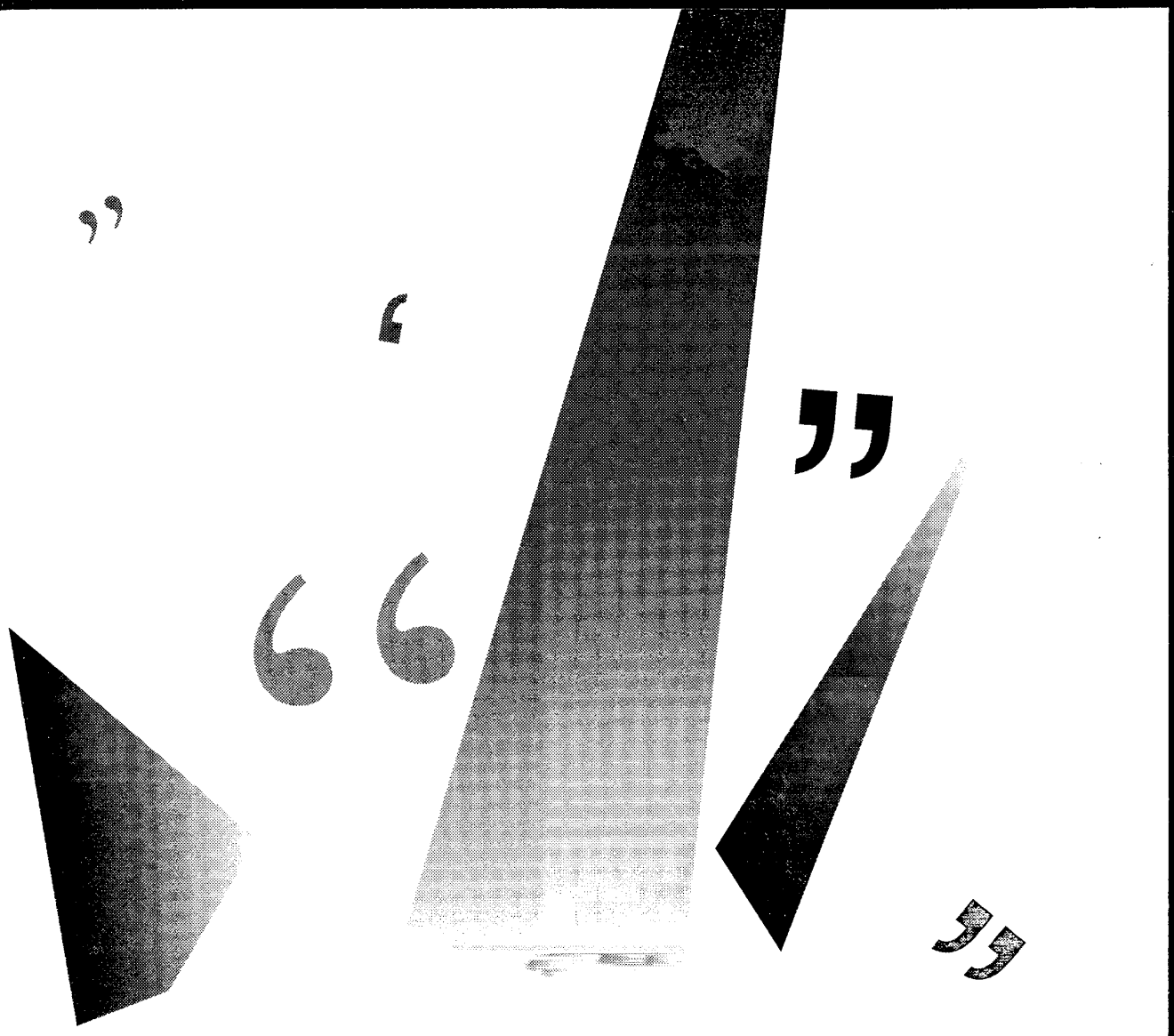

mental health

AND BRITAIN'S BLACK COMMUNITIES

melba wilson

NHS Management Executive
MENTAL HEALTH TASK FORCE

THE PRINCE OF WALES' ADVISORY GROUP ON DISABILITY

KING'S FUND CENTRE

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The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

Contents

Terminology

Throughout this report the term 'Black communities/populations' refers to people from racial or other minorities in this country who may be disadvantaged because of their racial backgrounds. It is accepted that there is no one word that embraces or is embraced by all members of minority racial groups in this country. When the term ethnic minority is used, it will be as a result of using quoted material.

For clarity, and where reference is to a specific group, the terms African-Caribbean, Asian, Chinese, Vietnamese, etc. will be used.

It is hoped that the use of both terms will encompass all those within Britain's multicultural communities for whom racial disadvantage is a relevant consideration.

Three generations of caring

'*I'm caring for three generations*,' said Mrs P. '*I'm taking care of my mum, my son and my daughter, and my grandchildren.*'

Mrs P. explained that her own mother had suffered a heart attack and was disabled by rheumatism and arthritis. She also has an 11- year old son, and a grown-up daughter who has had a breakdown and suffered from depression since the birth of her second child.

Mrs P. has been able to obtain some help from the Crossroads Care Attendance Scheme for her mother (following repeated attempts, and only after intervention from a representative of the Black Carers and Clients in Brixton). Though she has repeatedly contacted her local social services department, little help has been forthcoming for her daughter.

'*My daughter brings the children to me when she can't cope, usually late at night. I rang social services to ask for help for my daughter. They said they could care for the children if they were at risk, but there was nothing they could do for my daughter, because she wasn't a danger to herself or the children. Social services promised to pay me £15 a week to help with my grandchildren, but they never paid me. Finally, I had to take the children to them because I reached a point where I couldn't cope. It broke my heart. They put them into care. One social worker tried to get a holiday for my daughter. Nothing happened. Social services never followed through on any of its promises.*

'*To get help for my daughter I rang MIND in desperation, and they put me in touch with Shanti [Women's Counselling Service]. I went to Shanti and told them about my daughter and about my situation. They provided some counselling for my daughter. They put me in touch with the African-Caribbean Mental Health Association in Brixton. They then referred me to Maxine [from the Black Carers and Clients Project].*

'*I was desperate. I don't know what I would have done without Maxine and the project. If I hadn't gone to Shanti, I wouldn't have met the counsellor there or Maxine at the Carers Project.*'

Introduction

The purpose of this document is to take the debate and practice concerning the situation of Black people who are diagnosed as suffering from mental illness beyond the point of counting heads, and instead to focus more on acknowledging and highlighting positive methods of diagnosing and treating mental illness within these communities.

Black people in Britain who suffer from mental illness, are frequently over-, under- or mis-diagnosed. Their care is undertaken with a eurocentric bias which often leads to inneffective or culturally insensitive treatment. This situation is made worse by Black people's historical unequal access to service provision and, for those for whom English is not a first language, poor levels of communication.

There is increasing concern about the way in which mental health services in hospitals, general practice and community settings are provided in Britain's multiracial and pluralistic society. Psychiatric services have failed to respond to the needs and secure the confidence of Britain's ethnic communities. Furthermore, services are often discriminatory, culturally insensitive and inappropriate. Consultation with members of the ethnic communities about the planning and delivery of services has been sadly lacking.[1]

1.'A Cry for a Change: An Asian Perspective on Developing Quality Mental Health Care. Confederation of Indian Organisations, 1991.

Health of the Nation

The national agenda for mental health is set out in the Government's guidelines *The Health of the Nation.* Targets for mental health are:

- to improve significantly the health and functioning of mentally ill people;
- to reduce the overall suicide rate by at least 15 per cent by the year 2000 (from 11.1 per 100,000 population in 1990 to no more than 9.4 per cent); and
- to reduce the suicide rate of severely mentally ill people by at least 33 per cent by the year 2000 (from the estimate of 15 per cent in 1990 to no more than 10 per cent).

Department of Health guidance for meeting *Health of the Nation* targets include:

- meeting unmet need in mental health by enhancing services to persons with enduring and severe mental illness; persons who abuse alcohol and substances, children and their families, elderly people and their carers, persons from ethnic minorities, and persons with challenging behaviours;
- drawing together provision across secondary and primary care;
- drawing together health and social care;
- improving the quality of care; and
- maximising the effectiveness of care.

The client communities

The total Black population of Great Britain, according to the 1991 Census, was just over 3 million, or 5.5 per cent of the total population of 54.9 million. Nearly half (2.7 per cent) the total of the Black population is made up by people of South Asian ethnic origin, with Indians (1.5 per cent) comprising the largest individual Black group (1.5 per cent), followed by Pakistani (0.9 per cent) and Bangladeshi (0.3 per cent). The second largest group of Black people (1.6 per cent) includes 'Black-Caribbean' (0.9), Black-African (0.4 per cent) and 'Black-Other' (including those of mixed race, etc.) (0.3 per cent). The third largest grouping of Black people are the 'Chinese and Others' (1.2 per cent), of which the Chinese amount to 0.3 per cent; 'Other-Asian' (including East African Asian, Indo-Caribbean, etc.), 0.4 per cent; and 'Other-Other' (including North Africa/Arab/Iranian and Mixed Asian/White, etc.) 0.5 per cent.

Source: University of Warwick Centre for Research in Ethnic Relations, 1991 Census Statistical Paper No. 1, November 1992.

The African-Caribbean Community*

Most prevalent diagnosis:	Schizophrenia
Most prevalent response/treatment:	Drugs (major and minor tranquillisers)
	electro-convulsive therapy (ECT)
	sectioning in psychiatric institutions

'My boy just wanted someone to talk to and they electrify him.'

Black mother on ECT treatment at local mental hospital

Numerous hospital studies and anecdotal evidence suggest that Black patients, especially African-Caribbeans, are regarded by mainstream service providers as violent and dangerous. They are given stronger medication for longer periods of time, as a result, than White patients. The incidence of schizophrenia diagnosis for people of African-Caribbean origin is also well-documented, with some studies showing that they are 3 to 17 times more likely to attract a diagnosis of schizophrenia than the native White populations.

David Ndegwa, a consultant forensic psychiatrist in North East Thames RHA, and one of a handful of Black psychiatrists in Britain, has noted that Black people diagnosed as schizophrenic are over-represented in admissions to the general psychiatric services and the forensic service, which deals with offenders who have psychological problems, for example, in medium secure units and special hospitals.

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* MUCH OF THE LITERATURE TENDS TO INCLUDE AFRICANS AND AFRICAN-CARIBBEANS UNDER THE SAME HEADING. FOR THE PURPOSES OF THIS BRIEFING DOCUMENT, THEREFORE, THIS CATEGORY WILL INCLUDE BOTH GROUPS.

He stresses the need to examine Black people's contact both with general psychiatric services and the criminal justice system in order to unpack the high diagnoses of schizophrenia. His own research carried out three years ago found that 44 per cent of admissions to a medium secure unit were African-Caribbean, and that 75 per cent of these compared to 40 per cent for Whites, came via the penal system. In addition, his study found that 80 per cent of all the admissions had previous contact with other psychiatric services at lower levels of security.

In any situation where people are compulsorily detained, Black people are likely to be over-represented. In inner city areas, Black people make up 40 per cent of mentally ill in-patient offenders. Ten per cent of special hospital patients are Black, which is over-representation when you consider the total Black population of 5 per cent. The questions to be asked are: (1) do Black people pose more of a management problem in other hospitals? (2) Do Black people commit more crimes? (3) What part does racism play?[2]

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2. David Ndegwa, Consultant Forensic Psychiatrist, NE Thames RHA

The Asian Community

Most prevalent diagnosis:	Depression
Most prevalent response/treatment:	Over-use of compulsory admission to psychiatric institutions
	drugs; ECT; over-diagnosis using psychotic categories
	low referrals to psychotherapy and counselling

'The environment was so different – I was very lonely. I couldn't communicate because I only speak Bengali. I was afraid to leave the house.'
Asian woman about her mental health concerns.

A 1991 report by the Confederation of Indian Organisations (COI) indicated that mental health professionals had found a high prevalence of depression when working with Asian people.

Depression may be caused by a wide range of combining factors. Beliappa's study (1991) revealed that within the Asian community, many of these factors are related to marital and family relationships, and socio-economic conditions such as housing, employment, low economic status and racism.[3]

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3. A Cry for a Change: An Asian Perspective on Developing Quality Mental Health Care.

A study in Waltham Forest (Khan, 1983) analysing hospital records which was outlined in the COI report, showed:

Asians were most freqently admitted by a general practitioner under Section 4 of the [Mental Health] Act (admission for assessment in cases of emergency); and that eight per cent of Asian and African-Caribbean people admitted under Section 136 [removal by police to a 'place of safety'] were found not to be suffering from any mental illness and subsequently discharged.

Such evidence points to a low take-up or delayed take-up until the point of crisis, of services by Asians. These statistics call into question the role of GPs as the gatekeepers to mental health care. Often, notes the COI, GPs fail to respond to what the patients are saying, or to recognise the emotional affects of a physical condition. GPs also tend not to refer Asian patients to other agencies, such as counselling or psychotherapy services, and, says the COI, there is an 'adherence to myths and stereotypes related to gender, culture and race.'

The Chinese Community

Most prevalent diagnoses:	Schizophrenia, manic depression
Most prevalent response/treatment:	Drugs, injections, hospitalisation in psychiatric institutions

Britain's 220,000-plus Chinese communities (forming the third largest Black population in Britain, half of whom are in London) are said to be mentally robust and not to believe in talking therapies. The main 'problem' with this community, however, is that it is largely a 'hidden' community, because of the lack of information about the mental health needs of Chinese people generally.

Language is a major barrier. The 1985 Select Committee revealed that more than 80 per cent of Chinese people have difficulties in either understanding or speaking English. In addition, there are few Chinese mental health professionals in the statutory or voluntary sectors, to address the needs of Chinese people with mental health problems. Ealing Health Authority, in conjunction with the London Chinese Health Resource Centre, is currently working to compile demographic data on people of Chinese origin living in the borough, to find out what services they use. One finding, among 90 interviews carried out to date, shows that although most people were registered with GPs, a number rarely re-visited their GP because of communication problems.

The Refugee Communities

In the ten years to 1991, an estimated 45,000 applications for asylum were made by people seeking asylum in the UK. During 1992, the Refugee Council's advice and referral team saw more than 9,000 cases, representing 114 nationalities. The largest groups came from Somalia (1330), Ethiopia (904), the former Yugoslavia (850), Zaire (625), Ghana (619), Eritrea (522), Romania (418), Ivory Coast (393), Angola (274), Afghanistan (271), Sudan (233), Iran (225), Iraq (224), Uganda (191).

Source: The Refugee Council

The immediate problem for most refugees is to obtain political asylum or refugee status. This is closely followed by the need to find housing, employment, health care and education. The process of seeking asylum is a lengthy one, during which time many refugees are reluctant to bring attention to their situation for fear of being sent back to their country of origin. They also may not be aware of what services they may claim, or even that they can claim benefits.

Many Ugandans who come to this country will not seek help because they don't want to draw attention to themselves. They feel the reason why they are here is because of the establishment in their home country. Therefore, there is fear of the establishment.

Source: Worker in Ugandan community organisation, Haringey, North London

In addition, local GPs and health services are often unable to cope with the special problems of newly-arrived refugees. Few, for example, have experience in dealing with victims of torture or multiple bereavement.

The Vietnamese Community

Most prevalent diagnoses:	Schizophrenia and depression
Most prevalent response/treatment:	Hospitalisation, drugs, injections, tablets

The Vietnamese community in Britain numbers approximately 26,000, half of whom are in London with the remainder distributed throughout the rest of the country. Many Vietnamese clients/carers, coming from an agrarian area (one based on an equitable division of land), have problems coping because of isolation and unemployment, and, as a consequence of a long and disruptive war, have a disrupted education.

There is a reluctance or refusal by health professionals to take seriously the question of the language barrier with this particular community. Yet, this barrier prevents many Vietnamese people from gaining access to talking therapies. The use of interpreters, while useful, has its limitations as it inhibits an effective relationship between client and therapist.

With this and other factors remaining an issue for the Vietnamese communities, many seek western help as a last resort and as a way of avoiding misunderstanding or misinterpretations.

Commonalities between client communities

Racism

Racism is a fact of life for all of Britain's Black communities. It overshadows every aspect of Black life in Britain and works to demoralise, dis-enfranchise, and particularly with respect to mental health, dis-orient Black people. Cultural differences between patients and doctors, social workers, therapists, and so on, who are trained in a European psychiatric tradition, accounts in large measure for how this presents itself to Black people using mental health services.

Many of my clients have met with racism – overt and covert – at the point of entry into the mental health system. This can include ill thought-out remarks and making assumptions about behaviour, e.g., they will assume someone is on drugs. I have found in my work with young men between the ages of 20 and 33 with a diagnosis of schizophrenia that when looking into their backgrounds, the most appropriate diagnosis is that of adjustment reaction. We have now included that category in our work with African-Caribbean clients.

Source: Fayola Gabriel, Bristol Inner City Mental Health Project

Racism leads to isolation and distress and a feeling that there is nowhere to turn. This is exacerbated if people are suffering illness, and feel they are in a hostile and unsympathetic environment.

Mrs K. (an Asian woman in the East End of London) lives in a council flat. She has been racially harassed by her neighbours: her children have been attacked, her doorstep fouled a number of times and excrement dropped through the letterbox. Her living conditions caused her mental health to deteriorate. She has waited to be re-housed for the past three years. She went to hospital once when she had a nervous breakdown. Her comment is that the

hospital is as alien as the council flat. She ate nothing, there was nothing familiar to eat. She was there for her mind and not for her body. Mrs K. was treated with drugs.

Mis-diagnosis

Conventional psychiatric thinking . . . suggests that such over-representation of Black people in psychiatric facilities, particularly for the diagnosis of schizophrenia, is indicative of a racial or ethnic vulnerability to a major mental illness. Such an interpretation, however, is fraught with major problems. For example, evidence from many studies would appear to suggest that the diagnosis of schizophrenia is likely to be more unreliable, less specific, lacking stability over time and more readily and uncritically used in Black patients than among white patients.[4]

Though much has been written about the high diagnosis of schizophrenia among Black people, particularly African-Caribbeans, little has been said about why the diagnosis is so prevalent. Undoubtedly schizophrenia, depression and psychosis are illnesses which do afflict Black people, but mental illness cannot be looked at purely in terms of blanket characteristics attributed to groups of people who have diverse cultural characteristics.

Dr Parimala Moodley, director of the Maudsley Outreach Support and Treatment Team, notes a 'blurring of boundaries' when it comes to schizophrenia diagnoses:

People tend to be put in that category because they don't fit into anything else. There is concern that conditions and people are lumped together, which might not be reasonable to do. But it happens because we don't have alternative ways of categorising people. Schizophrenia is a kind of growth category. At some point we will be more sophisticated in separating out symptoms, but we're still a long way from that point. That means that people who are less well understood will be mis-categorised.

4. FRANCIS, ET.AL., 'BLACK PEOPLE AND PSYCHIATRY IN THE UK,' PSYCHIATRIC BULLETIN, 1989

Dr Sashidhran notes the 'methodological biases' of studies point to excess risk of schizophrenia among African-Caribbeans. It is, he concludes 'an unproven hypothesis,' and adds:

A question that is rarely asked ... is why madness or pathology, constructed according to arbitrary notions of normality and abnormality, which are so powerfully mediated through particular social realities and within specific cultural contexts, continues to be investigated in relation to ethnicity and race.

Source: S.P. Sashidhran, Deptartment of Psychiatry, University of Birmingham, All Saints Hospital

Language

Language is also one contributor to incidences of mis-diagnosis, as well as low referrals for psychotherapy and counselling. According to the COI report, a number of studies have shown that, for example, 'rarely are Asians referred to psychotherapy services'. In part, this is due to a closing of the gate by some GPs who anticipate, but fail to help remedy, problems of communication in some therapies; the reasoning being that a level of sophistication is required in order to make the best use of psychotherapy, a level which may be difficult for a patient for whom English is a second language. In addition, the language barrier may mean, for example, that the Chinese, Asian and refugee populations are unable to utilise talking therapies, not because they do not believe in such therapy, but because of the difficulty they encounter in making their views/feelings known to mental health professionals schooled in a European ethnocentric tradition, which is often alien and alienating.

Poor communication leads to misunderstanding or misinterpretation of symptoms, or a 'reluctance or refusal' by health professionals to take seriously the case at hand.

Source: Vietnamese Mental Health Project

Stereotypes

Stereotypes also influence the diagnosis and treatment which Black people receive from many mental health service providers. Knee-jerk reactions which summon up visions of violent and dangerous African-Caribbeans and passive Asians, who 'look after their own' do little to aid an understanding of the diverse cultural characteristics which contribute to multicultural Britain, and should be challenged on that basis.

Good practice

I feel secure here. We talk about things that I want to know. Like the discussions about racial issues and talks about African and Caribbean history. I don't think I would have talked about race and my Caribbean history if the group had white people in it. I always have problems talking about these things with white people. I don't think they can understand discrimination.

Source: Mental health user of a Black patients' group at day centre in London Borough of Wandsworth.

Many Black professionals and others who work with Black mental health clients and their carers recognise the need to establish a holistic approach in working with these groups. A holistic approach incorporates all aspects of a patient's background in assessing illness and arriving at treatment. It would include considerations of the impact of racism in Black people's lives; it would include an awareness not only of the medical needs of carers and clients, but also of the need for help, for example with housing and welfare benefits, it would recognise the effects of unemployment, or the consequences of living in a hostile environment. Most importantly, however, it would start from a frame of reference which took account of culture.

Having an awareness of culture and the needs of people from different cultural backgrounds, for example, would work against a tendency to slot people into cubbyholes for diagnosis; it would mitigate against blanket diagnoses for particular groups, and it would engender working

with clients and carers in the planning as well as implementation of appropriate treatment. It would, in short, mean carers and clients were listened to in any process affecting their care and treatment.

Quite often we find that a lot of carers don't know much about the diagnosis or medication or the community care plan. We work with CPNs and social workers to help them find out what's going on.

Source: Development worker, The Mental Health Shop, Leicester

Not all such work needs to be, or perhaps should be, carried out within a mental health context. One Black women's group in London, for example, undertakes mental health counselling for users in response to expressed need, and as part of it wide- ranging provision of services.

Much of the counselling that I do involves people talking about racism – how they feel about racism – because they don't often get the opportunity to express their feelings about it.

Source: Ayiah Jahan, Counsellor, Camden Black Sisters

The complementary treatment which Black counsellors and organisations provide for Black people suffering mental illness is a mainstay, and often a lifeline, for Black clients and their carers. Its basis lies in mutual respect and recognition of the need for an equal partnership in approaching the problem. It results in appropriate treatment for people according to their situation and their needs, based on an understanding of relevant cultural factors.

A recent report outlining the views of Black users on mental health services was carried out in Lewisham by the Black Mental Health Group. It recommended, among other things:

- the need for establishment of a Black mental health centre;
- the establishment of a range of residential services to meet the needs of Black users;
- comprehensive monitoring of existing services;

- systematic monitoring of all agencies' implementation of equal opportunities policies, including the numbers and levels of staff from minority ethnic populations;
- that training in racism in health should be the norm across agencies, and if necessary, compulsory in statutory services.

Questions for service practice

These questions should be addressed in conjunction with the next section on the way forward

1 **How do you monitor incidences of racism within your organisation and service provision?**

2 **Do you have a complaints procedure?**

3 **How do all service users access this procedure?**

4 **How are you developing strategies which involve people from Black communities, in order to develop more appropriate mental health services?**

5 **What media do you use to inform people about services, for example, videos or tapes?**

6 **What provision is there for advocacy services in your health authority/trust?**

7 **Is there over-reliance on the support of the extended family when working with Black people?**

8 **What alternative practices need to be developed in order to meet family support needs?**

9 **What steps are you taking/will you take to get to know the Black communities in your locality?**

10 **How do you make yourself aware of which Black organisations are working in your area to deliver mental health services to the Black communities?**

11 How do you maintain links with any such groups?

12 If no such groups exist, how will you involve the Black communities in planning services?

13 What plans are there in your area to link the work of Black groups/ organisations with mainstream service planning?

14 Is there specific service provision for Black people?

15 Is there specific service provision for Black carers?

Moving forward for good service practice/provision

Note: This is not intended as an exclusive list of options for the way forward, but is instead meant to provide a focus for implementing ideas or identifying areas for further work.

Government and intermediate tiers (including regions and outposts)

1 Establishment of more secure funding bases for community and voluntary groups currently carrying out innovative practices in Black mental health, including 'top slicing' or 'ring fencing' of mental health monies specifically to fund the development of current and future work.

2 Comprehensive ethnic monitoring of existing services to identify gaps in service provision for Black clients in regions/districts.

3 Funding of research into alternative and appropriate models of treatment for Black service users from a Black perspective; models which reflect the cultural diversity of Britain and which draw upon the views of Black clients, carers and professionals.

4 Encourage and ensure the involvement of Black people at senior management levels of health service planning.

Purchasers

1 Comprehensive consultation with Black service providers and professionals with a view towards incorporating their work/views into strategic planning exercises.

2 Incorporation of a holistic approach, from the top down in planning long-term provision for Black mental health service users, which takes account of external factors such as racism and racial disadvantage, as well as cultural diversity.

3 Contracting out of services to providers who can appropriately meet the cultural needs of Black service users.

4 Needs assessment procedure for Black mental health users to be based on consultation with Black groups/organisations. Needs assessment should be two-pronged to include (1) service needs and (2) diagnostic needs.

SERVICE PROVIDERS

1 Clinical assessment of Black mental health clients based on an understanding of cultural diversity.

2 Provision of 24-hour crisis intervention services.

3 Production of a Good Practice Guide for working with Black mental health service users.

4 Provision for more hostels and halfway houses staffed by Black providers, which would service the needs of Black people.

5 Specific day-care provision to meet the needs of Black users, including setting up groups in which Black users do not feel alienated.

6 Develop community responses at a local level to meet the mental health needs of Black people.

7 Develop discharge packages which establish links with Black communities.

GP PRACTICES

1 How much time do you/will you spend in learning about service provision in your area?

2 What plans do you have for buying in services for Black people?

Involvement of users and carers

1 Develop mechanisms for involvement of Black mental health users in planning and implementation of community care plans.

2 Provision of specialist and appropriate respite care for Black carers.

3 Establishment of a range of residential services to meet the needs of Black users.

4 Establishment of women only services, which would take account of cultural values.

Employment and training

1 Improved training in medical schools to take account of the specific needs of Britain's Black populations resulting from racial and cultural diversity.

2 Better recruitment and training of Black people into the professional medical establishment.

3 Ethnic monitoring of entry into medical schools to ensure representation of Black applicants in proportion to their numbers in the general population.

4 Training in race and health across all sectors and levels, to include an assessment of the impact of individual and institutional racism.

5 Recruitment and promotion of Black managers into strategic positions in mainstream planning and implementation of mental health services.

Existing service provision for Black communities

A number of initiatives already exist, instituted within the community by Black groups in conjunction with statutory and voluntary bodies, and point the way to good practice. They embody principles and practices which: (1) are culturally and racially sensitive; (2) involve the user communities; and (3) are mindful of the need for training of all mental health professionals in these approaches. They represent an important resource for contracting out of service provision which appropriately meets the needs of Britain's Black populations, in line with the goals of care in the community. Some of these initiatives are outlined below.

The African-Caribbean Mental Association, Brixton (ACMHA)

Formed in 1982 by Black people in Brixton in response to what was seen as inferior and inappropriate treatment received by Black patients in local hospitals. Initially it campaigned around issues of race and mental health locally and nationally and supported individual cases of Black clients. ACMHA's work has expanded 'towards creating an alternative to institutional psychiatry.' Workers include a multi-disciplinary team of social workers, nurses, therapists, counsellors, legal adviser, housing officer, researcher and volunteer organiser. Services also include a Black carers' and clients' project.

Address: 35-37 Electric Avenue, Brixton, London SW9 8JP
Tel: 071-737 3603

Harambee Housing Association and the Core and Cluster Mental Health Project, Birmingham

The homelessess of many single Black people in the Handsworth district of Birmingham provided the impetus for this project. A large proportion of young clients have been in psychiatric hospitals, and many carry the stigma of a serious psychiatric diagnosis. The project aims to deal with

issues such as loss of self-esteem, loss of communication skills, rejection by family and peer group, inability to seek help or support, and lack of appropriate and stable accommodation.

Address: 57-59 Wellington Road, Handsworth, Birmingham B20 2DY
Tel: 021-356 1948

The Asian Family Counselling Service (AFCS), Bradford

The Asian Family Counselling service was started in Bradford in 1982 as part of Relate, National Marriage Guidance Council. It was set up in London in 1985 as an independent voluntary group. Its initial purpose was to research the marital counselling needs and related stresses of Asian families settled in Britain.

Counselling is offered for a variety of problems, such as domestic violence, marital stress, adultery, pre-marital uncertainties, alcoholism, inter-generational conflict and young runaway girls. Its therapy is not based on conventional western models, but encompasses methods which are appropriate to user groups.

Bradford: Second Floor, Rooms 4/5, 40 Equity Chambers, Piccadilly, Bradford
London: 74 The Avenue, Ealing, London W13 8LB

Nafsiyat Intercultural Therapy Centre, Finsbury Park, London

Set up in 1983 by a group of mental health professionals examining the effects of non-drug therapies on clients who had migrated to Britain and whose concepts of mental health differed from the indigenous population. It offers a new approach to therapy in that users define their own problems, using terminology familiar to them, in order to move away from jargon or medical terminology and avoid labelling. Nafsiyat takes account of external factors, such as housing and racism, when treating people. Its main philosophy is to treat the whole person rather than concentrate solely on the internal world of the user.

Address: 278 Seven Sisters Road, Finsbury Park, London N4 2HY
Tel: 071-263 4130

Bristol Inner City Mental Health Project

The project was established in 1987 with a multi-racial team, with a specific brief to develop mental health services to meet the needs of homeless African-Caribbean, and Asian people. The team, which includes African-Caribbean as well as Asian development workers, works with clients to provide appropriate services. Clients are people who have been in the system for some time – through the courts, prison or hospitals.

Tel: 0272-556098

The Mental Health Shop, Leicester

The Mental Health Shop was set up in 1989. It was formed by the Black Mental Health Group in Leicester, a group of local community workers who came together in 1985 to discuss issues affecting African-Caribbean and Asian people and their experiences of mental health services. The Mental Health Shop offers advice, information and support to people experiencing mental problems, and their carers. The Shop is a broad-based advocacy project, which aims to help people 'in the ways they want to be helped'. It offers assistance with housing, benefits and debts, and provides information on education and leisure activities. A large part of its work is with Black carers.

Address: 40 Chandos Street, Leicester LE2 1BL
Tel: 0533-471525

The Vietnamese Mental Health Project, South London

The project was set up in 1989 'to provide relief for Vietnamese people with mental health problems and their families, by giving advice/ counselling/consultation on mental health issues, and to work in partnership with health professionals and social workers to improve the

services.' It has worked to: (1) establish effective working links with health professionals; (2) provide more effective services to users/carers through regular home visits and telephone contact; (3) create a network of befrienders to give carers more respite, as well as to assist them in sorting out problems regarding welfare rights or benefits; (4) organise respite holidays for carers and entertainment for users; (5) raise awareness of Vietnamese culture and the needs of Vietnamese patients and families; and (6) provide a six-bed psychiatric hostel in Brixton, south London, for rehabilitation.

Address: Tooting Bec Hospital, Church Lane, London SW17 8BL
Tel: 071-326 5565

Refugee Support Centre

The Refugee Support Centre was founded in 1989. It is committed to enabling all refugees and asylum seekers to live hopeful, healthy and purposeful lives. It provides counselling and psychotherapy; training, support and information; and is involved in special projects to address the unmet mental health needs of especially vulnerable groups, such as elderly refugees and children.

Address: King George House, Stockwell Road, London SW9 9ES
Tel: 071-733 1482

Useful further reading

1 Webb-Johnson. A Cry for Change: An Asian Perspective on Developing Quality Mental Health Care. Confederation of Indian Organisations. November, 1991

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Black people in Britain who suffer from mental illness are frequently over-, under-, or mis-diagnosed. Their care is undertaken with a eurocentric bias which often leads to ineffective or culturally insensitive treatment.

There is increasing concern about the way in which mental health services in hospitals, general practice and community settings are provided in Britain's multiracial and pluralistic society.

The King's Fund Centre, the NHS Management Executive Mental Health Task Force and the Prince of Wales' Advisory Group on Disability have produced this report as part of a strategy to generate discussion and debate on the provision of effective and sensitive mental health services for Black populations.

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