services, in some cases rooted in past scandals.
- Wariness of authority figures and professional framing.
- Misinformation circulating via Google, TikTok and similar channels, making it hard to distinguish good information from bad.

4.4. Who People Trust

Participants were consistent: trust sits with people, instead of institutions. The most trusted sources were:

- Faith leaders and faith communities, often the first point of contact.
- Family members.
- Community champions – people from within the community who do not present as professionals or authority figures.
- Peer networks: WhatsApp, Facebook groups, word of mouth, and school coffee mornings and parent networks.
- Culturally matched staff who share language, dialect and lived experience.

4.5. What would make services feel welcoming and culturally responsive

- Non-digital access options offered alongside digital ones.
- Translated, jargon-free materials in community languages, human-proofread rather than machine-translated.
- Bilingual staff – not only interpreters, but people who understand cultural tone, context and nuance.
- Visible representation: staff who look like the community and speak its languages.
- Services delivered in trusted community spaces – places of worship, libraries, community centres and youth hubs.
- Gentle, unhurried engagement with no compulsion, giving people time to process.
- One-to-one formats wherever possible, to preserve privacy.
- Simple, condensed explanations of what exists and how to access it.
- Responsive services that maintain momentum after first contact, rather than long waits that break trust.

4.6. What Services Could Do Differently

Outreach and visibility: Tailor outreach to community life; stalls at school and summer fairs, stands in community shops, music and drumming events, and sporting activities. Use social media strategically, favouring a community-driven, culturally appropriate presence over broadcast messaging.

Trusted relationships: Connect through existing connectors. Identify who already holds trust within the community and work through them, rather than bringing in unfamiliar professionals. Train community champions, including young men and trusted leaders, to lead conversations, and engage faith leaders directly at management level.

Representation and workforce: Representation was a headline finding. One of the clearest messages from the community was a wish to see more people who look like them in roles within services and their own communities. This points to a corresponding recommendation on workforce representation; building recruitment pathways that draw staff directly from the communities services are meant to serve, rather than relying solely on external recruitment.

Coordination and structural change: Coordinate through organisations by building a mapped network of services and ending silo working. Go into schools, particularly around the move to adult services at 18 and in special educational needs settings. Focus on prevention by investing in youth centres and early intervention rather than waiting for crisis point.

Language and interpretation: Improve interpreter quality through mental health-specific training, checks for community connections that could compromise confidentiality, and greater use of bilingual staff.

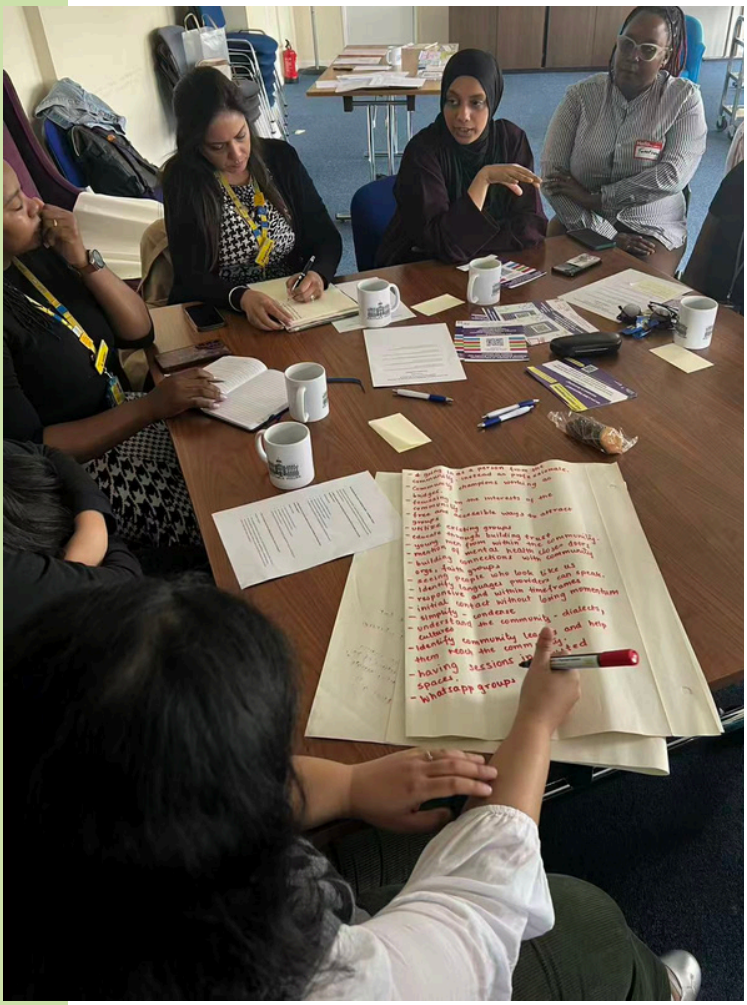


TABLE DISCUSSIONS AT GREENWICH

5. RECOMMENDATIONS

5.1. Build awareness in both directions

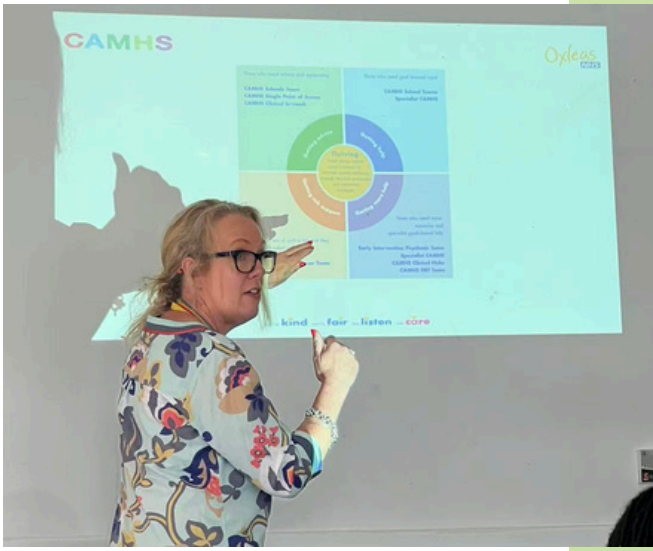
- Produce a simple, condensed guide to local mental health and learning disability services – what they are, who they are for, and how to access them – in community languages and non-digital formats.
- Invest in services' own understanding of local communities through sector mapping that identifies gaps, overlaps and the areas where Asian communities are concentrated.
- Clarify what services can realistically offer, so expectations are managed and trust is not lost to unmet promises.

5.2. Work through trusted people and places

- Recruit and train community health champions from within target communities, including young men and respected leaders.
- Engage faith leaders directly – including at management level – and explore models such as 'Be Well Hubs' based in temples and other places of worship.
- Deliver in everyday, high-footfall venues like places of worship, libraries, youth hubs, gyms, supermarkets, sports and football clubs, and other places people already use.
- Use peer facilitators and lived-experience storytelling so people hear from others who share their background and have been through it.

5.3. Support carers to support their loved ones

- Provide carers, particularly women who often manage a family member's condition alone, with practical and emotional support to sustain care within the community rather than reaching crisis point. This could include peer support groups for carers, respite options, and clear information on what help is available to them directly, not only to the person they are caring for.



CAMHS PRESENTATION

5.4. Make services culturally responsive

- Build cultural representation into front-line staffing as a foundation; prioritise bilingual staff over interpreters where possible.
- Where interpreters are used, train them in mental health specifically and check for community connections that could compromise confidentiality.
- Ensure all translated materials are written or proofread by people, given the risk of misinterpretation in machine translation – ideally written by the community rather than for it.
- Offer gentle, unhurried, one-to-one engagement, and keep momentum after first contact rather than leaving people in long waits.

5.4. Coordinate, prevent and follow through

- Establish joined-up working across local organisations, GPs, faith groups and Integrated Neighbourhood Teams, with stronger signposting and a maintained, up-to-date service directory.
- Strengthen referral and transition, particularly the move to adult services at 18 and engagement with schools and special educational needs settings.
- Shift investments towards prevention and early intervention – youth centres, outreach and voluntary opportunities that give young people purpose.
- Close the loop on feedback: act on what communities say and report progress back to them.

PRESENTATIONS AT GREENWICH

6. Action Checklist

- Produce a condensed, plain-language guide to local mental health and learning disability services, translated and available in non-digital formats.
- Map local services to identify gaps, overlaps and areas of Asian community concentration.
- Set clear expectations of what services can realistically offer.
- Recruit and train community health champions, including young men and respected leaders.
- Engage faith leaders directly, including at management level, and explore faith-space delivery models.
- Deliver services in high-footfall community venues (places of worship, libraries, youth hubs, gyms, sports clubs).
- Use peer facilitators for lived-experience storytelling.
- Support carers, particularly women, through peer support groups, respite options and clear information on help available to them directly.
- Prioritise bilingual staff recruitment over reliance on interpreters.
- Train interpreters in mental health and screen for confidentiality risks.
- Ensure all translated materials are human-written or proofread.
- Offer gentle, unhurried, one-to-one engagement with prompt follow-up.
- Strengthen joined-up working across services, GPs, faith groups and Integrated Neighbourhood Teams.
- Maintain an up-to-date local service directory.
- Strengthen transition support at 18 and engagement with schools.
- Shift in investment towards prevention, early intervention and youth voluntary roles.
- Report progress back to communities on feedback received.

7. NEXT STEPS

The sessions point towards continuous cycle of co-production rather than a single round of consultation. V4CE's contribution to this next phase is to embed a Plan-Do-Study-Act (PDSA) quality improvement cycle around the engagement work, so that each round of community input is tested, refined and built on rather than treated as a one-off exercise. V4CE can apply a PDSA cycle to the engagement programme: plan the next round of sessions based on this report's findings, deliver them, study what changes in awareness, trust and access, and act on that learning.

Priorities for the next phase are:

- **Expand** inclusive engagement across Greenwich, Bexley and Bromley to broaden representation, using co-production approaches such as World Café-style events, where participants move between small table discussions to build on each other's contributions rather than responding to a fixed agenda.
- **Address** referral inequality for Asian communities and for individuals with learning disabilities through targeted effort.
- **Run** co-production workshops with community members and partners to design culturally responsive solutions together.
- **Test** whether the data exists to target communities accurately, and build it where it does not.
- **Close** the loop with participants: report back on what has changed as a direct result of their input, as the basis for the next PDSA cycle.

DISCUSSIONS WITH THE COMMUNITY

8. CONCLUSION

The 'Your Voice Matters' engagement events demonstrate that Asian communities in Greenwich, Bexley and Bromley hold detailed, first-hand knowledge of the barriers preventing them from accessing mental health and learning disability services, and clear views on what would remove those barriers. The consistency of the messages across all three boroughs, on awareness, stigma, trust and the need for culturally responsive delivery, points to structural gaps rather than isolated local issues, and the recommendations in this report set out a practical basis for addressing them.

One tangible outcome has already emerged from this work: Greenwich CAMHS has begun a partnership with Gurudwara Sahib Woolwich, delivering services directly within a trusted community space rather a clinical setting. This is a direct, early response to what participants asked for consistently across all three sessions, that engagement be acted on, not simply gathered, and reflects 'Be Well Hubs' delivery model raised in the Bexley session, where services are sited within places that members of the community trust for e.g., places of worship rather than requiring communities to come to them. Colleagues from CAMHS are due to return to the Gurudwara to provide information sessions on how to access Oxleas CAMHS services, alongside the Gurudwara's safeguarding lead.

Another example of listening to visible action is the Older People's Team Lead for Greenwich Time to Talk has been leading a series of engagement and wellbeing events at Gurudwara Sahbit Woolwich (e.g., brain health, looking at dementia, etc.) bringing together local residents and NHS colleagues. Following a recent event attended approximately by 40-50 community members, feedback indicated that participants found the session highly valuable and were keen for further follow-up sessions. The Gurudwara committee also expressed a clear ambition to use the site as more than a place of worhsip, developing it as a community wellbeing hub that supports the wider community through health, wellbeing and prevention focused activites.

The partnership is now providing an early example of how engagement insight can be translated into practical service change.

Voice4Change England's contribution was central to how this evidence was gathered. Reaching participants whose lived experience is rarely captured through conventional consultation depended on trusted relationships that V4CE had already built, through faith organisations, community connectors, VCSE partners and local networks, and on facilitation that gave people a safe space to speak honestly rather than a formal audience to perform for.

The partnership is committed to a PDSA-based, co-produced next phase so that this engagement will not end as a single exercise and will develop into a sustained cycle of listening, testing and reporting back, which is the process by which trust between these communities and local services can be built over time.