

ETHNIC DIVERSITY AND MENTAL HEALTH IN LONDON

Recent developments

**FRANK KEATING, DAVID ROBERTSON AND
NUTAN KOTECHA**

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This is one of a series of papers being produced in 2002/03 as part of the King's Fund Mental Health Inquiry. The Inquiry aims to assess whether London's mental health and mental health services have improved over the last five years. In 1997 the King's Fund produced a report entitled London's Mental Health, describing services in inner London 'that cannot be sustained'. The current Inquiry asks what, if anything, has changed since then, as well as tackling some new questions.

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Executive summary

The need for change in mental health services, and the need to change and improve the experience and outcomes of care for black and minority ethnic (BME) communities has been well documented. This working paper provides:

- a snapshot of the changes over the past five years
- reflections on the current situation for black and minority ethnic communities in London
- a discussion of the implications for the future.

The various sections of this working paper reflect on changes and developments since the last review in 1997 and includes a discussion of the issues for women, refugees and asylum seekers.

Key findings

General

- London continues to have a significant black and minority ethnic (BME) population (over 50 per cent in some boroughs). BME communities tend to have a younger average age than other communities, but the average age is expected to increase with time.
- In the past five years, race equality in mental health services has been prominent in policy developments at a national level. However, at local levels, there is evidence that it is not accorded sufficient importance. For example, the needs of the Irish community are often overlooked in race equality strategies. Factors such as this highlight major gaps in the implementation of national policies.
- New structures have emerged to provide greater opportunities for partnership and consultation with BME communities. These include health action zones and local implementation teams. However, these initiatives are not always sustained.
- Acute care remains an area of concern for BME communities because of restrictive treatment regimes.
- Workforce development issues have mainly been addressed through training initiatives rather than co-ordinated strategies to improve staff competence on issues of race and culture.
- There are initiatives to strengthen the voices of service users, but these are at the early stages of development.
- The needs of families and carers and the importance of their role in the care process are overlooked.

Women

- BME voluntary sector organisations – including those working with women, refugees and asylum seekers – continue to operate at the margins of mainstream service delivery.

- The mental health needs of women, including women with children, have been accorded national prominence, and there has been an acknowledgement that social and economic reasons often lie at the root of their development. However, BME women remain marginalised within current policy debates. They are often viewed exclusively, in stereotyped ethnic images – for instance, as ‘loud and difficult to manage’ in the case of African-Caribbean women, or in the case of Asian women, as having problems that are rooted exclusively in ‘cultural conflict or practice’ within the family. This results in their needs as women being ignored and overlooked.
- Many BME women only access services at crisis point. This is because of their experiences of services as inappropriate, their lack of confidence and trust in the service, and an inadequate knowledge of what is available.
- Services fail to take account of the needs of women with mental health problems who have children or dependants. This is significant, given the high numbers of African-Caribbean and mixed heritage young women in the care system.
- BME women are more likely to visit and receive treatment at primary care level than other women, but their experiences and outcomes within primary care are poor. Communication difficulties in this and other settings comprise a significant problem that should be addressed by more first-language services.
- BME women are over-represented in the criminal justice system, yet there is little information available to explain the reasons for this, or about the mental health needs of these women.
- There are indications that suicide and self-harm rates are higher than average among certain groups of Asian women and among young African-Caribbean and Irish people.
- Asian women (and young Asian women in particular) tend not to use GP services as a pathway to care, for fear of loss of confidentiality.
- There is a lack of specialist crisis and respite services for BME women in London.

Refugees and asylum seekers

- There are high levels of unmet need among refugees and asylum seekers, compounded by the fact that staff are not adequately equipped to assess these needs.
- NHS staff are unsure of the rights of refugees and asylum seekers to health care.
- Access to interpreting services for refugees and asylum seekers is limited.
- Mental health awareness and knowledge/information about mental health services is an area of concern for refugees and asylum seekers.

Recommendations

General

- The ethnicity profile and age structure of BME communities in London is currently seen as an ‘add-on’ activity. Instead, it should be considered ‘core business’ for all primary care trusts, mental health trusts and local authorities.
- Race equality and action to reduce inequalities need greater prominence in local strategies to achieve change. Primary care trusts must lead local action to tackle inequalities in mental health. All mental health services should actively strive to eradicate inequality while celebrating and promoting diversity.

- A priority area for service development should be to engage with local communities, by identifying strategies for active participation and representation of BME communities in needs assessment, service development and delivery. Partnerships based on principles of equality should be fostered by using the guidance from the Department of Health as outlined in *Saving Lives* (Department of Health 1997). Existing initiatives that work from service user, women-centred, and anti-racist perspectives need to be included in current partnership arrangements.
- Capacity-building initiatives should be developed for service-user groups and family and carer groups.
- Health promotion can be a powerful means to raise awareness about mental illness and increase access to services.
- An urgent, systematic review is needed of acute inpatient care provided for BME communities in the country as a whole, and in specific local communities.
- Work- and team-based training programmes should be introduced as part of an overall strategy to meet the needs of BME communities.
- Capacity building in the BME voluntary sector is needed to sustain the valuable contributions they make to mental health service provision

Women

- A range of accessible services is needed, including services that support women and their children to reduce the risk of family breakdown and the incidence of children's adverse experiences in care. These should be located in a host of organisational settings, and should include access to creative and spiritual outlets and complementary and talking therapies and practical support.
- Gender-specific advocacy services to improve access to and experiences of services need to be developed or strengthened.
- All mental health services accessed by BME women should emphasise confidentiality and safety and include access to self-help groups, facilitated, where necessary. First-language services to overcome the barriers created by interpreter presence should be developed as far as possible.
- Greater numbers of staff need to be able to understand issues of abuse and to work confidently and sensitively with women who may themselves have experienced abuse, and/or whose children have.
- The *Into the Mainstream* strategy (Department of Health 2002a) needs to be integrated with other policy initiatives more closely – especially public health, social and criminal justice, child and family welfare programmes and *Inside Outside* (NIMHE 2003b).
- Specialist and accessible crisis and respite services should be developed to support BME women who are experiencing severe mental distress, including attempted suicide and self-harm.
- Research is needed to obtain accurate information about the mental health needs of BME women in general, including information on pathways into care, women in the criminal justice system and those groups thought to be vulnerable to suicide.

Refugees

- To identify need and develop appropriate service responses, commissioners and service providers need to establish mechanisms to consult with local refugee community organisations, service users, families and carers.
- Access to services can be facilitated by making information about services available in a range of media, such as leaflets and videos. All information should contain appropriate images and language.
- Translation and interpretation services should be available to service users, families and carers.
- Staff should receive training and information about the rights of refugees and asylum seekers to health and social care.
- There should be places set aside for people to pray. For example, for Islamic refugees this could simply be a quiet room, or people may even be able to attend a local mosque.
- For people who are detained and unable to leave the hospital, arrangements can be made with the local clerics or with refugee community organisations. They should be consulted about religious festivals and holy days.

If these recommendations are taken seriously by everyone who is involved in providing mental health services to BME communities, we can make significant strides towards improving the outcomes for and experiences of service users, families and carers.

Introduction

The need for change in mental health services, and the need to change and improve the experience and outcomes of care for black and minority ethnic communities, has been well documented. This working paper collates evidence from published literature and telephone and face-to-face interviews with key informants.

The particular aim was to explore new developments, and not to revisit ground that has already been covered. Accordingly, this working paper provides:

- a snapshot of the changes over the past five years
- reflections on the current situation for black and minority ethnic communities in London
- a discussion of the implications for the future.

Developments in the field of mental health and other related areas over the past five years have seen a great deal of activity, particularly in the policy arena. These developments are explored in greater detail in later sections of this working paper. Epidemiological studies have not been included in this review because evidence about the over and under-representation of black and minority ethnic (BME) communities has already been established, and will only be reported to provide the context for this report. The importance of this evidence, and the gravity of the concern that surrounds it cannot be underestimated.

A key question remains: can anything new be said when the commentaries from BME communities suggest that no real and lasting change has been achieved over the past five years? We assert that the 'litmus test' for change is whether BME communities see positive changes in their experiences and outcomes of mental health services for service users, families and carers.

Specialist services for children and adolescents, services to older people, forensic services and services for psychosexual disorders or substance misuse have been excluded from this review.

Terminology

Diversity

The concept of 'diversity' is relatively new in the UK, and includes the following dimensions:

- nationality
- birthplace
- gender
- sexuality
- ability
- age
- religion
- ethnicity.

For the purposes of this review, ‘diversity’ refers to ethnicity, with specific focus on people from minority ethnic backgrounds, including the Irish community and BME women. The term ‘BME’ is used as shorthand, and references will be made to specific groups where necessary, or when authors are referenced. This should not imply that the heterogeneity in these communities is being denied or overlooked (Coker ed 2001).

The Irish community has been included in this review because it is the largest white minority group in London and findings show marked differences in the levels of mental illness in this group as compared to other white groups. Including the Irish does not signify that all forms of racism and discrimination are equal, but we believe that the processes, structures and attitudes that make it possible to be racist towards, and have stereotypical views about, one group applies to all groups that are viewed as ‘other’ in the UK.

‘Diversity’ is a problematic term because it seems to have become another shorthand term for referring to non-white people. More importantly, we assert that it can be used to obscure the individual and institutional racism that exists. Racism is an undeniable dimension of the BME experience, and the disadvantages and inequalities that arise from this cannot be ignored. Following the lead of Shashidharan (NIMHE 2003b), this working paper focuses on ethnic inequality rather than ethnic diversity. A key recommendation of this working paper is that mental health services should actively strive to eradicate inequality while celebrating and promoting diversity.

Race

We have used the term ‘race’ for want of more accurate terminology, but it should be remembered that various authors (see, for example, Chaturvedi 2001) have questioned its use because it has been used to create artificial distinctions between groups based on supposed genetic variations.

The context

Census data of 2001 (White 2002) shows the size of the minority ethnic population as 4.5 million (7.6 per cent) of the total population of the UK. This data suggests an increase of 44 per cent between 1991 and 2001. Figures show that London still has the largest representation of BME communities. Almost half (48 per cent) of the total minority ethnic population lives in the London region, where they comprise 29 per cent of all residents. In some boroughs, they comprise 48 per cent of the local population.

BME groups have a younger age structure, with the mixed group (which included white and black Caribbean, white and black African, white and Asian, and other mixed) showing that 55 per cent are under the age of 16. Findings of this nature present serious challenges for mental health promotion and the need for clear directives for young people – especially, for example, given the fact that young black men are over-represented in mental health services, and given the high rates of suicide among young Asian women. Census predictions are that progressive ageing is anticipated in minority populations, which has implications for service planning and provision for this sector of these communities.

Indicators show that certain BME communities are disproportionately affected by deprivation. For example, unemployment rates for Bangladeshi men are at 20 per cent and for African-Caribbeans at 15 per cent, whereas for white men the rate is 5 per cent. Unemployment rates for men from all groups show much higher rates among young men under the age of 25. Unemployment rates for young Bangladeshi men are at 44 per cent, and for African, Caribbean, Pakistani and young men from mixed groups between 25 and 31 per cent, whereas the comparable rate for young white men is 12 per cent (White 2002).

The significance of the issue

Evidence has shown that the mental health needs of these groups are often not met, and that services responses and approaches have not always been the most appropriate or relevant (Bhui ed 2002). Findings for mental health and mental health services indicate high levels of disadvantage and inequality for BME communities. The evidence shows that individuals from BME communities are more likely to be subject to:

- over-diagnosis of schizophrenia and under-diagnosis of depression or affective disorder.
- compulsory admission under the Mental Health Act, 1983 (Mental Health Act Commission 1999)
- involvement of police in admission to hospital and the use of Section 136/137 of the Mental Health Act, 1983
- over-use of psychotropic medication
- admission to medium- and high-secure facilities
- excessive admissions to hospital, especially via the courts.

They are less likely to be referred for psychotherapy, psychological treatments, counselling or other complementary treatments (see Bhugra and Bhal eds 1999 for a full overview of the evidence).

General health sectors seem to have taken account of inequalities. However, in the field of mental health, the response to calls to reduce inequalities has been slow. The Government's modernising agenda has inclusion, diversity and anti-racism at its heart. The Acheson Report of the Independent Inquiry into Inequalities in Health (Acheson 1998) found that London showed specific problems, including high levels of mental health problems. It recommended that as part of health impact assessment, all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities, and formulated in such a way that by favouring the less well-off, they will, wherever possible, reduce such inequalities.

More specifically on mental health, the report recommended the development of services that are sensitive to needs, and that the needs arising from ethnicity should be considered in needs assessment, resource allocation, health care planning and provision.

The status quo in 1997

- Refugees had a major presence in London, with high levels of unmet mental health needs. Providing effective, acceptable and appropriate care was a central issue for planners, commissioners and providers.
- Statutory services were not effective in detecting mental health problems across minority ethnic groups.
- Professionals had a limited understanding of how to adapt their ways of working to come to a full understanding of the needs and problems of people who did not share their background.
- Research had not addressed the concerns of these communities
- Apparently successful models of good practice had been established in the voluntary sector.

Recommendations for change

The 1997 report (Johnson et al 1997) recommended:

- There should be greater consultation with BME communities.
- Inpatient wards should be made more acceptable environments by providing bilingual workers, female-only wards, accessible places of worship and integration of non-medical and social models of care giving.
- Culturally sensitive training should be an integrated part of the core of professional and continuing education training for all professionals across statutory and non-statutory providers of mental health care.
- The expertise of voluntary and statutory providers need to be integrated both centrally and locally and more effective ways of working jointly needs to be developed.
- The workings of the Mental Health Act in relation to black and minority ethnic communities need to be examined.

We have used this set of recommendations as a framework to review developments in mental health services over the past five years.

Key developments 1997–2003

The care and treatment of black and minority ethnic people with mental health problems has been the subject of numerous policy initiatives at local and national levels.

Developments in policy over the past five years show increased activity in this arena (see Appendix 1 for an overview). The Mental Health Act Commission (biennial reports in recent years (seventh and ninth) have concluded that: services for patients from minority ethnic communities often remains basic, insensitive, piecemeal, leading to patients feeling alienated and isolated (Mental Health Act Commission 1997, 1999).

Policy developments at national level

In this section, we examine three key policies in more detail. We believe that these offer a framework and guidelines for developing and providing services that can meet mental health need in BME communities. These are:

- the Race Relations Amendment Act
- the National Service Framework for Mental Health
- Inside Outside.

The Race Relations Amendment Act 2000

Two key drivers for change have been the Stephen Lawrence Inquiry, also known as the MacPherson report (MacPherson 1999) and the introduction of the Race Relations (Amendment) Act 2000 (The Stationery Office 2000). For the first time in the UK, there has been public recognition that racism is embedded in our institutions. The term ‘institutional racism’ was introduced in the UK to define the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. The MacPherson report called on all public institutions to review its policies, measure their outcomes, and to develop mechanisms to guard against disadvantaging any section of the community.

Subsequently, the Race Relations (Amendment) Act 2000 was declared to:

- eliminate unlawful discrimination
- promote equality of opportunity
- promote good race relations between persons of different racial groups.

More specifically, the Act places a statutory duty on all health and social care agencies to work to eliminate unlawful racial discrimination and demonstrate evidence in the following areas:

- identifying functions and policies that are relevant to the duty
- assessing and consulting on the impact the organisation’s policy proposals are likely to have on the duty to promote race equality
- monitoring the effects of its policies on different groups
- publishing reports on its assessments, consultations, and monitoring every year
- ensuring everyone has access to information about its work, and to its services

- publishing a race equality scheme
- setting up race equality objectives for all its partnership work, and for work carried out under its contracts
- arranging to train its staff on the duty
- monitoring staff, applicants, and employment processes by ethnic group.

We eagerly await evidence of the impact of the Act on service delivery to BME communities.

The National Service Framework for Mental Health

The Government's modernisation agenda was introduced to establish a set of standards for mental health service provision in England and Wales (Department of Health 1999). Emphasis was placed on the needs of adults from BME communities and other groups that are known to be particularly disadvantaged. Standard One of the National Service Framework (NSF) stipulates that all mental health services should promote mental health for all, working with individuals and communities, and that these agencies should combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

The Mental Health Policy Implementation Guide (Department of Health 2002b) issued alongside the NSF, gives clear guidance on meeting the mental health needs of BME communities. It offers a framework for equality impact assessment requiring all health authorities to establish multi-agency local implementation teams to prepare for the implementation of the NSF. These teams are responsible for reporting to the Department of Health on progress in implementing the NSF. These structures created opportunities for partnerships across health and social care sectors, service users, and families and carers. However, social care sectors have reported that they are not seen as equal partners (Newbigging 2001).

Partnership with service users, families and carer involvement was also reported as patchy, and there was no infrastructure to support involvement. Engagement of practitioners was less successful because the NSF was perceived as a managerial agenda, rather than a practice agenda (Newbigging 2001). The box on p 6 provides an overview of the implementation of the NSF recommendations in relation to BME communities.

Implementing the NSF in London

The implementation guide identified specific actions, which need to be taken by local trusts and implementation teams with regard to BME communities. It required that a review of the local population needs to be carried out, including:

- ethnic breakdown of the general population
- community languages spoken
- religious diversity
- housing types (including homelessness)
- unemployment
- any vulnerable groups.

More specific data needed includes:

- ethnic, linguistic, religious, age and gender breakdown of service users
- linguistic, religious, age and gender breakdown of staff (at all levels)
- organisational policies on racial equality, ethnically equitable services, and so on, and results of any measures/audits of the policies
- representation of ethnic groups on (executive and non-executive) committees and boards within the organisation
- availability of interpreting services and their range of languages (the training received by interpreters and by health staff in how to work with interpreters in mental health settings should also be available for scrutiny)
- data from any previous audits or evaluations on cultural sensitivity.

Other issues to look at include whether there are multi-faith places of worship in hospitals. The implementation guidance suggests considering the following elements when developing a strategic approach to addressing problems identified by an audit:

- the human resources strategy, including promoting best practice in recruiting and retaining staff from minority ethnic groups across the range of disciplines
- anti-discriminatory policy and monitoring
- partnerships with voluntary and independent providers
- interpreting and providing good practice guidelines to address linguistic diversity
- staff training needs
- shortfalls in organisational procedures and practice
- service user-staff matching, including matching staff mix to local population diversity
- service-user views of the cultural and religious aspects of service
- a service user/staff/voluntary sector forum (feeding directly into the trust board)
- advocacy services for people from minority ethnic groups.

These are all specific measures. They do not prescribe methods for improving services directly, but focus on the pre-requisites for culturally sensitive services, such as effective monitoring and audit. However, if service providers implement these measures, it is an important step towards the desired goal of more relevant and appropriate services.

In autumn 2001, each local implementation team was asked to assess the progress in their borough on a number of specific areas, two of which related specifically to black and minority ethnic mental health services.

Data provided by the London Development Centre for Mental Health (2003).

Tables 1 and 2 (*see below*) show how the different local implementation teams (LIT) assessed progress for these two areas. A traffic light system was used to measure progress, with red signifying no progress, amber showing some progress and green indicating adequate progress.

Table 1: Services for black and minority ethnic people

Traffic light	Red	Amber	Green
No. of LIT reports of their position as at autumn 2001	1	13	0
Definitions of 'traffic lights'	No assessment made of needs of local black and minority ethnic communities	In consultation with service users and their carers, an assessment has been made of the needs of local black and ethnic minority communities, but services are inadequate or inappropriate to meet these specialist needs	In consultation with service users and their carers, an assessment has been made of the needs of local black and ethnic minority communities, and services are in place that are mostly or entirely adequate, and are appropriate to meet these specialist needs

Table 2: Representative workforce

Traffic light	Red	Amber	Green
No. of LIT reports of their position as at autumn 2001	1	13	0
Definitions of 'traffic lights'	Local services have no systems or strategies in place to build a workforce that reflects the diversity of the local population, or to promote cultural competence in the workforce	Local services have some systems and strategies in place to build a workforce that reflects the diversity of the local population and to promote cultural competence in the workforce	Local services have comprehensive systems and strategies in place to build a workforce that reflects the diversity of the local population, and to promote cultural competence in the workforce

From the above information, we can conclude:

- Most local implementation teams have assessed the needs of BME communities, but few could demonstrate that they were meeting those needs
- Most have developed systems to establish a more representative workforce of the communities served.

Inside Outside

This publication, with the full title *Inside Outside: Improving mental health services for black and minority ethnic communities in England*, is the first national policy document to specifically address the issues of 'race' and ethnicity in mental health services. The recently launched plan is aimed at 'reducing and eliminating ethnic inequalities in health service experience and outcomes' (NIMHE 2003b, p 36).

It proposes a strategy to:

- reduce and eliminate ethnic inequalities in mental health service experience and outcome
- develop a culturally capable workforce
- build capacity within black and minority ethnic communities and the voluntary sector.

A consultation process is in progress, and its results will be used to inform the implementation strategy that will be led by NIMHE.

Policy developments at local level

The NHS Executive for London outlined a plan for mental health services in London and determined specific outcomes for BME communities (NHS Executive 1999). These included:

- to establish a London-wide black and minority ethnic advisory group to advise and inform the development of mental health services in London that were sensitive to the specific needs and preferences of BME communities
- to ensure that mental health services should reflect the ethnic and cultural needs of the local population
- to ensure that the workforce should be representative of the local population
- to promote anti-racism and cultural-awareness training at undergraduate, vocational and continuing professional development courses
- to promote piloting of new ways of serving dispersed communities.

These recommendations have now been incorporated into the activities of the London Development Centre for Mental Health (LDCMH), launched in July 2002.

London Development Centre for Mental Health

The NHS Plan (Department of Health 2000a) made provision for establishing different structures for delivering mental health services. Regional development centres have now been established to support the implementation of national policy on mental health, and the development of services required to implement the NHS Plan. The centre has been in operation since July 2002, so it may be too early to report on achievements in relation to BME communities. However, through consultation, it has identified the mental health needs of BME and refugee and asylum-seeker communities as one of its priority areas of work (London Development Centre for Mental Health 2002, p 12).

With regard to refugees and asylum seekers, the centre will aim to:

- find out more about the barriers that asylum seekers and refugees face in accessing appropriate mental health care, and the numbers and needs of asylum seekers in London
- identify current initiative and good practice, including employment of refugees in health and social care.

Priority areas of work for BME communities will include:

- responding to the Department of Health plan to improve mental health services for these communities
- funding a post within the Greater London Authority to support its work on race and mental health
- collaborating with the London Race Equality Group
- developing proposals to improve access to, and build capacity of, mental health services for black and minority ethnic groups, within the current framework of legislation and policy.

In summary, we suggest that these initiatives and directives provide opportunities for change in the following areas:

Service dimension	Policy directive
<ul style="list-style-type: none"> ■ Promoting 'race' equality in service planning, provision and delivery ■ Assessing need at community and individual levels ■ Engagement and consultation with BME communities ■ Workforce development 	<ul style="list-style-type: none"> ■ Race Relations Amendment Act (2000), NHS Plan (2000), Inside Outside (2003) ■ NSF (1999) ■ NSF (1999), NHS Plan (2000), Inside Outside (2003) ■ NHS Plan (2000), Inside Outside (2003)

Major studies since 1997

This section is a selective review of some of the studies that have been produced in the past five years, shown in descending chronological order. (An earlier report on the Irish is included to highlight issues for this community.) It serves to illustrate the major concerns for these communities.

A common theme continues to emerge from the major studies examining the experience of BME communities in mental health services over the past five years. The evidence still shows that many BME people continue to have very negative experiences and poorer outcomes of mental health services than other people.

Breaking the Circles of Fear: A review of the relationship between mental health services and African and Caribbean communities

Keating et al (2002)

This report, carried out by the Sainsbury Centre for Mental Health, found that:

- There are 'circles of fear' that stop black people from engaging with mental health services.
- Mainstream services are experienced as inhumane, unhelpful and inappropriate.
- The care pathways of black people are problematic, primary care involvement is limited and community-based crisis care is lacking.
- There is a divergence in professional and lay discourse on mental illness.
- Service user, family and carer involvement is lacking.
- Conflict between professionals and service users is not always addressed in the most beneficial way.
- Black-led community initiatives are not valued.
- Stigma and social inclusion are important dimensions in the lives of service users.

The report made 15 recommendations, one of which was that gateway organisations should be commissioned to develop bridge-building programmes to support reintegration of service users with their communities. The Sainsbury Centre for Mental Health has secured funding to implement some of the recommendations, but still a great deal of work remains for statutory bodies to respond to these.

No Change

Rethink (2000)

This report, by Rethink (formerly the National Schizophrenia Fellowship), found that black people reported:

- more negative experiences of mental health services
- higher levels of dissatisfaction with services
- greater use of detentions under the Mental Health Act (1983)
- more frequent experiences of being forcibly restrained.

A significant number felt that their cultural needs were not taken into consideration in the care they received. Rethink has now employed a national race equality advisor to lead service development for these communities.

Barriers to Meeting the Mental Health Needs of the Chinese Community

Chinese National Healthy Living Centre (1999)

This national study set out to identify barriers to obtaining help. It found that:

- 98 per cent of the Chinese community were registered with a GP, but only 38 per cent used their GP as the first port of call for support. Chinese doctors and community workers were consulted instead and in cases of severe need they used accident and emergency departments.
- 71 per cent did not realise their symptoms were those of mental disorder
- 61 per cent were not fluent in English, yet only a few had access to an interpreter
- 25 per cent did not know what sort of mental health services were available.

Raised Voices

Mind (1997)

This study surveyed 100 African and Caribbean service users across England and Wales, and found that respondents felt that they were misunderstood because they were feared, stereotyped or ignored. This led to a lack of trust in services and an unwillingness to engage with mental health services.

Researching Irish Mental Health: Issues and Evidence – A study of the mental health of the Irish community in Haringey

Muintaras (1996)

This study found that:

- Irish people had the highest overall psychiatric admission rates compared to any other group.
- Rates for Irish women were particularly high.
- Rates of admission for depression and alcohol abuse were highest compared to all other groups.
- There was significant under-use of statutory community based resources.
- Irish social and welfare organisations were perceived as important sources of support by service users.

According to Mary Tilki of the Federation of Irish Societies (personal communication 2003), there is evidence that little has changed for this group. She suggests that the Irish community continues to be excluded from regional and national mental health strategies a situation that requires immediate and urgent attention. There is greater need for consultation with the Irish community to develop strategies and responses that are sensitive and appropriate to their needs. (For a more comprehensive overview of these issues, see Tilki 1998).

A key theme in all these studies is that despite a growing body of evidence about the high levels of unmet need and inappropriate service responses to BME communities, there is little evidence that this intelligence informs service planning and delivery.

The current situation

This section aims to assess to what extent the initiatives listed on the preceding pages have affected change. It has to be acknowledged that some of these initiatives are relatively new and will not have been subjected to evaluation. We have used the recommendations of the previous King's Fund Mental Health Inquiry (Johnson et al 1997) as a framework for discussion, except for the recommendation on the Mental Act 1983, as this was under review at the time of writing this working paper.

Consulting with communities

The reorganisation of NHS and local authority structures and systems to support work for the health and wellbeing of local communities presents opportunities for community involvement at local level. In addition, health action zones (HAZs) seem to provide a mechanism for community consultation and involvement.

Health action zones are partnerships between the NHS, local authorities, community groups and the voluntary sector to address inequalities in health. Seven principles underpin the work of HAZ teams. They are:

- achieving equity
- engaging communities
- working in partnership
- engaging frontline staff
- taking an evidence-based approach
- developing a person-centred approach to service delivery
- taking a whole-systems approach.

The four London HAZs are:

- Brent
- Camden and Islington
- East London and the City
- Lambeth, Southwark and Lewisham.

A range of projects have been developed to reduce inequalities in general health, and specifically in mental health. The following case study highlights one such initiative, to illustrate what can be achieved through effective consultation and partnership working.

There are also various structures and opportunities for working closely with BME communities to increase access to services, such as the Antenna Outreach Service in Haringey, which was launched in July 1999 to reach young African-Caribbean men with mental health problems. An evaluation of this service (Greatley and Ford 2002) found that it was able to engage effectively with the wider community through establishing partnerships across a range of stakeholders.

We believe that partnership working based on principles of equality and inclusion points the way forward. This principle is explored in detail in the final section of this paper.

Case study: Mellow (Men Emotionally Low Looking for Other Ways)

Following an in-depth needs assessment, Mellow was launched, to:

- address the over-representation of young African and Caribbean men in psychiatric services in east London
- promote better mental health services among African and Caribbean men
- develop better community-based services
- work in line with government health and social care reforms
- take into consideration the effects of racism, and personal and racial identities.

The project is using local knowledge and networks to develop an agenda that is shared and owned by all the relevant stakeholders. An evaluation of their work (Mentality 2002) shows that Mellow has been successful in:

- empowering service users
- improving mental health services
- influencing the policy agenda locally
- involving the wider community.

Some of the difficulties for the project are that mental health professionals perceive non-medical interventions as less credible than a more clinical approach, which means that these tools do not receive sufficient support and recognition. Some staff in mainstream services are resistant to acknowledging the project and its approach, and this is still an issue.

Project co-ordinator Sandra Griffiths suggests that a possible reason for this is that when comments are made about the failure of services to address and meet the needs of BME communities, there is a perception that the implied criticism is about a lack of commitment and a lack of achievement. She recommends that there should be safe spaces for black and white professionals alike to discuss their mutual concerns, but also to be better informed, and to work from a knowledge base with which they can engage.

A key lesson from this project and its success is its dual identity – that is, on the one hand it is independent (through an independent advisory body), while on the other had it is part of mainstream services. Consequently, it can influence the agenda in the community and mental health services alike, and build bridges between the two. Due to its ability to interface both with mainstream services and with the wider community, the project has gained credibility in both spheres.

Inpatient wards

The 1997 King's Fund Inquiry (Johnson et al 1997) made specific recommendations relating to inpatient care. However, this component of care still receives the greatest level of censure. A range of studies (see SCMH 1998, Baker 2000, Department of Health 2000b) have highlighted concerns about the untherapeutic conditions on psychiatric wards and the adverse effects of the ward environment on the experience of mental health services.

More specifically, for African and Caribbean communities, Keating et al (2002) found that when acute care was discussed, service users expressed high levels of fear and apprehension. It was evident that hospital care dominated thinking about mental health care as a whole. A comment from one service user summed up this idea:

I remember when I first went into hospital... I feared that I was going to die.

(Personal communication 2002)

Acute inpatient care has received attention in terms of policy guidance on the implementation of mental health policy (Department of Health 2001). Two additional areas of guidance were issued for adult inpatient care units and low secure environments and national minimum standards for these services (Department of Health 2002b). More specifically, this guidance sets out a minimum set of standards on issues related to ethnicity and gender. These include assessment that is sensitive to ethnic and gender need and access to interpreting services.

Attempts have been made to improve life on the wards. For example, the Sainsbury Centre for Mental Health is currently involved in a project to change the culture on acute wards. There are pockets of good practice, but there is very little evidence that these have been incorporated into practice. (*For a description of an initiative on an acute ward, see Appendix 2.*)

Culturally sensitive training

In seeking to explain patterns of health, illness, service utilisation and provision to people seen as 'other', the major explanation that is forwarded is one of culture. The entire debate around the relationship with mental health services tends to be articulated as an issue of culture or cultural complexity. For example, Galanti suggests that:

Patients differ in many ways. Some of these differences are due to patient illness, personality, socioeconomic class, or education, but the most profound differences may be cultural.

(Galanti 2000, p 335)

However, this 'culturalist' approach is said to have a negative impact on the provision of care, because, it is argued, professionals misunderstand the notion of culture as a result of prejudice, and stereotyping increases the chances of misdiagnosis and inappropriate treatment (Burr 2002). It should also be remembered that people have individual beliefs and values that may differ from the shared norms and values within their cultural background. In other words, people are more than simply instances of any given culture.

Training on issues of 'race' and cultural awareness has long been viewed as the vehicle for changing practice. However, Keating et al (2002) found that conventional training does not prepare staff adequately to provide models of care that are valued and respected by service users, families and carers. The study recommends that training programmes should be short, focused and built around the needs of each staff group, and the communities they serve.

A national study of 412 local authority departments to survey the implementation of the NSF and its recommendations on cultural diversity (Birtwistle 2002) found that training received by fieldworkers was patchy. For example, only 37 per cent of staff reported having received training in anti-discriminatory practice, and the majority of these were approved social workers, who needed to demonstrate their ability to work in an anti-discriminatory manner to achieve the approved status. The study concludes that urgent attention is needed to ensure that all staff, managers and care pathways are culturally competent.

Professional training bodies are currently heeding to calls to address issues of 'race' and culture in basic training curricula. For example, Moodley (2002) describes the approach of the Royal College of Psychiatrists to developing such a curriculum to build a culturally capable workforce. Such initiatives are welcomed, because they could ensure that professionals are equipped with knowledge and skills at the outset of their careers, and not when they have already become part of institutionalised practices.

Mental health trusts have incorporated training into their race equality strategies. For example, the St George's Mental Health Trust has adopted a 'zero tolerance' policy on racial harassment, and has introduced a two-day training module for its entire staff complement. Camden and Islington Mental Health NHS Trust and the Barnet, Enfield and Haringey Mental Health NHS trusts have piloted a model of training to promote cultural competence among mental health staff from selected services in these trusts (*see Lees et al 2002 for a full discussion*).

However, these training initiatives have largely failed to achieve substantive change in the various areas where they have been delivered, whether in local authority social services or in the criminal justice system. Training courses around race or diversity issues have tended to centre on a series of abstract, ethical positions that have often been attacked as being too psychological, personal (London Strategic Policy Unit 1987) or 'politically correct'.

We suggest that service providers and training bodies need to be careful about instituting yet more training – especially of the 'cultural competence' type, as there is no way of evaluating its impact on practice. More importantly, we believe that any training initiative on 'race' equality should be an integral component of an overall race equality strategy.

Black voluntary-sector agencies

The Department of Health has acknowledged the positive contributions of the black voluntary sector to mental health service provision, and has been noted that it is vital to the success of the mental health system (Department of Health 2001, p 95). Users value the services offered by this sector, yet there is little evidence to show that expertise in this sector is integrated into mainstream services. These organisations still report having to work with limited resources, with detrimental implications for organisational growth and development (Keating et al 2002). There is an urgent need to build capacity in these organisations.

It has been suggested that measures to support and sustain these organisations need a much more prominent and central role (McLeod et al 2001). Capacity-building programmes should be developed in terms of the needs of BME voluntary sector organisations. It should not only be about developing administrative and management

infrastructure, but also about helping or enabling BME organisations to deliver and develop services (McLeod et al 2001).

Developments in service-user involvement and activities

The Sainsbury Centre for Mental Health recently conducted a study to explore the development of the service-user movement in the UK, and to assess the extent of service-user involvement (SCMH 2003). In a survey of 312 user groups in England and Wales, 72 per cent reported that they were involved in local services.

However, when the study examined the issues and concerns specifically of black Service-user groups, it found that these groups were generally not involved in service developments and planning at local level. Most of them were in the early stages of development, and seemed to focus more on the needs of the group rather than externally paying attention to involvement in local service delivery. They were characteristically under-resourced, lacked access to supportive infrastructures and countenanced an array of barriers and obstacles to development. However, there are pockets of good examples, one of which, SIMBA, is described overleaf.

Other groups

To our knowledge, there are very few groups like SIMBA in London. Two other such groups are London's Black Women's Mental Health Project and the Black Unity Forum in Kensington and Chelsea.

Greater London Action on Disability (GLAD) recently launched a project called Black and Ethnic Minority User Action, which aimed to map developments in black service-user action, and to support and develop infrastructure among black service-user groups. Project development worker Millie Reid reports having found that most black user groups are run by professional workers. These groups fulfil a range of functions, including arranging cultural activities, events, outings and general support. This has implications for developing and building independence among group members. There is a perception that groups led by service users have greater appeal to other users, and that service users find them more empowering.

Case study: SIMBA

One of the few groups that have been able to overcome some of these barriers is Share in Maudsley Black Action (SIMBA), established in 1999. SIMBA emerged organically – its formation was inspired by black members of a mixed service-user group who felt that they needed a separate group to address their specific needs and concerns as black service users.

The group adopted various roles in relation to its membership and the local trust. Initially, it aimed to meet the needs of the members through support on the wards, and facilitating self-awareness and identity-building activities through music, poetry and creative writing.

SIMBA decided that the more traditional mechanisms for service-user involvement did not serve its purposes, so it embarked on different strategies of action. For example, it decided to communicate its concerns to the trust board in the medium of a poetry performance to portray their experiences of services. One of its key successes was to secure funding from the trust for a development worker. This worker, Robert Jones, has now been in post since April 2002. His tasks include:

- to develop legal structures to enable the group to operate as a legally constituted organisation
- to attract additional funding to secure stability and continuity of the group
- to expand membership
- to develop the range of activities
- to oversee day to day operational matters.

In a face-to-face interview, Robert Jones reflected on the advantages and disadvantages of receiving funding directly from the trust. He believes that it has given the group access to information and the trust infrastructure, as well as greater credibility within the trust. The funding is short term, and this causes a great deal of uncertainty over the future of the group and its ability to be self-sustaining.

SIMBA's capacity to sustain action has fluctuated, due to a variety of reasons. Robert suggests that some of these difficulties are compounded by an institutional culture, in which innovation is not valued, and where staff and managers give more focused attention to central policy initiatives than to strengthening local service users' voices.

Robert suggests that individuals should be empowered to take control over situations. He believes that the policy agenda should be driven by service users' need and should be aimed at improving the quality of life, both on the wards and in the community. This initiative has not been evaluated, but monitoring reports show that there is consistency around meetings, membership has increased and become more stable, and new activities have been developed – for example, a black book club to provide free access to culturally specific reading materials during hospital stays and post-discharge.

The challenge for this group is to continue to develop and sustain its capacity to be a voice for black service users.

Families and carers

There is growing awareness of the needs of carers in general, but there is a serious lack of evidence about the needs and wishes of carers of people with mental health problems (Keating et al 2002). The NSF specifically recommends that carers should have their needs assessed separately from the person they are caring for, and that a care plan for the carer should be derived from this assessment. However, there is evidence that this is not happening.

A compounding factor is that the needs of families and carers are often conflated with those of service users. There has to be an acknowledgement that their needs are different – and often competing – and that they must be addressed separately, rather than under the rubric of service-user involvement. Moreover, the assumption is often made that family members are the ‘natural’ or usual carers. How carers are perceived, and the models used to understand the caring role and its various dimensions, should be of concern for mental health services.

Black carers face significant challenges due to stereotypical views about caring in their communities. For example, stereotypes relating to extended families and notions that ‘they look after their own’ can serve to hinder effective service interventions and support for carers.

Achieving change

Partnership and engagement with black and minority ethnic communities are key principles for achieving change. However, independent evaluations show that there are still significant barriers to engaging fully with black communities (Bitel and Hill 2001, Levenson and Jeyasingham 2002). Local strategies do not give enough prominence to issues of ‘race’ and ethnicity. Furthermore, in areas of innovation, there was not enough evidence that these had fundamentally altered what Levenson and Jeyasingham (2002) term ‘cultural viewpoints’ on how best to improve health and health services. Overall, Levenson and Jeyasingham found that obstacles to engage or reach BME communities were entrenched in broader issues, such as funding arrangements, performance management and community development.

Representation of – and by – BME communities, and how this is conceptualised, is another factor at play. More often than not, workers in the BME voluntary sector act as representatives of – or spokespersons for – BME communities. In a focus group that we held with directors and managers from black-led services to explore ideas about leadership, the participants held an overwhelming view that they were often used as community leaders by statutory services, despite not perceiving themselves as leaders in this context.

The danger of treating senior staff in this way is that they become gatekeepers to these communities. More importantly, organisations that are not perceived as established, stable and well organised are excluded from consultation processes and decision-making structures. This can lead to unhealthy competition between these organisations, further entrenching the inequalities that exist. Although inconclusive, this has implications for how leadership is conceptualised in different communities. Our view

is that this issue needs closer analysis if services are aiming to use community leaders as a mechanism for engaging with BME communities.

This section has reviewed some of the initiatives and practice that ensued from this. It demonstrates that there are a number of opportunities and mechanisms in place to achieve positive change in mental health services for BME communities. Key concerns still remain, including how to:

- overcome barriers to change
- engage usefully with BME communities
- breach the implementation gap between policy and practice
- sustain initiatives and developments.

These are discussed in more detail in Conclusions and recommendations, p 47.

Black and minority ethnic women

In this section, we focus on women from the largest BME communities in London: African-Caribbean, Asian, and to some extent on Irish women, although many of the issues referred to will also be significant for other communities of BME women.

We examine some key issues for women in general, and discuss the recent consultation document on mental health care for women, *Into the Mainstream* (Department of Health 2002a) and the National Suicide Prevention Strategy for England (Department of Health 2002c). We also outline some of the research findings relating to BME women, and highlight areas for further investigation and action.

There is a significant level of need among black and minority ethnic women that is unmet within mainstream mental health services. Later in the section we refer to literature that points to a potent mix of gender blindness and negative views of minority cultures as key underlying factors that result in the needs of BME women being severely neglected across the spectrum of research, policy development, service provision and practice.

What is needed is a gendered understanding of race and culture for women and a recognition of the consequences of this for service provision. Action on these issues is long overdue.

Black and minority ethnic women – a profile

Black and minority ethnic women in the UK comprise an extremely diverse group and form a substantial proportion of London's citizens. London's BME women may have cultural and family ties in countries as diverse as Ireland, Somalia and China. Many of them will also have strong roots in the UK, particularly for many British-born black women, a significant number of whom are of dual heritage. Any consideration of the needs of BME women must bear in mind that these communities of women in London will encompass:

- single women
- mothers
- working women
- women with different sexual histories and orientations
- women who care for people with a range of disabilities
- women with disabilities of all kinds
- teenagers
- older women
- homeless women
- refugees and asylum seekers
- women in prison
- women with alcohol or drug dependency
- women who speak languages other than English as their mother tongue.

However diverse they are, all these women have one thing in common: a remarkable lack of presence or visibility in the literature relating to mental health need and service provision.

Although a body of writing has been developing specifically about BME women and their needs from the early 1990s, in relative terms, little detailed information is available on the experiences and numbers of women from BME communities who are affected by mental health issues. Much of the research reports either on gender or ethnicity, but rarely examines the interaction between the two. While we set out some of the key research findings relating to BME women later in this section, the lack of systematic inquiry into the needs of BME women in the literature available is apparent for example, in the lack of information about suicide rates for Irish and African-Caribbean women.

The context

Women's issues were not covered in depth in the initial Inquiry of 1997, so we begin with a brief overview of some mental health issues that are relevant for women from all communities. Evidence shows that there are clear gender differences in the prevalence and incidence of mental illness between men and women (Mind 2003a). Figures suggest that more women than men will experience some form of mental health problem – 20 per cent of women compared to 14 per cent of men (Bird 1999). Furthermore, figures suggest that two-thirds of people using mental health services are women (Black and Shillitoe 1997).

As has been mentioned in earlier sections of this paper, social deprivation (at high levels in inner London) is strongly linked to the prevalence of mental health problems (Bird 1999). Women tend to be subject to many adverse socio-economic experiences, making up two-thirds of the proportion of adults living in the poorest accommodation. Women are also more likely to be lone parents and are therefore more likely to experience social isolation and lack of mobility.

However, the over-representation of women in mental health statistics is not only due to these socio-economic vulnerability factors. It also stems from discriminatory attitudes within health and social care (which are embedded in the structures and processes of most mental health services), rather than being due to the attitudes of individual staff, many of whom are acutely aware of the issues women face (Williams and Scott 2002, Raine 2000).

Another variable in the complexities related to mental health service provision for women is how their mental health problems are conceptualised and perceived. Williams and Scott (2002) suggest that there is a dichotomy, in that services approach women's mental health from an individual pathology perspective, whereas service users consistently ask for a more holistic view of their lives. They sum up this difference in attitude as the difference between asking 'What is wrong with this woman?' as opposed to 'What has happened to this woman?'

Williams and Scott suggest that to overcome this fragmented view of women's lives, service planning and delivery need to be rooted firmly in people's social experience. Services must be able to understand and work with the fact that individual expression

of mental distress and requests for help will be affected by a range of aspects of women's identity, including their class status, age and gender, and their previous experiences, including any previous stigmatising experiences when seeking support.

A recent survey of attitudes to women's mental health services confirms previous indications that many service providers are aware of the paucity of mental health service provision for women (Williams et al 2001). This study notes failures to address women's needs for safety, including single-sex wards in hospitals and secure settings, and the lack of recognition of child-caring responsibilities, domestic violence and childhood abuse and need for social contact.

We now look at two overarching issues that are common experiences for many different groups of women, whatever their diagnosis or situation:

- the issue of abuse and violence
- issues concerning children.

Abuse and domestic violence

Research indicates that 50 per cent of women who see a psychiatrist report experience of sexual abuse (including non-contact abuse) as children (Perkins ed 1996). Young women who have been sexually abused are at risk of further abusive experience, early and lone parenthood and, in some instances, becoming vulnerable to drug misuse (Abel et al 1996, pp 42, 130).

Women with enduring mental health problems and women within secure services are more likely than men in similar situations to have:

- experienced sexual abuse by their father or stepfather
- been the victim of more than one abuser
- been 'in care'
- had numerous changes of placement (Williams and Scott 2002).

Sadly, these experiences are often compounded by women not being believed by services when they do take the difficult step of revealing their experience of abuse, or by further sexual harassment during inpatient stays (Warner and Ford 1998).

Domestic violence against women accounts for 25 per cent of all reported violent crime (Department of Health 2002a), and the actual figures are likely to be much higher. Agencies dealing with this issue, along with organisations such as Rape Crisis, are often left on the margins of mental health partnership working, rather than being perceived as having useful knowledge and expertise to offer (Chantler 2002). Even though the association between domestic violence and mental health has been established, Abel et al (1996) suggest we need a great deal more research to analyse this relationship.

In addition to the factors experienced by male and female refugees and asylum seekers alike – such as exile, war, famine, persecution and separation from family – refugees and asylum-seeking women may also have been subjected to violence and rape. As such, they are likely to have high mental health support needs in a context in which they

may face questioning about their experiences, often before they are able and willing to talk about these.

Women and children

Services seem to fail to take account of the needs of women with mental health problems who are also parents. A significant source of fear for women is that if they reveal their mental health problems, their children are more likely to be taken into care. Moreover, the mental health status of women and their need to access mental health services can be used by male partners in child custody disputes. In terms of generational issues, being in care as a child is a risk factor in the development of mental health needs in later life.

Given the high numbers of women in hospital and the fact that women provide the majority (and often sole) care for children and other dependants, issues concerning arrangements for the care of children when women are admitted to hospital remain of great concern. There is now some recognition that further action is required (NIMHE 2003a).

In addition, the provision for family visiting in most services is inadequate. The consultation document *Into the Mainstream* (see p 57) recommends:

- separate family visiting areas
- visiting environments appropriate for children of a range of ages, with access to refreshments, toilets and baby-changing facilities.

Research, service users and staff all identify adverse social experiences – particularly experiences of discrimination, abuse, domestic violence and being in care as a child – as critical and common factors contributing to women's mental health problems. However, dealing with these undoubtedly difficult experiences is seen as a specialist area of care, with public debate around issues of abuse and domestic violence in particular being very limited, even in mental health arenas.

This leaves those staff who are appreciative of the issues without access to support and supervision for themselves, while failing to address the need to change attitudes and practice among those services where women are routinely misunderstood, disbelieved and stereotyped as 'attention seeking' when they report what has happened to them.

We need to encourage wider debate and knowledge within mental health arenas about the social base for women's mental health needs. Additionally, we need to establish better working links with non-mental-health agencies. These agencies often have a great deal of experience of working to prevent and deal with the consequences of the range of social inequalities and problems (including racism) that women face in a range of settings, from child protection, domestic violence or welfare benefits to housing and employment.

Gender within the policy context

Many policy developments have taken place over the past decade (see pp 58–59). In this section, we refer primarily to two key policy developments since 2000: *Into the Mainstream*, the recent strategy for mental health care for women (Department of Health 2002a) and the *National Suicide Prevention Strategy* (Department of Health 2002c).

In total, the Government promised three service-based commitments for women at the beginning of this millennium:

- women-only (community) day services in every health authority by 2004 (Department of Health 2000a)
- removal of mixed-sex accommodation in 95 per cent of NHS trusts by 2002 (Department of Health 2000b)
- development of a strategy in relation to secure care for women (Department of Health 2000c).

Service specifications for day services and secure care are published in the *Mental Health Policy Implementation Guide* (Department of Health 2002b), together with an implementation plan.

Into the Mainstream

Into the Mainstream, the consultation document for the strategic development of mental health care for adult women of working age, was published by the Department of Health in October 2002. The strategy's key proposals include:

- providing gender-specific services that are supported at leadership level
- developing services informed by need and with the involvement of service users
- ensuring that the workforce is aware, informed, gender-sensitive and supported by management
- supporting the voluntary sector
- addressing the need for further research
- noting that in assessment, treatment and care planning, factors such as abuse, physical health, medication, housing, employment and caring responsibilities must be addressed
- emphasising mental health promotion – particularly for BME women and other vulnerable groups, including women involved in prostitution
- particular recommendations for specialist mental health services, including changes to the way women are placed in high security services.

Many of these proposals are welcome, highlighting as they do the broad areas that require action. However, the strategy is essentially very general with a checklist approach, leaving many complex issues underdeveloped and lacking sufficiently strong guidance and recommendations.

An example of this approach can be seen in Section 12 of *Into the Mainstream*, which focuses on developing services for women on the basis of specific experiences and challenges, such as:

- women with:
 - experience of abuse and violence
 - a diagnosis of personality disorder
 - a dual diagnosis with substance misuse
 - mental health problems before or after childbirth
 - eating disorders
- women who self harm
- women in prison.

The importance of this detailed discussion of the specific issues relating to women in these situations cannot be denied. However, considering women's needs largely on the basis of their diagnosis and situation does not address the fact that there will be a great deal of overlap within all these categories. Moreover, in doing so, the strategy inevitably neglects a whole range of women in other situations and with other problems, including asylum-seeking women, lesbian, bisexual and transsexual women, older women, homeless women and women with a diagnosis of psychosis.

Having acknowledged the broad social base of mental health problems for women, it is therefore unfortunate that the strategy proceeds to present the way forward for service design in a manner that compartmentalises women's lives.

Areas for development

If *Into the Mainstream* is to make a real impact on mental health care for women, some key measures in service planning, many which have been well documented in writing on women and mental health (for example, see Perkins 1996), need to be included, or given a much stronger emphasis within the strategy.

This would include issues such as:

- the recruitment, training and retention of quality staff, especially within inpatient settings (including discussion of the adverse impact of over-use of agency staff)
- access to core training and supervision relating to issues of discrimination, violence and abuse for all staff
- drawing on the strengths of the holistic working methods of many voluntary sector organisations and the expertise of service users to develop and expand mainstream service provision
- drawing up specific recommendations for complaints procedures
- providing access to suitable advocacy and information
- providing women with a choice of a female mental health worker.

All these factors are needed to facilitate a better outcome for women within mental health system settings.

BME women

Historically, groups of BME women have invariably been at best marginalised, or at worst, invisible or within forums concerned with either race or gender alone. Disappointingly, this pattern of marginalisation remains evident within *Into the Mainstream*. Only four substantive comments on the issues relating to BME women appear in *Into the Mainstream*, and even these are scattered throughout the document. The issues that merit inclusion are as follows:

- The document states that BME women are vulnerable to mental ill health and subject to the impact of a range of social, economic and political pressures. It acknowledges the existence of important differences between groups of women, and two particular patterns of mental health problems are highlighted, namely:
 - suicide, self harm and eating disorders among young Asian women
 - post-traumatic stress disorder and other mental illness in some groups of asylum seekers and refugees (Section 2.3.3).
- The document records the vulnerability of BME women to experiencing mental ill health at or around childbirth. It states that this vulnerability may be due to a range of cultural and circumstantial factors, including isolation, lack of access to family support due to migration or family pressures, racism and lack of suitable responses from statutory services (Section 12.5.3).
- The document states that assessment and care planning must take into account the ethnicity and culture of BME women and must recognise that racism commonly affects women from BME communities. It notes that services often fail to meet womens' cultural and spiritual needs (Section 9.1.5).
- It states the need for further research on the interaction of gender, ethnicity and culture, and its impact on mental health and illness (Section 7.3).

So it is not surprising that the national consultation process that was undertaken following publication of *Into the Mainstream* generated a wealth of feedback. This included strong comment on the absence of both a fuller discussion of, and detailed plans to address, the complexities and simultaneous discriminations faced by different communities of vulnerable women, including BME women (St John 2002, Ibrahim 2003).

The failure of the Department of Health to cross-reference *Into the Mainstream* with *Inside Outside* (NIMHE 2003), the consultation document on black and minority ethnic mental health care, serves only to reinforce the current divide and disconnection in debates around gender and race.

Although many issues raised within the *Into the Mainstream* public consultation period will be incorporated into the final strategy document (scheduled for publication by autumn 2003), these omissions represent a missed opportunity to place the mental health needs of BME women firmly on the policy agenda.

The National Suicide Prevention Strategy

The Department of Health published this strategy in 2002. It aims to support the target in *Saving Lives: Our healthier nation* (Department of Health 1997) of reducing the death rate from suicide by 20 per cent, by 2010. This strategy will be delivered as one of the core

programmes of the National Institute for Mental Health in England (NIMHE). The stated goals of the strategy are to:

- reduce risk in key high-risk groups
- promote mental wellbeing in the wider population
- reduce the availability and lethality of suicide methods
- improve monitoring of progress towards suicide reduction target
- improve reporting of suicidal behaviour in the media
- oversee research on suicide and suicide prevention.

The first goal, reducing the risk in key high-risk groups, includes targeting suicide by people who are or have recently been in contact with mental health services, as well as suicide following deliberate self harm. As women figure significantly in both categories, it is hoped that integrated prevention measures will be developed to target their specific needs.

The second goal deals with promoting mental wellbeing and lists a range 'vulnerable' groups within society about whom concern has been expressed and 'for whom additional specific measures should be taken' (p 13). These groups include:

- survivors and victims of abuse, including child sexual abuse
- members of black and minority ethnic communities, including Asian women
- women during and after pregnancy.

It is a matter of some concern that although some research evidence does exist, the strategy states that these groups are not considered high-risk groups because 'there are no satisfactory current figures and/or there are no research data suggesting the main preventive measures that should be taken.' However, the strategy does make a commitment to take steps to address these gaps in information.

With reference to BME groups, the strategy refers readers to a toolkit of health promotion for people from BME groups that is due for publication by NIMHE in late 2003. Secondly, it states that NIMHE will request the Coroners' Review Group to consider routinely recording ethnicity, to allow monitoring of suicide patterns. A commitment is also made to support the implementation of Into the Mainstream, particularly measures for women who have experienced violence and abuse.

In conclusion, services need to make an impact on the particular challenges facing BME women who have a need for mental health care. In order to achieve this, services will need to address:

- the need for and value of support in self-help settings (with facilitation, if necessary)
- the importance of spirituality for many BME women
- the provision of crisis and respite support
- the demands by BME women service users themselves to be involved in service planning and delivery (Parton 2003)
- the lack of appropriate advocacy services (Rai-Atkins 2002).

While we can welcome a strategy for women's mental health care as a positive development, Into the Mainstream does not currently offer the strong holistic vision that is needed. There needs to be development of initiatives on BME women's health, along

with clearer linking of the Into the Mainstream strategy with other key strategies and initiatives, such as:

- dual diagnosis guidance
- public health strategies
- the National Service Framework
- Inside Outside.

The launch of the National Suicide Prevention Strategy can be similarly welcomed. However, the strategy does not specifically mention that Irish people living in the United Kingdom have been noted to be more vulnerable to suicide (MHF 2003). It also remains to be seen how vigorously steps are taken to confirm the indications that suicide is a major concern for groups of BME women.

Developing services for BME women

Access to services: primary care

Most diagnosis and treatment occurs within primary care settings, so this is the setting in which most women with mental health problems are seen by health professionals, and most are treated here too. Women are more likely to be labelled mentally disordered than men (Corney and Strathdee 1996), yet are also less likely to be referred to a mental health professional than men.

The 1997 Kings Fund Inquiry catalogued a range of findings indicating adverse experiences by BME communities, including black women, in primary care. These included embarrassment, language difficulty and lack of access to information and same-sex GPs (Bhui ed 1997). Specifically, it appears that Asian and black African and Caribbean women are less likely to:

- have mental health problems identified by their GP than their white counterparts
- be offered follow up consultations than women of other groups.

However, they are more likely to be critical of their overall experience of primary care (Bhugra and Bahl eds 1999), so there is little to indicate any change since the previous Kings Fund Inquiry.

Some research into the prevalence of mental health problems in BME communities confirms differences in patterns of primary care consultation and indicates high levels of GP consultation for certain groups. The Bangladeshi group in Lloyd and Fuller's study (2002) reported high levels of physical problems to GPs. The authors concluded:

This raises important questions about the understanding of stress, access to services and the perceived value of consulting for emotional problems across ethnic groups.

Lloyd and Fuller (2002), p 106

This finding may well be relevant to BME women from other communities too. Later studies on Asian communities, referred to later in this section (p 33) suggest that some young people do not use GPs as a route to mental health support because they fear loss of confidentiality.

The experience of refugee and asylum-seeking women from a range of communities in accessing care is fraught with difficulty. Many are not only fearful of engaging with statutory bodies but clearly have a need for social and mental health support, however that is defined. Some have become sole parents due to the death or disappearance of a partner. It is crucial that strategies exist to respond effectively in primary care settings, including:

- establishing relationships of trust
- ensuring communication can take place
- working to ensure that the practical difficulties that women face are not overlooked (Perkins ed 1996).

Where practices are developing effective responses to these challenges, these examples need to be shared more widely.

We have seen that many BME women are more likely than many other groups of people to visit and receive treatment in primary care settings, particularly GP services, but that the quality of care they experience is often poor. It follows, therefore, that if this setting is to be more responsive to the needs of a range of BME women, services (including GP practices) need to be developed and integrated as a whole. Steps should be taken to ensure that these practices are accessible to those who may be at present be reluctant to seek help, such as younger women, women whose first language is not English and refugee and asylum-seeking women. These steps should include:

- first language, interpreting and information services
- more female doctors from all communities
- high levels of confidentiality
- support such as counselling services and self-help groups.

Women and children

There is evidence of higher rates of detention of African-Caribbean women than other women in the mental health system, including higher rates of detention by police (Wilson and Francis 1997). So it is critical that women from these groups can access appropriate care and support at an early stage to prevent all the negative consequences that this entails, not least separation from their children.

While national data is lacking, evidence from a number of local studies make it clear that there are high numbers of black and minority ethnic children in the child protection system – particularly those from mixed heritage and African and Caribbean backgrounds (Biehal et al 1995). A recent study examining young women's experiences in one local authority over a nine-year period (Lees 2002) found that 79 per cent of the sample were from BME communities, with 54 per cent from African or African-Caribbean backgrounds.

This study, and others in this area, points to a range of factors, including:

- eurocentric assessment tools
- lack of cross-generational support resulting from migration
- language barriers
- differences in child rearing practices
- strains generated by poverty, racism and abuse resulting in pressure on family relationships.

All these factors can affect how BME young people enter the care system.

An important area for further research and analysis is the number of children from BME communities who enter care as a result of their mother's mental health status. The Lees study found that in the one-quarter of the sample who were in care as a result of court order, one of the key factors contributing to their entry into care was the lack of a carer due to bereavement or hospitalisation, often as a result of mental illness. This finding has been confirmed elsewhere (Chand 2000).

Both these studies suggest (as many others have done – see Wilson 2001) that the pathologising of the behaviour of African-Caribbean people, for example as 'loud, aggressive, and difficult', manifests itself in higher numbers of black women in the mental health system, and that these ideas also affect social work judgements in the child protection field.

Suicide

Evidence shows that BME women are disproportionately represented in suicide rates. Lack of ethnic monitoring data in death certificates and coroners' verdicts may be concealing higher actual rates. Irish-born people have high rates of suicide, particularly among those aged 20–29 (Muinteras 1996). Young black African and African-Caribbean people may be disproportionately vulnerable to suicide (NIMHE 2003b, p 16).

Suicide rates for first-generation Asian women are more than double the national average for young women aged 15–24 years. At ages 25–64, they are 60 per cent higher than the national average in those born in India. The suicide rate among women born in Kenya or Uganda is also high, with figures showing a two-fold excess of suicides.

Findings have also shown that young British-born Asian women have high rates of attempted suicide and self-harm, as well as of eating disorders (Newham Inner City Multifund and NAWP 1998). Respondents in this study (which was of young Asian women in Newham) pointed to a far wider range of factors contributing to self-harm and distress than conventional and over-simplistic explanations of 'culture conflict' within the family. These factors included:

- an absence of someone to talk to about their distress
- the difficulties associated with transition to different life stages
- a range of experiences of abuse, including bullying at school and racism.

Women in the criminal justice system

The proportion of females in the prison population has been rising rapidly in recent years, mainly due to tougher sentencing policies and legislative changes. While women form a small percentage of all offenders and generally commit offences for shorter periods of time than men, a higher number of women than men in the criminal justice system have mental health needs: 56 per cent of sentenced women are reported to have a psychiatric disorder, compared with 37 per cent of sentenced men.

Male and female prison populations also differ in their ethnic composition. Black and minority ethnic women are represented in prison at an even more disproportionate level than BME men. Black and minority ethnic women make up 25 per cent of female prisoners. Information to clarify this worrying overrepresentation is lacking. The context

for these figures and an analysis of the mental health needs of BME women within the criminal justice system requires further investigation.

Contact with services

Overall, there is evidence that people of African-Caribbean origin receive more coercive treatment by mental health services than do patients from other groups, and this applies equally to African-Caribbean women and men. Women are also over-represented in secure provision within mental health services, while in literature referring to schizophrenia there has been a particular emphasis on the high degree of psychotic illness in African-Caribbean communities. Such findings need to be viewed carefully within the context of ongoing and contentious debate about how psychosis is measured in relation to BME communities (see Nazroo and King 2002, p 53). This measurement is often based on analysis of contact with treatment services, which many argue is insufficient to confirm higher illness rates. Indeed, as Nasroo and King (2002) explain in their analysis of symptoms and rates of psychosis, the reasons for the differential in diagnosis rates may in fact lie in the nature of contact with treatment services:

Possible explanations are racism by psychiatrists and in the community, misunderstanding of cultural expressions of distress, differential responses by police, social and treatment services and social inequality.

(Nazroo and King 2002, p 54)

These factors may explain why studies of first admission rates for African-Caribbean women with a diagnosis of schizophrenia indicate they are 13 times higher than those for white women, and double the rate for African-Caribbean men, except for those admitted under Mental Health Act section (Knowles 1991). Other figures suggest that the rate of first admission for African-Caribbean women diagnosed with schizophrenia is 3.9 times higher than it is for white people, while for African-Caribbean men it is 4.3 times higher (Mind 2003a).

Nazroo and King's work shows the differential in prevalence of psychosis between white and black groups to be much smaller. However, the differential they found appeared to be largely due to higher rates of psychosis among black-Caribbean women, while also showing that for both black and white groups those from poorer backgrounds living in inner cities were at higher risk.

Findings show that there is a low uptake of mental health services among Asian women. This is not a reflection of need, but rather of the impact of some familiar themes:

- the inappropriate nature of services
- communication problems
- lack of confidence and trust in the service
- inadequate knowledge of what is available.

One local study (Newham Innercity Multifund and NAWP 1998) of young Asian women in Newham experiencing mental distress – particularly that relating to self-harm and suicide – found that they had little knowledge of voluntary or statutory support services. Most of these young women did not consider their GPs to be a pathway to care because they feared loss of confidentiality and the stigma attached to accessing support.

A study mainly of Muslim women in Manchester (Chantler et al 2002) had similar findings. The women communicated their answers about definitions of mental distress, attempted suicide and self-harm in terms of a powerful combination of social, political and economic pressures, both from inside and outside the community. Again, women feared loss of confidentiality, but they also felt they would be misunderstood and judged by mainstream services, and were reluctant to talk about intimate matters in front of interpreters.

As Chantler et al state, there has been a tendency to privilege race and culture over gender. For example, in some instances workers in services have felt that certain types of abuse were cultural practices and therefore should not be questioned (see Perkins 1996). This response left women with an extreme sense of isolation and, again, discouraged them from accessing services until crisis point.

Clear recommendations have emerged from various studies relating to Asian women about how to overcome the many obstacles they face in accessing services. Such recommendations include:

- **primary care trust commissioning arrangements** – such as developing PCT-wide counselling services, including first-language services
- **better partnership working** – with the voluntary sector and with specialist agencies, such as women's refuges
- **addressing particular needs** – the need of PCTs to highlight the particular needs of south Asian women within their population arrangements, making them aware that many women access services at crisis point (Chantler et al 2002)
- **mental health promotion** – mental health awareness campaigns and producing appropriate information targeted at Asian communities, with specific approaches for younger and older generations
- **education services** – for example, by building on the strength of the education system as a safe environment for many young Asian women, including the provision of counselling, support and peer education (Newham Innercity Multifund and NAWP 1998).

Some of these suggested measures are reflected in the recommendations set out in this working paper.

Some commentators have pointed to the need to be aware of indications of high levels of physical and sexual abuse experienced by Irish women (Perkins 1996), as well as other challenges, which are contributing to significant but unrecognised mental distress. Findings indicate particularly high psychiatric admission rates for Irish women, high rates of suicide and high rates of diagnosis of psychosis among Irish communities in comparison to other groups. This area is a clear priority for further research and action (Nazroo and King 2002, p 48).

London initiatives

The 1997 Kings Fund Inquiry did not deal specifically with the mental health needs of women. In this section, we look at some services for BME women that have been in existence for many years, as well as some more recent initiatives.

Over the years, a number of initiatives have developed in response to the failure of mainstream services to meet the needs of BME women. Some innovative black women's initiatives that existed five years ago have lost funding and closed. One example is Shanti, an intercultural psychotherapy service in south London, tailored specifically to meet the needs of local women, and offering the option of black women therapists. For more details on this project, the impact of which was evaluated with positive findings, see Abel et al (1996), chapter 16. However, Shanti's sister project – The Bridge, in Hammersmith, west London – is still running.

Of the range of services for BME women that exist across London, some provide ethnic-specific services, while others support a range of communities of black women around domestic violence, such as Southall Black Sisters in west London. The Ashiana Project in Waltham Forest was set up in the late 1980s to provide a service to young Asian women but has successfully extended its service to Turkish and Iranian women. Some services have been in existence for some time but struggle constantly to meet the level of demand, such as the Irish Women's Centre in north London.

Several services addressing mental health needs have been set up or developed more recently, including the African Health for Empowerment and Development Project. This scheme provides support services for black people generally, but is in the process of implementing a specific service for women with mental health problems, in addition to its existing HIV/AIDS support services. Drayton Park, a statutory-funded women's residential crisis project in north London set up in 1996, is one of the few of its kind in London, and is very much in demand.

What most of these projects have in common is that they all provide outreach, information and social space to meet. Many are located within projects that have a broader focus than mental health, reflecting the social base of mental distress for black and minority ethnic women. Three projects are highlighted in the following case studies. The first is based within a domestic violence project. The second case study is organised around a faith identity. The third is unique in being the first survivor-run black women's mental health project.

Case study: Muslim Women's Helpline

This service is unusual in being based on a faith identity rather than an ethnic one. Founded in 1989, it runs without any state funding and uses volunteers. It provides a listening service, emotional support, practical help and information and, increasingly, face-to-face counselling for hundreds of Muslim women and girls. This work includes home visits and accompanying women to appointments with a psychiatrist or social worker.

The service developed in response to an awareness that Muslim women in crisis were not accessing statutory authorities or mainstream voluntary services because the women felt they were negatively stereotyped because of their religious and ethnic backgrounds. Staff working in the services had viewed Islam, in particular, as oppressive to women, and they equated liberation from oppression with women leaving behind their adherence to their religion – which was often not what the women wanted. The service has reported higher levels of need, particularly at community-based and primary care levels.

Women from the group want the following changes:

- an end to mixed-sex wards
- accessible points of contact for information and support – for example, one-stop shops that are well equipped and located in high streets, to provide somewhere safe, confidential and comfortable for women in distress to go
- good advocacy services and counselling by people from same background as the service users (and relevant training in order to develop this).

Case study: The Black Women's Mental Health Project

The Black Women's Mental Health Project (BWMHP), based in north London, is a self-help project managed by black women service users and survivors. The project was set up in 1996 with few resources and is unique in being managed mainly by women with personal experience of mental distress.

Its aim is to support 'all Black women and women who define themselves as Black in this society, to collectively demand for themselves good practice in mental health', as well as to enable 'Black women to speak for themselves regarding the care and services they need to regain their own means of coping.' (Black Women's Mental Health Project 1999, p 3).

The project developed in response to what the women showed that they needed, and at its peak in the late 1990s had a very hands-on approach, taking responsibility where services were failing to address needs, and making sure a wide range of information was available to meet the obvious needs of women attending the project.

In addition to providing a drop-in service, members made home and hospital visits, supported women attending meetings with social or housing services and helped find out more about medication, as well as helping them retain care of their children. Leaflets were distributed at the local market, and news of the group was spread by word of mouth. Currently, the future of the project is uncertain because of funding difficulties.

Case study: the Newham Asian Women's Project

This organisation runs a domestic violence refuge, a second-stage hostel and a resource centre for South Asian women. It established a further project called TEENS@NAWP in 2000, to promote the mental health of young Asian women.

The TEENS@NAWP project provides a social space that is non-threatening and confidential, where young women can escape home, school and society pressures via support groups, residential and local school-based workshops and counselling. This project is well attended by young women who self harm and have felt suicidal. The counselling service has accredited counsellors who speak a range of languages. The organisation also runs a mental health scheme for older women. This comprises a weekly mental health support group and employs a full-time psychologist who has an advocacy and liaison function with statutory and other agencies, while women can also access one-to-one counselling.

Findings

- BME voluntary sector organisations, including those working with women, refugees and asylum seekers, continue to operate at the margins of mainstream service delivery.
- The mental health needs of women, including women with children, have been accorded national prominence, and there has been an acknowledgement that social and economic reasons lie at the root of the development of many women's mental health needs. However, BME women remain marginalised within current policy debates about gender and race. BME women are often viewed exclusively in stereotyped ethnic images – for instance, as 'loud and difficult to manage' in the case of African-Caribbean women or for Asian women as having problems that are rooted exclusively in 'cultural conflict or practice' within the family. This results in their needs as women being ignored and overlooked.
- Many BME women access services only at crisis point, due to experiences of services as inappropriate, a lack of confidence and trust in the service and an inadequate knowledge of what is available.
- Services fail to take account of the needs of women with mental health problems who have children or dependants. This is significant given the high numbers of African-Caribbean and mixed-heritage young women in the care system.
- In general, it appears that BME women are more likely than women from other groups to visit and receive treatment at primary care level, but indications are that their experiences and outcomes within primary care are poor. Communication difficulties in this and other settings is a significant problem that should be addressed by more first-language services.
- BME women are over-represented in the criminal justice system, yet there is little information available on the reasons for this, or about the mental health needs of these women.
- There are indications that suicide and self-harm rates are higher than average among certain groups of Asian women and among young African-Caribbean and Irish people.
- Some Asian women (and young Asian women, in particular) tend not to use GP services as a pathway to care, for fear of loss of confidentiality.
- There is a lack of specialist crisis and respite services for BME women in London.

Discussion and conclusions

In this section, we have set out a range of issues at policy and practice levels that need to be acted upon to ensure that the needs and experiences of BME women start to be addressed by mainstream mental health services.

A potent mix of gender blindness and negative views of minority cultures are contributing to BME women's mental health needs being severely neglected across the spectrum of research, policy development, service provision and practice. There is a significant level of unmet need among black and minority ethnic women, both within and outside of mainstream mental health services. Action on these issues is long overdue. Mental health services need to strive for a gendered understanding of race and culture for BME women that is reflected in service provision.

A range of accessible services are needed, including those that support women and their children. We have set out a range of issues at policy and practice levels that need to be acted upon to make sure mainstream mental health services start to acknowledge the experiences of BME women and meet their needs. Many BME women have insufficient knowledge of services and how they may help, highlighting the need for mental health awareness and promotion strategies. The challenge services face will be easier to overcome by involving BME women themselves in the planning and commissioning of these services. Information is a powerful tool in promoting access to services, and should be considered part of an overall strategy targeted at individuals, groups and organisations.

However, careful attention needs to be paid to involving women in how services aimed at them are funded and configured. Services need to learn from, and secure, the good practice that is already present in services – especially in the voluntary sector – and to evaluate these models from user-centred perspectives.

With such a large population of BME women, London can lead the way in demonstrating that it can support the health needs of its communities positively and adequately. Extensive support networks – especially crisis services, advocacy and self-help groups – need to be established, and fuller research should be commissioned into the needs of the many black and minority ethnic communities living in the city.

Refugees and asylum seekers

The 1997 report (Johnson et al 1997) reported high levels of unmet need in refugee and asylum-seeker communities. In this section, we provide a brief overview of these groups' experiences of health and social care.

The context

Refugees and asylum seekers have become the pariahs of Europe. Politicians and the media speak of the threat to national security and the need to defend borders and mount a 'war' on asylum seekers. The terminology is highly emotive and confrontational, and tends to inflame passions and foster insecurity among the European population. Refugees find themselves being blamed for everything, from GP shortages to spreading 'killer diseases'. Both of these claims have been shown to be false by the Department of Health and the British Medical Association (Raymond 2003, Hinsliff et al 2003).

The Nationality, Asylum and Immigration Bill 2002 exemplifies the UK Government's new, tougher approach. It proposes the segregation of refugees from the general population, and puts forward plans that will mean that refugee children are excluded from local schools and not educated with British children, despite evidence that schools benefit from their presence (Harrison 2002).

In addition, with the implementation of the voucher system for asylum seekers, many are faced with the prospect of malnutrition and hunger (iNexile 2001), although the voucher scheme is to be phased out with the implementation of the Nationality Immigration and Asylum Bill 2002. There are some welcome changes within the new Asylum Bill, but aspects of it are less welcome. These centre on issues such as the proposed accommodation centres and the policies of dispersal, citizenship testing and detention and removals. These measures have not yet been fully implemented, but they already seem to be having a detrimental impact on the health of refugees (Hargreaves 2003).

The numbers of asylum seekers and refugees in the UK has been highly politicised. It is important to know the total number of refugees in London in order to plan and deliver services effectively. However, this is extremely difficult to achieve – primarily because of the way in which the figures are collated. As a result, most of the total figures put forward are estimates. The figures are estimates for the following reasons:

- Agencies such as National Asylum Support Service, social services, benefits agencies and housing departments that are involved in supporting different groups of refugees and asylum seekers all collect different data, which is not collated.
- Some refugees and asylum seekers are not supported by any agency and therefore do not appear in statistics.
- There is no clear definition as to when a refugee ceases to be a refugee – it appears to be a matter of self-perception.

In the UK, support to asylum seekers is the responsibility of the National Asylum Support Service (NASS). NASS works with local authorities and voluntary sector organisations to provide accommodation, legal advice and financial support. Health and social care

agencies provide specific services, but a wide variety of voluntary-sector organisations offer more general services and advice.

Refugee community organisations and organisations working with refugees can secure public funding from a variety of sources. However, the voluntary sector is under-resourced, and organisations tend to be funded on an ad hoc basis. The reception policies mean that refugees are dependent on formal and informal community organisations.

Refugees do not constitute a homogenous group. They come from a wide range of ethnic and social backgrounds and have very different life histories. However, they do share a certain commonality of experience pre- and post-migration (*see below*).

A report by Oxfam and the Refugee Council found that asylum seekers are commonly suffering poverty, hunger and ill health (Penrose 2002). According to the report, 85 per cent of the organisations working with refugees surveyed said their clients sometimes or frequently experience hunger, and 80 per cent reported that they were unable to maintain good health. They also found that asylum seekers could not afford to buy food or clothing.

There is a tendency to perceive refugees in terms of their problems rather than their strengths. Undoubtedly they have significant problems, but refugees are survivors, with skills and qualities that can enable them to become active and useful members of their country of settlement.

Mental health and social care issues for refugees

It has been acknowledged that refugees have problems accessing appropriate mental health and social care, and studies have shown that their needs are not being met (see Aldous et al 1999). Globally, there is an emerging interest in the mental health needs of refugees, as evidenced by the growth in the numbers of refugee-assistance programmes based on psycho-social interventions (Ahearn 2000).

By definition, refugees have been the focus of traumatic events or some form of crisis. Common experiences include:

- torture
- imprisonment
- serious injury
- enforced isolation
- being in a combat situation
- poor health
- witnessing a murder
- separation from family
- shortage of food
- being without shelter (Bhui et al 2003).

In the UK, specific mental health issues have been recognised by central government, according to Standard One (health promotion) of the National Service Framework (NSF) for Mental Health:

Refugees and asylum seekers are a particularly vulnerable group. Post traumatic stress disorder is the most common problem, and the risk of suicide is raised in the long term.

(Department of Health 1999, p 17)

There is very little data about use of mental health services or incidence of psychiatric disorders among refugee populations in the UK (Murphy et al 2002). However, local studies and reports indicate a high prevalence of mental health problems for these communities (CVS Consultants 1999).

Language difficulties exacerbate the difficulty in making accurate clinical assessments, and the provision of psychological support is further undermined by the lack of trained interpreters (see Tribe and Raval 2002). Using relatives or members of staff as interpreters is highly inappropriate, and they should not be used as such, but using bilingual staff is one way of meeting this need.

Identifying mental illness

A result of their experiences, refugees have special health (physical and mental) needs. Refugees are especially vulnerable to psychiatric disorders, including depression, suicide and post-traumatic stress disorder (Johnson et al 1997).

However, there are some fundamental questions relating to:

- what constitutes mental illness
- what causes it
- how we define it
- how we treat it.

What is particularly significant for asylum seekers is the extent to which their problems or distress are interpreted as being psychiatric. Refugees are fairly resilient, and can cope with their problems if given appropriate help. According to von Kaehne (2001) only a few refugees actually need drug treatment for mental health problems.

Identifying mental illness across cultures, and particularly within refugee communities, is problematic (Watters 2001). For example, Kleinman (1977) makes reference to 'category fallacy' – in other words, the imposition of concepts and classifications of mental illness as used in Western psychiatry on people from non-Western cultures.

There is undoubtedly a great deal of ignorance about mental illness, regardless of the cultural/societal settings. In Western cultures, many members of the public cannot correctly recognise mental disorders and do not understand the meanings of psychiatric terms, there are also differences between lay and professional explanations and conceptualisations, as well as beliefs about what constitutes an effective treatment (Jorm 2000).

Diagnosis and the relevance of psychiatric diagnostic categories are particularly problematic when people do not speak the same language. The psychiatric assessment of asylum seekers under these conditions presents a real challenge for health professionals.

In many non-Western cultures, there are no words for the categories set out in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Statistical Classification of Diseases and Health Related Problems (ICD). It is argued that these categories do not have the same linguistic and conceptual meaning in non-Western cultures (Phan and Silove 1997, Summerfield 2002).

Psychiatrists taking a biological perspective tend to downplay these problems, but the difficulty is not simply a matter of words – it is also about the meaning attached to the specific words used to describe distress. There are fundamental questions as to the validity of psychiatric diagnoses, and so to the usefulness of the distinction made between physical and mental illnesses (Mindham et al 1992, Kendell 2001).

In addition, rather than being exclusively bounded by refugee ‘culture’, the health problems experienced by refugees are not necessarily specifically related to their status, but are often in common with those of other minority ethnic, deprived and excluded groups in the country where they settle (Aldous et al 1999).

Despite already being among the most vulnerable groups, due to the effects of poverty, inadequate housing and lack of social support, the health of refugees seems to decline after two-to-three years of their arrival in the UK. It has been argued that this has less to do with their pre-flight experiences and more due to their experiences of settlement and the lack of appropriate health care (Aldous *et al* 1999).

The individual’s kin, family, relatives and community are also important, as they play an important role in legitimising the role of the sick person, and the care and support that they receive (Fernando 1991). So it is important that, where possible, families and the community are involved in treatment and care. Services also need to incorporate traditional beliefs and treatments.

According to some commentators, mental ill health is the single most important problem facing refugees (Gammell et al 1993). However, not only do the specific issues for refugees change over time, but certainly the initial concerns of refugees appear to be safety, food and shelter (Aldous et al 1999).

The role of community organisations

In the 1990s, there was a growth of psychosocial interventions offered by voluntary sector organisations aiming to alleviate the ravages of the mind, as well as the body (Ahearn 2000). Prior to this, the primary concern of the voluntary sector organisations was to deal with the basic material needs of refugees: water, food, shelter and preventing and treating disease (physical health care). This new approach reflected mounting concerns regarding the effects of trauma (pre- and post-migration), life in exile, and the increasing influence of psychological and psychiatric approaches to human migration (Lavik et al 1996).

Many researchers have acknowledged not only the importance of strong community organisations for refugees and other groups, but also informal social networks (Wahlbeck 1998). These organisations have an important role in enabling refugees to cope with the problems they face in the receiving countries. This is particularly the case in the UK, where government policy seeks to actively discourage those seeking asylum, and a hostile media and public is highly critical of any attempts to integrate refugees (Black 2001).

Community organisations can play a vital role in assisting statutory services in the provision of health care. Burnett and Peel (2001) highlight the lack of understanding among health professionals when dealing with refugees, and language difficulties only serve to complicate matters further. On the whole, refugee-specific initiatives (such as those seeking to improve health, housing or general welfare) tend to be viewed with scepticism and suspicion. Any assistance given to refugees that is perceived to exceed more than is necessary to sustain the most basic levels of existence seems to validate claims that:

- they are simply economic migrants
- this will ultimately encourage even more to claim asylum within these shores
- that Britain is ‘a soft touch’ (Readers Digest 2000).

It could be argued that other factors (such as housing) have an equal or possibly even greater impact on the physical and mental wellbeing of refugees, causing and exacerbating pre-existing conditions (Bardsley et al 1998). It has been documented that poor quality, temporary accommodation in bed-and-breakfast hostels in overcrowded and unsanitary conditions is all too often the bane of refugee life (Aldous et al 1999).

Access to services

At the same time that refugees are attempting to access services, professionals are questioning their entitlement to health care. It is therefore not surprising that refugees and asylum seekers experience difficulty in accessing GP services because of fears about services being ‘overwhelmed’ with difficult and demanding patients. This lack of understanding by professionals means that refugees/asylum seekers are often (incorrectly) told that they are not entitled to services free of charge, questioned about the extent of their entitlement, or simply refused treatment (Aldous et al 1999). The reception meted out to refugees by some GPs is particularly worrying because of the GP’s role as gatekeeper and the implications for primary care. Some GPs have even put up signs in the windows of surgeries saying ‘no refugees’ (Kmietowicz 2001).

Refugees and trauma

Refugees are exposed to severe physical and psychological trauma as a result of war, imprisonment, torture and oppression. The fact that refugees are exposed to pre-migration violence and trauma does not mean that they will go on to develop post-traumatic stress disorder (PTSD). The link between pre-migration violence and trauma is quite complex, and post-migration difficulties are highly significant mitigating factors. Some commentators see PTSD as the medicalisation of distress and suffering, and the validity of its clinical diagnosis much criticised (Bracken 1998 and Summerfield 1999).

Although the evidence seems quite clear cut and well established, the nature of the relationship between catastrophic events or trauma and PTSD is unclear. Some theorists believe it to be causal (Mollica et al 1998) while others are somewhat sceptical (Summerfield 2001). Eisenbruch (1991) also highlights the danger of using Western psychiatric diagnostic categories rather than the conceptualisations and meanings of distress held by the refugees themselves. Eisenbruch uses the term 'cultural bereavement' to explain what is both a normal response to trauma but also a positive way of dealing with, and eventually overcoming it.

The way in which refugees are treated in the country of settlement may be a critical factor in their mental health (Silove et al 1997) and it may be that despite all their difficulties, perhaps the greatest problem facing refugees is the barriers they encounter in their chosen country of settlement (Black 2001). Indeed, it has been argued that the distress refugees experience in the UK is equally important as the traumatic events that took place before migration (Steel 1999).

Similarly, Nicholson's study of the impact of pre- and post-migration stressors on refugees (Nicholson 1997) found that current stress – in other words, events occurring in the post-migration environment – was the strongest predictor of mental health outcomes. Nicholson states that policies and programmes should be developed to address the current stresses and health concerns of refugees. Once their immediate concerns are addressed, they may be better equipped to deal with PTSD.

Gender issues

In addition to the common issues and experiences of refugees as a group there are specific issues for men and women – and children (Lynch and Cuninghame 2000). Unfortunately, most refugee women do not have a voice and are increasingly marginalised, and their concerns and the specific problems that affect them are not adequately acknowledged and addressed.

Refugee women are subject to a range of physical and mental health problems, including gender-related difficulties, domestic and sexual violence, and sexual and reproductive health problems. The psychological stress they suffer is further compounded when they are separated from their children or faced with the loss of family members. As a consequence, anxiety, depression and PTSD are commonly occurring among refugee women, along with widespread mental health problems. Attention also needs to be given to the activities of organised criminal gangs in the trafficking of women and children for sexual exploitation (prostitution) and forced labour (Demir 2003).

A major study of refugee women by Refuge Action (Dumper 2002) found that in their country of settlement they:

- feel unsafe
- experience extreme difficulty in getting their health needs met
- are very isolated
- are vulnerable
- are fearful.

The women recounted stories about racial and physical abuse and living under self-imposed curfew. For newly arrived refugee women, there were major concerns about their asylum status and possible repatriation. Housing is problematic, and single women, married women with families and pregnant women all experience real difficulty as a result of living in mixed-sex accommodation. Communication problems with GPs arise as a consequence of language difficulties, English not being their first language and the lack of trained interpreters. According to the study, the women interviewed described life in terms of 'loneliness, despair and loss' (Dumper 2002).

It has been widely agreed that migration had a major impact on the traditional roles of men and women. Women are said to be particularly isolated as a result of family responsibilities, but men also experience difficulties associated with loss of status. While men by virtue of unemployment have lost their traditional role as sole provider, many women, on the other hand, have continued to do what they have always done – look after the household, look after the men and look after the children. However, the benefit system has meant that women are also able to fulfil the role of breadwinner and therefore less dependent on men. As far as benefits are concerned, it should be noted that asylum seekers are not part of the mainstream welfare system and so are ineligible for the complex system of benefits linked to income support.

All these pressures have a deleterious effect on individuals and refugee families giving rise to resentment and unhappiness leading to marital problems and divorce. The impact of migration on gender roles and life in exile leading to marital problems, and breakdown and violence has been reported elsewhere (CVS Consultants 1999, Callamard 1999).

The hardships and deprivation that migrant women endure must be acknowledged. Many women have to cope on their own, look after children without much help and support from the men. Conversely, the consequences of unemployment for men cannot be underestimated. A study of gender roles and mental health found that 'the majority of husbands felt that employment is the cornerstone of their family roles' (Simon 1995, p 191). Men have particular issues that make them less inclined to seek help, and more prone to ill-health (Kraemer 2000). Suicide and substance misuse are also major issues for men (CVS Consultants 1999).

London initiatives

The following is by no means a comprehensive list of services available within London. It is merely intended to give examples of the range of services on offer. The following case studies include two examples from the statutory sector and one from the voluntary sector.

Case study: The Sanctuary (statutory)

The Sanctuary is a GP surgery that caters exclusively for refugees and asylum seekers. It is based at the John Scott Health Centre, Hackney, and opened in August 2002. The practice is the first of its kind in London, and was set up by Hackney Primary Care Trust to cater for the growing population of refugees and asylum seekers in the Finsbury Park area of Hackney. The practice is situated near a hostel for refugees and asylum seekers run by the Refugee Council. Dr Angela Burnett, the lead GP at the practice, has worked for seven years with the Medical Foundation for the Care of Victims of Torture.

Providing a dedicated clinic for refugees is one solution in areas such as Hackney that are under considerable pressure.

Case study: Refugee Service, Traumatic Stress Clinic (statutory)

The Refugee Service at Camden and Islington Mental Health and Social Care Trust's Traumatic Stress Clinic provides services for refugees and asylum seekers experiencing psychological difficulties following traumatic experiences in their country of origin. These include being directly involved in or witnessing war, civil conflict, persecution, detention, torture, rape, sexual assault, murder, dislocation, separation and loss, within the context of organised state violence. It also deals with problems relating to adapting to life in the United Kingdom.

Services are provided to refugees and asylum seekers presenting with complex traumatic stress reactions. Services are provided in the refugee's language of preference with the assistance of interpreters and health advocates. The team does not work with people who are psychotic or who have severe drug and alcohol problems. Services include:

- assessment
- treatment
- bi-cultural therapy
- consultation and supervision for other professionals working with refugees and asylum seekers
- education and training
- legal advice and professional court reports regarding asylum status
- research.

Case study: Breathing Space (voluntary)

Breathing Space is a mental wellbeing project for refugees and asylum seekers. Its bicultural team addresses the mental wellbeing needs of refugees and asylum seekers in London. The project is a development project between the Refugee Council and the Medical Foundation for the Care of Victims of Torture, in partnership with and funded by the Camelot Foundation. The main working areas of the projects are advocacy, training and research. Within the service, aims are:

Advocacy and training

- to inform and improve understanding of the mental wellbeing needs of refugees among target organisations in the voluntary and statutory sectors
- to deliver effective training programmes to help target organisations provide high-quality mental health services to refugees
- to take referrals from the Refugee Council and the Medical Foundation, to provide an effective casework service to support individual refugees with mental health needs
- to facilitate the capacity building of refugee community organisations providing mental health services to community members

Research

- to investigate the impact of settlement in the UK on the mental wellbeing of refugees.

These case studies show that primary care services, such as the Sanctuary– and, in particular, GPs – can play a key role in facilitating access to appropriate services. From the Refugee Service example, it is clear that providing bicultural therapy and services in the refugees’ own languages proves beneficial. The Breathing Space example shows that advocacy services can be valuable in directing refugees to appropriate support services.

Discussions and conclusions

To conclude, any strategy that aims to address the mental health needs of BME communities should also include meeting the needs of refugees and asylum seekers. The experiences of refugees and asylum seekers in mental health provision, including primary care services and social care, mirrors that of long-established BME communities. The issues for refugees and asylum seekers are particularly complex, due to public perceptions of their status – and, more importantly, questions about their rights to health care.

A significant concern relates to the processes and systems used to assess mental health problems in these communities. Like Ghebrehewet et al (2002), we believe that a starting point in addressing the needs of these communities has to be a strong commitment to providing services based on respect for human rights.

Conclusions and recommendations

Conclusions

From the issues examined in the previous sections, we can see that a number of concerns of the 1997 King's Fund Inquiry remain outstanding, and that there are still major barriers to be overcome, relating to:

- engaging BME communities in service development, planning and utilisation
- the gap between implementation and recommendation
- sustainability.

These three categories are discussed in detail below.

Engagement

Mental health services are still unsuccessful in engaging BME communities in service development, planning and utilisation. Birtwistle (2002) found that services that could demonstrate an understanding of the particular needs of BME communities were able to effectively engage these communities in services. Black-led voluntary agencies have demonstrated that they are able to engage these communities, and consistently receive positive feedback from service users. However, there are some challenges:

- The successful track record of the black voluntary sector is often not seen as valid.
- Its contributions are not part of strategic thinking.
- Its responses are reactive, rather than proactive.
- There is a view among the statutory sector that the black voluntary sector is 'unprofessional' and prone to problems of financial probity and financial irregularities, hence the reluctance to engage.

Statutory mainstream services need to develop and acquire the community engagement skills and links from black-led organisations and establish true and equal partnerships if they are serious and committed to meeting the mental health needs of BME communities. Partnerships of this nature can be used to ensure that policy, practice, research, service users, family and carers, and broader community agendas link up.

At individual levels of engagement with service users, there is evidence that services are not able to do this effectively. However, this can be achieved through accurate and appropriate assessment of need that takes full account of the social context and experience of service users.

The implementation gap

The plethora of policy initiatives and directives over the past five years still seem not to have reached, or impacted on, frontline services. There are significant gaps in terms of implementing the directives from these policies. In some instances, it would be fair and accurate to observe that insufficient time has elapsed to evaluate the impact of these policies on quality of life for service users, families and carers from BME communities.

Sustainability

Sustainability – or a lack of it – is of particular concern for BME communities and voluntary sector services. Often, initiatives are launched with great enthusiasm, but due to limited and short-term funding, as well as inadequate lead-in time, lasting change is seldom achieved. Short-term funded projects often find it difficult to evaluate services, preventing them from demonstrating their capability to secure future funding. A significant area that requires attention is seeking and developing strategies to sustain initiatives that are launched. There also needs to be a complete overhaul and review of the funding mechanisms for voluntary sector agencies.

This raises one question: What stops change? We propose that a number of factors work together to reinforce a situation that seems to have become intractable. These are:

- societal and institutional racism
- approaches to, and models of, mental health care
- the relationship between BME communities, mental health services and other institutions – for example: education, the police and the criminal justice system
- societal attitudes towards mental illness, including stigma, fear, prejudice and ignorance
- the role of cultural factors as mediators or stressors
- the ‘problem’ of culture.

We recommend that these factors need careful attention, and should inform solutions for change. Once these factors are incorporated into our approach to needs assessment, service development, planning and delivery, we will move closer to reduce the inequalities that BME communities face in mental health service provision.

Recommendations

General

- Race equality and action to reduce inequalities need greater prominence in local strategies to achieve change. Primary care trusts must lead local action to tackle inequalities in mental health.
- Engagement with local communities should be a priority area for service development, by identifying strategies for active participation and representation of BME communities in needs assessment, service development and delivery.
- Partnerships based on principles of equality should be fostered by using the guidance from the Department of Health as outlined in *Saving Lives: Our healthier nation* (Department of Health 1997). Existing initiatives that work from service-user, women-centred, and anti-racist perspectives need to be included in current partnership arrangements.
- Capacity-building initiatives should be developed for service-user groups and family and carer groups.
- Health promotion can be a powerful means to raise awareness about mental illness and increase access to services.
- An urgent, systematic review is needed of acute inpatient care provided for BME communities, both countrywide, and in specific local communities.

- Work- and team-based training programmes should be introduced as part of an overall strategy to meet the needs of BME communities.
- Capacity building in the BME voluntary sector is needed to sustain the valuable contributions they make to mental health service provision

Women

- A range of accessible services is needed, including services that support women and their children to reduce the risk of family breakdown and children's adverse experiences in care. These should be located in a host of organisational settings, and should include access to creative and spiritual outlets and to complementary and talking therapies and practical support.
- Gender-specific advocacy services, to improve access to and experiences of services, need to be developed or strengthened.
- All mental health services accessed by BME women should emphasise confidentiality and safety, and include access to self-help groups, facilitated, where necessary. First-language services to overcome the barriers created by interpreter presence should be developed as far as possible.
- Greater numbers of staff need to be equipped to be able to understand issues of abuse, and to be able to work confidently and sensitively with women who may themselves have experienced abuse and/or whose children have.
- The Into the Mainstream strategy (Department of Health 2001a) needs to be integrated with other policy initiatives more closely – especially public health, social and criminal justice, child and family welfare programmes and Inside Outside (NIMHE 2003b).
- Specialist and accessible crisis and respite services should be developed to support BME women who are experiencing severe mental distress, including attempted suicide and self-harm.

Research is needed to obtain accurate information about the mental health needs of BME women in general, including information on pathways into care, women in the criminal justice system and those groups thought to be vulnerable to suicide.

Refugees

- In order to identify need and develop appropriate service responses, commissioners and service providers need to establish mechanisms to consult with local refugee community organisations, service users, families and carers.
- Access to services can be facilitated by making information about services available in a range of media, such as leaflets and videos. All information should contain appropriate images and language.
- Translation and interpretation services should be available to service users, families and carers.
- Staff should receive training and information about the rights of refugees and asylum seekers to health and social care.
- There should be places set aside for people to pray. For example, for Islamic refugees, this could simply be a quiet room, or people may even be able to attend a local mosque.

- For people who are detained and unable to leave hospital, arrangements could be made with the local clerics or with refugee community organisations, which should be consulted about religious festivals and holy days.

We believe that if these recommendations are taken seriously by everyone who is involved in providing mental health services to BME communities, we can make significant strides towards improving the outcomes for and experiences of service users, families and carers.

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Appendix 1

Recent BME-related policy developments

1993

Mental Health and Britain's Black Communities

This report, published by the King's Fund (Wilson 1993) highlighted areas in which black and ethnic minority service users were dissatisfied with services.

1994

The Ritchie Report

This HMSO report (Ritchie 1994) highlighted a series of errors and omissions in the care of Christopher Clunis, a black man with schizophrenia, who stabbed Jonathan Zito to death. The report found that his ethnicity had affected the assessment and management of his care.

Mental Health Task Force

The task force started a London project and regional race programmes. It demonstrated dissatisfaction with services, as well as highlighting good practice.

Black Mental Health: A dialogue for change

This publication (NHS Executive Mental Health TaskForce 1994) advocated a new way of integrating voluntary and statutory sector practice. Voluntary sector seen as valuable in managing mental illness among black and minority ethnic service users.

NHS Executive letter EL (94) 77

This letter, published by the NHS Executive (1994) for hospital inpatients and day cases requires that all service providers collect data on service users' ethnic origins, to help assess which groups were using particular services and whether these groups' needs were being adequately considered.

Ethnic Health Unit

The unit attempted to address the needs of black and other minority ethnic users of physical and mental health care services. It had a short lifespan but initiated some important work.

1995

Learning the Lessons

This Zito Trust report (Sheppard 1995) looked at all the homicide inquiries where the perpetrator was mentally ill, and attempted to identify common lessons. It emphasised the role of race and ethnicity of mentally ill people and looked at service shortfalls for minority ethnic groups.

Mental Health: Towards a better understanding

This public information booklet (Health of the Nation 1995) was produced for ethnic minorities and their carers, highlighting the plight of carers and their needs.

1998

A First Class Service

This publication by the Department of Health advocated national service frameworks that set standards of care with best quality and fair access and highlighted inequalities in health care.

1999

The Stephen Lawrence Inquiry

Following the murder of black teenager Stephen Lawrence and the failure of the criminal justice system to bring his murderers to justice, this report (MacPherson 1999) highlighted institutional racism. The NHS (along with other public bodies) expected to examine its structures and services in the light of the report to eradicate racism.

The National Service Framework for Mental Health

This document (Department of Health 1999) set out national standards of care and measures for monitoring performance. It gave special emphasis to the cultural sensitivity of services for African and Caribbean ethnic groups, the assessment of Asian ethnic groups and the plight of socially excluded groups, such as refugees.

2000

The NHS Plan

This document (Department of Health 2000a) had a key aim of addressing inequalities in health, especially for people from minority ethnic communities.

2002

The Race Relations (Amendment) Act 2000 and the EC Article 13 Race Directive

The Act (The Stationery Office 2000) places a general duty on public authorities to work towards the elimination of unlawful discrimination and promote equality of opportunity and good relations between persons of different racial groups.

2003

Inside Outside

This publication (NIMHE 2003b) sets out proposals for reforming the service experience and service outcomes for people from black and minority ethnic groups with mental health problems.

Adapted and updated from Olajide (1999)

Appendix 2

ES3 Ward – SLAM NHS Trust

This is an example of good practice, which illustrates how change can be achieved. The information was obtained from the ward manager, Marva Clarke, and should be viewed from this perspective.

Eileen Skellern 3 Ward (ES3) is an acute inpatient psychiatric ward with 25 beds in the South London and Maudsley NHS Mental Health Trust, providing services for adult men and women aged 16–65 years old living within north-east Lambeth. About 40 per cent of patients come to the ward either on an informal, self-referral basis, while the remainder come under a section of the Mental Health Act.

Physical environment

ES3 is a typical acute inpatient ward. It is clean but very drab, and the imminent refurbishment that is planned will be welcomed. There is an open TV sitting-room area overlooked by a nursing office, with a few smaller rooms alongside, as well as a corridor leading to bedrooms. There are no places for private conversations, but there are single-sex facilities.

Concerning disability, there are no particular obstacles for wheelchair-bound people. However, special provision may be required for people who have other disabilities, such as visual or hearing impairments.

Service philosophy

Marva describes the service philosophy as involving ‘treating patients as people’, based on a Caribbean approach to inpatient psychiatric care. This approach is more personal than the British (European) style of psychiatric care, with an essential feature being a less pronounced demarcation between staff and patients. Marva draws on the model of the hospital in Trinidad where she worked in the past, where staff and patients prepared and ate meals together. This means it is more inclusive and nurturing, and discourages the ‘them and us’ mentality that tends to occur on inpatient psychiatric services.

This approach, together with a less hierarchical ward structure, an emphasis on team working and joint, shared decision making makes relationship-building easier. Marva tries to bring the spirit of caring and providing genuine relationships to the ward.

Interagency relationships

Marva has also worked in a psychiatric assertive community treatment (PACT) team and feels that she has an understanding of the need for inpatient wards to have strong links to community groups.

The ward has good relations with external agencies that are involved with service users, such as statutory services, including community mental health teams and GPs, and relevant voluntary organisations. It has good relationships with the local service-user group (SIMBA), which is hospital-based.

Position within the community

ES3 ward has been extremely successful in several ways. It has developed a caring atmosphere, and encourages linking with discharged patients, who also use the ward as an informal drop-in service. Within the hospital community, there is some recognition and support from other medical and nursing staff, but it is still vulnerable to funding arrangements.

Structural arrangements

The ward is part of the NHS Mental Health Trust, so there is no specific management committee for the ward, and the funding is from the trust budget. ES3 is one of three wards within the Maudsley Hospital that forms the 'Eileen Skellern' inpatient unit.

There are two consultants in charge of the ward who manage two 'sub-medical' teams, totalling 12 ES3 ward staff. The ward manager said that when she first came to the ward five years ago, the budget was overspent, the ward was mainly run by temporary agency staff, and medication was used punitively. All this has changed.

Staff competence, skills and experience

The ward makes use of trained psychiatric staff and nursing assistants. There is an emphasis on personal and professional staff development, and all staff go through an extensive induction and training programme in this model of working. The staff really care, and are very supportive, of the patients and of each other. Patients are made to feel appreciated, and are welcome to come back to the ward (which many do) once discharged. It is used as combination of informal drop-in and what one ex-patient described as 'halfway between hospital and home'.

This example illustrates how change can be achieved. The important factor here is that change has been driven through effective leadership – this seems key and should be supported.