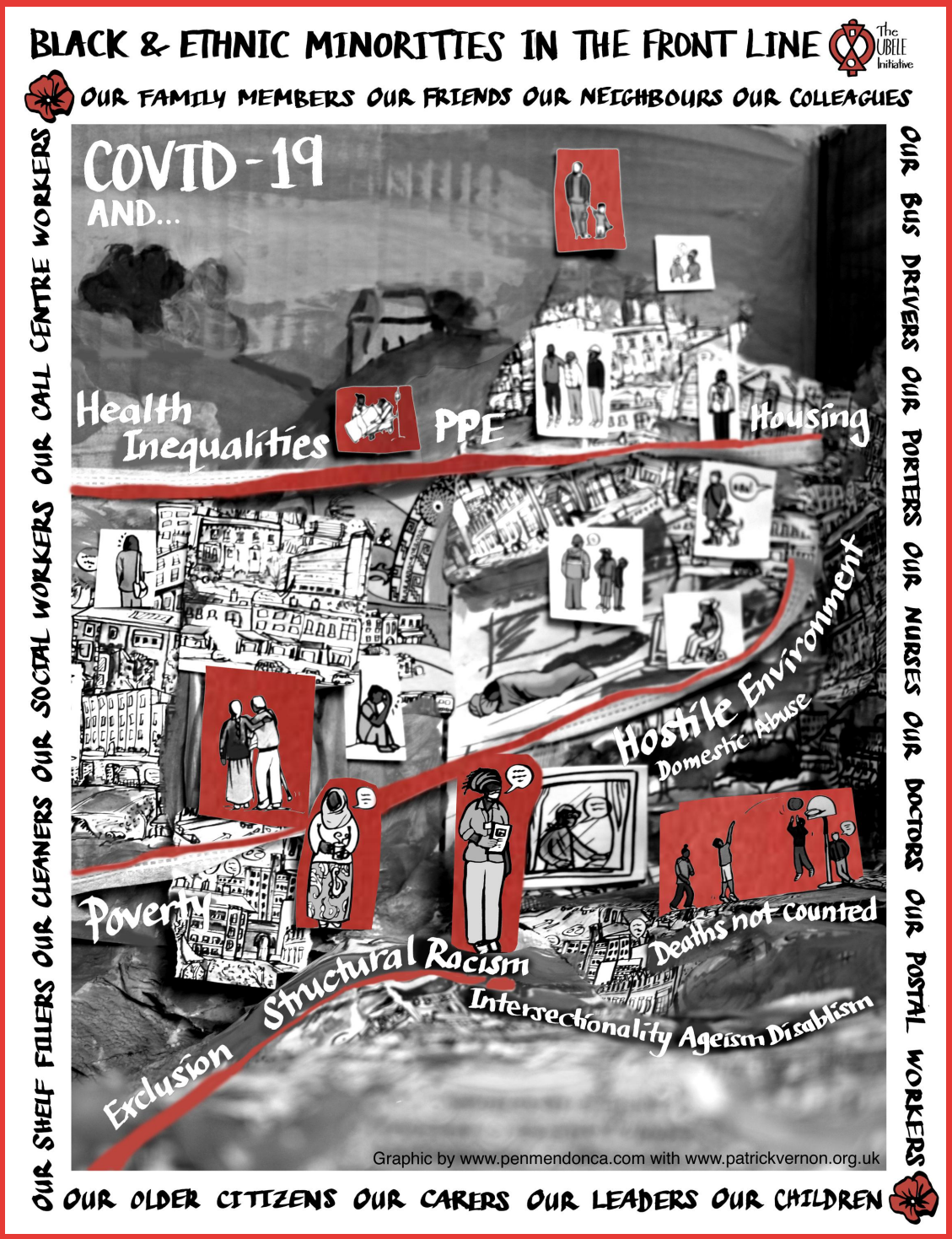

National Mapping of BAME Mental Health Services

Karl Murray

July 2020

BAMESTREAM

This report was first published in July 2020

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About BAMEStream

BAMEStream is a new alliance of practitioners, therapists, policy specialists, organisations, activists and academia who specialise in the areas of mental health and wellbeing and who's core purpose is to bring the mental health needs of the community into the mainstream. The COVID-19 pandemic is having a devastating impact on Black, Asian and Minority Ethnic (BAME) communities and this survey is the first step in trying to undertake impactful actions to address the urgent mental health and wellbeing needs of the BAME communities. Therefore, it is our intention to use the findings from the survey to support the development and delivery of mental health and wellbeing services to ensure that the needs of the BAME community are being met as a result of this COVID-19 pandemic and crisis.

Institutional apathy, structural inequalities racism, fear, stigma and discrimination means that BAME people are disadvantaged when it comes to accessing mental health and wellbeing services, and to the quality of care they receive. COVID-19 has amplified the level of the health inequalities, and it has also given rise to other social and economic disparities which when that is compounded by isolation due to lockdown, grief and bereavement it will undoubtedly have a significant impact on the mental health and wellbeing of BAME communities.

The events surrounding the killing of George Floyd and the Black Lives Matter movement has also added another dimension to the inequalities faced by BAME people. Witnessing the horrendous images of the final moments of the life of a Black man has had a significant emotional and psychological impact on Black people and has given rise to racial fatigue and trauma.

BAMEStream's commitment is to ensure that there is widespread awareness and understanding of the gaps in service, policy and practice, that lessons for positive change are learnt, and appropriate actions are taken to mitigate the differential risks and inequalities in mental health care. We will be working together as an alliance to ensure that culturally appropriate therapeutic, psychological and social interventions are integrated in the mainstream, and that they are widely available and accessible.

Helen George MA BSc (Hons) Reg. M(BACP) Accred
Dr Yansie Rolston
Patrick Vernon OBE

www.bamestream.org.uk

BAMESTREAM

ACKNOWLEDGEMENTS

This report would not have been possible without the contribution and responses from those individuals and organisations who took the time to respond to the survey. Given the number of people that responded it is not possible to name you all but do take from this that your contributions are most appreciated.

We extend our thanks to the BAMEStream Alliance members – Helen George MA BSc (Hons) Reg. M(BACP) Accred, Dr Yansie Rolston and Patrick Vernon OBE – whose dedication and critical support was most appreciated and valued in sustaining the momentum of the project.

Thank you to The Ubele Initiative (Ubele) for supporting the establishment and incubation of the BAMEStream Alliance and to the Mayor of London's office for their infrastructure support grant to The Ubele Initiative, which has enabled this project to come to fruition. The support is most appreciated.

In the final analysis, the sense made of the voices of those responding to the survey remain with the author.

LIST OF CONTENTS

EXECUTIVE SUMMARY

COVID-19 has exposed yet another inequality that Black, Asian and Minority Ethnic (BAME) communities experience in the United Kingdom (UK). The two analyses by Public Health England (2 June 2020 and 16 June 2020) revealed that BAME communities are at higher risk of contracting the virus, increased risk of severe symptoms and higher rates of death. As a result of this many BAME individuals have lost loved ones and whether the death is from COVID-19 or another cause - it is a traumatic experience.

It is crucial that anyone bereaved by COVID-19 receive the appropriate bereavement support that they need. It is well known that BAME communities are less likely to access mainstream services so the need for a culturally responsive bereavement support service is paramount to support their future well-being and mental health. The National Survey on Black, Asian and Minority Ethnic (BAME) mental health services in the United Kingdom (UK) is an initial approach in providing a snapshot of those BAME led services responding to the mental health needs of BAME communities. An important feature of the survey was to ascertain the impact COVID-19 was having on those organisations that were providing bereavement and other mental health support as well as the support they may need to assist them in the delivery of those services, especially as we move to the easing down of restrictions.

From the survey it is clear that mental health services are adapting as best they can to the changing circumstances we now find ourselves in; that social distancing has initiated new approaches to providing support and which now require that those newly acquired skills be further developed as ease-down looms. From the Public Health England (PHE) reports and the many rapid reviews reports that are now available, we know that there are strong associations between isolation, loneliness and depression as both an immediate as well as a longer-term considerations; one of which is the prospect of having to get used to the changes in routine and what has become known as the ‘new normal’. There are still many unknowns, including the prospect of finding a vaccine by the end of the year and whether a second wave will strike anytime soon. With this in mind, how soon will we return to ‘normal’? Or put another way: ‘What will this new renewal of the way we conduct business and live our lives look now?’

The conclusion to this report is that anxiety is high against a backdrop of the disproportionate impact of COVID-19 on BAME communities, which means the role of BAMEStream in supporting BAME led mental health service providers will be crucial over the coming months.

Based on the 101 responses received, the main characteristics of the respondents were:

- 10 out of 12 regions and home countries were reflected (no responses from Northern Ireland or Scotland), with the overwhelming majority coming from London (n=53), followed by North West (n=13) and Yorkshire & The Humber (n=10).
- Responding organisations indicated working with close on 22,000 clients on a weekly basis, with significant increase in reporting observed with those experiencing stress and anxiety and isolation and loneliness;
- 51 (50%) of responding organisations were 'BAME led', that is, having 51% or more of their governing body from a black, Asian and minority ethnic group. The majority of BAME led organisations were located in London (n=22) with the North West being the next highest responding region with 10 organisations represented.
- More than half of all responding organisations or agencies (66) were based in the charity, community and voluntary sector, 25 identified themselves as 'public accountable bodies' and 10 identified themselves as 'private/self-employed';
- The overwhelming majority of respondents either provided mental health support through commissioning of services (i.e. some of the public accountable bodies) or directly delivered services to those in the 25yrs to 40yrs age range (70%). Of those who provided services to the broader working age population (18 – 64yrs), the majority delivered 'common mental health concerns' [1] followed by counselling and bereavement and trauma support.

[1] We defined common mental health as comprising different types of depression and anxiety. They remain a major public health challenge given that if left untreated, they could lead to long term physical, social and economic disadvantage.

KEY FINDINGS

1. There is an increased demand for BAME led bereavement services. The lack of adequate dedicated services reflects the wider structural inequalities in mental health services, and this can have a compounding impact on the mental wellbeing of BAME people.
2. There is an increased demand for BAME mental health services, however there is a lack of BAME mental health provision
3. Smaller organisations who want to do work around bereavement are unable to access funding (previous research has found that 9 out of 10 BAME led charities are in danger of folding [2])
4. Mainstream providers acknowledge that there is a lack of cultural competencies and perspectives in their work
5. Commissioners are aware of equality issues but do not factor it into the decisions they make when commissioning services
6. BAME led organisations and mainstream mental health service providers need cultural competence training and awareness
7. BAME service providers are in need of capacity building and infrastructure support
8. There has been an increased move to online services which has created a need for infrastructure support in migration from face to face to online interactions
9. There is no national offer for bereavement services for BAME communities and the Public Health England (PHE) report did not discuss the need for cultural competences around bereavement
10. COVID-19 has meant that funerals cannot take place in the way that they usually do; it has been difficult for people to say goodbye to their family and friends in the way that they would like to. Grieving in isolation makes the loneliness and sense of loss more intense and this will inevitably have an impact on mental health and wellbeing, indicating an urgent need for a culturally competent bereavement service provision.

[2] Murray K (2020), Impact of COVID-19 on the BAME community and voluntary sector: Final report of the research conducted between 19 March and 4 April 2020; Ubele: https://www.ubele.org/covid19-supporting-bame-communities

RECOMMENDATIONS

Bereavement Support

- The need for a National BAME Bereavement Service that meets the cultural needs of the community
- Bereavement therapists and service providers have cultural competency training that is quality assured
- Address the existing gaps in research surrounding ethnicity, bereavement and loss in the UK
- The identification of good practice in addressing the disparity of bereavement and loss support for BAME communities using an intersectional approach

Commissioners/Funders of Mental Health Services

- More needs to be done in relation to funding, capacity building and commissioning of BAME mental health services especially around bereavement
- Training in cultural competencies and race equality
- Building on the mapped organisations that have been obtained through this survey (Appendix 1), produce a publishable Directory of Services and Independent Counsellors by regions using Kumu as an interactive online tool, which would be cost effective
- Development of training and other support packages using the collective strength of the BAMEStream Alliance

NHS and Statutory Providers

- Training in cultural competencies and equality impact assessments
- The recruitment and training of additional BAME counsellors, psychotherapists, psychologists and mental health practitioners

Mainstream Third Sector Providers and Infrastructure Organisations

- Joined up services working with existing mainstream providers e.g. Cruse Bereavement Care and The National Bereavement Alliance.
- Technical and awareness training - awareness training around bereavement support, mental health awareness that is culturally competent
- Recruiting trained volunteers as bereavement befrienders
- Support for the migration of services to online
- Capacity building and infrastructure support - governance and funding
- The licensing and recognition of bona fide BAME mental health providers should be explored which could then benefit the sector long term as a representative body of quality ‘assuring’ BAME mental health providers

BAME led organisation and providers

- Secure funding to develop the BAMEStream Alliance, especially in connecting with those who contributed to the survey

Policy Makers and Academics

- More research on the impact of COVID-19 on BAME bereaved families
- Department of Health and Social Care in conjunction NHS England to develop a mental health strategy on COVID-19 and BAME communities
- Policy makers grant scheme for BAME bereavement services

INTRODUCTION AND BACKGROUND

It is too soon to know the true scale and impact of the coronavirus COVID-19 pandemic on society as the pandemic is still ongoing and, without a vaccine, it is difficult to see how (and when) we are likely to return to what may be called a 'pre-COVID-19' existence. Data published by the John Hopkins Coronavirus Resource Center [3], for example, on 14 July 2020, showed 13,323,530 confirmed recorded cases around the world and 578,627 deaths (i.e. 4% of cases resulting in death); these figures are increasing daily and not showing any signs of slowing down as the pandemic takes control in areas of the world hitherto showing low incidences (e.g. Brazil, Mexico, Russia, India and South Africa in particular). In the UK, though the number of cases being reported coming into June have slowed down markedly to what they were in April and May, the number of reported cases across the UK is still rising, though at a slower rate (i.e. as at 14 July, the UK position is: 291,373 confirmed and recorded cases with 44,968 deaths (or 15% of recorded cases) [4].

The scale of the crisis has brought with it many challenges. Amongst the many challenges that society has had to accommodate, are the restrictions on movement, social distancing regulations, quarantine, isolation and 'shielding', all of which disrupts what we have been used to; that is, what we took as normal way of life. The Mental Health Foundation, for example, have been providing advice and conducting surveys to better understand the impact on mental health. One of their surveys conducted after the 'lockdown' showed that one in four people said they had feelings of loneliness compared to a pre-lockdown response showing one in ten people having feelings of loneliness; that, since lockdown, young people are almost three times more likely to have experienced loneliness, with almost half of people aged 18 to 24yrs feeling this way (Mental Health Foundation [5]).

Adding to the mix are concerns raised by the two Public Health England (PHE) review reports [6]. The reports reflect the concerns over the disproportionate impact of COVID-19 on people from Black, Asian and Minority Ethnic (BAME) communities, both within the health care sector, especially doctors and nurses, and in the general population as indicated by the ICNARC reports since April [7] and the ONS report [8]. Taken as whole, these reports pointed to certain vulnerabilities associated with particular population subgroups being at a higher risk of contracting and dying from COVID-19, and, as a knock-on effect, places such communities at heightened alertness, which adds further to the general concerns over the wider impact of the pandemic on mental health.

[3] https://coronavirus.jhu.edu/ (accessed 19 June 2020)
[4] Public Health England: https://coronavirus.data.gov.uk/ (as at 4.00pm, 14 July 2020)
[5] Mental Health Foundation: https://www.mentalhealth.org.uk/coronavirus (accessed 18 June 2020)
[6] Public Health England (2020 (i)), Disparities in the risk and outcomes of COVID-19; Public Health England, 2nd June 2020; Public Health England (2020 (ii)), Beyond the data: Understanding the impact of COVID-19 on BAME groups; Public Health England, 15th June 2020.
[7] Intensive Care National Audit & Research Centre (ICNARC), ICNARC report on COVID-19 in critical care; 22 May 2020 (available from: https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports)
[8] Office for National Statistics (ONS), Deaths involving COVID-19, England and Wales: deaths occurring in April 2020; 15th May 2020 See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020

Some of the reasons identified for the level of disparity is said to be due to greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, all of which intersect with factors including gender, ethnicity and disability. This is not a new phenomenon and therefore not ascribed to the effect of COVID-19; rather, they are and have been for decades, concerns within social and health discourse. For example, the recently published book, The International Handbook of Black Community Mental Health [9] (2020), has critically illuminated distinct socio-economic considerations within society that affects the mental health of BAME people of all ages and across the family life cycle; the Adult Psychiatric Morbidity Survey (APMS 2014 [10]) had shown how prevalent mental health conditions are in our society, how these patterns change over time and even differences between population groups. The most significant differences were for general anxiety disorder, phobias, panic disorder and mixed depression and anxiety (i.e. common mental disorder). Since 2017, there have a number of policy developments which has included the Race Disparity Audit, review of the Mental Health Act, establishment by NHS England Equality Taskforce for Mental Health and the Mental Health Use of Force Act (Seni's Law) all of which have sought to tackle aspects of racism in the mental health system as they affect BAME communities in the UK; and further, the Joseph Rountree Report (2018) on poverty indicated that certain key poverty factors can lead to mental health inequalities, such as:

- Material inequality: poverty, poor housing, lack of employment opportunities.
- Social inequality and injury: stigma and discrimination or experiences related to:
  - living in care
  - immigration status
  - ethnicity
  - sexual orientation
  - disability
  - experience of violence or abuse
  - health inequality - including having long-term physical health conditions.

These sets of complex social and environmental factors can (and do) impact adversely on mental health and getting to the root of the problem requires engagement with this complexity. It is against this backdrop that BAMEStream, an alliance of practitioners, therapists, policy experts, activists and academics who specialise in the areas of mental health and therapy, was established. The alliance's core purpose is to raise awareness and push for action to address the mental health and wellbeing needs of the UK's BAME communities. This survey report is based on a need to better understand, from a BAME focused perspective, the presence of BAME led mental health services and the extent to which they are impacted upon by COVID-19.

The National Survey on Black, Asian and Minority Ethnic (BAME) mental health services in the United Kingdom (UK), then, sought to map and capture BAME mental health and wellbeing services in UK, with the data obtained through this initial approach providing a snap shot of those BAME led services responding to the survey. An important feature of the survey was to ascertain the impact COVID-19 was having on those organisations and what support may be needed as we ease down out of the 'first wave' of the pandemic. It is the hope that the findings will be used to shape the development and delivery of mental health and wellbeing services that will ensure that the needs of the BAME communities are being met in the light of the COVID-19 pandemic and crisis.

[9] Richard Majors, Karen Carberry and Dr Theodore Ransaw (2020), The International Handbook of Black Community Mental Health; London, published by Emerald UK
[10] Mental Health and Wellbeing in England Adult Psychiatric Morbidity Survey 2014 - A survey carried out for NHS Digital by NatCen Social Research and the Department of Health Sciences, University of Leicester; National Statistics publication, 2016

SECTION 1: METHOD AND GENERAL CHARACTERISTICS

The survey was conducted between 5th May and 5th June 2020, using SurveyMonkey, an online survey tool. Some of the benefits/advantages of using Survey Monkey are:

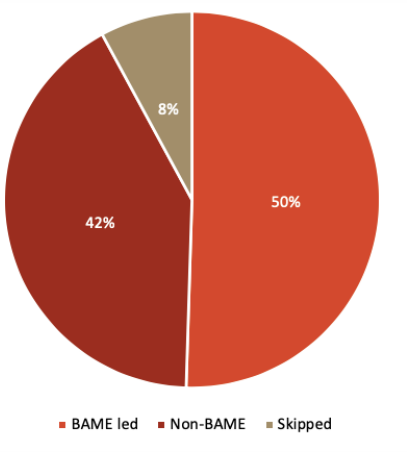
- Exportability of data results in various formats such as PDF, PPT, XLS, CSV, and SPSS, all of which allows for refinements and presentations;
- Creation of 'word clouds' that provides a visual representation of the most common words and phrases from respondents (i.e. open-ended questions only);
- Multiple response questions (i.e. frequency of responses across particular questions). An organisation is likely to work with a wider age range, for example, and to enable them to identify all the age ranges, a multiple response feature is helpful as they allow respondents to choose the ones that apply without being forced to select only one option and therefore negate who that organisation actually work with (e.g. questions on age, commissioning of mental health services, services offered to targeted groups and the impact of COVID-19 on organisations used this approach);
- Matrix/Rating Scale feature that allows closed-ended question to be asked that enables respondents to evaluate one or more row items using the same set of column choices (e.g. question on different services provided to beneficiary groups, and the types of support organisations may need over 3 to 6mths and 6 to 12mths used this approach);
- Likert Scale was used, where we asked respondents to choose from a five points scale to aid gauging feelings, attitudes and behaviour (e.g. outcome priorities commissioned by public accountable bodies and types of concerns presented by beneficiaries).

To promote and disseminate information about the survey, we undertook a multi-prong approach, using Ubele's data-base of close on 500 community and voluntary organisations (i.e. shared through weekly Newsletter as well as posted on their website), the data-base from partners within the consortium and more widely shared via email, WhatsApp and social media platforms, such as Twitter and Instagram. Additionally, where partners were engaged in open Zoom conference workshops, information and link to the survey was further shared.

From these processes, we received 101 responses to the survey. Based on the 101 responses received:

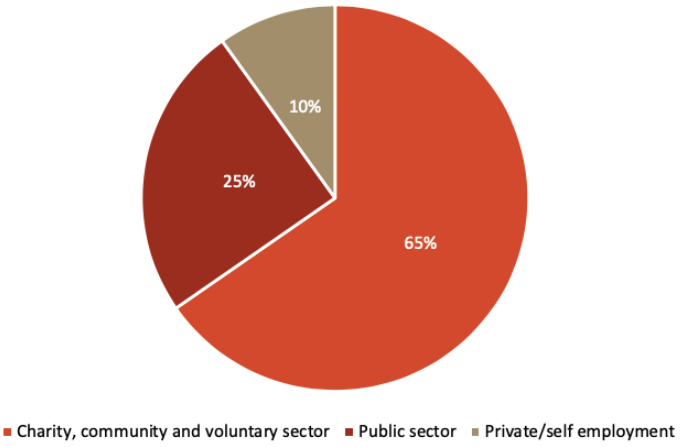
- 10 out of 12 regions and home countries were reflected (no responses from Northern Ireland or Scotland), with the overwhelming majority coming from London (n=53), followed by North West (n=13) and Yorkshire & The Humber (n=10). Attached as Appendix 1 is an overview of the organisations responding by region
- Responding organisations indicated working with close on 22,000 clients on a weekly basis, with significant increases in reporting of those experiencing stress and anxiety and isolation and loneliness (see Fig 12)
- 51 (50%) of responding organisations were 'BAME led', that is, having 51% or more of their governing body from a black, Asian and minority ethnic group (Fig 1). The majority of BAME led organisations were located in London (n=22) with the North West being the next highest responding region with 10 BAME led organisations identified.
- As Fig 2 shows, more than half of all responding organisations or agencies were based in the charity, community and voluntary sector (65%), with 25% identified as 'public accountable bodies' while 10% identified themselves as 'private/self-employed':
  - 37 organisations identified themselves as registered charities (including charity incorporated organisations) while 29 formed part of the wider charitable sector providers (i.e. unincorporated associations, Community Interest Companies and Companies Limited by Guarantee).
  - Respondents who had indicated that they were 'public accountable bodies' comprised NHS Hospital Trusts (n=19), Clinical Commissioning Group (CCGs: 3) and Local Authority commissioning providers (3)

Fig 1: Responding organisations that were BAME led



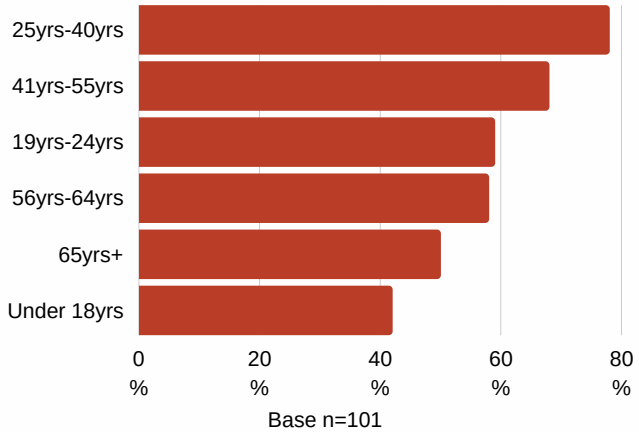
Base n=51

Fig 2: Breakdown of the sector within which respondents operate



Base n=101

Fig 3: Age range by % split across responses



Base n=101

- The overwhelming majority of respondents either provided mental health support through commissioning of services (i.e. some of the public accountable bodies) or directly delivered services to those in the 25yrs to 40yrs age range (70%: Fig 3). Of those who provided services to the broader working age population (18 – 64yrs), the majority delivered what we term 'common mental health concerns' [11] followed by counselling and bereavement and trauma support (Table 1).

Based on the multiple response approach [12], where respondents were able to select a number of choices from those available that applied to them, 62 respondents indicated that they offered bereavement and trauma support (Table 1).

Table 1: Does your organisation provide any of the following services to the indicated groups of beneficiaries?

	Children and young people (0 - 17yrs)	Working age (18 - 64yrs)	Older people (65yrs+)	Total
Counselling	13	45	8	**66**
Psychotherapy	8	34	4	**46**
Common health and wellbeing support	17	56	15	**88**
Bereavement & trauma support	10	46	6	**62**
Social prescribing	11	33	8	**52**

Base n=101

[11] Common mental health is defined in this report as comprising different types of depression and anxiety. They remain a major public health challenge given that if left untreated, they could lead to long term physical, social and economic disadvantage.
[12] Where an organisation is likely to work with a wider selection range, for example, to enable them to identify all the possible ranges that they work with, a multiple response feature was used as this allowed respondents to choose the ones that apply and hence, shows frequency of responses (i.e. the number of responses made by respondent as it applies).

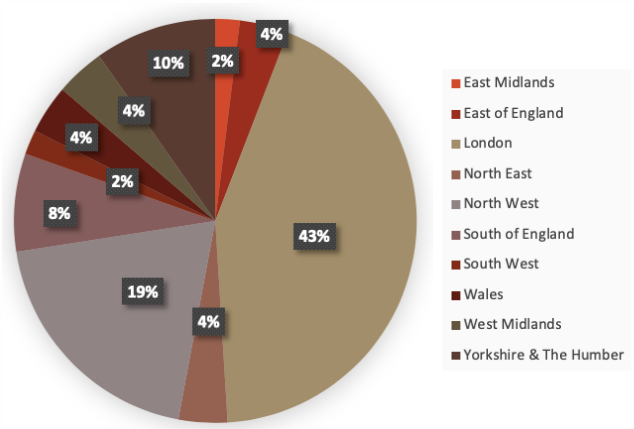
SECTION 2: BAME LED ORGANISATIONS AND MENTAL HEALTH SUPPORT PROVISION

This section focuses specifically on those organisations that identified themselves as being BAME led; that is having 51% or more of their governing body from a black, Asian and minority ethnic group. Through the Statistical Package for Social Sciences (SPSS) [13], we were able to disaggregate BAME respondents from the general responding survey population.
From this approach, 51 organisations indicated that they were BAME led mental health providers (Fig 1).

Based on the analysis:

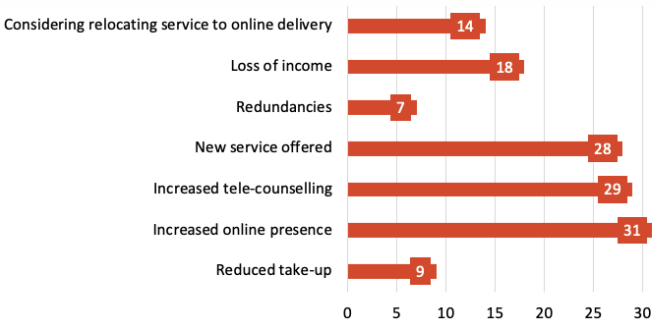
- 22 (43%) of BAME led organisations were based in London (Fig 4)
- 31 indicated increased online presence with 29 indicating an increase in having to use telephone counselling as their method of supporting clients (Fig 5)
- 41 BAME led organisations indicated that they had seen an increase in concerns associated with isolation, anxiety and stress and general or common mental health concerns as a result of the pandemic (Fig 6)
- 38 out of 57 micro, small and medium sized organisations were BAME led (i.e. averaging less than £100,000 over a 3yrs period: Table 2) with 13 out of 19 identified as 'large'; that is, having income over £100,000 per annum averaged over the last 3yrs.

Fig 4: BAME led organisations by region



Base n=51

Fig 5: Impact on BAME led organisations as result of COVID-19



Base n=51

[13] SPSS is an extremely powerful tool for manipulating and deciphering survey data and is widely used in research and those who conduct surveys. One of its strength is that it allows cross tabulations across more than one variable, and so provide for greater depth analysis of a range of variables. In our case, the relationship between BAME led organisation responders compared to the general population who responded, 40% of whom were not BAME led.

Of the 38 organisations, 24 were micro and small organisations; that is, having income of under £25,000. This raises questions over scale and capacity of micro and small mental health providers in being able to provide well needed --support at this time of immediate need (i.e. short-term needs).

- Linked to the above, we sought to understand the reach of organisations in terms of the number of clients they were supporting. The survey revealed that, on average, BAME led mental health providers were handling up to 5,982 cases per week across the regions indicated compared with the wider survey population reach of 22,000 clients/cases.

Fig 6: Types of concerns where respondents have seen a noticeable increase since the lockdown (BAME led compared to all respondents)

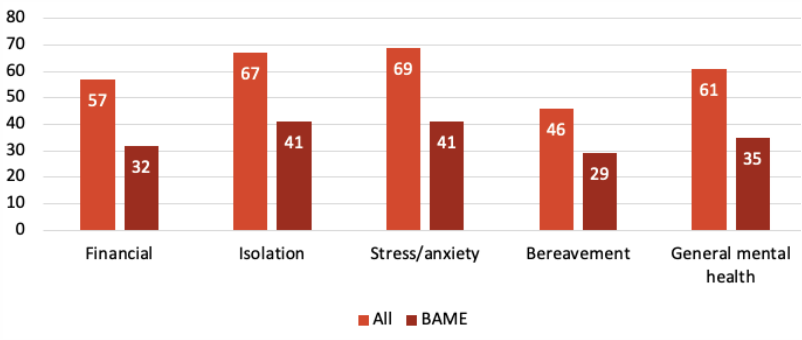


Table 2: Size of organisations by income averaged over last 3yrs

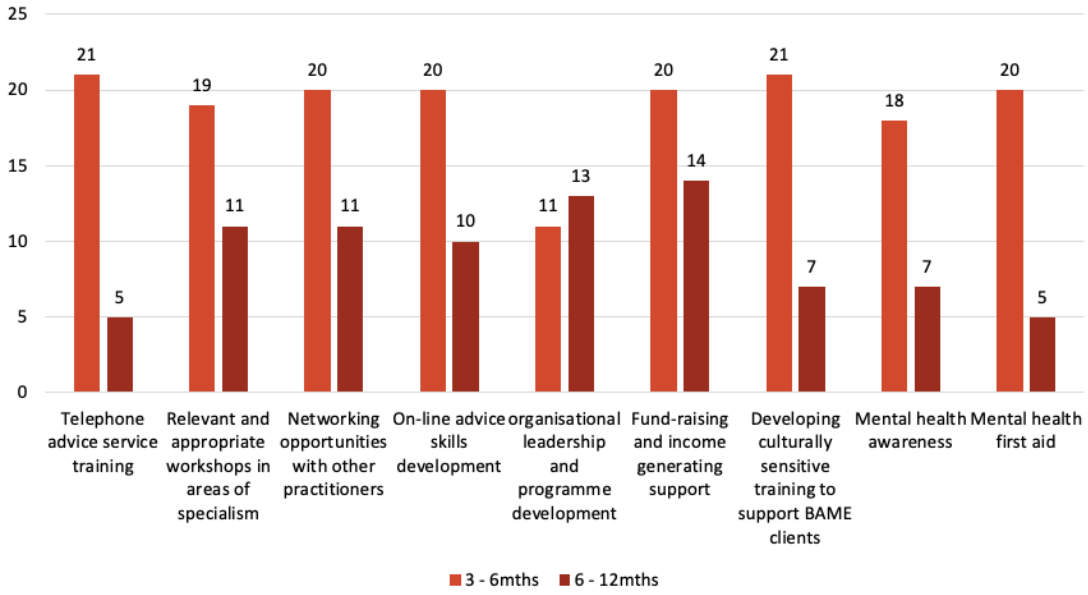
	All	BAME	BAME as % of All
Micro (<£10,000)	12	12	100%
Small (£10,000 - £24,999)	25	12	80%
Medium (£25,000 - £99,999)	20	14	92%
Large (£100,000 - £1,000,000)	19	13	65%
Public Accountable body	25		5%
Total	**101**	**51**	**50%**

Base n=101

BAME led organisations were asked to indicate the sort of support, other than financial funding resources, that would best enable them to deliver effectively over the next 3 – 12mths. From responses, the two most frequently cited areas of support need over the short term (3 – 6mths), were 'telephone advice service training and development of culturally sensitive support service, and, over the medium term (6 – 12mths), the two most cited support areas were fund-raising and income generation and organisational leadership (Fig 7).

From the analysis, the evidence suggests that there are short term needs that requires support, largely financial and training support, which tapers off over the medium to longer term. As a direct impact of COVID-19, more and more organisations were going online and using teleconferencing to provide counselling and therapeutic support (Fig 7), the majority of which are short term support requirements. It would seem, therefore, that a priority going forward would be for micro and small organisations to secure access to short term funding opportunities (Table 2).

Fig 7: Training and development needs



Base n=51

Illustrative comments by respondents highlighted the following:

We are recruiting volunteer counsellors and training them to deliver support online or by phone. Any experience to assist with this training from those with previous experience will help.

We require additional funds to recruit more BAME therapists, support to recruit media and communications officer to share language specific information to people in the community.

We need more resources to enable an enhanced and appealing online presence.

Tablets and dongles to aid connectivity and enable group work/sessions.

We require additional resource for next 6 month to provide telephone counselling.

SECTION 3: PUBLIC SECTOR COMMISSIONING OF MENTAL HEALTH SERVICES

25 respondents indicated that they worked for 'public sector bodies', which included NHS Hospital Trusts, Clinical Commissioning Groups (CCGs) [14] and Local Authorities, drawn from 8 regions (Table 3 and 'word cloud' below).

Of this number, 6 NHS Trusts' were represented [15]:

- South London and Maudsley NHS Foundation Trust
- Barnet, Enfield and Haringey NHS Mental Health Trust
- Sheffield Health and Social Care NHS Foundation Trust
- East & North Hertfordshire NHS Trust
- Cambridgeshire & Peterborough Foundation NHS Trust
- Manchester NHS Foundation Trust

Table 3: Public sector respondents by region

Region	Public sector bodies			Total
	NHS Hospital Trust	Clinical Commissioning Group (CCG)	Local Authority commissioning provider	
East Midlands	1	0	0	**1**
East of England	1	0	0	**1**
London	12	0	3	**15**
North West	0	1	0	**1**
South of England	1	1	0	**2**
South West	0	1	0	**1**
West Midlands	3	0	0	**3**
Yorkshire & The Humber	1	0	0	**1**
Total	19	3	3	**25**

Base n=25

[14] Clinical Commissioning Groups (CCGs_ are statutory bodies that are clinically led, and which include all of the GP practices in a geographical area. The aim of this is to give GPs and other clinicians the power to take commissioning decisions for their patients. Each CCG has a constitution and is run by its governing body and is overseen by NHS England.
[15] There were multiple responses from different services within the same Trust.

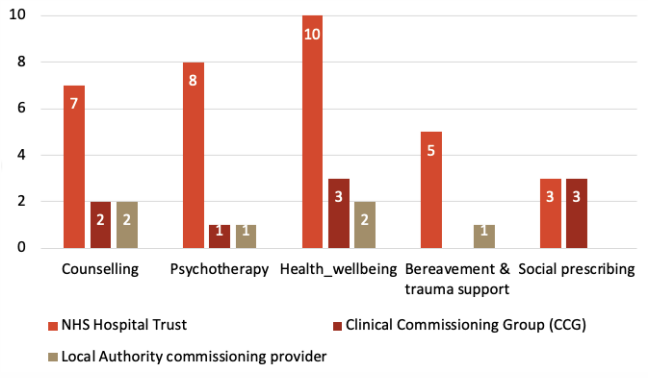
Three areas of consideration and approaches to public bodies commissioning were explored:

- Commissioning by service type;
- Commissioning by outcome; and
- Commissioning by targeted support needs.

Commissioning by service type

More public sector bodies commissioned generic 'health and wellbeing' programmes from the voluntary and community sector, with 10 out of 25 indicating that this is their main area of commissioning, with psychotherapy being the next more frequently commissioning area followed by counselling (Fig 8).

Fig 8: The types of services public sector bodies commission from the voluntary and community sector



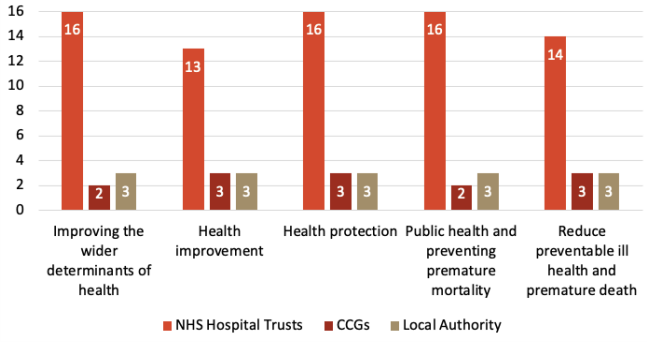
Base n=25

Commissioning by outcome

NHS Trusts commissioned across the five outcome priorities reflected broadly in the NHS Commissioning Board's report [16] (2015) and the Marmot Review: 10 Years On [17] (2020). As Fig 9 shows, more Trust's commissioned outcomes based on:

- Improving the wider determinants of health (16)
- Health protection (16)
- Public health and preventing premature mortality (16)

Fig 9: Outcomes commissioned by commissioning services

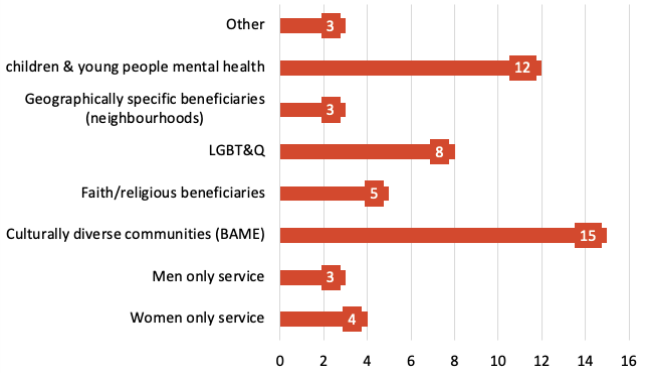


Base n=25

Commissioning by targeted support needs

Where they commissioned by targeted support and need, the overwhelming responses indicated that BAME communities (15) and children and young people (12) were the most targeted communities within the commissioning approaches of Trusts and local authorities (Fig 10).

Fig 10: Commissioning by targeted groups

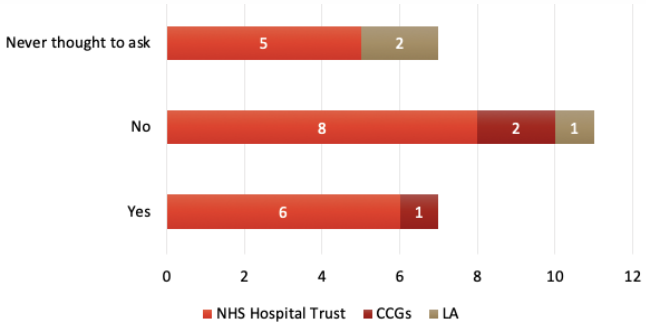


[16] NHS England/Department of Health (2015), Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing; NHS England Publication Gateway Ref. No 02939.
[17] Michael Marmot, Jessica Allen, Tammy Boyce, Peter Goldblatt, Joana Morrison (2020), Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity

While the survey predated the recent public demonstration for Black Lives Matter (BLM), accompanied by the many 'woke' voices that has since emerged in its aftermath, it is interesting to note that the systemic structural 'white privilege' discussions that the movement has engendered, came through in the survey at an 'unconscious' level. We asked, for example, whether commissioners of mental health services consciously asked applicants whether an organisation is BAME led or not. [18] The point being, this 'colour blind' approach lay at the heart of some of the evidence contained in the two recently published PHE Reviews [19] (2 June and 16th June 2020). [20]

The overwhelming response was that they did not ask if an organisation was BAME led: 11 respondents indicated outright that they did not, while 7 indicated that they had 'never thought to ask' (Fig 11). Taken together, this showed that 18 out of 25 responding public commissioning bodies of mental health services – though stating commissioning BAME specific support – never thought to ask if providers were BAME led or not. If there is a conscious attempt to target resource to particular community of interest, then how will you know if you do not ask the question of applicants? Given what is already known about identification and 'cultural sensitivities', this possibly could be an example of 'unconscious bias'.

Fig 11: Did public bodies ask applicants if they were a BAME led organisation?



Base n=25

[18] We would expect that if this question was asked of BAME then the same should be asked in relation to women, LGBTQ, disability etc. Indeed, in the aftermath of the Ubele report and the wide ranging discussions that followed, the London Community Response Fund programme started to ask these questions ahead of the BLM protests and similarly, the National Lottery Community Fund made reference to supporting BAME led organisations.
[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892085/disparities_review.pdf (2 June 2020)
[20] https://www.bbc.co.uk/news/health-53035054 (17 June 2020)

SECTION 4: IMPACT OF COVID-19 ON THE MENTAL HEALTH OF CLIENTS

Following the publication of the Public Health England (PHE) report, which outlined the disparities in the risk and outcomes of COVID-19, found that BAME people were more at risk of dying from the virus. David Weaver, BAMEStream alliance member and President of the British Association for Counselling and Psychotherapy (BACP), offered the following statement:

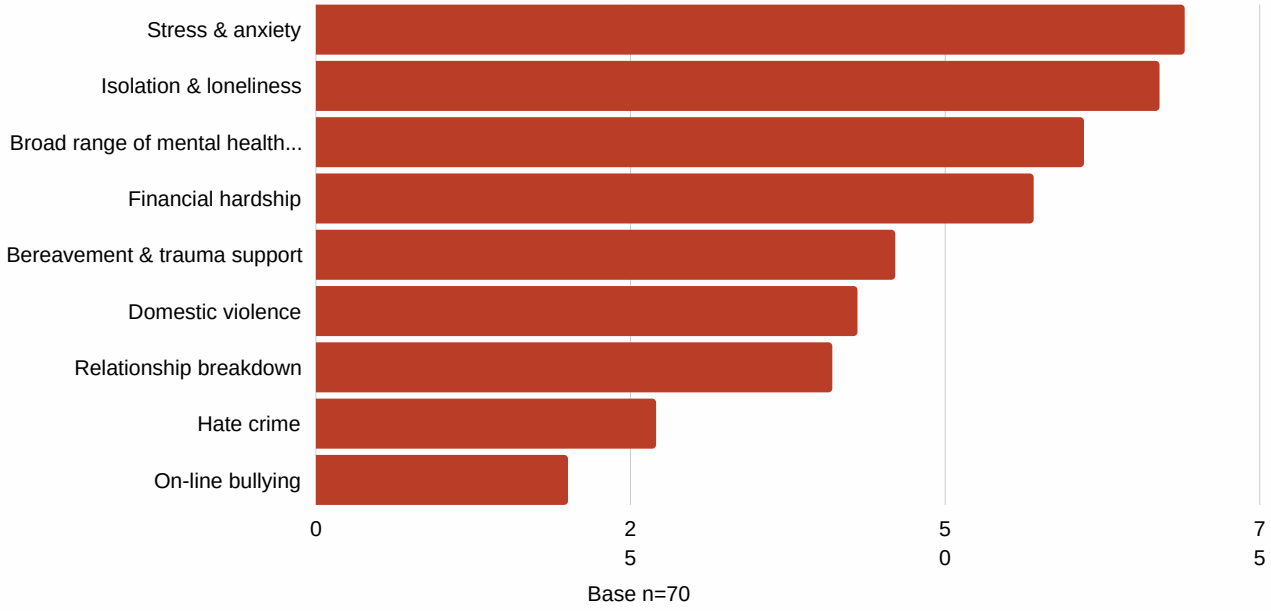
> *…BAME people and communities are dying in disproportionate numbers because of this virus. This report recognised what we already knew. While we welcome that this has been acknowledged, the Government now has to take urgent action on this…We want to see a strategy that addresses the ongoing trauma that is being faced by BAME communities. There needs to be an urgent conversation about culturally appropriate high-quality therapeutic interventions. We need… to see the importance of counselling services at this time and the role they can play in reaching these communities. [21]*

This response goes to the heart of the primary purpose underpinning the survey. We already know through the reports produced by PHE of the clinical and structural impact of COVID-19 on BAME communities but what is not so clearly articulated is the mental and psychological impact on individuals. As this survey did not target or focus on individuals experiencing mental health breakdown, we were able to ascertain the extent to which clients were presented with increased or heightened concerns. Specifically, we asked: *As a result of COVID-19, have you noticed any difference in the types of concerns being presented by clients?*

Respondents indicated that they were witnessing significant increase in reporting of stress and anxiety alongside isolation and loneliness (Fig 12). Comments from respondents revealed some further additional information, which help to better understand the impact being felt by individuals trying to cope with some of the restrictions imposed around movement, for example. For example, respondents reported that clients presented anxiety concerns over "… employment legal advice, food poverty and help with applying for Universal Credit…" and "… homelessness and migration issues." The result of these concerns had shown themselves in feelings of "suicide" and "psychotic delusions about what Covid-19 is or is not" and in some cases, had caused some people to question their "faith and beliefs", which included strengthening and increasing those faiths and belief systems.

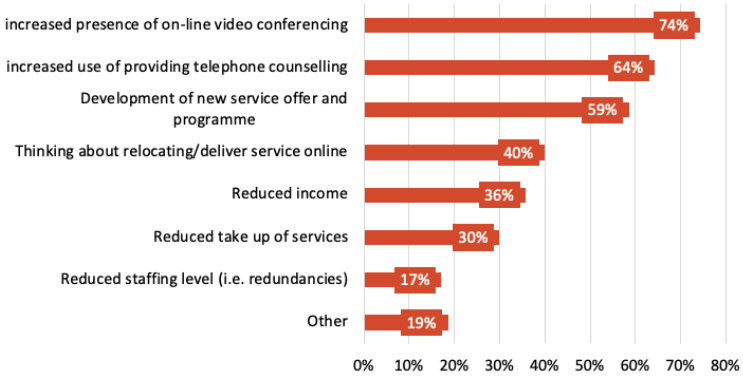
[21] See https://www.bacp.co.uk/news/news-from-bacp/2020/4-june-call-for-urgent-strategy-to-increase-access-to-therapy-for-bame-communities-facing-covid-19-trauma/ (5 June 2020)

Fig 12: Increased reporting by clients as reported by respondents



Implicit in identifying increased need, respondents indicated that to better support their clients they had to adopt new approaches. From this, as Fig 13 shows, 74% of respondents indicated that they have witnessed an 'increase presence of on-line video conferencing' with 64% seeing 'increased use of providing telephone counselling'. Taken together, this showed that on-line and teleconferencing were the main new approaches that organisations and providers now found themselves having to adopt.

Fig 13: Has there been any noticeable impact on your organisation as a result of COVID-19?



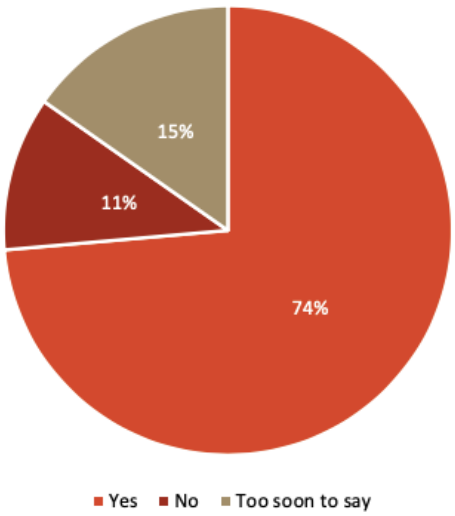
Comments made by respondents illustrate aptly insights into some of the challenges they are having to deal with:

…we offer financial help such as providing supermarket vouchers which we didn't before the outbreak.
…moved from face to face information and advice to telephone as part of our support and now providing emotional support.
Adjustments to face to face group work.
Increased requests for information.
Sign-posting and up to date information; delivering food parcel and well-being bags.
Massive increase in referral rates (I work in a service supporting people experiencing their first episode of psychosis).
Most staff with offering same service.
Telephone and email communication with clients.
No use of physical church building.

To get a better understanding of what it would take for organisations/providers of mental health services to meet the increased need identified, coupled with the new approaches required to meet those needs and to provide a service, respondents were asked to indicate what resources they would require to meet those needs.

Respondents indicated that they would need additional resources to meet the needs of their clients/beneficiaries (Fig 14). Of the 72 respondents who answered this question, 74% indicated that they would need additional resources while 11% indicated they would not and that 15% indicated that it was perhaps 'too soon to say'. Taken as a whole, 26% indicated they would not need additional resources, which is perhaps not too surprising since those who indicated as such by and large Trusts and local authorities.

Fig 14: Respondents indicating whether they would require additional resources



Of the three-quarters of respondents who indicated needing additional resources over 3 – 12mths, responses were broken down into four themes:

- Financial support (39% of respondents)
- Online presence support (i.e. equipment/technical: 35% of respondents)
- Additional staff/volunteers (26% of respondents)
- Any help with developing service/ideas (12% of respondents)

The below 'word cloud' summarises the most frequently cited key words capturing the core themes as indicated:

Some specific comments by thematic categories:

Financial support

Funding to buy the equipment required for the business, funding to train volunteers on bereavement support skills (culture sensitivity), funding to support families with possible discretionary money for those families who have been affected by COVID and can't afford a living or have no food ...

Funding sessions for those who want support but cannot afford it.

Our financial impact assessment show that Covid-19 related changes have had a negative impact on our financial position, which means that we will be spending reserves to continue.

Funding to pay for additional staff.

We need funding to increase days available per week.

We need more funds for the food bank to increase our food parcels and food storage facilities to meet the overwhelming demand of food.

Online presence support

More technical help for website, video/ laptop/ phones to have more online presence for other team members to work from home.

Digital equipment and skills training for clients.

Technical – laptops, iPad/Tablets and software.

Bereavement support helpline.

More equipment such as Laptops and phones.

Set up on-line support group; on-line counselling; art therapy (i.e. make reusable masks; promote health eating -delivery health meals to people who are isolation.

Additional staff/volunteers

More mental health support.more staff to carry out assessments as so many people are likely to present with post effects of Covid-19.

Volunteers and transportation.

Extra staff to meet increased demand particularly from children.

Therapists and counselling.

Qualified counsellors specialising in BAME women who can deal with oppression and intersecting needs.

Any help with developing service/ideas

Development of new services
Training

Respondents were asked 'Other than funding, which of the following do you think your organisation could benefit from over the next 3 - 12mths?' (Table 4). From the responses, the four highest ranked needs over the short term 3 – 6mths were:

- Developing culturally sensitive training to support BAME clients (39 responses)
- On-line advice skills development (39 responses)
- Telephone advice service training (38 responses)
- Relevant and appropriate workshops in areas of specialism (36 responses)

Over 6 - 12mths respondents indicated the following four highest ranked support needs:

- Fund-raising and income generating support (17)
- Organisational leadership and programme development (17)
- Networking opportunities with other practitioners (17)
- Relevant and appropriate workshops in areas of specialism (15)

Table 4: Other than funding, which of the following support do you think your organisation could benefit from over the next 3 - 12mths?

	3 - 6mths	6 - 12mths	Total
Telephone advice service training	38	8	46
Relevant and appropriate workshops in areas of specialism	36	15	51
Networking opportunities with other practitioners	35	17	52
On-line advice skills development	39	12	51
Organisational leadership and programme development	24	17	41
Fund-raising and income generating support	33	17	50
Developing culturally sensitive training to support BAME clients	39	13	52
Mental health awareness	31	14	45
Mental health first aid [22]	33	10	43

[22] Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues. An educational course teaching you how to identify, understand and help a person who may be developing a mental health issue. In the same way as we learn physical first aid, mental health first aid teaches you how to recognise those crucial warning signs of mental ill health (see https://improvement.nhs.uk/resources/mental-health-first-aid/). Additional resource can be found at https://www.mentalhealthfirstaid.org/ and https://mhfaengland.org/.

SECTION 5: CONCLUDING REMARKS AND RECOMMENDATIONS

COVID-19 has brought about some major disturbance to our way of life in ways that many had not suspected would have happened when first identified in Wuhan, Hubei Province, China, back in December 2019. Since then, the epicentre of the pandemic has shifted from Asia (in particular from China, where the virus is said to have emanated from) to North America as the Table 5 below shows. In the UK specifically, the death rate to cases is 15%, almost twice that of the European regional average of 8%.

Table 5: COVID-19 cases by regional breakdown

Region of the world	Actual and proportion (%) of all cases	Total deaths (actual/% of regional cases)
World	**13,487,326**	581,968 (4%)
North America	4,154,684 (31%)	189,024 (5%)
Asia	3,089,319 (23%)	73,111 (2%)
South America	2,993,241 (22%)	108,399 (4%)
Europe	2,607,587 (19%)	197,479 (8%)
Africa	629,619 (5%)	13,807 (1%)
Oceania	12,155 (0.1%)	133 (1%)
Cruise Liners (Diamond Princess & MS Zaandam)	721 (0.01%)	15 (2%)

Source: Worldometer, as at 15 July 2020

An impact of the pandemic included restrictions on physical social interaction and restrictions prevent movements of people and closure of businesses; in some countries it has meant imposition of curfews. A by-product of these restrictions has been on the mental health of people, especially those who are most disadvantaged.

Under these circumstances, it was therefore not surprising to note the level of increased reporting of stress and anxiety (69 out of 70 respondents indicated this) and isolation, where 67 respondents reported this had increased since the pandemic (see Fig 12). This would suggest, not only do we need to seek ways to address and support those exhibiting heightened anxiety and stress as a direct consequence of the restrictive measures in place, but how to deal with those symptoms as we start to ease down on those measures.

There will be the need no doubt to better manage personal anxiety alongside concomitant implications associated, for example, with death and bereavement. One of the implications of the restriction measures has been the capping of people able to attend 'funerals', which, for some communities, can be traumatic as they would not have had the chance to 'properly' see off their loved ones or hold 'wakes', 'nine nights' and so on. If they ever felt loneliness, such an occasion as this adds further to such feelings.

From our survey we found that 51% (26) of BAME led organisations indicated that they offered bereavement and trauma support and there is the likelihood that this may increase as the pandemic continues. In Europe, for example, the death rate is 8% of confirmed cases compared to 4% of the global cases. Within the UK context, as the ICNARC, ONS and PHE reports show, BAME communities are twice as likely to die from COVID than their white British counterparts, which adds to a widespread deep concern over safety and wellbeing as we prepare to ease down. We could therefore be looking at a mental health epidemic as a direct concomitant impact of COVID-19, for which BAME communities could be disproportionately impacted upon, unless something can be done to 'protect' those likely to be affected.

We found also that, of the 51 BAME led organisations captured by the survey, 39 (47%) indicated that they had a website, and, as we are seeing more and more service now going online, this is an area for development alongside other digital support approaches (i.e. video conferencing and telephone support lines). Given that online presence is likely to be the future, this low digital footprint should be considered a need at this time given the high number of charitable sector organisations responding who have not got a website and who are being commissioned by public sector bodies, such as the NHS Trusts, CCGs and Local Authorities (Fig 10).

The survey identified that the majority of BAME led organisations who responded were micro, small and medium sized organisations (i.e. averaged annual income of less than £100,000 per annum: Table 2). This raises questions over scale and capacity to provide well needed support at times of need from micro and small mental health providers, in particular [23]. Furthermore, six (6) of the micro and small BAME led organisations have been established within the past 12mths, with 3 only recently established since the pandemic (April and May 2020). Further work and support will be needed to enable these fledgling organisations to develop and thrive as well as determining of their suitability, viability and appropriateness.

It was noted in some of the responses that the request for funding was linked to 'establishing' a service and in some instances, to developing provisions that are not psychotherapeutic services such as providing food banks, financial advice and information. Under these circumstances, BAMEStream may want to be clear as to whether such services could be classified as 'mental health services', and therefore, to be aligned with the Alliance as it develops. They may have a supportive approach but not one based on a psychotherapeutic approach for which the British Association for Counselling and Psychotherapy (BACP), for instance, may recognise. There is a danger that some organisations may present themselves as offering mental health services, for instance, but may not necessarily have the competence to deliver where it matters, and in so doing, perhaps exacerbate an already fraught and compromising situation. The survey did not ask of respondents whether their organisation was registered with or a member of a recognised body such as, for example, BACP or if anyone held a particular recognised counselling or similar qualification/accreditation/license.

[23] A previous research found that 9 out of 10 BAME led charities were in danger of folding as a result of lack of funding as a result of the pandemic. See Murray K (2020), Impact of COVID-19 on the BAME community and voluntary sector: Final report of the research conducted between 19 March and 4 April 2020; Ubele: https://www.ubele.org/covid19-supporting-bame-communities

Comments such as the below exemplifies the concerns being raised:

…we don't do counselling or mental health support (not qualified for that although it is an area in which we are interested). and one of my colleagues is a trained counsellor outside her work with us .

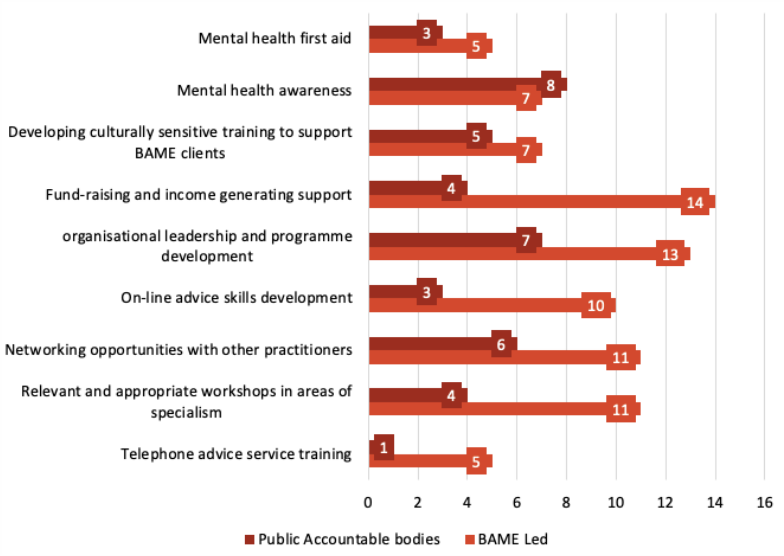
Unable to meet as a group due to COVID 19 measures and social distancing; our elders are becoming/feeling isolated, so more time is spent on the telephone offering reassurance and encouragement on a one to one basis. ""Our services shifted towards an emergency support foodbank.

Funding needed to buy the equipment required for the business, to train volunteers on bereavement support skills (culture sensitivity), to support families with possible discretionary money for those who have been affected by COVID and can't afford a living or have no food ...

We need more funds for the food bank to increase our food parcels and food storage facilities to meet the overwhelming demand for food. We need more materials to create practical virtual learning resources for the supplementary school project that provides English and Math classes to children between 7-11 years including those with SEND needs.

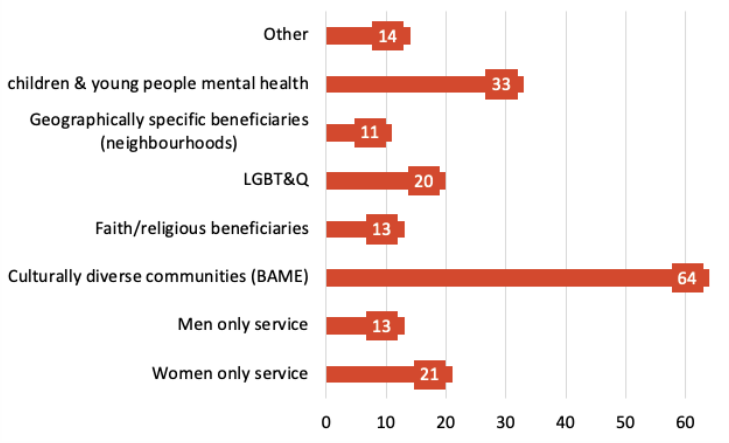
Training/support needs were considered in the survey and, given the increased use of digital platforms, it was not therefore surprising to note that over the short term (3 – 6mths), many of the responding BAME led community and charitable sector organisations saw the further learning of these platforms and technology an area of training and development. Those Public accountable bodies that responded, on the other hand, saw the longer term needs more in terms of 'mental health understanding and awareness, organisational leadership and development and networking opportunities' (see Fig 15).

Fig 15: Training and support needs over 6 - 12mths: public and BAME led community organisations



The role of commissioners of services will be crucial as we ease down out of lockdown, as they offer opportunities to engage with BAME led mental health organisations who may be well placed to offer culturally sensitive counselling and support measures to those communities they are working closely with. Based on our survey it was evident from the frequency responses that both funders (public accountable bodies) and other providers (charities and social enterprises and private agencies or individuals) provide targeted support to 'culturally diverse communities (BAME)' more than any other singular targeted group in the list provided (64 out of 101 responses: Fig 16). This shows that rather than ignoring their needs, there is a recognition of their needs and this provides a good starting point for collaborative and engaging dialogue across a range of services and commissioners.

Fig 16: Targeted support by broad categorisations



As a result of the impact of COVID-19, many BAME individuals have lost loved ones, and whether the death is from COVID-19 or another cause, it is likely to be a traumatic experience. It is crucial that anyone bereaved by COVID-19 receive the appropriate bereavement support that they need. From the studies, reviews and reports cited in this report, it has been shown that BAME communities are less likely to access mainstream services, which means that the need for a culturally responsive bereavement support service is paramount to supporting their future well-being and mental health. With COVID-19 this has further highlighted the inequalities in mental health services as reflected in this survey, especially around bereavement support and mental health wellbeing services in general.

From the survey it is clear that mental health services are adapting as best they can to the changing circumstances we now find ourselves; that social distancing has initiated new approaches in providing support (i.e. digital online platforms), which now require that those newly acquired skills will need to be further developed as ease-down looms. From the PHE reports and the many rapid reviews reports that are now available, we know that there are strong associations between isolation, loneliness and depression as both an immediate as well as a longer-term consideration; one of which is the prospect of having to get used to the changes in routine and what has become known as the 'new normal'. There are still many unknowns, including the prospect of finding a vaccine by the end of the year and whether a second wave will strike anytime soon. With this in mind, how soon will we return to 'normal'? Or put another way: 'what will this new renewal of the way we conduct business and live our lives look like?'

The conclusion to this report is that anxiety is high against a backdrop of the disproportionate impact of COVID-19 on BAME communities, which means the role of BAMEStream in supporting BAME led mental health service providers will be crucial over the coming months.

Making the start in mapping those BAME led mental health services is a step in the right direction, especially as the evidence from the range of organisations reached through this survey suggest there is a need to develop a 'directory' and/or some form of online Kumu-type [24] capture for ease of navigation and connectivity.

A word of caution. Acceptance of change and the need for flexibility means that in going forward, expectations will need to be realistic of organisational capacity as well as objectives, especially as we enter the next critical phase; that of easing down in a safe and healthy way.

RECOMMENDATIONS

Bereavement Support

- The need for a National BAME Bereavement Service that meets the cultural needs of the community
- Bereavement therapists and service providers have cultural competency training that is quality assured
- Address the existing gaps in research surrounding ethnicity, bereavement and loss in the UK
- The identification of good practice in addressing the disparity of bereavement and loss support for BAME communities using an intersectional approach

Commissioners/Funders of Mental Health Services

- More needs to be done in relation to funding, capacity building and commissioning of BAME mental health services especially around bereavement
- Training in cultural competencies and race equality
- Building on the mapped organisations that have been obtained through this survey (Appendix 1), produce a publishable Directory of Services and Independent Counsellors by regions using Kumu as an interactive online tool, which would be cost effective
- Development of training and other support packages using the collective strength of the BAMEStream Alliance

NHS and Statutory Providers

- Training in cultural competencies and equality impact assessments
- The recruitment and training of additional BAME counsellors, psychotherapists, psychologists and mental health practitioners

[24] Kumu is an online interactive tool that makes it easy to organize complex data into relationship maps that is easily accessible (see https://www.kumu.io/). An example of its use can be seen in the work of Ubele regards the Grenfell Fire in 2018 and their Erasmus funded project, Black to the Future (2018), both of which are available on request: info@ubele.org

Mainstream Third Sector Providers and Infrastructure Organisations

- Joined up services working with existing mainstream providers e.g. Cruse Bereavement Care and The National Bereavement Alliance
- Technical and awareness training - awareness training around bereavement support, mental health awareness that is culturally competent
- Recruiting trained volunteers as bereavement befrienders
- Support for the migration of services to online
- Capacity building and infrastructure support - governance and funding
- The licensing and recognition of bona fide BAME mental health providers should be explored which could then benefit the sector long term as a representative body of quality ‘assuring’ BAME mental health providers

BAME led organisation and providers

- Secure funding to develop the BAMEStream Alliance, especially in connecting with those who contributed to the survey

Policy Makers and Academics

- More research on the impact of COVID-19 on BAME bereaved families
- Department of Health and Social Care in conjunction NHS England to develop a mental health strategy on COVID-19 and BAME communities
- Policy makers grant scheme for BAME bereavement services

APPENDIX 1: Responding organisations by region

East Midlands

- NHS Hospital Trust (did not specify)

East of England

- The Bridge Plus
- Family4sure
- National health service (did not specify)
- East & North Hertfordshire NHS Trust
- Cambridgeshire & Peterborough Foundation NHS trust
- Efficacy E.V.A

London

- Royal Borough of Greenwich
- Petals
- Mind Works UK
- The Black, African and Asian Therapy Network
- South London and Maudsley NHS Foundation Trust
- Youth Offending Service (Royal Borough of Greenwich)
- CARAS
- Southwark Travellers Action Group
- UKLGIG
- Centre for Armenian Information & Advice
- Barnet, Enfield and Haringey NHS Mental Health Trust
- Vietnamese Mental Health Services
- BB Studio
- Arctherapy.
- St Peter's Walworth C of E Church
- Therapyish
- Light Project Pro International
- Friends of the Caribbean Charity
- Black Thrive (Healthwatch Lambeth)
- The John Roan School
- Advice Resolutions Ltd
- The Manor Trust Asian Women’s Resource Centre
- Active Horizons
- Metropolitan Thames Valley Housing
- Ealing RISE NHS Trust Foundation (did not specify)

APPENDIX 1: Responding organisations by region

- Lifeafterhummus Community Benefit Society
- Nafsiyat
- EACH Counselling and Support NAZ
- Imperial College Healthcare NHS Trust
- The Passage
- Mind in Haringey
- Balance Lifestyle Ltd
- DERMAN
- African Caribbean Leadership Company

North East

- BAA

North West

- Dimobi Children Disability Trust
- Manchester Health and Care Commissioning
- Jesus Foundation Family International
- Out There
- Empower Consultants
- African & Caribbean Mental Health Services
- Manchester NHS Foundation Trust
- Wai Yin Society
- Hope Bereavement Support
- Yaran Northwest CiC
- Youth Action

South of England

- Envision Counselling
- Inspirational YOU
- Ndokwa Association UK
- Time4Recovery
- Frontline Therapist

South West

- South Western Ambulance Service NHS Foundation Trust

Wales

- Saannie Medical Services
- Transformations
- New leaf
- Diverse Cymru

West Midlands

- Birmingham City Hospital Foundation Trust
- Pattigift Therapy CIC
- ASDA
- Birmingham Women’s and Children

Yorkshire & The Humber

- Black Health Forum
- Sharing Voices, Bradford
- Touchstone
- Black Health Forum Bradford
- Sheffield Health and Social Care NHS Foundation Trust
- Naye Subah
- Page Hall Medical Centre

BAMESTREAM