Briefing from Mind

Inequalities for Black Asian and Minority Ethnic communities in NHS mental health services in England

About Mind

We're Mind, the mental health charity for England and Wales. We believe no one should have to face a mental health problem alone. We provide advice and support to empower anyone experiencing a mental health problem. We campaign to improve services, raise awareness and promote understanding.

Summary

This briefing will explore what is known about the differences for people from Black, Asian and Minority Ethnic (BAME)[1] communities in accessing mental health services, their experiences of these services and the outcomes they receive. It identifies statistics to demonstrate key differences in access, experience and outcome. It also outlines Mind's policy work in this area and our recommendations to address some of these inequalities. This is a continually developing area of research and understanding, and we hope more research will be done on this in the future. There will be gaps in knowledge, plus issues that this briefing has not covered. We will look to update this briefing in the future.

This briefing covers:

- Prevalence of mental health problems within BAME communities
- The role of racism in contributing to higher rates of diagnosed mental health problems and mistrust of mental health services
- Inequalities in use of the Mental Health Act, including restraint
- Inequalities in the provision of services, including inpatient care, talking therapies and support from your GP
- Mind's other policy work on Race equality

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[1] We know the acronym BAME (Black Asian and Minority Ethnic) is controversial. It can be problematic in terms of putting different groups into a single category, which obscures identities and the particular challenges experienced by those groups referred to in the BAME acronym. However, it can be useful as shorthand to refer to groups who don't experience White privilege (though this is complicated by fact that "Minority Ethnic" does include some groups who are generally perceived to be White). It can also be useful when working with other organisations that also use this term on shared goals to do with these groups. However, we acknowledge the problems with the term mean it's ultimately unsatisfactory and we're currently reviewing the use "BAME" within Mind.

Mind's recommendations:

Mental Health Act (MHA)

- UK Government to urgently publish the MHA White Paper. We have called for a number of changes to the Act to go some way to combating the current racial disparities in use of the Act, including:
  - Rights and principles on the face of the Act including an anti-discrimination principle referencing racism.
  - Explicit reference within the Act to ensure that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background.
  - To amend the definition of treatment to include a full range of appropriate treatments. Treatments should lead to an improvement of a person's condition, or prevent its worsening. This should take into account cultural identity and other relevant factors, with the objective of discharge from detention and ongoing recovery.
  - The introduction of an individual right to culturally appropriate advocacy.
  - That it be obligatory where appropriate for membership of the Mental Health Review Tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.
  - Aftercare planning should be co-produced with the person concerned, and whoever they wish to have involved, and conducted in a culturally competent way.

Use of restraint

- Given the higher rates of the use of restraint on black people in the UK's mental health hospitals, and the tragic death of Olaseni Lewis in 2010, the UK Government to urgently publish draft statutory guidance for the Mental Health Units (Use of Force) Act - Seni's Law - for public consultation, implement the Act without further delay, and take action to ensure use of restraint is dramatically reduced.

Provision of services

- The development of the Patient and Carers Race Equality Framework needs to be conducted with genuine engagement with BAME communities throughout, and adopted by all mental health Trusts, and other NHS and partner organisations in England.
- People of all ages must be able to access culturally competent and relevant community services at an earlier point. This will require investment in initiatives to address the cultural barriers to certain groups seeking support, including funding for BAME-led voluntary and community sector organisations.
- All relevant NHS services (including mental health inpatient services, advocacy, IAPT, primary care, etc) and relevant partner organisations (police forces, Immigration Removal Centres, social care etc) need to ensure they are providing

support for people from BAME communities through the provision of culturally relevant and competent services that meet their individual needs.

- All relevant staff should be trained in cultural competency.

Coronavirus

UK Government to:

- Provide a package of support for those groups at most risk of developing mental health problems, including people from BAME communities.
- Build upon the work begun by the Advancing Mental Health Equalities Taskforce to capture information about the impact of coronavirus on the mental health of people from BAME communities, and take urgent action to address the issues identified so that local services are delivering tailored and culturally competent support in partnership with local communities.

Introduction

This briefing will explore what is known about the differences for people from Black, Asian and Minority Ethnic (BAME) communities in accessing mental health services, their experiences of these services and the outcomes they receive. It identifies statistics to demonstrate key differences in access, experience and outcome. It also outlines Mind's policy work in this area and recommendations to address some of these inequalities. This is a continually developing area of research and understanding, and we hope more research will be done on this in the future. There will be gaps in knowledge, plus issues that this briefing has not covered. We will look to update this briefing in the future.

"They don't see me as an individual, with a specific history. They see a catalogue of Black men who come off as this stereotype of being big and dangerous and angry."[2]

This briefing looks at the experience of BAME communities and mental health services broadly. It is important however, to recognise when reviewing the evidence in this briefing, that race is one of a number of individual characteristics that combine with other aspects of our identity, including gender, class, sexuality, religion, disability and others. These combinations (known as 'intersectionality'[3]) create unique systems of disadvantage and advantage. There will be particular and unique experiences of mental health and of racism based on these intersections. AN example being that we know that more women than men in the UK have experienced a common mental health problems in the last week, and Black, Asian and Mixed heritage women are more likely than White women to have experienced a common mental health problem in the previous week.[4] It is likely that the intersections of race and gender contribute to BAME women having higher rates of common mental health problems.

Why Race equality and mental health is important

Higher prevalence of mental health problems in some BAME communities

The evidence suggests that people from BAME communities are at higher risk of developing severe mental illness, compared to the White population. For instance,

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[2] Colin, Mind film participant: https://twitter.com/mindcharity/status/1270750715707785222?lang=en.

[3] The term 'intersectionality was coined by Kimberlé Crenshaw in 1989 – Crenshaw, K (1989) 'Demarginalizing the intersection of Race and Sex: A Black Feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics':
https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1052&context=uclf.

[4] UK Government (October 2019) 'Ethnicity Facts and Figures, Common Mental Disorders': www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-common-mental-disorders/latest.

studies estimate that for every one White person with schizophrenia, there are 4.7 Black people and 2.4 Asian people diagnosed with the disorder.[5] The schizophrenia incidence for Black Caribbean people in the UK has been identified to be amongst the highest in the world and is not replicated in 'native' populations in Caribbean contexts.[6]

There is great debate as to what are the likely causes of these higher rate of severe mental illness within these communities. Important factors that have been identified include being disproportionately impacted by social detriments associated with poor mental health, such as poverty, unemployment, poor housing, poor neighbourhoods, and school exclusion.[7] For this reason, to have an impact of the experiences of people from BAME communities, changes to mental health services and legislation cannot be done in isolation. There is a need for a commitment to wider reforms to promote social justice, equality and inclusion to help reduce the impact of these social determinants of mental health on these communities.

Racism and mental health

There is growing evidence that suggests that discrimination and particularly experiences of racism (interpersonal and institutional) contribute to increased likelihood of developing mental health problems. Experiences of racism has been linked to increased likelihood of developing depression; hallucinations and delusions; and if physical assault is involved, post-traumatic stress.[8]

Routine experiences of racism and discrimination, and the associated prolonged exposure to stress and distress, has been found to have a toxic 'wear and tear' effect on the body over time, leading to later health problems. For communities with experiences of historical trauma there is some evidence that trauma symptoms can be passed on from one generation to the next.[9]

One review of the literature identified that over half of studies exploring the reasons for disparity between ethnic groups in relation to mental health outcomes, gave 'Race-based' explanations (including negative stereotyping) as the most common

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[5] Synergi Collaborative Centre (Nov 2017). 'Ethnic inequalities in the UK mental health systems, briefing paper': https://synergicollaborativecentre.co.uk/briefing-papers/.

[6] Halvorsrud, K., Nazroo, J., Otis, M. et al. (2019). 'Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses'. Soc Psychiatry Psychiatr Epidemiol 54, 1311–1323. https://doi.org/10.1007/s00127-019-01758-y

[7] Synergi Collaborative Centre (March 2018). 'The impact of racism on mental health, briefing paper': https://synergicollaborativecentre.co.uk/briefing-papers/.

[8] Synergi Collaborative Centre (March 2018). 'The impact of racism on mental health, briefing paper': https://synergicollaborativecentre.co.uk/briefing-papers/.

[9] Centre for Mental Health (July 2017). 'Against the odds: Evaluation of the Mind Birmingham Up My Street programme': www.centreformentalhealth.org.uk/sites/default/files/2018-10/Against%20the%20odds%20-%20Up%20My%20Street%20evaluation.pdf.

reasons.[10] Racial stereotyping, particularly the idea that Black people are 'dangerous', has long been documented,[11] with some evidence supporting *perceived* risks of violence being contributing factors to increased rates of detention.[12]

> "...the psychiatrist who might be racially inclined to think, oh because they studied this in mental health and this is what Black people are supposed to be like...and the next minute you're schizophrenic."[13]

It is clear that the contributing factors for increased diagnosis of mental health problems among some BAME communities are complex and interrelated. Importantly, one study did find that experiences of racism had independent effects on the likelihood of developing common mental disorders and psychosis even after results had been adjusted for age, household occupational class, current employment status, and gender. This suggests that racism as an independent factor in increased mental health problems amongst people from BAME communities.[14]

Subsequently, it is not surprising that there has been found to be strong mistrust of mental health services amongst BAME communities. When looking at the experiences of African and Caribbean communities, poor experiences and resulting mistrust in services has led to a 'circle of fear' whereby Black people "become reluctant to ask for help or to comply with treatment, increasing the likelihood of a personal crisis, leading in some cases to self-harm or harm to others. In turn, prejudices are reinforced and provoke even more coercive responses, resulting in a downward Spiral".[15] This was echoed in the Review of the Mental Health Act, which found that "distressing and unacceptable experiences" of services had contributed to

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[10] Singh, Swaran & Burns, Tom & Tyrer, Peter & Islam, Zoebia & Parsons, Helen & Crawford, Mike. (2013). 'Ethnicity as a predictor of detention under the Mental Health Act'. Psychological medicine. 44. 1-8. 10.1017/S003329171300086X.

[11] The 1993 report of the Report of the Committee of the Inquiry into the death of Orville Blackwood, a patient in Broadmoor Hospital alongside two other African-Caribbean patients, was subtitled 'Big, Bad and Dangerous?', reflecting how much this impression was given to the committee. Dr Nuwan Dissanayaka, blog for the Centre of Mental Health, 'Racial disparity in mental health: challenging false narratives': www.centreformentalhealth.org.uk/racial-disparity-mental-health-challenging-false-narratives.

[12] Barnett, P., Mackay, E., Matthews, H. et al. (2019). 'Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data'. The Lancet Psychiatry. http://dx.doi.org/10.1016/S2215-0366(19)30027-6.

[13] Mind (2018). 'Mind's submission to the Mental Health Act Review': www.mind.org.uk/about-us/our-policy-work/mental-health-act-review/.

[14] Karlsen, S. et al. (2005). 'Racism, psychosis and common mental disorder among ethnic minority groups in England'. Psychological medicine, 35(12), pp. 1795-1803.

[15] Keating, F., Robertson, D., McCulloch, A., & Frances, E. (2002). 'Breaking the circles of fear: A review of the relationship between mental health services and African and Caribbean communities'. London: Sainsbury Centre for Mental Health: www.centreformentalhealth.org.uk/sites/default/files/breaking_the_circles_of_fear.pdf

"widespread" fear amongst people from ethnic minority communities of what may happen if they were detained, how long they may be in hospital and even if they would get out.[16]

Racism and psychiatry

Some have argued that the Western model of psychiatry is itself institutionally racist. A lack of scientific objectivity means "stereotypes and assumptions based on perceptions of cultural and racial 'types' result in the practice of psychiatry often being biased, coming over in practice as being institutionally racist and culturally insensitive."[17] So racism is embedded in clinical practice, informing diagnoses and assessments, particularly risk assessments, echoing the stereotype of being black and dangerous.

In July 2020, over 150 members of the Royal College of Psychiatry wrote to the body identifying that psychiatry shares "a history with psychology and psychotherapy of not just ignoring the effects of discrimination, but painting other cultures as psychologically primitive and casting their approaches to understanding distress as backward superstitions." It continues on to call for the College to "to set up an independent commission to examine all training curricula and practice guidelines that the College produces" in order to be at the forefront of tackling systemic racism.[18]

Inequalities in use of the Mental Health Act

It has long been known that there is racial disparity in the use of the Mental Health Act (MHA). People from Black African and Caribbean communities in particular, are disproportionately detained under the Act and more likely to be victims of the most coercive powers under the Act, such as forcible restraint. This disparity was one of the reasons for the 2018 Review of the Mental Health Act.

"The 'big, bad Black man syndrome'...you're more likely to be heavily medicated or physically restrained. You expect it."[19]

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[16] HM Government (December 2018). 'Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion. Final Report of the Independent Review of the Mental Health Act': www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review.

[17] Suman, F (16 November 2014). 'Guest blog for ROTA: Racism in the delivery of mental health services': www.rota.org.uk/content/racism-delivery-mental-health-services.

[18] Open letter to the President of the Royal College of Psychiatrists (1st July 2020): www.rcpsych.ac.uk/docs/default-source/news-and-features/news/call-to-action-letter-to-rcpsych---final-(01-07-20).pdf?sfvrsn=7f7be8ea_2.

[19] Mind and NSUN (2015) 'Restraint in mental health services: what the guidance says': www.mind.org.uk/media-a/4429/restraintguidanceweb1.pdf.

MHA key statistics

Compared to their White peers, Black people are:
- More likely to access treatment through a police or criminal justice route (Black and mixed Black groups are between 20 per cent and 83 per cent more likely to be referred from the criminal justice system than average);[20]
- Four times more likely to be sectioned;[21]
- More likely to be detained more than once;[22]
- Three times more likely to be the subject of 'restrictive interventions' such as being restrained or held in isolation while in hospital;[23]
- Eight times more likely to be given a Community Treatment Order (CTO).[24]

People from BAME Communities have told us that certain aspects of the MHA, for example CTOs (where people are released from hospital but have to follow compulsory treatment advice) are being used as a means of control.[25]

Mind's recommendations

Mental Health Act (MHA)
- UK Government to urgently publish the MHA White Paper. We have called for:
  - Rights and principles on the face of the Act including an anti-discrimination principle referencing racism.
  - Explicit reference within the Act to ensure that a diagnosis for a 'mental disorder' must take account of the patient's social and cultural background.
  - To amend the definition of treatment to include a full range of appropriate treatments. Treatments should lead to an improvement of a person's condition, or prevent its worsening. This should take into account cultural identity and other relevant factors, with the objective of discharge from detention and ongoing recovery.
  - The introduction of an individual right to culturally appropriate advocacy.

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[20] Care Quality Commission (2010). Count me in 2010: results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales': www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf.

[21] Mental Health Services Data Set, (May 2020) 'Detentions under the Mental Health Act': www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest.

[22] NHS Digital (October 2019) 'Mental Health Act Statistics, Annual Figures 2018-19': https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures.

[23] NHS Digital (Nov 2019) 'Mental Health Bulletin 2018-2019': https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report

[24] NHS Digital (October 2019) 'Mental Health Act Statistics, Annual Figures 2018-19': https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures.

[25] Mind (2018) 'Mental Health Act Review, Mind's engagement and influence': https://mind.turtl.co/story/5c3f4b11903f285d2e0f30e3/page/1?ctaId=%2Fabout-us%2Four-policy-work%2Fmental-health-act-review%2Fslices%2Fwhat-is-the-review%2F.

- o That it be obligatory where appropriate for membership of the Mental Health Review Tribunal to include people from diverse cultural communities and/or people with knowledge or experience in race relations and anti-discriminatory practice.
- o Aftercare planning should be co-produced with the person concerned, and whoever they wish to have involved, and conducted in a culturally competent way.

Use of restraint

- Given the higher rates of the use of restraint on black people in the UK's mental health hospitals, and the tragic death of Olaseni Lewis in 2010, the UK Government to urgently publish draft statutory guidance for the Mental Health Units (Use of Force) Act - Seni's Law - for public consultation, implement the Act without further delay, and take action to ensure use of restraint is dramatically reduced.

Inequalities in the provision of services

Inpatient care

Changes to the Mental Health Act need to sit alongside changes to services.

A 2010 report from Social Action for Health, found that African Caribbean men tended to stay longer on wards and were less included in ward life. The involvement of lay people acting as 'health guides' however was found to make a big impact, simply through relating to the men in an ordinary way and taking an interest in their health and wellbeing.[26]

During interviews conducted in 2018 to feed into Mind's submission to the independent review of the Mental Health Act, detained patients told us about racism from both patients and staff, seeing White patients get better treatment and more time and patience, cultural insensitivity and racial inequality in the staff team.[27]

We know that people from some BAME communities are more likely to be the subject of restrictive interventions during inpatient care, including observation; being held in isolation; physical restraint; mechanical restraint (use of handcuffs or other equipment); and chemical restraint which may include rapid tranquillisation (for the use of controlling or subduing disturbed / violent behaviour).

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[26] Mind (2011) 'Listening to experience: an independent inquiry into acute and crisis mental healthcare': www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf.
[27] Mind (2018) 'Mental Health Act Review, Mind's engagement and influence': https://mind.turtl.co/story/5c3f4b11903f285d2e0f30e3/page/1?ctaId=%2Fabout-us%2Four-policy-work%2Fmental-health-act-review%2Fslices%2Fwhat-is-the-review%2F.

We want to see a reduction in the use of restraint in mental health settings - an experience that can be scary, humiliating and cause unnecessary distress, and which is being disproportionately used on people from BAME communities. Coercive or restrictive practices need to be minimised, and we need wards that are calmer and safer places, where staff and patients know each other better, instead of a reliance on force. Inpatient services need to be providing culturally competent services and a more therapeutic experience for all.

> *"there were white staff on duty during the day, and black staff on duty at night which 'gave it a certain feel: it was clear who has status, power and importance."[28]*

Talking therapies

People must be able to access culturally competent and relevant community services at an earlier point, to enable more people to be helped before they reach crisis point. This will require investment in initiatives to address the cultural barriers to certain groups seeking support.

Accessing psychological therapies is still not the reality for many people from BAME communities. For those who do receive support through the IAPT[29] programme, the recovery rate on average for people from BAME communities is consistently lower.

Key statistics

Compared to their White peers, people from most BAME[30] communities are:
- Less likely to complete treatment having been referred to IAPT (35 per cent compared to 40 per cent of White people)
- More likely to see a deterioration of their mental health after a course of IAPT (7.3 per cent compared to 5.6 per cent of White people)
- Less likely to see an improvement of their mental health after a course of IAPT (65 per cent compared to 68 per cent of White people)
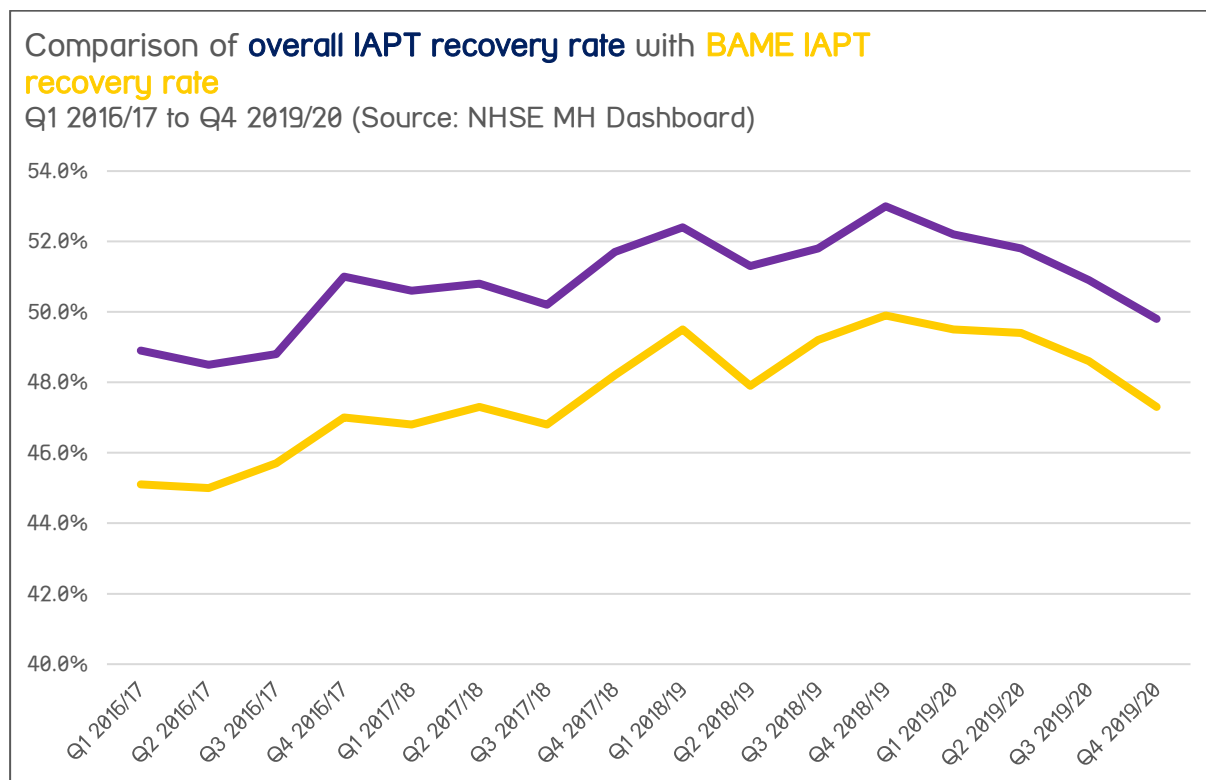
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[28] From one of 10 telephone interviews with people with experience of the Mental Health Act including current inpatients for Mind's submission to the Mental Health Act Review (interviews unpublished). Mind (2018) 'Mental Health Act Review, Mind's engagement and influence': https://mind.turtl.co/story/5c3f4b11903f285d2e0f30e3/page/1?ctaId=%2Fabout-us%2Four-policy-work%2Fmental-health-act-review%2Fslices%2Fwhat-is-the-review%2F.

[29] Increasing Access to Psychological Therapies.

[30] Asian or Asian British, Black or Black British, Mixed, Other Ethnic Groups

- Less likely to achieve full recovery (42 per cent compared to 47 per cent of White people)[31]

Comparison of **overall IAPT recovery rate** with **BAME IAPT recovery rate**
Q1 2016/17 to Q4 2019/20 (Source: NHSE MH Dashboard)

Support from your GP

Less is known about differences in accessing mental health support from your GP, however research does suggest that people from BAME communities are less likely than their White peers to have contacted their GP about mental health problems in the last year, to be prescribed antidepressants or be referred to specialist mental health services.[32] In general, rates of referral to inpatient mental health services from GPs are eight per cent higher for White groups and lower than average among some Black and mixed heritage groups (by 28 per cent to 78 per cent).[33]

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[31] NHS Digital (July 2020). 'Psychological Therapies, Annual report on the use of IAPT services 2019-20': https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2019-20.

[32] Memon, A., Taylor, K., Mohebati, L. M., 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, 6(11), e012337. doi:10.1136/bmjopen-2016-012337: http://sro.sussex.ac.uk/id/eprint/63553/4/2016%20-%20BMJ%20Open.pdf.

[33] Care Quality Commission (2010). Count me in 2010: results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales': www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf.

> **"How can a pill solve everything? You're better off actually speaking to people who are either similar to you or face similar situations."[34]**

Culturally competent practices

Being able to have a doctor, therapist or counsellor of the same Race or culture (racial / cultural concordance) has been explored in research, and evidence is mixed in regards to impact on outcomes. Research does however suggest that concordance supports positive perceptions of a therapist amongst BAME clients.[35] [36]

Importantly, research does suggest that cultural competency and communication style of mental health providers (regardless of concordance) does impact positively on aspects such as disclosure of depression, considering talking therapy,[37] and developing therapeutic relationships.[38]

Ensuring choice of treatments is vital, and this should include a range of therapeutic models and approaches that are culturally relevant, such as transcultural therapy and embedding a 'black empathic' approach (sensitively relating to a client's racial and cultural experiences and emotions evoked by racism).[39]

> **"I found somebody, a Black lady...I had this beautiful Black nurse and she was absolutely amazing, she just brought it out of me. Because she could identify with me... I just cried, it all just came out."[40]**

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[34] Focus group participant. Mind focus group with young African Caribbean men (2016). Unpublished.

[35] Cabral R.R, Smith T.B (2011). 'Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes.' J Couns Psychol. 58(4):537-554. doi:10.1037/a0025266

[36] Kim, Eunha & Kang, Minchul. (2018). 'The effects of client–counselor racial matching on therapeutic outcome'. Asia Pacific Education Review. 19. 10.1007/s12564-018-9518-9.

[37] Adams A, Realpe A, Vail L, Buckingham CD, Erby LH, Roter D. (2015) 'How doctors' communication style and race concordance influence African-Caribbean patients when disclosing depression'. Patient Educ Couns. 98(10):1266-1273. doi:10.1016/j.pec.2015.08.019

[38] Gilburt, H., Rose, D. & Slade, M. (2008) 'The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK'. *BMC Health Serv Res* 8, 92. https://doi.org/10.1186/1472-6963-8-92

[39] Termed coined by Dr Isha McKenzie-Mavinga: 'The Challenge of Racism in a Post Racism Society': www.ishamckenziemavinga.com/articles.html.

[40] Mind (2018). 'Mind's submission to the Mental Health Act Review': www.mind.org.uk/about-us/our-policy-work/mental-health-act-review/.

<u>Mind recommendations</u>

- The development of the Patient and Carers Race Equality Framework needs to be conducted with genuine engagement with BAME communities throughout, and adopted by all mental health Trusts, and other NHS and partner organisations.
- People must be able to access culturally competent and relevant community services at an earlier point. This will require investment in initiatives to address the cultural barriers to certain groups seeking support, including funding for BAME-led voluntary and community sector organisations.
- All relevant NHS services (including mental health inpatient services, advocacy, crisis care, community services, IAPT, primary care, public mental health etc) and relevant partner organisations (police forces, Immigration Removal Centres, social care etc) need to ensure they are providing support for people from BAME communities through the provision of culturally relevant and competent services that meet their individual needs.
- All relevant staff should be trained in cultural competency.

Mind's other policy work on Race equality

<u>Advancing Mental Health Equalities Taskforce</u>

Mind strongly supports the work of the Advancing Mental Health Equalities Taskforce, established in January 2020, to set out an action plan for how the NHS can tackle inequalities and racism within mental health services. In 'advancing equalities' the taskforce is seeking to ensure the NHS addresses inequalities in access, experience and outcomes, and that service account for the particular needs of groups at risk of, or already experiencing, inequalities.

<u>Patient and Carers Race Equality Framework (PCREF)</u>

The development of the PCREF was a recommendation of the Independent Review of the Mental Health Act. The aim of this framework is to provide a practical tool which enables NHS and other public sector organisations to understand what steps need to be taken, and to put in place changes to improve services for people from BAME communities. Development of the framework is being supported by work in three pilot sites.

Mind will be working to encourage and support this process, emphasising the need for genuine engagement with BAME communities throughout, and lobbying for this framework to be adopted by all mental health Trusts, and other NHS and partner organisations.

Ethnicity and Mental Health Improvement Project (EMHIP)

EMHIP is a collaborative project involving the local mental health service, South West London and St George's Mental Health NHS Trust, and a BAME community mental health organisation, Wandsworth Community Empowerment Network (WCEN). The project is designed to reduce ethnic inequalities in access, experience, and outcome within local mental health services. Mind is working to promote and learn from this approach.

Coronavirus: Our five tests for the UK Government

The peak of the coronavirus pandemic may have passed, but we're now experiencing a mental health emergency. We're asking the government to meet our five tests to make sure mental health is a priority.[41]

As part of this campaign, we are calling on the Government to protect those most at risk. This includes people from BAME communities, who we know have been disproportionately impacted by coronavirus.[42] The mental health impacts will be similarly disproportionate and increased levels of anxiety as well as experiences of bereavement are likely to have a devastating impact.

The UK Government must now prioritise urgent reforms, including making financial support available to grassroots organisations based within these communities and changing commissioning systems to steer mainstream services away from institutionally racist practices and towards provision aligned with all sections of the community.

We have asked the Government to:
- Provide a package of support for those groups at most risk of developing mental health problems, including people from BAME communities.
- Build upon the work begun by the Advancing Mental Health Equalities Taskforce to capture information about the impact of coronavirus on the mental health of people from BAME communities, and take urgent action to address the issues identified so that local services are delivering tailored and culturally competent support in partnership with local communities.

Conclusions

The Black Lives Matter movement and the disproportionate impact of coronavirus on BAME communities have made us examine how we address systemic racism at Mind

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[41] Mind (2020). 'Mental health after coronavirus: Five tests for the UK Government': www.mind.org.uk/media-a/6039/minds-five-tests-for-mental-health-final-090720.pdf.

[42] Public Health England (2020). 'Understanding the impact of COVID-19 on BAME groups': www.gov.uk/government/publications/covid-19-understanding-the-impact-on-bame-communities.

– both our campaign work but also within our organisation. In our 2021 strategy, we are committing to becoming a proudly anti-racist organisation and we are currently launching an organisation wide review to identify what we need to do to achieve this.

October 2020