

More than black and white: mental health services provided to people from black and minority ethnic communities

SARAH ELLIX and KALA SUBBUSWAMY

Research over 30 years has established that there are disturbing links between poor treatment/outcomes, and differentials in ethnic origin within many of Britain's public institutions, leading in 1999 to the MacPherson report's unveiling of the concept of 'institutional racism'.¹ The mental health system is no exception, but the adverse treatment of black people within it, as within the criminal justice system,² is of particular concern because those who access it are not only likely to be relatively powerless and liable to isolation, but they are also more likely to be misunderstood and/or feared by wider society, and more susceptible to abuse.

In this chapter, we will be using the terms 'black' and 'black and minority ethnic (BME)', referring primarily to people with African, Caribbean, Asian, or dual/multiple heritages. This also includes people who regard themselves as Black British or British Asian. There are issues of inequality and discrimination for some White ethnic groups, and we certainly do not exclude them from our analysis. However, figures available suggest that the greatest inequalities and disadvantages within the mental health system are still experienced by non-White ethnic groups. The terms 'mental health survivor' and 'service user' will also be used. 'Service user' is the currently favoured term in most government literature, but we also use 'survivor', to indicate people's survival through the discrimination, exclusion and prejudice that they often experience in society because of their label of mental illness, as well as their survival through everyday emotional and mental struggles.

In 2005, the Government published its *Delivering Race Equality in Mental Health Care (DRE)*³ strategy. The vision of *DRE*, which is expected to deliver on outcomes by 2010, is:

- less fear of mental health services among BME communities
- increased satisfaction with services
- a reduction in the rate of admission of people from BME communities to psychiatric inpatient units
- a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units
- fewer violent incidents that are secondary to inadequate treatment of mental illness
- a reduction in the use of seclusion in BME groups
- the prevention of deaths in mental health services following physical intervention
- more BME service users reaching self-reported states of recovery
- a reduction in the ethnic disparities found in prison populations
- a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective
- a more active role for BME communities and black service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services
- a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

The publication of *DRE* was partly prompted by the inquiry into the death of David Bennett in the Norvic Clinic (a medium-security unit), in 1998. This followed an earlier report, published in 1995 on the deaths of three African-Caribbean patients at Broadmoor Hospital,⁴ the recommendations of which chime strongly with those from the Bennett inquiry.

David Bennett was African-Caribbean, and had been diagnosed with schizophrenia in 1985. He was subject to racist abuse from another patient on 30 October 1998, following an argument where each man struck the other, and David was removed from the ward. The staff failed to discuss the issue of racism with the other patient, and David's subsequent and unfair removal from the ward appears to have agitated him, leading to his hitting a nurse. David was subsequently held in a prone position (face down) for approximately 25 minutes. During the struggle he collapsed and was later pronounced dead at hospital.



FIGURE 5.1 David 'Rocky' Bennett. Reproduced with permission.

It is significant, yet disturbing, to note that in 1993 David Bennett wrote an eloquent letter to the Head of Nursing at the Norvic Clinic, which indicated a personal and expert awareness of issues affecting his care.

As you know, there are half a dozen black boys in this clinic. I don't know if you have realised that there are no Africans on your staff at the moment. We feel there should be at least two black persons in the medical or social work staff. For the obvious reasons of security and contentment for all concerned, please do your best to remedy this situation.⁵

Reproduced with permission.

David received a reply stating there had been no black applicants for years, and by the time of the inquiry it appeared little further positive action had been taken to address his legitimate concerns. It is evident that the service, the community and society have lost a great advocate here, as well as a sensitive human being; for his family, the sense of loss must be insurmountable.

In a small, national consultation by the authors on the state of current mental health services to black and minority groups, Michael Howlett of The Zito Trust offered the following powerful statement:

The social and healthcare implications of the DRE, and the lessons to be learned from the inquiry into the death of David Bennett, highlight the importance of not only arriving at an understanding of what is going on within our mental health

(and prison) services, but also what realistically can be done to act on that understanding to bridge the divide which currently exists in the many different experiences people have of the care offered to (or withdrawn from) them.

Initiatives which are explicit and practical in terms of design and delivery have the power to bring people together for a common purpose. These initiatives must, however, tackle the unconscious agenda, which lies at the heart of racism and many other forms of discrimination. Some of the motivation here will be based on fear arising from stereotypes. The core of the problem is deep-rooted and complex. Likewise, the process, which leads to change, must also be sufficiently probing as well as properly resourced.

Organisations including The Zito Trust, the Sainsbury Centre for Mental Health, the Joseph Rowntree Foundation, and Mind, have long asserted the need for far-reaching, radical changes to improve the experiences of black people who need to use mental health services. Despite this, the recent *Count Me In* national census of people in psychiatric inpatient wards found that people from BME communities (particularly people of African/African-Caribbean heritage) are still over-represented in psychiatric admissions, including detentions under the Mental Health Act 1983, and still report more negative experiences in the mental health system itself.^{6,7}

Mental health survivors from black communities, and their carers, frequently report negative experiences of mainstream mental health services, including that services stereotype them, offer control rather than assistance, and assume their intellectual inferiority, especially if English is not their first language.⁸ Other themes include: experiences of isolation and alienation, not feeling understood or respected, and lack of acknowledgement of racism – both past and present.^{9,10}

Two important questions arise here for those with responsibility to provide, deliver, plan and develop such services: Why have the inequalities for black people experiencing mental ill-health not yet been reduced? and How can mental health services and the wider community create real and lasting change in the future?

In their challenging and thought-provoking chapter in this book, 'Race and mental health: there is more to race than racism', originally published in the *British Medical Journal* in 2006, Swaran P Singh and Tom Burns criticise the contention that mental health services are institutionally discriminatory and racist.¹¹ They suggest a number of other explanations, including (disputed) evidence of differential patterns of psychiatric illness in different ethnic groups; variations in social/economic circumstances, and differences in help-seeking behaviours leading to different routes into service provision.

Singh and Burns also point to a 'spiral of downward engagement' between black service users, their carers and mental health services, leading inevitably to more coercive responses from services. They seem to gloss over the complex reasons for this, implying that 'alienation and distrust of statutory services among inner city black youth' and the concept of institutional racism itself are to blame. However, their criticisms of the label of institutional racism seem to stem from a misunderstanding of what the term truly means.

It is our understanding that wherever there are processes or patterns, systems or structures, that have disproportionate effects on certain sections of the population, this is institutional discrimination. Where this impact is negative in disproportionate degrees against certain BME communities, this is unlawful discrimination under *Race Relations* legislation. If there are practices within psychiatry that are producing adverse outcomes for certain groups, systems should be properly checked for such influences. There is no room to hide through complacency, or by passing the buck to the community itself or to the service user. The fact that there will always be a power imbalance between service users and professionals requires professionals to take more proactive responsibility for removing these barriers, in order to provide more appropriate care

WHAT IS IT ABOUT THE MENTAL HEALTH SYSTEM THAT CREATES (OR FAILS TO PREVENT) RACIST OUTCOMES?

A western model of mental health and mental health problems

As Fernando¹² says, 'statutory mental health services [in Britain] have continued to use a model that encapsulates most mental health problems as essentially medical illnesses based on traditional western European psychiatry', giving a number of examples about the nature of 'self' and the relationship between the individual and the collective, which are at odds with other cultural world views.^{13,14} The dominance of the medical model has profound practical consequences on communication, understanding and feelings of respect between mental health professionals, black service users, their families/carers and wider communities.

Avoidance and denial of issues of racism, discrimination, power and abuse

The impact of personal and cultural histories of racism, discrimination and oppression is a strong theme in many stories of black people within the mental health system.¹⁵ Within this context, similar experiences of the system itself, including the powerlessness of being subject to coercive interventions

such as compulsory detention, seclusion or restraint, may compound to become unbearable. It is essential that issues of racism, discrimination, abuse/oppression and power are acknowledged and discussed within mental health services. However, many staff within the system feel strong anxieties about talking openly about race and culture, let alone exploring racism.¹⁶ This could be one of the reasons why 'cultural competence' or 'cultural awareness' training has failed to really impact on the inequalities experienced by BME communities within the mental health system so far.

'Us' and 'them' culture

The prevailing attitude within modern British society, and to some degree within the mental health system, towards people with a label of mental illness is that 'they' – the mentally ill – are fundamentally different from 'us', the normal – with consequences including stigma, prejudice, discrimination/abuse, and barriers to building positive relationships. People from BME communities who experience mental health difficulties often face multiple layers of discrimination and exclusion, being seen as doubly different because they are mentally ill, and even more so, because they are black. If this is also the case within services, barriers will be even greater, and there will be less likelihood that services will provide adequate support to black service users.

'Brotherly love was always at a premium, and the more obvious the differences between the brothers, the less the loving.'

Braithwaite ER. *Paid Servant*. London: Bodley Head; 1962, p. 100.

LEGISLATION PROTECTS AGAINST DISCRIMINATION, SO WHY DO INEQUALITIES STILL EXIST?

Racism is an incredibly powerful and insidious form of discrimination, either direct or indirect, open or 'stealth'. As Trevor Phillips stated recently, 'the kind of racism that smiles to your face just as it's dumping your job application in the bin marked Not White Enough'.¹⁷ Disturbingly, there seems to be an increasing unspoken prejudice, seen most recently in *The Guardian's* undercover report into British National Party (BNP) membership among the middle/upper classes.¹⁸ Clearly racism should not be underestimated as a force working within healthcare.

Legislation cannot regulate against all thoughts, or indeed all actions. It can merely prohibit and try to prevent the worst kinds of discrimination. The will to change demands conscious thought and empathy, a will to reflect on

one's own culture and beliefs, before trying to understand someone else's; and a radical and fundamental commitment to care.

It is clear to the authors that there is no personal escape from individual liability for the existence of institutional or structural forms of racism/discrimination. Processes and structures are products of human design and, as such, each of us holds some accountability for these unfair systems, as well as for changing them. As Ferns¹⁹ suggests, mental health practitioners need to be 'willing to stick their necks out', to challenge and change the systems in which they work. And it should be acknowledged that everyone is institutionalised by unfair systems, those who benefit and those who do not.

This is not to disrespect, undermine or fail to acknowledge the great deal of professionalism and care provided to patients every day by committed and compassionate individuals. It is understandably hard to accept such criticism and not be defensive, particularly if you fall honourably into the category of workers described above.

This level of change can feel unsettling. Often change occurs at such a pace that there is little time to reflect properly on elements of practice, and refine our tools for future use. There must be more time and emphasis given to professional development, reflective practice, transcultural thinking and effective communication skills. This will inevitably be hard, in a system that is often forced to be reactive, and bears the brunt of increasing public pressure. And it cannot be the case that while such change takes place, vulnerable people with mental health needs, from BME communities or otherwise, are left to suffer without appropriate support.

LEICESTER: THE LOCAL PICTURE

Leicester is an incredibly diverse city and the challenges and issues described above are of great relevance here. In the 2001 census 36% of Leicester's population classed themselves as non-White, and nearly 50% of Leicester's junior school population come from ethnic minority backgrounds. It is estimated that some 8000–10 000 Somali people have arrived since the 1990s.²⁰ This proportion will now be even higher. Almost 6% of people under 18 years old are of dual heritage, according to the 2001 census.

There is a huge diversity of languages, cultures, religions, backgrounds, circumstances and patterns of settlement. Leicester's recent history includes the arrival of Polish and Latvian refugees in the 1940s; Indian, Pakistani and African-Caribbean workers filling the labour shortage in the 1950s; the arrival of a large East-African Asian community fleeing Idi Amin in the 1960s–70s, and the more recent Kosovan and Somali arrivals. This level of diversity is

reflected in the fact that over 100 languages are spoken in the city.²¹ All of the major world religions are represented, with the largest faith communities being Christian (45%), Hindu (15%), Muslim (11%) and Sikh (4%).

In terms of mental health the pattern is also mixed, with some communities over-represented and others under-represented in different parts of the service. People of African and Caribbean descent are over-represented in assessments under the Mental Health Act 1983, in inpatient admissions generally, and in a range of mental health services locally, from assertive outreach teams to advocacy. People from the South Asian communities are under-represented in most of the service, the one exception being day-services, with the existence of two specifically South Asian day-services projects run by the voluntary sector. Overall, people from South Asian backgrounds are also under-represented in Mental Health Act assessments, but this pattern may be changing, with younger Asian men being represented at levels commensurate with their levels in the general population, and the same trend occurring with Asian women, raising interesting questions and concerns for the future.²²

In spite of the large black presence and influence in the city, their voices are still not as strong as they should be within the local mental health system.

Still we see users of mental health services from BME groups sitting isolated by patients and staff on wards, because they dress differently and have no one to communicate with them in their own first language. Still we see people from BME groups being expected to fit with the predominantly western understanding, culture and diet offered by local mental health services. Still we see African Caribbean men far more likely than their white peers to be labelled with a psychotic diagnosis, to be heavily medicated, to be seen as aggressive and a potential threat, or to merit seclusion.²³

The mental health community in Leicester, including the City Council, has responded to these challenges in a number of ways in recent years, in line with the *DRE*'s three building blocks, requiring:

- more appropriate and responsive services
- community engagement
- better information.

MORE APPROPRIATE AND RESPONSIVE SERVICES

Several specific BME mental health projects are supported within the city, including the Savera Resource Centre and Adhar Project, voluntary sector

day-services for people from South Asian communities, and Akwaaba Ayeh, an advocacy service for people from BME communities.

If it were not for the Advocacy Worker I do believe that I would not be out of hospital because I had great trouble articulating, for example, asking questions. They have questions for me and I have trouble answering. They were trying to confuse me and hold me down in the system, criminalizing me trying to put me into forensics and I was not aware that they were doing this to me. If it were not for the intervention of my advocacy worker I might still be in hospital. I am grateful and thankful for Akwaaba Ayeh input. I have my freedom back.²⁴

The Council has supported some development work within the black mental health voluntary sector, with the employment of Community Development Workers in line with the *DRE*, and it is hoped that this will impact on mainstream mental health services by making them more accessible and appropriate for black and ethnic minority people, while also building capacity within our diverse communities to aid recovery. The Leicester City Mental Health Strategy Team has recently completed an Equality Impact Assessment on mental health information and advocacy, resulting in some key recommendations which should have a positive impact on people's access to, and relationships with, services in future.

The Council commissions both group and individual support specifically for carers of people with mental health difficulties from South Asian communities. It has also established a Carers Strategy Ethnic Minority sub-group, with the aim of discussing with frontline staff issues raised by black carers, who are then able to monitor progress on actions agreed during these discussions. The local Caring for Carers sub-group, established in response to the 1999 National Service Framework for Mental Health, has produced a *Mental Health Carers Resource Pack*, translated into the main Asian languages spoken in Leicestershire. Leicester also has a BME Care Workers Network, and in 2006 hosted the regional Reach Out conference, for carers from black communities.

The Child and Adolescent Mental Health Service (CAMHS) has a strategy built on consultation/research with the local black communities which specifically addresses the cultural and mental health needs of these young people. The concluding report recognised the national picture:

That the extent of social exclusion amongst black and minority ethnic communities, levels of racism and racial discrimination experienced by them in public life and, more pertinently, when they come into contact with institutional agencies are key determinants of psychiatric morbidity within these groups.²⁵

Within City Council Adult Services, the department's Black Workers Group and Race Equality Sub-group have provided valuable forums to discuss these issues. Leicester has also developed panels to test the quality assurance of assessment outcomes, including a specific focus on culturally appropriate care, and has implemented the Heritage Model to guide Fair Access to Care procedures.

The Heritage Model helps practitioners to work in a person-centred way, guiding them to assess care packages in relation to an individual's whole identity and to explore the factors such as race, gender, age, religion, social

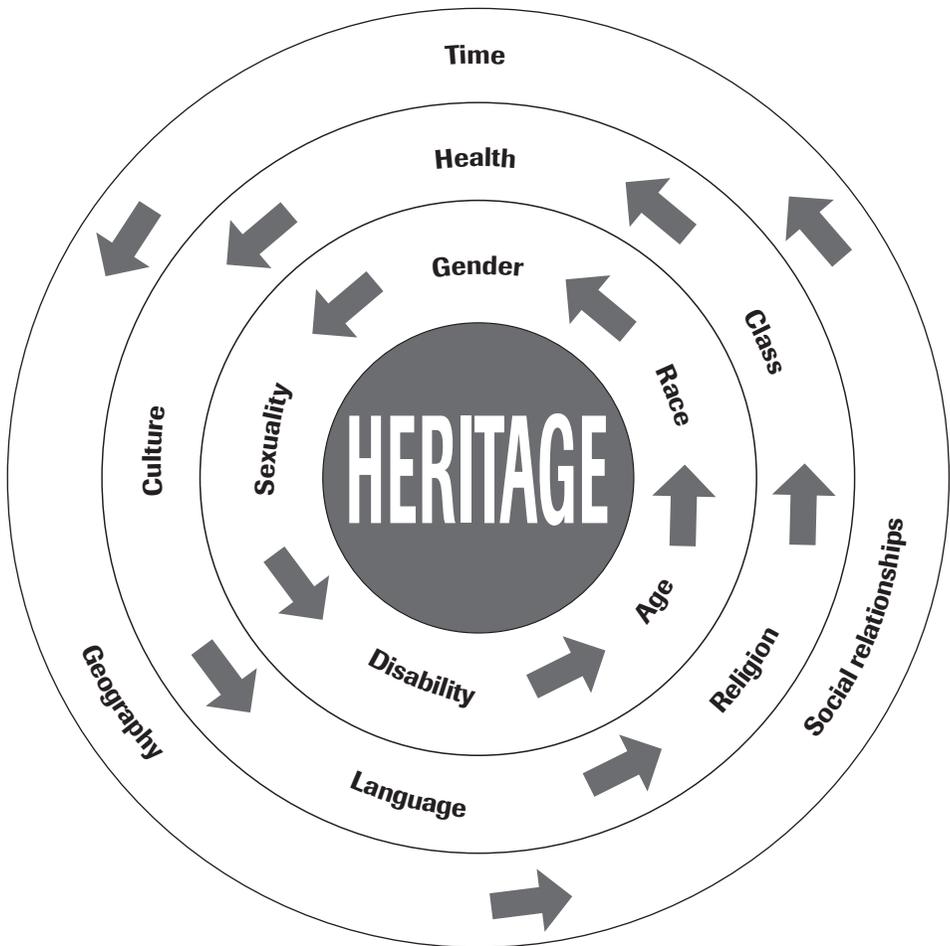


FIGURE 5.2 The Heritage Model. © 2001 Hilal Barwany for Leicester City Council (unpublished).

class, social relationships, sexual orientation and health (both physical and mental). The model acknowledges that heritage/identity is multi-faceted, fluid/dynamic, and evolves over time, meaning that assessments require regular review to ensure the continuing relevance of services.

The power of the model is that it respects and celebrates individual diversity, and explicitly embraces anti-discriminatory/anti-racist practice. It is hoped that consistent use of the model will lead to more tailored care for all service users in the future, not least those from black communities requiring access to mental healthcare.

One of the key requirements if services are to be responsive to the needs of all their communities is access to good interpretation/translation services. In Leicester these are provided for the social care and health communities mainly by Leicester City Council's Interpretation and Translation Service and the Ujala Resource Centre, part of the city's Primary Care Trust (PCT).

The Council's Interpretation and Translation Service covers over 70 languages, and through monitoring service use responds to the changing demographics in the city – for example, recently recruiting more interpreters in a number of languages such as Somali, Kurdish and Romanian, to respond to recent increases of these communities in the city.²⁶

Mental health and equality training has been provided for interpreters over recent years through partnership work between the interpretation and translation providers, the City Council, the PCT, the local NHS Workforce Deanery and the local Mental Health Trust. A recent evaluation by Sure Start Highfields (Leicester) found high levels of satisfaction from staff and clients with the interpretation services they used and also showed the many positive impacts of having access to interpreters, leading to better and more sustainable relationships.

An interpreter went into a Bengali family, she was a Bengali woman herself and there were complex problems in the family. The interpreter was able to support the family and the Sure Start professional, she had a real understanding of the culture of the family and was able to gather very sensitive information, but at the same time maintaining confidentiality within the community which was very important. Because the interpreter was bound by her professional code of conduct she was able to work within this small community confidentially.²⁷

COMMUNITY ENGAGEMENT

A recent consultation project commissioned by the City Council, undertaken by Akwaaba Ayeh, reiterated the urgent need to improve our engagement

with local BME people, especially those from African/African-Caribbean communities.²⁸ Carers from these communities reported struggling in isolation with huge challenges and barriers, including a lack of information about available support, a reluctance to identify themselves as 'carers', mistrust of services and community taboos in discussing mental health issues. One suggestion has been to build links with faith institutions, and this is being explored through the local Mental Health Promotion Steering Group.

There have been attempts to increase the black survivor and carer voice within mental health services, through direct consultation with existing black service user and carer groups and funding for specific consultation projects, as well as trying to support mainstream service user and carer forums to involve more people from BME communities. However, there are still major issues that mental health services need to confront, including the inaccessibility of meetings and the lack of adequate/consistent interpretation support.

BETTER INFORMATION

The City Council routinely collects and analyses data on ethnicity, gender, age and religion, with regard to use of social care services, and in our monitoring agreements with voluntary sector service providers. Mental Health Act assessments are also monitored in this way. This information does have an impact on service provision – for example, it has been taken up in recent reviews of counselling services and mental health day-services.

The local mental health community is trying, too, to improve data collection/monitoring around ethnicity, including making improvements to Mental Health Act monitoring forms and processes, and through commissioners' service-level agreements with the local Mental Health Trust. Ethnicity monitoring is becoming more embedded in all areas of practice, with cultures developing within the new services (such as crisis resolution), regular performance and progress reports, and the inclusion of issues relating to ethnicity as core.

WHAT ELSE NEEDS TO BE DONE?

- We need to link agendas around alternatives to the medical model, e.g. social models/recovery/person-centred approaches, and race equality expertise; and ensure that developments around alternative approaches include black voices in their discussions.

- We will need to encourage the black mental health service user and carer movements to have a stronger, more meaningful voice. While inclusion and participation may lead to vocal conflict, it is necessary for meaningful change.
- We should provide opportunities for black service users and carers to develop their skills and to be involved in the delivery of user-led training for professionals.
- We must provide 'safe space' for employees and service users/carers to explore and discuss issues affecting recovery or practice, including the impacts of racism. Less prescriptive processes, more room for narrative and recognising the importance of 'story-telling', could provide real opportunities to explore underlying issues/causes, and to enable genuine understanding and less fear of 'the other'.
- There should be sustained support for the black independent mental health sector to build its capacity, speak with a strong voice, and to work efficiently and co-operatively with other voluntary and community sector organisations and statutory services. There should be mechanisms to support and fund independent alternatives to hospital admission: e.g. service user-/voluntary sector-managed crisis houses.
- We should examine ways to ensure that experiences of admission do not damage relationships with BME service users; e.g. involve black advocacy workers early in the process; and, especially given the disproportionate numbers of black people coming into the system via a criminal justice route, ensure mental health institutions *feel* distinctly different from prisons.
- We must work to develop more representative mental health workforces; overcome issues leading to the marginalisation of black professionals in less powerful roles, while also addressing their constraints in challenging dominant cultures/models in services.
- We should ensure that people from black communities have good access to direct payment and individual budget schemes – these, by enabling people to commission their own care services, should provide more targeted, individualised support, guided/directed by the service user (and/or carer) themselves.
- We must actively promote carers' rights to assessment under the Carers Recognition and Services Act 1995 and Carers (Equal Opportunities) Act 2004 within the black community. It must be recognised, as one leading psychiatrist stated, that:

Carers are an integral part of the patient's support system . . . they are the ones with the day-to-day experience of the patient's condition . . . The carer's voice in decision-making about admission and discharge is ignored at everyone's peril – and yet, so often it is.²⁹

- We should learn from innovative projects, including those in Bradford, Liverpool and Tower Hamlets,³⁰ which seem to show better outcomes for black service users. Characteristics include: less formality (e.g. it is acceptable sometimes to be late); calm/pleasant environments; approachable/non-threatening practitioners; people's linguistic/other needs met without issue; use of clear language and avoidance of medical terminology; and the sharing of common experiences. In an ideal world, as 'mainstream' service provision improves, the need for 'separatist' and/or 'specialist' services may well diminish over time. However, as human need is diverse, the avenues for accessing services may need to remain so, too.

CONCLUSION

No challenge is impossible to overcome, given enough human will – not even the combined current stigma of racism and mental ill-health. Society itself has a role to play in supporting recovery, and will also reap the benefits of success. The Department of Health's guidance, *Action on Stigma*,³¹ offers a useful starting place for promoting positive mental health and ending discrimination in employment. It is to be hoped that black survivors will benefit from a combined approach of this strategy and the better promotion of racial equality in the future.

The *DRE* could change the picture for black mental health service users and survivors by 2010. Yet this demands proper implementation; action, not rhetoric. The current reality is an illusion of progress. The news that Lord Kamlesh Patel, the national director of the Government's strategy, resigned just twelve months after his appointment, sent shockwaves through the black voluntary and community sectors, and left the *DRE* without a champion. Additionally, in a recent article by the 1990 Trust, a member of the independent inquiry panel into the death of David Bennett, Dr Richard Stone, has stated that 'not one of the recommendations . . . have [sic] been implemented since its publication'.³²

Any improvements made to mental health service provision for the benefit of people from black and/or minority ethnic groups will arguably be beneficial to all people experiencing mental health difficulties. There are clear

social, demographic, financial³³ and economic reasons for moving forward to develop the mental health service with a disposition of activism, rather than restraint.

It is time to act now, and implement change, so that today's (and tomorrow's) BME people who require access to mental health services can do so without suffering further oppression from the system itself, and can be appropriately supported to recovery. Let us accept that sometimes 'equal' does mean 'different', and that our similarities and our differences need to be acknowledged. Only when services appear and act in a genuinely culturally sensitive way will the downward spiral of engagement with some BME communities come to a halt, and will relationships begin to travel up towards equality.

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