

Celebrating our Cultures: Guidelines for Mental Health Promotion with Black and Minority Communities

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Foreword

Britain is recognised as a multiethnic and multicultural society. But the poor socio-economic status of many people from black and other minority ethnic groups in Britain is a significant cause of poor health among them. This finding highlights the need for policies and programmes to reduce inequalities in health. Good mental health promotion activity with black and other minority ethnic groups exists but these communities still experience high levels of discrimination and mental ill health.

Promoting mental health among minority ethnic groups raises a number of complex issues. These include well-documented cultural differences in the way psychological distress presents, is perceived and interpreted. Different cultures also develop different responses for coping with psychological stress. As a consequence, mental health interventions that emphasise individualism may not be appropriate for all cultures and belief systems.

This resource, “Celebrating our Cultures: Guidelines for Mental Health Promotion with Black and Minority Ethnic Communities” provides information about specific mental health promotion needs relevant to a number of black and ethnic communities in England. It builds on “Inside Outside” published last year.

I believe the publication of this resource is another significant step in combating the health inequalities still faced by people from black and other minority ethnic communities.

Lord Chan of Oxtou MBE

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We would also like to thank the many projects and organisations that submitted information about their work, and in particular those that gave their time for us to visit them. It has not been possible to include all the projects because of limitations on space, but the following are included as examples of excellent work taking place:

African Caribbean Community Initiative

Antenna Outreach Service

Bi-Cultural Support Project

Cara Irish Housing Association Specialist Support Team

Culture Works

Endurance

Frantz Fannon Centre for Mental Health

Himmat Project
London Irish Women's centre
Longside/Moss Side Community Project
Maan Somali Mental Health
Mellow
Mental Health Needs of Asylum Seekers and Refugees in Plymouth
Mental Health Training for the Bangladeshi Community
Muslim Women's Helpline
National Chinese Mental Health Project
Naye Subah Project
Newham Asian Women's Project
North Birmingham Asian Services – Dosti
North Sheffield Young People's Mental Health Project
Pennine Care Primary Mental Health Service
Positive Vibrations
Raabta and Deeplish Mind Mental Health projects
Sikh Community Healthy Living Project
Suaimhneas Project
Turkish and Kurdish Drama Project
Vietnamese Mental Health Services
Women of Colour Project

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***Celebrating our Cultures: Guidelines for Mental Health Promotion with Black and Minority Ethnic Communities* is dedicated to Billy Ko, MBE, JP, Chair of the Chinese Mental Health Project (UK) until his death in 2002, for his huge contribution to mental health promotion with the Chinese community and the black and minority ethnic population as a whole.**

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Introduction

This resource makes the case for mental health promotion with black and minority ethnic communities in England. It sets out a framework for developing local interventions and addressing the needs of black and minority ethnic communities within mental health promotion strategies being implemented in response to Standard One of the National Service Framework for Mental Health.

The National Institute for Mental Health in England (NIMHE) has commissioned this guide as part of their Mental Health Promotion Programme to provide support and information to a range of people working within health and social care, local authorities, the voluntary sector, community groups and beyond to deliver mental health promotion to the black and minority ethnic communities they serve. It follows the publication of *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England* (Department of Health 2003) which recognises the need to improve service experience and service outcome for black and minority ethnic communities, and also includes proposals aimed at improving the overall mental health of people from black and minority ethnic groups living in England. This new resource builds on *Inside Outside* and focuses on mental health promotion to improve the mental health of both the black and minority ethnic community as a whole, and people from these communities who currently have a mental health problem.

The guide aims to:

- provide information about mental health promotion with black and minority ethnic communities and the evidence to support it, to inform the delivery of local mental health promotion strategies
- support people working locally to plan and deliver interventions which meet the needs of black and minority ethnic communities
- offer examples of mental health promotion with different communities and in a range of settings
- identify ways to evaluate mental health promotion interventions for impact and effectiveness with black and minority ethnic communities.

Who the guide is for

This guide is intended for a wide range of people with a role in promoting the mental health of black and minority ethnic communities, including:

- voluntary sector workers – the black and minority ethnic voluntary sector, community development workers, advocacy services and others
- public health and health promotion specialists

- primary care workers – GPs, health visitors, practice nurses and others
- mental health workers – community mental health teams and secondary care workers
- local authority workers – community workers, social workers, housing officers and others
- community and self help groups, community leaders
- prison staff – specialist health promotion staff, prison officers, nursing staff and others
- faith communities – religious leaders, lay volunteers.

We hope this guide will serve as a resource for people to dip in and out of, making use of those sections which are most relevant to their work. The following summary will help to signpost you to the themes that you are interested in:

Chapter One ***The Mental Health Promotion Environment***

Chapter One introduces the guide and sets the scene for mental health promotion with black and minority ethnic communities in England. It offers a brief overview of what is meant by mental health promotion and highlights the need for specific information and support to ensure that the mental health promotion needs of black and minority ethnic communities are met and inequalities are addressed within local mental health promotion strategies.

Chapter Two ***Mental Health Issues for Different Black and Minority Ethnic Communities***

Chapter Two considers the specific mental health needs and issues relevant to a number of different black and minority ethnic groups within England. It provides background information about demography and the prevalence of mental health problems, common backgrounds and social experiences and risk factors for mental health relevant for each group.

Chapter Three ***Strategies for Mental health Promotion with Black and Minority Ethnic Communities***

Chapter Three describes some of the key principles and approaches needed to ensure that mental health promotion strategies effectively meet the needs of black and minority ethnic communities. It explores the need to consult with and engage different communities and the black and minority ethnic voluntary sector to ensure programmes of work are appropriate and meaningful.

Chapter Four ***Principles of Effective Practice***

Chapter Four considers the risk and protective factors which underpin mental health, how they can most effectively be demoted and promoted and how we can measure these changes at an individual, community and structural level.

Chapter Five ***Settings for Mental Health Promotion with Black and Minority Ethnic Communities***

Chapter Five explores a number of different settings for mental health promotion with black and minority ethnic communities that are of particular relevance for reaching and making an impact on their mental health and well being, and identifies some of the key issues for each setting.

Chapter Six ***A Framework for Evaluation***

Chapter Six provides an overview of how to approach evaluation of mental health promotion projects and initiatives. There is a range of issues for consideration when developing an evaluation framework and these include planning and realising your evaluation as well as sharing the learning from your evaluation.

Chapter Seven ***Examples of Mental Health Promotion with Black and Minority Ethnic Communities***

Chapter Seven provides examples of mental health promotion initiatives taking place across England with different communities and target groups and in a range of settings, to illustrate a variety of ways of working and principles of effective interventions.

Appendix One ***The Policy Context***

This reviews a range of national and local policy initiatives that have broad implications for mental health promotion with black and minority ethnic groups, including those related to general health, inequalities, mental health, race and refugees and asylum seekers.

Appendix Two *Useful Organisations and Websites*

This includes key national organisations and useful websites.

Appendix Three *Feedback*

A feedback form is provided to record your views on these guidelines.

References

1 The Mental Health Promotion Environment

This Chapter provides a brief overview of what is meant by mental health and mental health promotion, and sets it in the context of the National Service Framework for Mental Health. It highlights the need for specific information and support to ensure that the mental health promotion needs of black and minority ethnic communities are met.

The National Service Framework for Mental Health

The National Service Framework for Mental Health was launched by the Department of Health in 1999 and sets out seven standards for mental health, including Standard One that is devoted to mental health promotion and requires health and social services to:

- promote mental health for all, working with individuals and communities
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

There is an emphasis on interventions with whole populations (for example, children, older people), with vulnerable or at-risk individuals and groups (for example, black and minority ethnic groups, refugees and asylum seekers), and with people with mental health problems.

The inclusion of mental health promotion as Standard One within the National Service Framework for Mental Health (Department of Health 1999a) presents an important opportunity to take mental health promotion forward. It is vital that the mental health promotion needs of black and minority ethnic communities are identified and addressed as part of the work that is taking place across England. There is a need for both universal mental health promotion programmes that are sensitive to the needs of the whole population, as well as specific mental health promotion interventions that work with and target particular black and minority ethnic groups.

What is mental health?

Mental health means different things to different people. How people define mental health will be influenced by different factors such as culture, background, beliefs and spirituality. It is important to recognise the different values and belief systems held by different communities and the impact these have on views of mental health and illness. Spirituality is a dimension that pervades the entire being and encompasses the need for meaningful answers to questions about life, illness and death. Campbell (1999) identifies some fundamental differences between eastern and western thought, and for mental health these include:

Eastern thought:

- Man and nature are one
- Spiritual and physical are one
- Mind and body are one

Western thought:

- Man is separate from nature
- Body, mind and spirit are different
- Rational thoughts are encouraged

The following definition is just one way of describing mental health:

‘Mental health is the emotional and spiritual resilience that enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own and others’ dignity and worth.’

(Health Education Authority 1997)

What is mental health promotion?

Mental health promotion involves any action to enhance the mental well being of individuals, families, organisations or communities. It recognises that how people feel is a significant influence on health and is therefore essentially concerned with:

- How individuals, families, organisations and communities think and feel
- The factors which influence how we think and feel, individually and collectively
- The impact that this has on overall health and well being

(Department of Health 2001)

Effective mental health promotion interventions ideally should include some or all of the following principles:

- Reducing anxiety
- Enhancing control
- Facilitating participation
- Promoting social inclusion

(International Union for Health Promotion and Education 1999)

All of these are of particular importance for people from black and minority ethnic communities because of the high levels of social exclusion, barriers to participation and lack of control within their lives that many people from these communities have to deal with.

Mental health promotion operates at three interconnected levels and at each level has relevance for the whole population, individuals at risk, vulnerable groups and people with mental health problems.

- **Strengthening individuals** – by increasing emotional resilience through interventions designed to promote self-esteem, life and coping skills eg. communicating, negotiating, relationship and parenting skills
- **Strengthening communities** – by increasing social support, social inclusion and participation, improving community safety, neighbourhood environments, promoting childcare and self-help networks, promoting mental health within schools and workplaces eg. through anti-bullying strategies and race equality schemes
- **Reducing structural barriers to mental health** – through initiatives to reduce discrimination and inequalities, developing health and social services that support mental health, and promoting access to education, meaningful employment, housing, services and support for those who are vulnerable.

(Department of Health 2001)

Mental health promotion has the potential to provide a really useful framework for a holistic approach that considers mental health needs in the context of people's lives. Mental health promotion is the responsibility of a wide range of people across different sectors, and for it to have any chance of being effective, it must harness expertise, resources and partnerships across all sectors and disciplines.

Many of the factors that influence mental health lie outside health and social care and this is particularly true for black and minority ethnic communities who may engage less easily with and have poorer access to statutory health and social services. Mental health promotion is therefore relevant to the implementation of a wide range of policy initiatives, including social inclusion, neighbourhood renewal and community strategies – within the health service, local authorities, voluntary sector and the private sector. Family, friends, schools, employers, faith communities and neighbourhoods also have an important role to play in promoting the mental health of people from black and minority ethnic communities and enabling people with mental health problems to enjoy the same range of services and facilities within the community as everyone else.

Potential benefits of mental health promotion

- Improving physical health and well being
- Preventing or reducing the risk of some mental health problems
- Improving health at work, increasing productivity and reducing sickness absence
- Assisting recovery from mental health problems
- Strengthening the capacity of communities to support social inclusion, tolerance and participation, and reducing vulnerability to socio-economic stresses
- Improving mental health services and the quality of life for people experiencing mental health problems
- Increasing the 'mental health literacy' of individuals, organisations and communities

(Department of Health 2001)

Mental health promotion for black and minority ethnic communities

While much good mental health promotion with black and minority ethnic communities is already underway (see Chapter Seven which provides examples of mental health promotion initiatives), these communities are still experiencing high levels of discrimination and mental ill health. A more targeted approach is needed to ensure that the specific needs of different groups are met. Better pooling of resources between and across sectors and communities would help avoid duplication and contribute to better mental health promotion and mental health services for black and minority ethnic communities.

Mental health promotion can play a key role in promoting a wide range of health and social benefits for people from black and minority ethnic communities, for example more accessible services, increased employment opportunities, more social inclusion. They are amongst the most socially excluded people in society, being more likely than others to live in deprived neighbourhoods, be poor, be unemployed, experience ill health, and live in overcrowded and unpopular housing. People from black and minority ethnic communities experience the added jeopardy of widespread racial harassment and racist crime that also impacts on their mental health and well being.

It is widely recognised that people from black and minority ethnic communities experience disparities and inequalities compared with the majority white population in terms of rates of mental ill health, service experience and service outcome (Department of Health 2003).

Tackling ethnic inequalities within mental health services, in terms of prevention, early detection, access, diagnosis, care and quality of treatment and outcome is a huge challenge. The National Institute for Mental Health in England will be taking forward the Department of Health's Black and Minority Ethnic Mental Health Implementation Framework based on the recommendations of *Inside Outside* (Department of Health 2003). This recognises the need not only to reform service experience and service outcome, but also to improve the overall mental health of people from black and minority ethnic groups living in England.

Consultation with black and minority ethnic groups, including those who use mental health services, has consistently found a strong demand for a much greater emphasis on mental health promotion (Mental Health Act Commission 2001; Friedli et al 2002). The findings of the consultation exercise with black and minority ethnic communities in the North East of England conducted by the Mental Health Act Commission as part of their long term strategic Equal Opportunities Programme suggested strong support for a much broader and more holistic focus:

'Early intervention and mental health promotion were widely identified as being immediate priorities.... Alternative models of understanding and the provision of alternative therapies were also promoted by voluntary organisations as being conducive to improved mental health.'

(Mental Health Act Commission 2001)

In the consultation events for *Inside: Outside* (Real Voices 2003), raising awareness of mental health, both within minority ethnic communities and the wider population as well as among health professionals, was a common theme among the majority of respondents across all the ethnic communities surveyed. Much of the rationale for this was that education and information was necessary in order to facilitate prevention and early detection, and to reduce fears and stigma associated with mental illness.

'We need to look at preventative/support work before the treatment stage. Hence more educational, outreach and promotional work. Prevention is better than cure.'

(Chinese female at *Inside:Outside* consultation event in Manchester, Real Voices 2003, p.29)

2 Mental Health Issues for Different Black and Minority Ethnic Communities

This Chapter considers the specific mental health needs and issues relevant to a number of different black and minority ethnic communities in England:

- African Caribbean
- Chinese
- Irish
- Refugees and asylum seekers
- South Asian
- Vietnamese

It includes demographic information such as the numbers of people from each community living in the UK, and social experiences and risk factors for mental health problems.

It is important to recognise that there is immense diversity within each community and that each individual within an ethnic group is unique and different, with individual differences sometimes outweighing group differences in extent and importance (Fernando 2002). Individual experiences may sometimes be over simplified, or assumptions wrongly made that people have similar views, experiences or needs because they belong to a particular black or minority ethnic group. It is important not to overlook a range of relevant issues for an individual – not only ethnicity but other factors such as gender, age, employment status, place of birth, experience of migration, family environment. To work effectively with vulnerable groups, it is necessary to recognise the complexity of people's lives and respond accordingly. Individuals seldom see themselves as belonging to only one group or having a single set of issues. The challenge is for policy makers and practitioners to recognise the complexity of need when planning and delivering mental health promotion to black and minority ethnic communities (Heer and Woodhead 2002). To make this more manageable, they also need to identify some common factors to be taken into consideration when planning work that is culturally appropriate.

The African Caribbean Community

Introduction

According to the 2001 Census, the number of people of Black Caribbean descent living in the UK is around 1.0% and people of Black African descent is 0.8%. Those defining themselves as Black Other make up 0.2% of the population. In the main, the community lives within the inner cities, and over half are British born.

Many African Caribbean people are extremely resilient, spiritual and active participants in community life, yet people from this community, and especially young men, experience high levels of unemployment, homelessness, poor housing and social deprivation. All of these may contribute to the higher rates of mental health problems experienced by this group. What is needed is a focus on promoting mental health and developing mechanisms to deliver high quality and appropriate mental health services that engage the African Caribbean community.

Mental health issues

African Caribbean people experience high rates of mental health problems and face a number of specific issues around access to and use of mental health services. Over the past decade, a picture has emerged of inappropriate detention under the Mental Health Act, excessive use of medication, over diagnosis and failure to offer psychological therapies to this community (Bhui et al 2003).

Use of primary care

Primary care involvement with the African Caribbean community is limited and community-based crisis care is lacking (Sainsbury Centre for Mental Health 2002). African Caribbean people often fail to access appropriate mental health care from primary care services, leading to long delays in accessing treatment until conditions reach crisis point. Carers also experience problems accessing GPs and primary care, and the potential partnership between families and carers and services to identify problems early is often missed.

Use of secondary services

Many black people fear mental health services because they associate them with other more obviously coercive agencies such as the criminal justice system (Sivanandan 1991). It is a fact that African Caribbean people are more likely than any other ethnic group in England to be admitted to a psychiatric hospital under the compulsory powers of the Mental Health

Act and to receive restrictive and punitive forms of treatment, and African Caribbean men may be ten times more likely to be sectioned than their white counterparts (Mind 2002, Reid-Galloway 1998). Admission to hospital often takes place through the criminal justice system rather than via GPs or social care services. This discriminatory pattern of service experience has been the case for many years. People associate police involvement with criminality rather than therapeutic care, and this impacts negatively not only on service users but on black families and carers, increasing the stigma associated with mental illness. It seems that mental health professionals are likely to perceive black people as being more dangerous than white patients (Bhui 2001).

There are apparent high rates of psychotic illnesses among African Caribbean people (Sproston and Nazroo 2002). For African Caribbean men and women respectively, the rate for first admission with a diagnosis of schizophrenia is 4.3 and 3.9 times higher than it is for white people (Mind 2002).

Depression and anxiety

Depression is the most common mental health problem suffered by African Caribbean people in the UK. A study by Nazroo (1997) suggests there is massive under-diagnosis of depression and anxiety in the African Caribbean community. National surveys have shown that African Caribbean women in the UK are twice as likely as white British women to suffer from depression, and African Caribbean men, especially non-manual workers, are more likely than white British men to suffer from depressive ideas and anxiety (McKenzie 2002).

Suicide and self-harm

While not a lot is known about suicide rates for African Caribbean people living in the UK, suicide rates among young African Caribbean people appear to be rising dramatically, and therefore self-harm should be of more concern than the perceived danger to others from people with schizophrenia (McKenzie 2002). Social risk factors may precipitate serious mental health problems and possibly suicidal behaviour in African Caribbean people in the UK, and young black women may be especially vulnerable to suicide (Raleigh 1996; Whitley et al 1999; Department of Health 2001; McKenzie et al 2001).

Social risk factors

Social risk factors are likely to contribute to the high rates of mental illness among African Caribbean people in the UK, with life events leading to both acute and chronic stresses. Personal risk factors include living in a city, thwarted aspirations, financial strain, employment involving low autonomy, parental loss, uncertainty about the future and

discrimination. Increasingly, also, evidence points to the impact that living in a deprived area can have on mental well being.

- Whereas 28% of white households have incomes below half the national average, the figure for African Caribbean families is 41% (Modood et al 1997).
- African Caribbean women have high rates of paid employment but generally unemployment is high in the African Caribbean community. (Modood et al 1997) Young African Caribbean men have the highest levels of unemployment of all groups even though they are just as likely as white men to stay on at school to further their education after age 16 (Berthoud 1999). Nearly a third in the 20-24 age range are unemployed (Matherson and Babb 2002) and this is particularly significant given the young age profile of the black community.
- For a substantial minority of African Caribbean young men, their poor educational success, lack of employment and detachment from family and social commitments can lead to disaffection, alienation and resentment (Berthoud 1999).
- Evidence shows that the distress arising from experiences of racism can lead to mental health problems (Sanders-Thompson 2002).
- The disproportionate number of African Caribbean children excluded from school is a particular issue, with boys being more than four to five times more likely than girls to be excluded (Gillborn 1995).
- African Caribbean children are disproportionately found amongst children in care (Barn 1993).
- African Caribbean young men are over-represented at every stage of the criminal justice process, from stop and search to imprisonment and there is a strong perception among minority ethnic young people that the police assume they are potential criminals (Social Exclusion Unit 2000).

Stigma

There is a great deal of stigma associated with mental illness within the African Caribbean community. People find it very difficult to contact and engage with mental health services, primarily because they are viewed as intrusive and coercive, as identified in a review of the experience of mental health services (Sainsbury Centre for Mental Health 2002) and interventions and services on offer are not always appropriate to individual need. Problems therefore may often be kept within the family or community.

Social exclusion

The social distance between people with mental health problems and the rest of society is created because of the fear associated with mental illness, and leads to mental health service users being socially excluded (Sayce 2000; Link et al 1999). Fear of mental illness and mental health services is a factor delaying black people from seeking help or accessing appropriate mental health care from primary care as long as possible so that they present to services only when they are in crisis. This can lead to stereotypes that black people have more severe mental health problems than white people (Mclean et al 2003; Sathyamoorthy et al 2001). Mental health services may be viewed as being controlling, oppressive and discriminatory in the same way that exclusion from schools or contact with the police and the criminal justice system is viewed, again reducing access to services (Sainsbury Centre for Mental Health 2002).

The Chinese Community

Introduction

Based on the 2001 census, the Chinese in the UK is around 0.4% of the total population. 40% live in London and the rest are spread across the UK living mainly in cities and urban areas. Compared with other minority ethnic groups the Chinese community is less concentrated geographically and therefore tends to be less visible. Often this leads to them being neglected in terms of service provision as low numbers do not make them a priority group. Immigration to the UK took place during the 1860s and 1950s, but the majority of Chinese people arrived in the UK in the 1960s in response to demand for Chinese cuisine. The rest include Chinese refugees from Vietnam, and people from main land China who sought asylum after the Tianenman Square student revolt in 1989 (Li et al 1999).

The Chinese community is a diverse group both socially and culturally. It includes both first generation migrants who speak little or no English, and second generation who are often well educated and in employment. Around 28% of the Chinese community have been born in the UK, the lowest proportion of all the principal ethnic minority groups in the UK, with almost half of the remainder born in Hong Kong (Birmingham City Council Race Relations Unit 1996). A variety of languages are spoken in addition to Cantonese, and there are a range of religious practices and variations in identification with the dominant culture (Yee & Au 1997).

Mental health issues

It appears that Chinese people have a similar incidence of mental health problems to white people in Britain, with evidence for lower rates of mental health problems in the community being inconsistent (Cowan 2001).

Use of primary care

There is some evidence of under-use of mental health services by the Chinese community, even amongst those with serious mental health problems, with consultation rates for mental health problems, particularly for anxiety and depression, being low. A study of General Practice in Tower Hamlets, London, (Li et al 1994) found significantly reduced uptake of primary care services by Chinese people, while another study found they had reasonably high levels of consultation with GPs, but that their use of other services was low (Li & Logan 1999).

A national survey of the mental health needs of Chinese people in Britain (Li & Logan 1999) interviewed people attending Chinese community centres in cities with larger Chinese communities, and also surveyed a variety of community, professional and health and social care workers. They found that Chinese people tend to access their GP only after long delays. Where people found their contact with a GP negative, it was because they did not understand their diagnosis and found the treatment ineffective. Others found the GP insensitive to their problem and unable to give them enough time.

In some cases the period between onset of the problem and individuals seeking professional help was as long as fifteen years. Triggers included detection by health professionals such as the GP, behavioural changes such as auditory and visual hallucinations and suicidal attempts, somatic symptoms such as insomnia and persistent pain, and recognition of symptoms by family members. The GP was the first contact person for less than 40% of all individuals, with others using Accident & Emergency Departments, family, friends, Chinese community workers or Chinese doctors, and more than 12% failing to seek help. Chinese people with mental health problems are more likely to receive drug therapy and have contact with psychiatrists, as opposed to being offered community psychiatric services, counselling and psychotherapy.

Use of secondary services

There is an under-representation of Chinese people among psychiatric inpatients (Li et al 1999). In 1981 the admission rate for Chinese patients represented 50% of the rates predicted by the size of the population, and was lower than the admission rate in 1971 (Wong & Cochrane 1989). The well-recognised excess of compulsory admission rates found among black ethnic groups does not apply to the Chinese population.

Depression and anxiety

The Fourth National Survey of Ethnic Minorities (Nazroo 1997) found significantly lower rates for anxiety, depression and non-affective psychosis among the Chinese population compared to the white sample (although this study was based on a small sample of Chinese respondents). Chinese people tend not to separate physical symptoms from more affective components such as feelings of sadness to express depression, compared to Western cultures where these are a common expression of depression (Zheng & Lin 1991).

Social risk factors

Chinese people identified a number of key issues increasing the risk of mental health problems (Li et al 1999), including:

- family problems such as marital breakdown
- societal pressures such as pressures at work, unemployment, caring responsibilities
- loneliness and isolation
- poor physical health
- life events such as bereavement and rape
- the 'culture shock of living in England' and unfulfilled expectations of life here. In a study comparing first and second generation Chinese immigrants from Hong Kong (Furnham & Li 1993), this was linked to mental distress and depression, particularly in second generation Chinese, while for first generation Chinese, holding traditional values was a bigger factor influencing mental health problems. In the younger generation, those reporting they did not feel part of the host community were more likely to have psychological symptoms.
- poverty is also a factor. Male unemployment rates are similar to the white population but female rates are slightly higher (Li & Logan 1999)

- only 25% of first generation Chinese living in the UK have been educated beyond primary school level, but overall substantially more adults are in full time adult education compared with the white population – 74% versus 13.5% and 34% versus 7% for men and women respectively (Cowan 2001)
- Chinese carers experience problems of unemployment, financial hardship, language difficulties, limited awareness of services, particularly respite care, lack of culturally and linguistically appropriate services and the stereotype of Chinese families as large, close, supportive and self-sufficient and thus not needing support (Yee 1997). There is a need for access to interpreters, training, transport, information and targeted publicity to improve uptake of services
- mental health assessments and interventions are crucially dependent on language so that lack of a common language is an important barrier to seeking help for the Chinese community. In the study by Li & Logan (1999), 77.5% of those interviewed needed an interpreter for communication in English. For non-English speaking people, lack of appropriate language skills amongst mental health professionals and difficulties in accessing appropriate interpreter services make mental health care difficult to access. The widespread use of family members is inappropriate because of the issue of confidentiality
- research suggests that Chinese people in the UK have experienced much racism and discrimination (Lee & Ottati 1995). Racism is significant and pervasive in the lives of young Chinese people in Britain (Parker 1995). Song (1999) found racial abuse and discrimination among Chinese people working in the catering industry to be a pervasive but not a universal experience. A study of Chinese adolescents in Britain (Verma et al 1999) found the majority had experienced racism and fear of racism was universal, but nevertheless, self- esteem was higher than for a white European comparison group
- differences in mental well being between the Chinese community and the indigenous white population in the UK may also be a result of the influence of traditional cultural beliefs and practices, and cultural differences in expression of emotions, which impacts on psychological measurements. There is a widespread identification of psychological problems as physical problems among the Chinese community (Leung 1998, Kleinman 1977, Li & Logan 1999), with physical illness being much more common and culturally acceptable than psychological problems among the community. This is partly due to the stigma associated with mental illness, communication difficulties, and cultural differences in the way mental illness is presented

- lack of knowledge about statutory services also prevents Chinese people from accessing appropriate help (Li and Logan 1999; Li et al 1999). There is a general lack of awareness of a range of statutory services such as psychiatrists, day centres, community psychiatric nurses and social workers, and of non-statutory services such as community centres, Chinese mental health services and Chinese health resource centres.

Stigma

There is a low level of understanding about mental illness in the Chinese community, resulting in discrimination and harassment from the community towards people with mental illness. This stigma can lead people to conceal their illness. There is a widely held belief that 'fate brings on mental health problems' or that it is due to possession by evil spirits, and different beliefs can influence the way individuals handle mental illness and treat others with mental health problems. In a study by Li & Logan (1999) 15% identified stigma as a barrier to accessing mental health services, whereas 77% of community workers surveyed identified stigma as an issue for the Chinese community.

Social exclusion

The impact of mental illness can be very negative, and may lead to unemployment and social exclusion. Families may view mental illness as embarrassing or frightening, and few Chinese people believe their family would be supportive (Li et al 1999). The prevalence of social exclusion and poverty among Chinese people with mental health problems contradicts the stereotypical image of extended families supporting and caring for each other. In the study by Li & Logan (1999), 24% of those interviewed lived alone, and only 13% were in any work, despite the median age of the sample being only 49. Loneliness, breakdown of family relationships, discrimination and harassment from family members and from the wider Chinese community are all common experiences for Chinese people with mental health problems and add to levels of distress (Li et al 1999).

The Irish Community

Introduction

The Irish community is the largest ethnic minority by immigration in Britain, with between two and eight million people born in Britain who identify as Irish – that is around 11% of the population (Hickman and Walter 1997). Over half the Irish population lives in London and the rest in major metropolitan cities. The Irish are often viewed as an invisible minority, frequently classified with the indigenous population or with other white minorities, while sharing similar experiences to black and South Asian groups. There is evidence of quite significant disadvantage, high levels of physical and mental health problems and long-term disability among this community.

As with other communities, the Irish community and individuals within it need to take responsibility themselves for improving their health and mental health, alongside the contribution of statutory and voluntary agencies.

‘What is needed is not a medical/ institutional model but a social model embedded in the community. We need an active, supportive, non-judgemental, out-reaching community to benefit all its members, not just the most vulnerable’ (Tilki 2001).

Mental health issues

Like all minority groups there is a combination of social and cultural needs that increase the likelihood of mental distress.

Use of primary care

Recent evidence shows that Irish people, and particularly young men, have higher than average rates of consulting GPs for psychological problems (Erens et al 2001). Evidence from community groups suggests that some groups of Irish people, in particular older homeless men, people with alcohol problems and travellers do not access primary care (Department of Health 2001). Reasons given include stereotyping, hostility, mental health problems not being addressed, lack of confidence, and lack of knowledge of what services are available. Some Irish people prefer to access emergency services for general and mental health problems which may indicate dissatisfaction with GP services, a failure of GPs to recognise mental health problems, or a greater prevalence of alcohol and mental health problems culminating in referral to A & E Departments (Gater 2002). Irish community groups express concern about the lack of apparent skills around Irish mental health at primary care level. During the community consultation events on Inside: Outside, the

proposed Government strategy to improve mental health services for black and minority ethnic communities, an overwhelming 94% of Irish respondents felt that lack of cultural awareness amongst staff was a service problem (Real Voices 2003) .

Use of secondary services

Compared with the majority white population, Irish people appear to have higher rates of hospital admission and coercive care within mental health services (Sashidharan 2001). In an analysis of admissions to psychiatric hospitals in the London Borough of Brent and the City of Westminster in 1991, Irish-born people comprised 15 per cent of clients with identifiable origin, while the local Irish population was far lower, at 8.7 per cent (Reid-Galloway 1998). Another London study found that Irish people had the highest overall admission rates compared with black and white British populations (Walls 1996), yet a study in Birmingham did not find an excess of hospital admissions among the Irish (Commander et al 1999). People born in the Republic of Ireland have two and a half times the rate of admission to hospital for depression than the indigenous population (Bracken et al 1998). A disproportionate number of Irish people are compulsorily detained under the Mental Health Act and Electro Convulsive Treatment (ECT) is more likely to be used with Irish patients (Farrell 1996; Butler 1999).

Depression and anxiety

Excessively high rates for depression have been found for Irish people admitted to psychiatric hospital and within community samples, particularly Irish women (Cochrane and Bal 1989; Walls 1996). Of particular concern to Irish community groups is the problem of depression among some Irish women, and of depression and anxiety among Traveller women (IMHS). A study in Haringey, London in 1995 found that Irish women's hospital admission rate for depression was 22 (per 10000) compared with 6 for English women and 7 for Black women (Walls 1996).

Suicide and self-harm

There are significantly high rates of suicide among Irish people of both sexes, with particularly high rates among young women. From 1988 to 1992, rates for suicide and undetermined deaths for Irish people was 53 per cent in excess of the indigenous population (Balarajan 1995) (higher than all other black and minority ethnic groups and the population of England and Wales). For young Irish people aged 20 -29 years, a 75% excess was found for men and nearly a three-fold excess for young women (Raleigh and Balarajan 1992; Balarajan 1995; Bracken et al 1998; Leavey 1999). There is also concern in the Irish community about perceived high suicide rates among Irish men in prison,

particularly Irish Traveller men. There is also some evidence that these rates may in fact be an under-estimate (Needleman et al 1997).

Alcohol misuse

There is evidence that some groups of Irish people may have alcohol problems linked to mental health and wider disadvantages of isolation, poverty, being single men, employment histories, homelessness and marginalisation (Harrison et al 1997; Commander et al 1999; Leavey 1999; Erens et al 2001). Men born in the Republic of Ireland have approximately nine times, and women seven times, the rate of alcohol related admissions compared with the indigenous population (Bracken et al 1998) and they are more likely to use community-based alcohol agencies. Irish people, like other minorities, are subject to stereotyping which can influence people's willingness to seek help and may also have an impact on the care they receive. For example, the danger of stereotyping alcohol misuse may lead to a misdiagnosis of mental health problems. Irish community groups have expressed concern about the extent to which GPs fail to deal with mental health issues underlying presenting alcohol problems among Irish people. GPs may fail to treat depression and anxiety as relevant to alcohol problems, and they also tend to stereotype Irish people as alcoholics, thus obstructing treatment for mental health problems.

'...The alcohol problem is the perceived cause of illness, it is purely presumption, before a proper assessment takes place.'

(Irish female worker at community consultation event in Birmingham, Real Voices 2003 p. 21)

Social risk factors

- Irish immigrants have experienced similar social disadvantage to other immigrant groups (Bracken et al 1998) especially in areas of housing and social isolation. Loneliness and social isolation are common, especially among older people, middle aged men, and women with young children and the incidence of depression is higher among all these groups (Cara Irish Housing 1995).
- An important characteristic of Irish service users is the high level of breakdown in family relationships, often leading to guilt and distress (McKenna et al 2001).
- For many of those excluded from their own communities, who have left Ireland under duress, or are living in temporary accommodation, loss is a prominent feeling. This includes loss of close family contact, missing home and general isolation from family and friends. In later life, many Irish people have few social support networks or community links and this contributes to poor health and can delay recovery and rehabilitation (McKenna et al 2001).

- The age profile of the community is older than other minority ethnic groups, and there is evidence of widespread disadvantage in housing, employment and health (Tilki 1998; Connor 1987).
- There is a known connection between mental distress and homelessness. There are high levels of homelessness among the Irish community, especially young single people, and their housing, health and social needs are not being adequately met (Brent Irish Advisory service 1991).
- Evidence from the 1991 Census suggests that unemployment for Irish-born men is higher at 17.1% than for the rest of the white population. The figure for women is 8.1% which is below most other ethnic groups, although like other white women, Irish women are strongly represented in part-time work (Walter 1995).
- Irish people are less likely than other immigrants to maintain a distinct cultural identity and this can contribute to their invisibility and therefore the lack of attention by services to meeting their needs (Connor 1987). The identity of the Irish in England has not been supported by the catholic church or other institutions (Hickman 1995; Kellagher 1996), and unrest in Northern Ireland is likely to have added to difficulties in promoting a positive Irish identity.
- Irish women encounter general pressures such as anti-Irish racism, homelessness and some groups seem to be more vulnerable to mental health problems, including single, older, disabled, lesbian, unemployed, women with children and travellers. The level of domestic violence within the Irish community is a cause for concern, and many people have difficulty coming to terms with past experiences of abuse. Among Irish women there is a high demand for culturally sensitive services (Corduff 1997).

Stigma

A significant cultural barrier to the mental health of Irish people is their general reluctance to express their feelings, fears, anxieties and distress and their tendency to try coping alone rather than seeking help. This is particularly the case for older Irish people and often for Irish men. The attitude of society as a whole towards mental illness and the stigma associated with it means that many people, including Irish communities, are reluctant to approach mental health services or access the support they need.

Social exclusion

Irish people are often concentrated in the lowest paid jobs and in poor housing, and they are twice as likely to be unemployed and more likely to be involved in manual and unskilled work (Greenslade et al 1991). In inner London, one in three occupants of hostels for the homeless is Irish (O'Meachair 1998).

Anti-Irish racism is an everyday reality for Irish people and impacts on their health and well being as well as their willingness to access services (Hickman and Walter 1997).

Refugees and Asylum Seekers

Introduction

Refugees and asylum seekers are not a homogenous group – they have different cultural backgrounds, religious customs and come from different geographic areas and will have had a range of experiences before arriving in the UK. Men, women and children may have different needs and issues.

Nearly 22 million people throughout the world are estimated to be asylum seekers or refugees, with a further 21 million internally displaced within their own countries (UNHCR 2002 www.unhcr.ch). In 2000, the UK ranked ninth amongst EU countries and 78th in the world in terms of asylum seekers per head of population, with 1.7 asylum seekers per 1000 national population (Refugee Council 2002- www.refugeecouncil.org.uk).

Applications for asylum have increased steadily since 1997, and in 2002, 85,865 people applied for asylum in the UK (20% more than in 2001). Applications came from more than 42 countries, with the top ten countries being Iraq, Zimbabwe, Afghanistan, Somalia, China, Sri Lanka, Turkey, Iran, Pakistan and Congo. Considerable numbers of asylum applicants are recognised as being in need of protection or found to have a right to stay in the UK, for example, 84% of applicants from Iraq and 67% of applicants from Afghanistan were granted asylum in 2002. Additionally, 21% of appeals were granted on first appeal. For more statistics, see the Home Office website (www.homeoffice.gov.uk).

Rather than automatically assuming that refugee and asylum seekers' experiences lead to mental health problems, we need to identify the strengths, resilience, skills and coping mechanisms that so many individuals, families and communities have. And we need to identify how best to assist and enhance these positive characteristics at the same time as supporting people in crisis. What is needed is a positive definition of mental health that recognises social, economic, political and cultural needs and moves away from pathology towards appropriate support for those in need.

Mental health issues

Refugees and asylum seekers experience multiple problems relating to their mental health and well being (Woodhead 2000). Symptoms of mental distress are common but we should be careful not to interpret as mental illness what may be a natural response to a highly abnormal situation (Burnett and Fassil 2002).

Use of primary care

Despite being entitled to receive health care, many refugees and asylum seekers face difficulties in registering with a GP (Woodhead 2000). Once registered, primary care may have no facilities to respond to the diverse needs of asylum seekers in terms of language or culture, making it difficult to identify mental health problems or treat them appropriately. Some research suggests that 17 percent of asylum seekers have a limiting physical illness and two thirds have experienced significant anxiety and depression (BMA 2002; Carey Wood et al 1995).

Some of the physical ill-health experienced by asylum seekers may also be stress related, notably heart disease, infection and gastrointestinal disturbances. Homesickness, separation from family and friends, loss of status and racial harassment are also factors. Loss events are a significant trigger for both depression and suicide, with loss of a cherished idea the most important risk factor for suicide (Cheng 2000). Poverty, severely restricted freedom and dispersal also compound both physical and mental health problems. Detaining asylum seekers in removal centres may compound the psychological damage they have already suffered (BMA 2002).

Social risk factors

While there is a great deal of diversity among refugees and asylum seekers in the UK, as a group they share a range of experiences and social pressures that impact on their mental health

- **Experiences in home country**

Refugees and asylum seekers are likely to have experienced traumatic events associated with war, famine or persecution in their home country and the process of flight from that country can also be hazardous and stressful. These experiences may have an impact on mental health, in some cases manifested in the development of post-traumatic stress disorder, including flashbacks, intrusive thoughts, insomnia and eating disorders, compounded by depression and anxiety (Burnett and Peel 2001a, and b; British Medical Association 2002). Post-Traumatic Stress Disorder may sometimes not surface for some years after becoming a refugee (UNHCR/WHO 1996).

- **Experience on arrival in the UK**

There is a growing recognition of the mental health impact of the environment that refugees and asylum seekers experience on arrival in the UK (Silove et al 2000). They may face a variety of difficulties, including being sent back home or detained in camps or prison contexts, and there is evidence to show that this can lead to feelings of hopelessness and despair and a decline in refugees' mental health (Pourgourides et al 1996).

- **Lack of control**

The prolonged waiting for refugee status can lead to feelings of insecurity and isolation, resulting in depression, anxiety, frustration, aggression, anger and social withdrawal. Even when permission is granted to stay, adapting to a host society that may be hostile or indifferent and which has different values, culture, religion and language can prove problematic. Insecurity, threats, racism, fear and non-recognition of former qualifications, training and experience have a negative influence on self esteem, and the whole experience of applying for asylum can lower self confidence and lead to a reduced sense of self worth (Carey-Wood et al 1995; Gilbert and Allan 1998).

- **A sense of loss**

A sense of loss may include loss of homeland, loss of family and friends, and loss of personal identity. Once safety is assured, most exiles will begin to feel the grief of the losses they have experienced, akin to a bereavement reaction (Eisenbruch 1990). Rebuilding relationships and finding sources of social support are often of crucial importance at this point. Having contact with people from similar backgrounds may go some way to easing this. In other cases, people may be suspicious of others from their home country and, depending on ethnic or clan affiliations, contact may make them feel vulnerable or afraid.

- **Isolation and marginalisation**

Refugees and asylum seekers may experience a sense of acute isolation and marginalisation, in which people feel detached from the host country and from people from their own backgrounds. This form of isolation is associated with the highest levels of mental health problems (Berry 1997). Those experiencing threats and abuse may feel disinclined to venture out, especially on their own, reducing their sense of connection with the host culture.

- **Detention**

Being placed in detention can lead to extreme anxiety, vulnerability and a deep sense of isolation. Visitors from voluntary organisations or religious groups can make an important contribution by providing contact with someone who understands their home country and culture.

- **Dispersal across the UK**

This may have an impact on mental well being. In a study of the mental health experiences of asylum seekers over a six month period (Watters 2002), almost all those interviewed believed the prospect of dispersal exacerbated their mental health problems and reduced opportunities for developing community networks. This was seen as impacting on continuity of care and, where dispersal was to areas with low concentrations of refugees, leading to high visibility and an increase in racial abuse.

Stigma

The stigma and taboo associated with mental health means communities may deal with mental health problems by ignoring them or sweeping them under the carpet, rather than facing the situation and seeking help. This is compounded by a lack of information, mental health promotion campaigns or education targeting these communities and few if any services for them to access. For many refugees and asylum seekers, issues of culture and religion are powerful forces that shape community attitudes to health and health related issues.

Social exclusion

Racism and social exclusion, both from the general public and from service providers, can result in direct and indirect discrimination. Refugees and asylum seekers may find themselves with no choice over where they live, and may have no, or minimal, access to cash. In a study of Iraqi asylum seekers, depression was more closely linked with poor social support than with a history of torture (Gorst-Unsworth and Goldenberg 1998). Studies are revealing the impact of boredom, isolation, unemployment and poverty on mental health, and how without the existence of support networks to act as a buffer to social stress, mechanisms for preventing mental ill health are eroded (Beiser 1999; Watters 2001). Asylum seekers are not allowed to work. Men granted refugee status are less likely to find employment than women, which may contribute to a greater sense of loss of status. In an overview of refugee needs, the importance of building on and supporting people's survival skills and resilience and creating opportunities for refugees and asylum seekers to use their skills and qualifications was highlighted (Woodhead 2000).

The South Asian Community

Introduction

The South Asian community is the largest ethnic minority group living in Britain, representing just over 4% of the population (2001 Census) and consists of four main groups of people – Indian (1.8%), Pakistani (1.3%), Bangladeshi (0.5%) and other Asian (0.4%). Most immigration from the Indian subcontinent occurred in the late 1950s and there are now at least three generations living here with some people considering themselves as British Asian rather than Indian, Pakistani or Bangladeshi. South Asian culture is very diverse, encompassing hundreds of languages and dialects, many religions, beliefs, people of different classes, beliefs, histories and countries. The structure of the South Asian population differs markedly from the white population, in that there is a large proportion of children and a smaller older population.

The Bangladeshi communities live predominantly in the Greater London area, mostly inner London. One third of the entire Indian community lives in outer London boroughs, with substantial concentrations also in the West Midlands and Leicestershire, while the Pakistani population tend to be more concentrated in the West Midlands and West Yorkshire.

Mental health issues

The South Asian community hold onto the belief that mental health services are only for those with severe mental health problems and that there is a real danger of being labelled and confined to institutions. This fear, lack of information, past negative experience and lack of adequate provisions have led to mental health services being inaccessible to the community.

Use of primary care

Many South Asian people experiencing mental health problems find it difficult to seek effective help. Consultation rates for mental health problems, in particular anxiety and depression, may be lower in South Asians than in the white population, and patients from this community are less likely to have mental health problems recognised by their GP (Gillam et al 1989; Odell et al 1997; Bhui et al 2001; Jacob et al 1998). Alternatively, the nature of their presentation may be wrongly attributed to mental illness (Wilson 1993).

A number of studies explore the mental health and illness experiences and expressions of distress by South Asian people and these highlight how discordant the experiences of patients and their doctors can be (Krause 1989, Fenton and Sadiq-Sangster 1996, Curren 1986). There is an underestimation by GPs of psychological distress among South Asian women (Williams et al 1997).

In a study (Women Speak Out 2002) the majority of South Asian women felt that women from a similar culture were more likely to understand them, and some felt male South Asian doctors would not be supportive to South Asian women. This raises the need for workers to be alert to the interaction of race and gender inequalities.

Use of secondary services

In relation to the South Asian community, there is evidence of multiple barriers to access of appropriate services, lack of preventative care, and the evidence that services are mainly accessed at the point of crisis.

Depression and anxiety

It is unclear whether people from South Asian communities experience an increased prevalence of depression compared with the white population. Consultation rates with GPs for anxiety and depression are lower for people from South Asian communities, but presentation of somatic symptoms is higher (Gillam et al 1989). It is possible that depressed people of South Asian origin do not consult their GP, or they may do so principally with somatic symptoms and the depression is not recognised (Balarajan et al 1989; Gillam et al 1989; Lloyd 1992).

A study conducted in Birmingham showed a higher rate of depression and very low rate of dementia among elderly South Asians compared to elderly white people (Ananthanarayanan 1996).

Suicide and self harm

The rate of attempted suicide by young South Asian women is amongst the highest in this country. National data show that women born in India and East Africa have a 40% higher suicide rate than women born in England and Wales (Raleigh and Balarajan 1992; Raleigh 1996). Excessive suicide among women of South Asian origin is particularly high in the age group 15-24 years where it is more than twice the national average. In contrast, for South Asian men and the elderly, suicide rates are lower than the national average (Bhugra et al 1999a).

Among South Asian women, attempted suicide is less likely to be related to untreated mental health problems (Glover 1989; Bhugra et al 1999b and 1999c; Raleigh and Balarajan 1992). Being married does not appear to lessen suicide risk for this group. For young South Asian people, cultural conflict has been suggested as a precipitating factor in suicide and attempted suicide (Merrill and Owens 1986; Raleigh et al 1990; Raleigh 1996; Bhugra et al 1999b; Department of Health 2001). Adolescent South Asian girls are more likely than other girls their age to suffer certain types of mental health problems such as suicide, self harm and eating disorders (Department of Health 2002; Chantler et al 2002; Newham Inner City Multifund and NAWP 1998).

Alcohol misuse

Indian born men have the highest rates of admission to psychiatric hospital for alcohol problems, while South Asian women consume less alcohol than their white counterparts (Shaikh & Naz 2000). Excessive drinking is associated with depression, anxiety, eating disorders and personality problems. 10% of psychiatric inpatients have an alcohol problem. There are also high rates of suicide among people with alcohol problems and alcohol is involved in up to 65% of suicide attempts.

Social risk factors

- Isolation is a key issue for South Asian women and self help groups are valued by them as a way of breaking isolation, gaining practical and emotional support and in providing a sense of belonging (Women Speak Out 2002).
- Elderly South Asian people are more likely than their white counterparts to live in overcrowded and substandard housing in inner city areas, have little knowledge of health and social services and limited access to transport and telephone (Norman 1985).
- Unemployment among white men is 15% compared with Indian men (19%), Pakistani men (38%) and Bangladeshi men (42%) (Nazroo 1997).
- A study of unemployment among British Asians living in the North of England showed that the unemployed group had lower levels of psychological well being, self esteem and employment commitment than the employed group (Shams et al 1994). Absence of a full-time worker in the household is significantly associated with depression in South Asian people (Nazroo 1997).
- South Asian communities experience high rates of social deprivation, lack appropriate preventative care and often wait for conditions to reach crisis point before they reach services (Nazroo 1997).

- Pakistani and Bangladeshi owner-occupiers occupy the poorest quality properties and experience the highest levels of overcrowding than any other group (Nazroo 1997).
- Religion has a big part to play in the lives of South Asian families, with religious practices crossing over with cultural practices (Nazroo 1997).
- More than four out of five Bangladeshi and Pakistani households fall below a poverty benchmark which affects one fifth of white non-pensioners, unemployed people, single parents and disabled people (Nazroo 1997).
- Educationally, Bangladeshis are the least qualified of any group in the UK (Nazroo 1997).

Stigma

There are negative perceptions and stigma around mental health among the South Asian community commonly associated with a lack of understanding of the range of mental health conditions and lack of awareness of available support. Stigma creates a barrier to accessing services.

Both professionals and community members identify stigma as an issue, and believe that myths and stereotypes about South Asian communities coping on their own or not having mental health problems still prevail (Bashford et al 2002).

Social exclusion

In a review of mental health service provision for South Asian communities in Bury and Rochdale (Bashford et al 2002), users from the South Asian community highlighted the detrimental impact of mental health problems on education and expressed feelings of isolation and detachment from social networks.

The Vietnamese Community

Introduction

Between 1975 and 1990, following the war between North and South Vietnam, over two million Vietnamese people fled to nearly 70 countries across the world. In 1979, a group of 11,000 refugees from Vietnam was invited to settle in the UK, followed by a further 2,000 in 1989. Since then, more Vietnamese people from Hong Kong and the South East Asia camps have been accepted. The Vietnamese refugee population in the UK is currently estimated to be 27,000, with 16,000 living in the Greater London area and the rest dispersed throughout Britain, in particular Birmingham, Manchester, Edinburgh, Leeds, and Milton Keynes.

The majority (70%) of Vietnamese in the UK comes from North Vietnam. 60% of the population here are ethnic Chinese, most of whom are from families who lived in Vietnam for many generations and mostly speak Vietnamese as well as Cantonese.

The Vietnamese community in the UK is comparatively young, but successful in terms of educational achievement and business development (2002 National Conference of Vietnamese Community Organisations – unpublished, available from Vietnamese Mental Health Association). Because the Vietnamese community is now relatively established, other refugee groups have tended to be prioritised for funding.

Mental health issues

Use of primary care and secondary services

A national survey on Chinese and Vietnamese mental health needs was commissioned in 1997 (NHS Ethnic Health Unit 1997). Key findings from this research have shown that Chinese and Vietnamese people experience long delays before coming into contact with health professionals. Lack of knowledge about the health and social care system contributes to the low take up of mental health services provided at both primary and secondary level. This includes not knowing when and how to approach services and who to seek help from (Vietnamese Mental Health Services 2001).

Language barriers also lead to poor access to services. Lack of interpreting and translation services means users sometimes have to rely on family members.

Social risk factors

Although the Vietnamese community has been settled in the UK for longer than most other refugees and asylum seekers, they share a range of experiences and social pressures that impact on their mental health. People may experience a mixture of hope, fear and uncertainty about the future, with unmet expectations and harsh realities that contribute to making life difficult.

- **Experience in Vietnam and on route for the UK**
Many people from Vietnam experienced long term exposure to violence and insecurity during the warfare between 1945 and 1975; their journey out of Vietnam was often very dangerous; and many were kept in harsh detention camps in Hong Kong and South East Asia.
- **Dispersal across the UK**
The Government's dispersal strategy meant Vietnamese people were scattered across the UK, some living in parts of the country where there was no significant minority ethnic community.
- **Unemployment**
Another major barrier to social integration has been high unemployment, because of a lack of marketable skills, language barriers and discrimination.
- **Poor housing**
Many Vietnamese people were originally housed in poor properties, often in inner city areas in what were sometimes hostile communities. Many of those settled in rural areas migrated to join the Vietnamese communities in London and other major cities, usually moving to poor accommodation.
- **Breakdown of traditional family structures**
Vietnamese people are used to living in an extended family, but this has now broken down for many families. This has a particular effect on elders who find their traditional family roles compromised and their value challenged.
- **Low educational attainment**
Long term instability in North Vietnam where most Vietnamese refugees come from meant that many people arrived in the UK with limited formal education, and language difficulties have added to the problem.

- **Different concepts of mental illness and health**

Cultural beliefs about mental health make it difficult to accept Western models. Many Vietnamese people believe strongly in spirituality. Mental health problems are often interpreted as a punishment imposed on people by supernatural powers for sins committed by their ancestors. Thus, no treatment or management can be effective except praying or seeing a medium to evict the 'bad spirit' from the patient's mind. Differing cultural perceptions can be a difficult problem to get over but not impossible if adequate information and continuing support is provided, and if the approach to users and carers is friendly, non-judgmental and supportive.

Stigma

Mental illness brings strong stigma to the whole family. Stigma associated with mental health problems prevents many Vietnamese people from seeking help until they reach crisis. Because of stigma, some carers prefer to hide their family member at home rather than seeking help, in many cases exacerbating the illness (Vietnamese Mental Health Services 2001).

Social exclusion

Vietnamese refugees are vulnerable and disadvantaged when they arrive in the UK, having to cope with new lives. Language and cultural barriers can cause isolation and distress, and elders may be particularly lonely.

There are also difficulties adapting to the education and employment system and adjusting to living in a very different environment. The benefits system is complex and information in Vietnamese is non-existent.

Key mental health issues for black and minority ethnic communities:

This table summarises information in this chapter and shows some common issues affecting all communities, such as racism, stigma and poverty, as well as highlighting some issues that affect some communities disproportionately (while recognising the immense diversity within each community and avoiding stereotyping).

	African Caribbean	Chinese	Irish	Refugees and Asylum Seekers	South Asian	Vietnamese	
General:	Racism	◆	◆	◆	◆	◆	
	Stigma	◆	◆	◆	◆	◆	
	Language barriers		◆	◆	◆	◆	
	Cultural beliefs and practices			◆	◆	◆	
Social risk factors:	Poverty	◆	◆	◆	◆	◆	
	Unemployment	Men	Women	◆	◆	◆	
	Low levels of education		1st generation		Bangladeshi	1st generation	
	Exclusion from school	◆					
	Loneliness and isolation	◆	◆	◆	◆	◆	
	Homelessness	◆		t		◆	
Contact with the criminal justice system	◆		t			◆	
Health:	Alcohol misuse		◆		men		
	Low rates of anxiety and depression						
	High suicide rates		◆		women		
	Over diagnosis of schizophrenia	◆					
Under diagnosis of depression/affective disorders	◆	◆			◆		
Service issues:	Lack of knowledge of services	◆	◆ especially men	◆	elderly	◆	
	Under use of mental health services		◆ especially men				
	Delay seeking help	◆	◆	◆	◆	◆	
	Over use of physical/drug treatments	◆		◆			
	Under use of psychological/talking treatments	◆	◆				
	Compulsory admission under Mental Health Act	◆		◆			
	High rates of admission/readmission	◆		◆			
	Low rates of admission		◆				
	Families/Carers have difficulties accessing help	◆	◆				◆

3 Strategies for Mental Health Promotion with Black and Minority Ethnic Communities

This Chapter explores some of the key principles and approaches needed to ensure that mental health promotion strategies effectively meet the needs of black and minority ethnic communities, challenge health inequalities and promote the mental health of all including the most vulnerable. For mental health promotion strategies and interventions to impact positively on black and minority ethnic communities, programmes of work need to be relevant to their needs and targeted directly to those communities. Black and minority ethnic-led initiatives are more likely to be sensitive to and responsive to the needs of the communities they serve, and are generally perceived by the communities themselves as committed and credible. The Race Relations Amendment Act requires all stakeholders within the local mental health promotion strategy to have an awareness and understanding of race equality issues and to include race equality as fundamental to all aspects of their work rather than viewing black and minority ethnic communities as an issue or problem to be solved.

People involved in developing and delivering mental health promotion strategies, in particular all stakeholders within the Local Strategic Partnership, need to consider the extent to which the needs of the whole population, including local black and minority ethnic communities are or are not being met. Their knowledge and understanding of the voluntary sector and the communities they serve will enable them to engage more effectively with black and minority ethnic communities. Many organisations involved in a Local Strategic partnership are bound by the race equality duty to carry out impact assessment to identify whether the needs of the whole population including all local minority ethnic communities are being met. The Commission for Racial Equality has produced some guidelines *Public Authorities and Partnerships: A guide to the duty to promote race equality*. This sets out the steps a partnership should take to meet the duty to promote race equality effectively.

Consultation with black and minority ethnic communities carried out by the Mental Health Act Commission (2001) identified a number of themes that are relevant to the development of local mental health promotion strategies including:

- the need to consult with and act upon the views, perceptions and priorities of black and minority ethnic communities
- the stigma attached to mental illness within communities

- the need to recognise the religious, linguistic and cultural needs of black and minority ethnic communities
- the non-therapeutic environment of local services
- the need for partnerships with the black and minority ethnic voluntary sector to be fostered and developed.

Consulting and working with black and minority ethnic communities and organisations

The Race Relations Amendment Act (2000) requires all listed public authorities in their Race Equality Schemes to set out their arrangements for assessing and consulting on proposed policies as well as monitoring them for adverse impact. This links to Government emphasis on user involvement and into formal structures and legal framework for patient and public involvement.

- Public services are required not only to consult the public, but also to encourage involvement in decision making on policy and service delivery issues, as part of the Government's wider modernising agenda. However, the evidence suggests that such exercises often fail to genuinely include black and minority ethnic communities, and where consultation does take place there is scepticism about the influence it has on decisions.
- Consultation is seen as an essential tool for providing effective and responsive public services, strengthening accountability and increasing effectiveness of service delivery. The most popular approach to community engagement has been consultation, but this in itself is not enough, especially where there is a history of consultation that has not resulted in desirable and sustainable change. When decisions are taken elsewhere, communities are left with a sense of having things done to or for them, not with them.
- Consultation needs to lead to innovation about ways to improve mental health services and mental health promotion. At the heart of consultation is the issue of representation and who is selected to be involved. Workers in the black and minority ethnic voluntary sector are often used as representatives, spokespersons and community leaders for black and minority ethnic communities, although they may not perceive themselves in this context (Keating et al 2003). Those black organisations that are viewed as less well established or stable tend to be excluded from consultation processes and decision-making structures, increasing the inequalities that exist between groups.

It is important to engage black and minority ethnic communities in the design and delivery of creative and sensitive consultation formats – identifying who to consult with, where and when; being actively involved in promoting and carrying out the consultation, and analysing the findings. People from black and minority ethnic communities should be employed in health promotion teams or as consultants to engage with different community groups to assist this process.

Barriers to involvement and inclusion of black and minority ethnic communities include:

- limited access to information and advice
- lack of knowledge and skills
- lack of confidence amongst mainstream partners in the voluntary and community sector to manage programmes of work
- mistrust of mainstream agencies among many black and minority ethnic community groups, based on a belief that services have not adequately addressed their needs
- capacity constraints – most black and minority ethnic organisations are small and target localised communities
- language barriers
- unequal partners and unequal competitors for funding – bureaucracy, the burden of administrative and monitoring requirements, lack of support or guidance, complexity of partnership arrangements.

There are legal implications for failing to involve and include black and minority ethnic communities, for example if an NHS Trust makes a decision on a policy where individuals do not consider there have been effective arrangements for consulting them and this has resulted in adverse impact. Public Authorities are required to demonstrate that they have arrangements to ensure access to information and services for all members of the public. This builds on Section 20 of the Race relations Act 1976 but it is now a specific duty. The provision of language support is key to this but it must be done in a way which is effective and comfortable for users. Bilingual advocates are very important and should be distinguished from interpreters.

- Difficulties in involving black and minority ethnic groups in general consultation strategies such as surveys and neighbourhood forums have led some local authorities and healthcare providers to develop more innovative approaches. For example, links are being made between capacity building and consultation as part of a drive toward helping people build skills and develop employment opportunities, while helping

services consult with 'difficult to reach' groups. Within healthcare, deliberative methods such as citizen's juries have been used to assess the healthcare needs of ethnic minority groups, prior to planning the public information strategy in a Health Action Zone. Theatre story-telling workshops, facilitated by bilingual advocates and separated by gender and age have been used to encourage freer discussion on sensitive issues such as drug abuse and sexual health among Bangladeshi participants in East London.

- It may be necessary to consult women and men separately, sometimes on a one-to-one basis. Specific consultation techniques should not lead authorities to ignore the need to ensure that general consultation exercises are as inclusive as possible of the whole community.
- People from black and minority ethnic communities need to be fully involved in the design of mental health promotion programmes, and mental health promotion teams need to reflect the cultural diversity of the local population. Mental health promotion programmes are needed to build the mental health literacy of black and minority ethnic communities and to get across the message that it is acceptable to talk about mental distress and better to do something about it as soon as concerns arise.
- Communities must be involved in planning, implementing and evaluating mental health promotion interventions to ensure they are based on a real understanding of people's values and beliefs and the factors that influence their lifestyles. Mental health promotion initiatives need to be planned and implemented in partnership with black and minority ethnic communities, including the involvement of service users and carers, because they are fully aware of the needs of the community and, where appropriate, can communicate in relevant languages.
- Black and minority ethnic voluntary organisations are generally community-based and reflect the cultural traditions of the communities they serve, and the support and care provided by them is highly valued within different communities. What these voluntary services are often able to do, compared with mainstream services, is to tap into and reflect personal experiences and histories, providing a safe environment that is non-stigmatising and affirming.
- Black and minority ethnic voluntary agencies have pioneered a wide variety of mental health promotion interventions and services. They have the skills to work with local people to identify and solve problems affecting their mental health, and help build capacity within communities to meet their own mental health needs through, for example, mental health promotion and training for health professionals.

- The black and minority ethnic voluntary sector requires sustainable core funding so that it can work with black and minority ethnic service users, families and carer groups. It also needs funding to provide support and advocacy services to allow groups to identify and meet their own mental health needs and promote better mental health within the community. Mental health promotion programmes need to work in partnership with this sector and contribute to building their capacity and sustainability.
- Gateway agencies are needed to build bridges between the black and minority ethnic community and statutory services whilst advocating for service users from these groups, and some of these could be developed from existing community organisations (Sainsbury Centre for Mental Health 2002). These agencies could have a mental health promotion role, providing education, training and advice around mental health issues and black and minority ethnic communities.
- Community organisations working with a particular community, for example the Chinese community, are well placed to develop both mental health advice and mental health promotion, involving culturally and linguistically competent mental health workers linked to mainstream services and trained community workers. Mental health workers who are familiar with different languages can link with community organisations as well as in primary and secondary care health services in areas with larger black and minority ethnic populations.
- Refugee community organisations are very unevenly distributed, with most being in London and a few other large cities across the UK where dispersal of refugees takes place. While few, if any, directly provide mental health care, these organisations provide an important preventative function through helping refugees establish social support networks and a sense of purpose. Community organisations may also have an important role in helping local agencies to deliver services more effectively and to avoid costly mistakes (Audit Commission 2000).

Checklist – Action points to help you develop a model for engaging with black and minority communities on mental health promotion:

You need to take account of the Race Relations Amendment Act (2000) which requires listed public authorities to promote race equality, including making sure the public have access to information and services and carrying out ethnic monitoring (see information about the RR(A)A in Appendix 1)

- Do you have an accurate baseline of black and minority ethnic communities in your area, endorsed by those black and minority ethnic communities?
- Do you know about the local black and minority ethnic voluntary sector – what services are provided, which communities are served, who is involved?
- Has there been active promotion to raise awareness of mental health and the local mental health promotion strategy (through outreach, working through voluntary, community and faith organisations)
- Are you engaging with black and minority ethnic communities to be involved in planning, delivering and monitoring mental health promotion
- Is key information, for example about project development and plans, produced in accessible formats?
- Have you set aside resources for capacity building and support to develop projects and pilot schemes
- Are black and minority ethnic groups and the agencies that work with them encouraged to work together?
- Do you have a rigorous monitoring and evaluation framework for black and minority ethnic engagement and impact?
- Do you have a workforce and management structure that reflects the local black and minority ethnic population?
- Do you ensure that black and minority ethnic communities are not ‘ghettoised’ on particular themes?

(Adapted from www.renewal.net/)

Developing appropriate services

- Mental health promotion strategies should identify ways to ensure services are meeting the needs of black and minority ethnic communities more effectively. People want a positive attitude and a person-centred approach whatever the background of staff members. Services need to adopt a holistic 'whole person' approach and place a greater emphasis on the value of positive professional and interpersonal relationships. Service users, families and carers need to be treated with dignity and respect, valued, listened to and heard, and staff should be able to engage with them and see the world from their perspective (Secker and Harding 2002).
- Both specific services and generic services are needed to meet the needs of black and minority ethnic communities. In one study, most African Caribbean service users said they wanted a service that everyone could access and benefit from, rather than one that was ethnic-specific (Robertson et al 1999). For generic services to meet the needs of different communities, they must show how they are engaging effectively with them and enabling them to define the service agenda or at least influence the process. Otherwise black and minority ethnic communities cannot be expected to trust mainstream services and engage with them.
- Counselling services need to be provided that are responsive to the needs of black and minority ethnic communities and provided in relevant languages, including the development of school and college based counselling. Support for counselling services provided by black and minority ethnic voluntary organisations can contribute to this goal.
- An emphasis on treating illness primarily through medication may fail to meet the needs of people from black and minority ethnic communities, who feel their beliefs, culture and language have been undermined and not taken into account in the provision of care. This mismatch may lead to mis-diagnosis and treatments that deny individuals choice and the opportunity to express their feelings using familiar concepts and language. The delivery of services by practitioners trained in Western medical models may not be appropriate in detecting, assessing and treating mental illness in some communities, for example South Asian communities. These models are inappropriate for use with South Asian communities whose life experiences and belief systems are based on non-western paradigms.
- The environment in which services and interventions are provided is also important to service users, with, for example, decoration reflecting cultural diversity through colour and style, cultural artefacts and posters. Primary care and other services need to be

made more welcoming, accessible and relevant so that, for example, African Caribbean people engage with services earlier ensuring the provision of less coercive crisis services.

- Mental health promotion can contribute by providing training for service providers to raise awareness and increase understanding and appreciation of cultural traditions and the impact of racism on people's lives.
- Services need to provide access to interpreters as well as to professionals who speak relevant community languages, especially GPs. Counselling services also need to be available in different languages. Access to and appropriateness of interpreters is crucial to the delivery of effective mental health assessments for black and minority ethnic communities.
- More resources and funding are needed for better, accessible, culturally and linguistic appropriate, bi-lingual services and resources to address mental health issues for refugees and asylum seekers within their social context, taking account of issues around race and gender. GPs need help to identify where to refer refugees for appropriate care, and how to involve interpreters in the process.
- Resources are needed to build on the coping mechanisms developed by refugees and harness the skills within their communities that can contribute to and compliment services. Their professional training and expertise used in careers in their home countries needs to be tapped and appropriate support and training provided to enable them to transfer skills and qualifications to employment here.
- Refugees and asylum seekers need to be listened to and empowered through access to advocates, information, training, and choice and decision making about care. The challenge for services and for mental health promotion is to be proactive, offering culturally competent, holistic and preventative approaches and providing an integrated approach.

'Appointments at GP very difficult to make due to language problem . Lack of social and emotional support finds many women presenting in mental health services in crisis.'

(Asian female worker at Inside:Outside consultation event in Bradford, Real Voices 2003 p.22)

Training

- Training is needed for a range of generic health and wider public sector workers who have frequent contact with people experiencing mental health problems. This would aim to improve the way in which people from black and minority ethnic communities experience services, to help workers better understand the mental health needs of different communities and how to engage with them. It can be very helpful to involve people from black and minority ethnic communities in planning and delivering this training. Service providers need the knowledge, understanding and attitudes to ensure they communicate, assess and provide services in a culturally sensitive way. Community organisations and black and minority ethnic voluntary agencies have a role to play in ensuring health and social care professionals understand the needs of the different communities.

Training should be provided for:

- Primary care staff including receptionists, practice nurses and GPs
- Mental health workers
- Social workers and housing officers
- Interpreters
- Benefits agency staff
- Agencies working with refugees and asylum seekers
- Prison officers
- Probation officers
- Police officers
- Workers within specific community organisations need training to help them recognise mental illness and know how to access appropriate services for their clients. People within different communities, for example refugee and asylum seekers, also need training to increase their knowledge and understanding of mental health issues, and the services and sources of support available.
- The Race Relations Amendment Act (2000) requires listed public authorities to provide training for their staff, especially those whose roles have direct relevance, in their duty to promote race equality. Staff also need to understand their own liability in exercising their functions.

Employment and training opportunities

- Employment can have a very positive impact on quality of life and mental health (Evans and Repper 2000), and therefore mental health promotion strategies need to identify ways to promote employment for people from black and minority ethnic communities with mental health problems. One approach is to develop partnerships with agencies that can offer opportunities for supported employment in a real workplace, as well as training opportunities, for example community-based training in computer literacy, that increase access to employment.
- In the Circles of Fear study (Sainsbury Centre for Mental Health 2002) African Caribbean service users identified a lack support in community settings, especially day centres, to help them re-engage with social activities, employment and training. The employment and training expectations of some of those interviewed were not matched by what was on offer. People expected real jobs or training opportunities.
- Opportunities for work need to be developed through training and employment initiatives, for example through Neighbourhood Renewal Funding, so that for example refugees can deliver local mental health support and mental health promotion. Refugee communities can also be encouraged to provide self-help and self managed support groups and networking.

Raising mental health awareness

- There is a need to increase understanding and knowledge about mental health and reduce the stigma associated with mental illness. A mental health promotion strategy should raise awareness of mental health issues, mental health services and how to access them, and demystify mental illness and encourage people to seek help. Such a programme must be designed and delivered in partnership with the black and minority ethnic community and their community organisations to ensure the content, language, tone and delivery mechanisms meet the needs of the community.
- Awareness raising can take place through education, campaign work, and via the local media. Information should be produced in relevant community languages and in easy-to-understand formats and made available to mental health service users and their carers, and to the wider community.

- There is a strong sense in the Chinese community that self help, early detection and greater awareness about mental health through information would help avoid the problems currently associated with mental illness for many individuals (Cowan 2001; Li & Logan 1999).
- To deal with the fear and mistrust of mental health and mental health services, mental health promotion strategies need to raise awareness of mental health in different communities and reduce the stigma associated with mental illness. A number of innovative approaches can be used such as videos, drama, and local health festivals, and developing a mental health awareness campaign in the community, including links with the Health Promoting Schools initiative.

‘Work should be done with communities to acknowledge mental health as an important part of a whole person. We all have mental health but I feel this is not acknowledged so that when mental health becomes ill health – individuals and communities can understand what has happened and deal with it with support.’

(Asian female user/carer at Inside: outside consultation event in Birmingham, Real Voices 2003 p. 29)

Support for black and minority ethnic user groups, carers and families

- Black and minority ethnic user movements and groups are emerging only slowly, despite evidence to show the importance of user involvement and empowerment in achieving responsive services (Rose 2001) and the value of bringing people together to share common problems and gain more confidence and control over their health. There is a lack of infrastructure to aid and support capacity in these groups. Mental health promotion strategies need to address the barriers to the development of these groups within black and minority ethnic communities, and support user groups to work in tandem with other groups rather than working in isolation that can lead to marginalisation and reinforce stereotyped views.
- Mental health promotion strategies need to identify work with carer organisations to promote support, training and information for carers and families. Interventions to help increase their knowledge and understanding about positive mental health, mental illness, symptoms and ways of dealing with them, and mental health services are needed so they are empowered to promote their own mental health and well being and that of the person they care for. Primary care has an important role in ensuring that carers needs are identified and appropriate emotional and practical support is provided.

- Carers provide a high level of support that can have a detrimental effect on their own health, and often they face a number of barriers in gaining access to appropriate services. Carer organisations and support groups were identified by carers as useful sources of support and solidarity, allowing them to share their experiences with others in similar situations and access useful information (Sainsbury Centre for Mental Health 2002).
- Carers and family members are often used by service providers as interpreters which is inappropriate and can lead to tensions and conflicts of interest.
- African Caribbean carers and families tend to be much more involved in the early stages of contact with mental health services than is the case in the white population. They are powerful advocates with a key role to play in seeking help early, mental health care planning, intervention and recovery (Bates 2002).
- South Asian carers' experiences parallel those of others but there are some issues that are distinct, including language and communication barriers, culturally inappropriate service and implicit or explicit racism (Katbamna et al 2002).

'Work with families where possible. Mental ill health affects the carers and dependents too.'

(Asian female user/worker/carer at Inside:Outside consultation event in London, Real Voices 2003, p.35)

Promoting holistic approaches

- Mental health promotion strategies and interventions should take account of the value black and minority ethnic communities place on services that offer a holistic approach (whole mind and body approach), promote greater community involvement in decision making and recognise the impact of racism on people's experiences of every day life. For example, the Chinese community has a holistic approach to health and places importance on prevention as a means of achieving this, making them open to mental health promotion interventions (Li & Logan 1999; Li et al 1999). There is also a strong demand among the African Caribbean community for a holistic approach (Alexander 1999) and African Caribbean young men particularly value mental health promotion programmes involving arts, creativity, spirituality and alternative therapies, integrated with education, training and employment opportunities (**mentality** 2002, unpublished).
- There is enormous potential to promote mental health within informal and non health-specific settings. For example, the strength and resources within families, cultural groups, the church, other religious or spiritual groups and community self help groups

can be used, and leisure facilities, commercial organisations and local meeting points such as coffee shops or barbers exploited. The aim should be to develop activities that build self-esteem and independence, provide choice and increase participation.

- Mental health workers need to incorporate a range of belief systems and explanatory models into their understanding of mental health in their work with black and minority ethnic communities, so that healing strategies that are embedded in other belief systems are incorporated into Western models of care (Barnes & Bowl 2001).

'...I feel a medical model does not address central issues of mental health for Asian people (and other minority groups), which are to me linked to social issues...'

(Asian male at Inside:Outside consultation event in London, Real Voices 2003 p. 26)

Challenging discrimination, stereotypes and disadvantage

- There is widespread experience of discrimination and disadvantage among black and minority ethnic communities. Mental health promotion strategies need to address this and challenge stereotypes to enable people from different communities to develop positive cultural identity and thereby build their confidence and sense of worth. People from different communities will benefit from living in a community that understands them, values, supports and empowers them.
- Work is needed to challenge stereotypes and reduce the political, social and economic barriers influencing the capacity of different communities to participate. For example, in the Irish community, interventions are needed to break down some of the cultural barriers that prevent the expression of real emotion and distress. In this way, people will be enabled to be more open and self-disclosing to protect their own mental health and allow them to reach out to other members of their community in distress. Work is also needed to improve housing situations, increase access to benefit entitlements, ensure people are registered with a doctor and have access to good quality health care including specialist drugs and mental health services and other support services when they need them.
- Strategies should develop links with the Irish business community and work in partnership to encourage employers to consider more positive action, job creation and sponsorship. Volunteer programmes may also help. Lessons can be learnt from other communities who value and support more vulnerable members whilst recognising the success of others.

- Social capital within African Caribbean communities needs to be valued and enhanced (Diamond 2001), and social exclusion and stigma reduced by broad-based programmes that provide social and material support. Mental health promotion programmes can contribute through schemes providing befriending and social support, employment and training opportunities.
- Building partnerships to address hostility, racism, stigma and taboo towards refugees and asylum seekers within the wider society is crucial, including tackling negative media coverage. A holistic approach for work with refugees and asylum seekers should include preventative measures to address the social deprivation affecting their mental health.

Promoting social support and reducing isolation

- Many black and minority ethnic communities experience high levels of isolation and strategies to reduce isolation and promote social support can contribute to mental well being.
- Chinese people have identified the need for greater understanding and support from family members, opportunities for family reunions, and wider social networks for mutual support, as well as opportunities for more leisure activities, and better childcare provision to make it more accessible
- Reducing isolation and dependence and identifying suitable accommodation should underpin mental health promotion strategies for refugees and asylum seekers. Refugee community organisations provide an important role in addressing issues of isolation. They can provide information and practical support to refugees from a particular geographical area or belonging to a particular political or ethnic group, be a link to the home country, and act as advocates in interactions with services.
- For refugees and asylum seekers, Burnett and Peel (2001a and 2001b) identify support for people from within their own communities and opportunities for developing links and friendships with the host community as crucial to promoting health and well being. Participation in all parts of social life and creative social activities as fully participating citizens will promote relationships within the community and should be encouraged.
- For some refugees, religious organisations may provide some sense of community and support. Those that belong to major faith communities will find churches, mosques and temples within the UK who can offer support and may provide an opportunity to meet with others from similar backgrounds.

- For the Irish community, interventions are needed to promote opportunities for social links and help people to keep in touch with friends, Irish culture and music, for example, and maintaining contact with family both in Ireland and England. This is an especially important issue for Irish people living in temporary and vulnerable accommodation.

Tackling racism and discrimination

- Racism affects mental well being in two main ways.
 - It contributes to mental distress and can lead to feelings of isolation, fear, intimidation, low self esteem and anger. Depression may be caused by feelings of rejection, loss, helplessness, hopelessness and an inability to have control over external forces (Gray 1999; Sashidharan and Francis 1993). Research has found that many people from black and minority ethnic communities regard racism and its effects as a major contributing factor to the prevalence of mental health problems (Alexander 1999).
 - It can act as a barrier to the access and provision of appropriate services. Black and minority ethnic groups may feel excluded from services because of direct discrimination, for example the attitudes of staff towards them, or through indirect discrimination such as being unable to access services because of language barriers. Racial harassment of staff and patients by staff and patients is a widespread problem in the NHS (Rawaf and Bahl 1998).
 - Identity is an important component of self-esteem and positive mental health and for black and minority ethnic communities it is important to provide opportunities to build a sense of identity to help externalise stress and provide a sense of meaning, history and group affiliation (Dana 2002). Racism, however, erodes positive identity and leads to much poorer mental health. An individual's perception of society as racist and the experience of everyday minor acts of discrimination acts as a chronic stressor, while experience of more overt racism acts as an acute stressor superimposed on this chronic stress (Bhugra & Cochrane 2001).
- Mental health promotion strategies need to recognise the double stigma of racism and mental illness, and identify effective ways to tackle racism and discrimination by:
 - providing training to ensure the provision of more culturally competent services that are accepting of diversity and difference, ensuring that people working in health and social care are aware of their duty to provide services without prejudice

and in a manner that acknowledges and respects the cultural diversity of the communities served

- supporting black and minority ethnic mental health needs assessment and its use in service planning and the planning of mental health promotion initiatives
- promoting the mainstreaming of the equalities agenda across the board so as to minimise the risk of issues affecting black and minority ethnic communities becoming marginalized
- encouraging a systematic evaluation of both generic mental health promotion initiatives and those designed specifically for black and minority ethnic communities to establish how far these are meeting actual needs, and promote research into areas of unmet need to fill gaps in existing data.

Summary – Mental health promotion with black and minority ethnic communities

You need to take account of the Race Relations Amendment Act (2000) which requires listed public authorities to promote race equality, including making sure the public have access to information and services and carrying out ethnic monitoring (see information about the RR(A)A in Appendix 1)

- Challenge health inequalities and promote community cohesion by ensuring mental health promotion strategies effectively meet the needs of black and minority ethnic communities
- Consult effectively with black and minority ethnic communities and ensure community involvement and ownership in planning, implementing and evaluating mental health promotion interventions
- Identify adequate and sustained funding for black and minority ethnic voluntary sector organisations and projects
- Provide training for a wide range of workers to improve the way in which people from black and minority ethnic communities experience services
- Challenge racism and discrimination, both within services and in the wider community
- Raise awareness about mental health issues and build the mental health literacy of black and minority ethnic communities

- Provide accessible information about local services
- Develop health promotion materials, including written and multimedia information, specifically designed for individual communities
- Work with opinion formers and key black and minority ethnic community organisations, including religious leaders, youth agencies, businesses
- Provide support for families and carers, including access to information, training and involvement in care planning and intervention
- Provide support for black and minority ethnic user groups
- Offer services and support within community venues that the community will access, including youth centres, schools, leisure facilities, businesses and churches
- Ensure effective interpreting services are in place
- Promote employment opportunities for people from black and minority ethnic groups
- Work with services to ensure they meet the needs of black and minority ethnic communities

4 Principles of Effective Practice

Chapter Four considers the risk and protective factors which underpin mental health, how they can most effectively be demoted and promoted and how we can measure these changes at an individual, community and structural level. It includes:

- the risk factors which demote mental health and the protective factors which promote mental health among black and minority ethnic communities
- a review of the current literature relating to effective practice for promoting mental health and the principles which underpin promising practice
- – measures that can be used to prove the effectiveness of interventions and programmes aimed at this target group.

Risk and Protective Factors

Addressing risk and protective factors for black and minority ethnic communities raises a number of complex issues, because of the difficulty of analyzing the reasons for the over and under representation of different ethnic groups for different mental health problems. While all ethnic groups share key risk and protective factors, different black and minority ethnic groups may be exposed to a range of additional risk factors, such as the experience of racism and discrimination, increased social exclusion, reduced participation and inequalities in service provision or access.

Race and culture also determine the context within which individuals define their reality, their experiences and their judgements. Each culture has its own framework for mental health. This is fundamental in shaping different interpretations of the causes of mental health problems and the relevance and prevalence of mental health problems within specific groups, as well as impacting on the broader structural determinants of health and well being. Finally an individual's cultural context has relevance to positive or protective factors such as appropriate methods for individuals and communities to cope with mental health problems and the treatments and services which they feel would most appropriately meet their needs.

Causal Factors

In qualitative research, the most commonly mentioned causes of mental distress among the main ethnic minority groups in England (Bangladeshi, Caribbean, Indian, Irish and Pakistani people) were family difficulties, experience of racism, employment, financial problems and poor physical health (O'Connor and Nazroo 2002). However, within these causal factors, different groups experienced different kinds of pressures, influenced by

beliefs, family living arrangements, the role of the extended family, being forced to work below their qualifications, experience of health services, the impact of the cold weather.

O'Connor and Nazroo (2002) found that broadly defined causes occurred across all groups, including the White population, but that some risk factors were specific to or more prevalent in some groups. These included longing for home among African Caribbean peoples, and experiencing family difficulties linked to a sense of community reputation or pressure in South Asian communities. Different causal beliefs about mental distress also affect attitudes to seeking professional help among black and minority ethnic communities including British Asian and Pakistani groups (Sheikh and Furnham 2000).

Prevalence and Interpretation

Some studies have suggested cultural differences in the way in which psychological distress is presented, perceived and interpreted, and that different cultures may develop different responses for coping with psychological stressors (Bhugra and Cochrane 2001).

A recent major qualitative study (O'Connor and Nazroo 2002) found that experiences of distress were similar across ethnic groups, although some specific symptoms were different, notably among those who have migrated from South Asian countries, particularly those from Bangladesh. In addition, low rates of mental disorder among South Asians only apply to those who migrated to the UK in late childhood or adulthood. Second generation South Asian people do not have lower rates (O'Connor and Nazroo 2002). Nevertheless, there are substantial variations in the rates of detection of anxiety and depression, depending on the screening methods used and the ethnic background of patients and this may account for under-diagnosis in South Asian patients in particular (Comino et al 2001). Suicide rates among women from the Indian sub-continent are higher than those for the general population, while rates for young British born Asian women aged 15-24 are more than twice the national rate (Soni-Raleigh 1992; 1996). The importance of language and cultural factors will therefore vary considerably within the same ethnic group.

It has also been recognised that services have delivered an inequitable service to different minority communities. There are many explanations for this, ranging from services being institutionally racist to individuals from ethnic minorities not viewing the services provided as relevant and therefore not accessing them by choice. Every service, whether related to mental health or not, should be working towards ensuring its relevance to the whole community which it serves. Having effective and appropriate services will promote the mental health of whole communities including individuals from different ethnic communities living within them.

Broader Determinants of Health and Well Being

Socio-economic factors

Ethnic differences in mental health status are at least partly accounted for by socio-economic factors. The poor socio-economic position of many black and minority ethnic groups in this country is a major cause of poor health and also increases exposure to risk factors for poor mental health (Nazroo 1997; Lloyd 1998). People from black and minority ethnic groups are more likely to live in areas of high social deprivation and poor social cohesion and to report poor self-assessed general health and a severe lack of social support (Erens et al 2001).

In a recent cross sectional study a higher proportion of African Caribbean, Indian, Pakistani and Bangladeshi children belonged to lower social classes than the general population (Saxena et al 2002). The prevalence of certain illnesses has been seen to vary in different socio-economic or ethnic groups and differentials also existed in service use and service provision.

An American study in 2000 showed that poverty was not the only determinant within the community that impacted on the health and well being of members of black and minority ethnic communities. The relative inequalities in wealth, prospects and power were also identified by the black participants within the study. The white individuals living in close proximity were viewed as dominant in relation to decisions and local politics which gave them a greater sense of control over their life chances. In this analysis, racial disparities in both economic and political power were reflected in greater vulnerability to psychological problems among the black community.

There are significant differences in the experiences of different minorities in education, housing, and the criminal justice system, some black and minority ethnic children are more likely to be looked after by local authorities, excluded from school, less likely to be in higher education and more likely to be unemployed on leaving university. Black and minority ethnic groups (including foreign nationals) make up 19% of the male prison population and 25% of female prisoners (Nazroo 1997; Nazroo 1998; Department of Health 2003; Alexander 1999). The over-representation of black and minority ethnic groups in care and in prisons constitutes a significant additional risk factor for poor mental health, deliberate self-harm, suicidal behaviour and suicide.

Social exclusion

It is now widely recognised that social exclusion damages mental and physical health and contributes significantly to health inequalities. Research in the field of 'stress biology' demonstrates how experiences associated with exclusion – the chronic stress of financial

strain, racism, injustice, fear of crime, lack of control and perceived powerlessness – impact on the immune system and the cardiovascular system, affecting blood pressure, cholesterol levels, susceptibility to infection and growth in childhood (Marmot and Wilkinson 1999).

A study of communities by the Joseph Rowntree Foundation identified the crucial role which public services can play in preventing social exclusion, all of which are relevant to black and minority ethnic communities, particularly where they are consolidated geographically. To prevent exclusion public services should be:

- keeping vulnerable people connected to mainstream society;
- maintaining a visible physical embodiment of civil society in areas where community safety and mainstream values are breaking down; and
- providing vital support to vulnerable families and children at risk (Page 2000).

Racism

Racism has been shown to be negative for society as a whole, it seems to effect the health of black and white members of the community to some extent (Kennedy et al 1997). The experience of racism, including racist bullying at school and at work, is central in both qualitative and quantitative analysis of black and minority ethnic mental health (O'Connor and Nazroo 2002; Karlsen and Nazroo 2002; Chakraborty and McKenzie 2002). Cumulative exposure to racism and racial discrimination is a key risk factor for mental health problems, notably for depression and is particularly damaging for people who are already vulnerable, for example mental health service users. (Jackson et al 1996) There is also longitudinal evidence of a link between experiencing discrimination and the development of psychotic symptoms (Chakraborty and McKenzie 2002). Social exclusion and poor experience with statutory services, including mental health services, also influence both the prevalence and outcome of mental health problems among black and minority ethnic groups.

Brown et al (1999) found that perceptions of racial discrimination predicted psychological distress, while poor mental health did not predict subjective perceptions of discrimination. This study therefore challenged the view that people in existing poor mental health would be more likely to perceive themselves as potential victims of discrimination.

More recent research also suggests that racial harassment and perceptions of racial discrimination have a considerable health impact. Karlsen and Nazroo (2002) found that over and above socio-economic effects, both experience of racial harassment and perceptions of racial discrimination contribute independently to health (Chakraborty and McKenzie 2002; McKenzie and Chakraborty 2003). Rawaf and Bahl (1998) also found that the experience of racial discrimination exacerbated the likelihood of depression for all groups.

In their qualitative study of ethnic differences in the experience of psychiatric illness, O'Connor and Nazroo (2002) found that there was a recurrent mention of how tiring it was to cope with racism. It was considered exhausting in terms of the experience, the challenge and the aftermath of coping with the consequences.

'Yes (racial discrimination) –on a grand scale... services' inability and reluctance to recognise black issues/ community issues, problems and barriers. Open in my face racial discrimination.'

(Black female service user at Inside: Outside consultation event in Birmingham, Real Voices 2003 p. 23)

Social capital

Social capital consists of informal and formal networks, customs and relationships that make up our individual and our community reality and interactions. An important feature of social capital is that it is a property of groups rather than of individuals. The ecological nature of social capital distinguishes it from social networks and social support, which are properties of individuals.

The key areas in which social capital can be monitored are:

- social resources – informal arrangements between neighbours or within a community
- collective resources – such as self help groups, community support or safety schemes
- economic resources – such as levels of employment, housing
- cultural resources – such as art centres, museums, libraries, festivals etc.

Social capital is not necessarily based on geographically defined areas but on communities and these could include black and minority ethnic communities. As individuals there is a large range of groupings or communities which we may belong to which may impact on our levels of social capital. Different communities overlap and influence each other greatly.

McKenzie notes that although high levels of social capital may be beneficial to community members, the impact may be felt differently by minority groups. Communities which are high in social capital may become more intolerant of difference or deviance. Minorities therefore, which could include ethnic minorities therefore may experience increased exclusion from communities rich in social capital. This will increase still further the inequalities relating to their health (McKenzie et al 2002).

Risk factors potentially influencing the development of mental health problems and mental disorders in individuals				
Individual factors	Family/social factors	School context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> • prenatal brain damage • prematurity • birth injury • low birth weight, birth complications • physical and intellectual disability • poor health in infancy • insecure attachment in infant/child • low intelligence • difficult temperament • chronic illness • poor social skills • low self-esteem • alienation • impulsivity 	<ul style="list-style-type: none"> • having a teenage mother • having a single parent • absence of father in childhood • large family size • antisocial role models (in childhood) • family violence and disharmony • marital discord in parents • poor supervision and monitoring of child • low parental involvement in child's activities • neglect in childhood • long-term parental unemployment • criminality in parent • parental substance misuse • parental mental disorder • harsh or inconsistent discipline style • social isolation • experiencing rejection • lack of warmth and affection 	<ul style="list-style-type: none"> • bullying • peer rejection • poor attachment to school • inadequate behaviour management • deviant peer group • school failure 	<ul style="list-style-type: none"> • physical, sexual and emotional abuse • school transitions • divorce and family break-up • death of family member • physical illness/impairment • unemployment, homelessness • incarceration • poverty/economic insecurity • job insecurity • unsatisfactory workplace relationships • workplace accident/injury • caring for someone with an illness/disability • living in nursing home or aged care hostel • war or natural disasters 	<ul style="list-style-type: none"> • socioeconomic disadvantage • social or cultural discrimination • isolation • neighbourhood violence and crime • population density and housing conditions • lack of support service including transport, shopping, recreational facilities

Reproduced from: Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*, Mental Health and Special Programs Branch.

Protective factors potentially influencing the development of mental health problems and mental disorders in individuals				
Individual factors	Family factors	School context	Life events and situations	Community and cultural factors
<ul style="list-style-type: none"> • Easy temperament • Adequate nutrition • Attachment to family • Above-average intelligence • School achievement • Problem-solving skills • Internal locus of control • Social competence • Social skills • Good coping style • Optimism • Moral beliefs • Values • Positive self-related cognitions 	<ul style="list-style-type: none"> • Supportive caring parent • family harmony • secure and stable family • small family size • more than two years between siblings • responsibility within the family (for child or adult) • supportive relationship with other adult (for a child or adult) • strong family norms and morality 	<ul style="list-style-type: none"> • sense of belonging • positive school climate • prosocial peer group • required responsibility and helpfulness • opportunities for some success and recognition of achievement • school norms against violence 	<ul style="list-style-type: none"> • involvement with significant other person (partner/mentor) • availability of opportunities at critical turning points or major life transitions • economic security • good physical health 	<ul style="list-style-type: none"> • sense of connectedness • attachment to and networks within the community • participation in church or other community group • strong cultural identity and ethnic pride • access to support services • community/ cultural norms against violence

Reproduced from: Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – A Monograph*, Mental Health and Special Programs Branch.

Evidence Based Approaches

There are evidence based methods which reduce the risk factors related to mental health and enhance the protective factors of life. Effective approaches to reducing risk factors include programmes which:

- reduce the impact of negative life events and experiences for individuals eg interventions to support individuals experiencing domestic violence, abuse, bereavement, long term carers

- decrease social isolation and exclusion eg tackling discrimination in all forms such as racism or homophobia, investing in appropriate programmes to challenge the stigma that exists around those who experience mental health problems
- reduce the impact of deprivation and inequalities in health eg supporting programmes such as Sure Start, Urban Regeneration and Community Strategies.

Effective approaches to promote protective factors include programmes which:

- strengthen psycho-social, life and coping skills of individuals e.g. interventions to promote self-expression, self-efficacy, self-esteem, opportunities to learn new skills, stress or anger management and relaxation
- increase social support as a buffer against adverse life events e.g. initiatives that help build social contacts through self-help groups, networks and opportunities for new friendships
- increase access to resources and services which protect mental well being e.g. initiatives to promote benefit uptake, supported employment, access to mainstream services.

Personal Resources

There are positive personal resources which appear to be effective regardless of ethnicity and race. These resources include for example stoicism, survival, hopefulness, rationalisation and in certain circumstances avoidance (Sproston and Bhui 2002).

Although there is a limited literature on protective factors for individuals from black and minority ethnic communities, findings from the EMPIRIC quantitative data give some insight into the relationship between psychiatric morbidity, individual coping mechanisms and social support. For example people from black and minority ethnic communities in the UK are more likely than the white majority to be practising their religious faith. In one study a higher proportion of African Caribbean people affirmed a religious (predominantly Christian) belief than that of the white population or other minority ethnic communities (Faulkner 2000). South Asian women, have also been identified as using prayer as a major coping strategy for depression (Beliappa 1991).

Evidence of Effective Practice

Relevant evidence base

There is a very limited evidence base on the effectiveness of mental health promotion among black and minority ethnic communities in England. Mental health promotion recognises that often the process of promotion is as important as the outcome itself. Therefore mental health promotion practice should be inclusive, it should value diversity, support appropriate methods of consultation, development and evaluation with all members of the local community.

With any initiatives, for example to support parents and young families, in schools, in the workplace, in prisons, with looked after children, with carers, with older people and as part of neighbourhood renewal, the needs of black and minority ethnic groups must be addressed and appropriate partnerships developed. Every evaluation completed adds to the evidence base for effective practice and therefore the impact of programmes on specific minority groups must be considered at the planning stages of all programmes, whether they aim to target minorities or not. In addition, there is also a need to replicate initiatives to ensure that they are effective with different ethnic groups.

Limited evidence

There are also a number of problems impacting on the evidence that currently exists including the lack of validation for tools for assessment and evaluation among specific communities. For example studies have shown there is little difference across cultures among certain diagnoses, such as postnatal depression. However tools may not have been validated with these communities and therefore may not reflect the true incidence of prevalence among them. A recent study showed that there was an increased risk among new South Asian mothers to experience post natal depression due to a lack of service access, lack of information, isolation due in part to language problems, unfamiliar surroundings, unfamiliar services, expectations of families, increased levels of poor housing and of unemployment. However this increased risk is not supported in the prevalence data.

Data creation, collection, assessment and review will all be influenced by staff who may lack the knowledge and skills to engage effectively with specific communities. Templeton et al (2000) found that in practice health visitors had considerable concerns about identifying and managing postnatal depression in cultural contexts. In a recent study in the US improved detection and outcomes for individuals followed a programme of education for the local community, communication training for service providers and

early detection techniques for primary care professionals. Training that concentrates on understanding, enhanced respect and relevance of individuals' explanations, tailored treatment and information were most effective.

The race of the practitioner or professional also has an impact on possible diagnosis, type of treatment and service provision offered. In a study in 1999 researchers compared the diagnoses made by a Black Jamaican psychiatrist with those of White British psychiatrists. In 45% of cases reviewed they disagreed on the diagnosis made, which is a cause for concern (Hickling et al 1999).

It is difficult to extrapolate the findings of one programme with one target group on to another, as individual choice, appropriate targeting and effective methods of delivery can differ greatly across and among minority ethnic communities. Therefore a study showing parenting skills training can be effective with the Chinese community does not automatically mean it can be effective with the Irish community. Also what first generation and second generation South Asian men may find supportive may differ greatly. However too often in evidence based practice not having relevant evidence ensures the continued marginalisation of minority groups. Therefore as the evidence is so limited at the current time the best evidence based practice will be to consider the principles underpinning effective practice, to develop an intervention and then to consult widely with the local community and to amend delivery according to their specific circumstances and needs.

Principles for effective practice

From the general literature there are principles which we consider that underpin effective mental health promotion practice. Some of these have been proven to have specific relevance for individuals from black and minority ethnic communities including:

- Inclusive practice
- Expressive practice
- Holistic practice
- Participative practice
- Supportive practice
- Equitable practice

Inclusive practice

There is a wealth of evidence to show that inclusive practice has been proven to promote mental health. In qualitative studies individuals have shown the value which they assign to non-medical sources of support within the community. Examples of such positive practice include social prescribing schemes which provide a wider recognition of the determinants of mental health and the social and economic stressors which can contribute to a range of feelings and symptoms.

Examples of social prescribing include exercise on prescription, prescription for learning and arts on prescription. The schemes have been proven to be effective with people with mild and moderate mental health problems and their broader outcomes include enhancing self esteem, reducing low mood, providing opportunities for social contact, increasing self efficacy, transferable skills and greater confidence (Huxley 1997; Oliver et al 1996; Matarasso 1997; Fox 2000; Fox 2000a; Mutrie 2000; Darbishire and Glenister 1998).

For African and Caribbean young men priorities include building partnerships involving arts, creativity, spirituality and alternative therapies, and integrating these with education, training and employment opportunities, to form the basis of a holistic approach (**mentality** 2002, unpublished).

Principles and values of inclusive practice:

- Respect
- Reciprocity
- Equity
- Building trust
- Valuing cultural diversity
- Addressing race, gender and sexuality
- Facilitating participation
- Promoting access to information
- Developing life skills
- Building supporting networks
- Addressing underlying feelings of powerlessness
- Shared decision making

(Adapted from Dodd & Loeb, 1999)

Expressive practice

A qualitative study of the views and experiences of young African and Caribbean men in East London found very strong support for the mental health benefits of opportunities for arts and creativity (Friedli et al 2002). A central theme was the importance of arts and creative expression as protective factors in the face of the racism and discrimination experienced by the young men interviewed, both within mental health services and in the wider community.

Participation in the arts was seen as a resource that empowered young Black men to explore their histories and cultures and which acknowledged and validated their identity. Their emphasis on self-expression, growth, sharing cultural traditions and the development of new skills was widely seen as rooted in young men's lived experience and engaging with their needs.

The results of reviews of arts and creativity by both the Health Education Authority (1999) and Matarasso (1997) demonstrated improvements in well being as indicated by enhanced motivation, greater connectedness to others, more positive outlook, and reduced sense of fear, isolation or anxiety. Arts and creativity have also been seen as a means to empower communities, explore and affirm identity, strengthen social cohesion and challenge the stigma attached to mental illness (Friedli et al 2002). In addition, the strength of cultural life within a community may be a significant quality of life indicator, notably in relation to social capital (Cooper et al 1999; Lomas 1998).

Holistic practice

Needs assessment with Black and minority ethnic communities has frequently demonstrated a strong demand for services which offer a holistic approach – meeting the needs of the whole person, promote greater community involvement in decision making and recognise the impact of racism on people's experiences of everyday life (Alexander 1999).

Holistic practice may also be considered to be appropriate when considering how to combine traditional approaches to health, such as the use of traditional healing in South Asian communities in conjunction with professional Western psychiatry. (Dein & Sembhi 2001) When considering the needs of the whole person professionals are more likely to accept personal choices of complementary and traditional therapies.

Participative practice

There is a wealth of evidence to show that participation, particularly through volunteering can promote mental health within communities. Examples include home visiting programmes for new parents or older people and donating time to the local community through time banks.

Thurrock Community Mothers programme is an example of a project, now replicated nationally, which uses the expertise of trained volunteers with experience of mothering, to support local parents. There is equal emphasis on developing the skills of the Community Mother volunteers themselves and many move on to other employment opportunities. Community mother programmes have demonstrated positive socio-economic and health improvements for children, parents and volunteers, and have also been successful with traveller communities (Johnson and Molloy 1995; Fitzpatrick et al 1997; Johnson et al 1993).

Supportive practice

Social support has been proven to be a protective factor for mental health at every level and in almost every setting. In a study of Iraqi asylum seekers, depression was more closely linked with poor social support than with a history of torture (Gorst-Unsworth and Goldenberg 1998), Burnett and Peel (2001a and 2001b), in a review of the issues, identify support for people within their own communities and opportunities for developing links and friendships with the host community as crucial to promoting health and well being.

Equitable practice

A cause for concern when considering equitable service provision is the separation of cultural issues to specific individuals or services. Black patients are more likely than white patients to see a black member of the psychiatric team and are also more likely to see a junior member of the team (Ayonrinde 1999). This limits the cross-cultural learning in organisations and reduces the perceived necessity of effective training and supervision for all staff on multi-cultural issues of practice.

Reviews of Effective Practice

As previously stated it is poor research practice to assume that as an intervention has worked with one target group it will work for all. However there is a lack of effective evidence of specific relevance to people from black and minority ethnic communities, even though they may have been included in the research or reviews. It is rare for people to analyse cultural data separately so we are losing a wealth of relevant information and evidence, already collated.

The approaches outlined below are taken from systematic reviews and meta-analyses, therefore the evidence is robust across communities. This does not automatically mean that these approaches are effective for black and minority ethnic communities. A first step to increasing the evidence base would be to consider these broadly effective programmes and to test their validity and appropriateness specifically for black and minority ethnic communities. Some programmes may be transferable, although it is more likely that they will require some adaptation or review.

As this framework covers adults from black and minority ethnic communities no evidence is outlined below relating to children and young people. Parenting programmes are included but only those programmes where outcomes relate specifically to the improved mental health of the parent rather than the child alone.

Supporting self help

There is preliminary evidence that self-help treatments based on proven psychological therapies may offer some advantages. The evidence is related to the treatment and management of anxiety and depression, although data on cost effectiveness is very limited (Bower et al 2000).

Supporting physical activity

Exercise training can reduce trait anxiety (anxiety across a range of situations); single sessions of exercise can reduce state anxiety (anxiety triggered by a discrete situation); and single sessions of moderate exercise can reduce short-term physiological reactivity to and enhance recovery from brief psychosocial stressors (Taylor 2000).

A systematic review examined all studies with robust study design in which exercise had been used to treat clinically defined depression and concluded that the evidence was strong enough to support a causal link between physical activity and reduced clinical depression (Mutrie 2000).

Exercise and fitness seem to have a small positive effect on cognitive performance (Etnier et al 1997).

Supporting employment

Supported employment within a normal working environment is more effective in improving employment prospects for people with long term mental health problems than sheltered workshops or pre-vocational training (Crowther et al 2000).

Supporting parents

Parenting programmes can make a significant contribution to the short-term psychosocial health of mothers and have a potential role to play in the promotion of mental health (Barlow and Coren 2002).

Structured parent education programmes can have a positive impact both on children's behaviour and on parents' perceptions of their children's behaviour. These positive changes seem to be maintained over time (Barlow and Stewart-Brown 2000).

Day care has beneficial effects on children's behavioural development and school achievement and long-term follow-up shows a positive impact into adult life. There were also positive impacts on mothers' education, employment and communication with their children (Zoritch et al 2000).

Supporting older people

Home visiting demonstrated a positive impact on physical, mental and social health and also on health habits, knowledge and service utilisation (Ciliska et al 1996).

Providing opportunities for older people to do voluntary work increases mental well being in those who volunteer and also reduces depression in people who receive services such as visits or peer counselling from an older volunteer (Wheeler et al 1998).

Various forms of therapy such as reality orientation, cognitive training, physical exercise, socialisation, reminiscence and interactive contact or touch demonstrated therapeutic gains including increased social interaction, more attention to activities of daily living, less disruptive behaviour, decreased depression and better orientation (Burckhardt 1987).

Social activity both formal and informal was positively and significantly related to subjective wellbeing (Okun et al 1984).

Measures of Effective Practice

Current debates

Most of the evidence that is collated through the evaluation of mental health promotion programmes actually measures the reduction of mental health problems, rather than the promotion of mental health. Effective programmes are those that either reduce risk factors for example the incidence of domestic violence or promote protective factors such as the increase of supportive parenting. In the past, measures for mental health programmes have also tended to concentrate on the reduction of negative feelings such as isolation, depression

and anxiety rather than the enhancement of positive feelings such as connection, worth and value. Long term evaluation programmes have also tended to focus on the reduction of symptoms or related social problems such as crime, relationship breakdown and substance misuse, which may impact on mental health.

Mental health promotion is increasingly being recognised as a separate discipline, which when delivered effectively can contribute to the prevention of mental health problems through the positive enhancement of resilience and support. Mental health is far more than the absence of mental illness, in the same way that living in peace is far more than living in an area where there is no war.

Mental health measures have also tended to focus on the mental health of individuals. As the emphasis for mental health promotion changes to more sustainable programmes focusing on the mental health of families, organisations and whole communities, measures too will have to change.

When developing mental health promotion programmes and considering possible pointers to change it is important to consider what is already being measured and what is currently being developed. A number of other organisations will be developing pointers to evaluate complementary issues such as urban regeneration, renewal, community representation, social inclusion, social cohesion and community development. Service based agencies will also be measuring community and voluntary infrastructure support, levels of consultation and engagement, access figures for appropriate services and the quality of life of individuals.

When considering the development of measures for community based mental health promotion work it is important to consider pointers that will appropriately reflect that level of intervention. A range of measures and evaluation techniques need to be developed to capture the impact mental health promotion has on the lives of individuals and communities, and on structures.

Individual

There are a number of well-validated instruments which can be used to identify positive aspects of mental health.

Indicators of positive mental health for individuals:

- agency
- capacity to learn, grow and develop
- feeling loved, trusted, understood and valued

- interest in life
- autonomy
- optimism and hopefulness
- resilience.

Example: Affectometer measures include individual determinants that could be influenced by race and ethnicity

The 10 Mnemonic Qualities of Happiness

CO	Confluence	SI	Social Interest
O	Optimism	F	Freedom
SE	Self Esteem	E	Energy
SF	Self Efficacy	Ch	Cheerfulness
SS	Social Support	TC	Thought Clarity

Adjective Items

	(+)		(-)	r
CO	Satisfied	.76	Discontented	-.71
O	Optimistic	.57	Hopeless	-.68
SE	Useful	.54	Insignificant	-.54
SF	Confident	.62	Helpless	-.64
SS	Understood	.62	Lonely	-.61
SI	Loving	.64	Withdrawn	-.61
F	Free and easy	.49	Tense	-.57
E	Enthusiastic	.55	Depressed	-.76
Ch	Good-natured	.66	Impatient	-.48
TC	Clear-headed	.59	Confused	-.70

(Affectometer is copyrighted in New Zealand. Kammann and Flett 1983)

Community

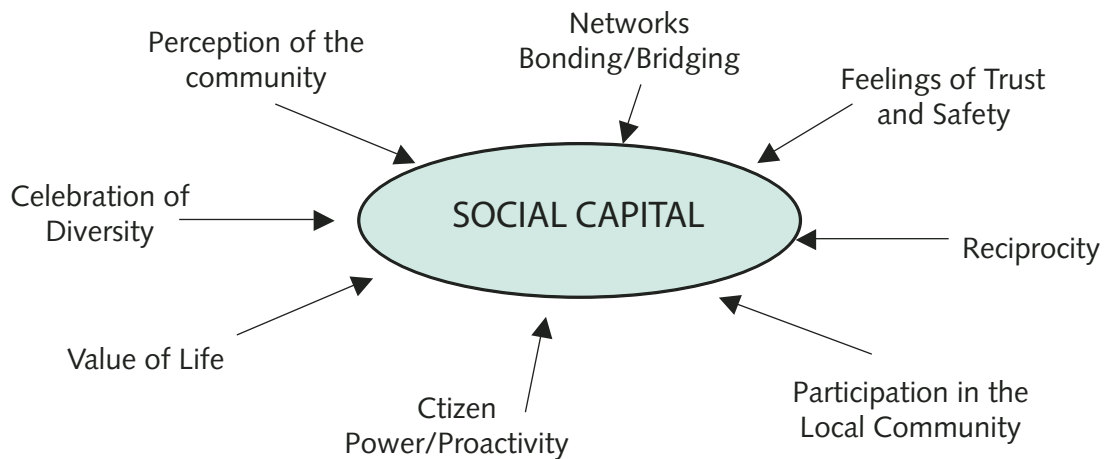
In a local community it is more difficult to measure a broader sense of well being or cohesion. However organisations are now recognising the need for this broader approach. In the most recent Health Education Authority (1998) measures are included to assess the impact of social capital, the social environment, social support networks and civic engagement. Similarly the Office of National Statistics have identified indicators to

underpin the mental health of communities including civic engagement, neighbourliness, social networks, social support and perceptions of the local area.

Indicators of positive mental health for communities:

- trust
- tolerance
- participation
- access
- influence
- sense of community cohesion and competence.

Example: Social capital measures will include measures of diversity and impact



Structural

The Audit Commission has piloted a series of quality of life indicators, many of which will have an impact on mental health or the determinants of mental health. The individual quality of life indicators relate to the structural determinants of well being.

Indicators of structural changes to promote mental health:

- employment and education
- expansion and deprivation

- housing stock and access
- health linked to inequalities
- noise, energy and water
- access to services
- community well being.

5 Settings for Mental Health Promotion with Black and Minority Ethnic Communities

While mental health promotion is relevant in all settings, this chapter explores six settings for mental health promotion that have been identified through consultation as being of particular importance for reaching and making an impact on the mental health and well being of black and minority ethnic communities:

- Neighbourhoods and communities
- Primary care
- Faith communities
- Mental health services
- Workplace
- Criminal justice system

For each setting, some of the key issues for black and minority ethnic groups are identified and a mental health promotion action plan is provided.

SETTING: Neighbourhoods and communities

Deprivation and mental health

The link between social disadvantage and mental health is well established. Some evidence suggests that people who are socially isolated or feel marginalised, who do not have a strong sense of belonging to a neighbourhood, or who do not participate in local groups, experience higher levels of mental ill health (McKenzie et al 2002). Living in poor housing and on low incomes is associated with higher levels of mental illness and lower levels of well being (Hoggett et al 1999; Blackman and Harvey 2001). Communities that are disproportionately affected by poverty are often located in unsafe neighbourhoods, with poor infrastructures, sub-standard services and high rates of unemployment (London Health Commission 2002). Additional evidence indicates that living in a poor area close to one that is affluent or regenerated can have adverse effects on health.

Black and minority ethnic communities experience a double disadvantage. They are disproportionately concentrated in deprived neighbourhoods and are more likely than others to be poor, be unemployed compared with white people with similar qualifications, report ill health, live in over-crowded and unpopular housing and be victims of crime. But they also suffer the consequence of racial discrimination, services that fail to reach them or meet their needs, and language and cultural barriers to gaining access to information and services.

70 per cent of the black and minority ethnic population live in the most deprived areas of the country, compared with 40 per cent of the population as a whole

(Social Exclusion Unit June 2000)

Rural Communities

People from ethnic minority communities are concentrated in a few urban areas, with over two-thirds living in London and the three metropolitan areas in the West Midlands, Greater Manchester and West Yorkshire. The small numbers of people from black and minority ethnic groups who live in rural areas face a particular isolation compounded by their experience of discrimination. They may be more likely to be singled out and vulnerable when they are in a small or dispersed minority, and may have reduced protection against stress and life events due to isolation and fewer social networks. A study in Camberwell, South London, found the incidence of schizophrenia in non-white ethnic minorities increased significantly as the proportion of such groups in the local population fell (Boydell et al 2001; Sharpley et al 2001). In rural areas where the black and minority ethnic population is tiny, the agenda needs to focus on racism awareness since the local white population may see racism as an urban issue that does not affect them.

Poor access to transport, common in rural areas, can affect mental well being because it reduces people's access to recreation, education, shops, health care and social networks, leading to isolation and loneliness, especially for the elderly, those with disabilities and the poor.

Strategies for tackling poverty and inequalities

The Government's strategy for tackling urban poverty and health inequalities emphasises area-based initiatives such as **Single Regeneration Budget, Sure Start** and **New Deal for Communities**. All of these have the potential to influence community-level factors which in turn influence mental health and quality of life in disadvantaged areas. Because black and minority ethnic communities are disproportionately located in these areas, these programmes will have an important impact on their mental health and well being.

Mental health within a community can be enhanced by, for example, improvements to housing and interventions targeting people who have experienced job loss or unemployment can help reduce mental health problems (Huxley and Rogers 2001). Huxley and Roger's study looked at mental health status, quality of life, and perceptions of the community, using a Community Experience Scale consisting of 11 items including local employment prospects, co-operation, safety, community identity, leisure facilities and local leadership.

Higher overall quality of life ratings were associated with a greater sense of belonging, less isolation, better leadership, more leisure opportunities, more neighbourliness/security and the absence of a feeling that the area was in decline. Higher scores for mental health problems were associated with less neighbourliness/ security, fewer leisure opportunities and the feeling that the area was in decline.

Regeneration programmes can help build neighbourhood social capital, promote social networks, address crime, increase access to green open spaces, and improve the quality of the built environment, all of which may have a beneficial impact on mental health (Chu and Thorne 2002). However, regeneration funding does not always meet the needs of black and minority ethnic communities and these groups are often under-represented in regeneration programmes. Inter-community resentments can result from competition for regeneration resources that lead to winners and losers. Instead, programmes are needed that promote contact and understanding between and within black and minority ethnic communities, the white community and different faith communities. Different communities should be encouraged to work together to tackle issues such as poverty and deprivation. A report by the Social Exclusion Unit (June 2000) stresses that minority ethnic participation and leadership in the National Strategy for Neighbourhood Renewal will be critical to its success and emphasises the need for minority ethnic participation at the local level.

Local Strategic Partnerships, bringing together public, private, voluntary and community sectors to agree a common neighbourhood renewal strategy should represent all sections of the community and make specific efforts to involve minority ethnic representatives. LSPs are a major engine for the mental health promotion agenda across most settings. Local **Health Improvement Plans** that seek to reduce health inequalities can use mental health promotion as a vehicle for bringing together work with regeneration, education, housing and other relevant areas of work to promote the mental health of the whole community. They also need to work within the Race Relations Amendment Act (2000) (see Appendix 1).

Community sector organisations play an important role in **capacity building** so that communities are able to identify needs and their own solutions to complex problems. Most black and minority ethnic voluntary and community organisations are small, targeting localised communities, and are limited in terms of time and staffing. There has been under

investment in this sector over many years, and voluntary and community groups have limited access to local decision-making, power and influence. Black and minority ethnic community groups often mistrust mainstream agencies because of a belief that services have not adequately addressed their needs. Likewise, mainstream organisations may lack confidence in the voluntary and community sector's ability to manage regeneration and other programmes of work, exacerbated by a lack of understanding of the black and minority ethnic voluntary sector. Black and minority ethnic organisations need the opportunity to develop the organisational capacity and skills necessary to manage and deliver mental health promotion programmes of work.

Inside Outside, a major report on black and minority ethnic mental health (Department of Health 2003) emphasises the need to build capacity within black and minority ethnic communities and the voluntary sector for dealing with mental health, including mental health promotion. The aim is to build on the capacity of minority ethnic groups to deal with mental health issues within the communities themselves, through investment in community development, leading to an increase in community participation and ownership of black and minority ethnic groups around mental health. Projects led by black and minority ethnic groups are more likely to be sensitive to and responsive to the needs of the black communities they serve. Furthermore, they are generally seen within their respective communities as committed to improving services available to those communities.

Community development workers can work with black and minority ethnic communities to promote mental health by:

- identifying particular communities who have strengths and capabilities around mental health, can manage and heal mental distress, deal with social and cultural stresses contributing to mental illness, and explore ways in which such approaches could be used in a holistic way to manage mental health problems
- organisational development- identifying stakeholders, organising groups, working with volunteers
- leadership development – recruiting community leaders, creating and delivering training and development activities
- high quality community development support
- help to develop local concerns
- support to develop skills, knowledge and confidence to become involved in creating local solutions

- support for local groups so they can be partners in developing services and identifying gaps in current service provision
- support to develop local networks and to become involved in self help projects
- advice on finding sources of funding so that local groups can take action in meeting their needs

You need to take account of the Race Relations Amendment Act (2000) which requires listed public authorities to promote race equality, including making sure the public have access to information and services and carrying out ethnic monitoring (see information about the RR(A)A in Appendix 1)

(Department of Health 2003)

Mental health promotion in the neighbourhood and community setting

The community is an important setting for delivering mental health promotion to black and minority ethnic communities. Community resources and venues, including schools and after school clubs, leisure facilities, libraries, information points, one stop shops, support and advice services, community and self help groups, provide the means for people to improve their well being through participation in day-to-day activities and increased social contact. For people with mental health problems, active participation in local mainstream facilities can help promote self-esteem and self identity and can combat social exclusion. Community organisations working with black and minority ethnic groups have a role in drawing together different communities to promote common interests through networking and joint activities, and using community venues for cross cultural interaction and activities.

Mental health promotion programmes need to find ways to:

- address the wider structural barriers to mental health such as discrimination, unemployment
- ensure that Local Strategic Partnerships represent all sections of the community and make specific efforts to involve minority ethnic representatives
- strengthen social networks, build capacity and invest in 'social capital', including activities and interventions that develop the resilience, resourcefulness and well being of black and minority ethnic communities to improve their mental and physical health

- combine the development of alternative services alongside challenges to mainstream service provision, so that both can better meet the needs of black and minority ethnic communities
- identify and nurture mental health promotion champions within the black and minority ethnic community, including community leaders, key voluntary sector workers and councillors, to keep mental health promotion on the agenda and advocate for it in a range of fora and agencies
- ensure that local projects to involve residents in deprived areas having a say in the services provided and opportunities to run them, reflect minority ethnic interests and are led by minority ethnic groups where these populations are large.

Protective factors that create conditions for good mental health within a community include:

- Equality of access to resources and services
- meaningful employment
- good quality housing
- support for parents and carers
- activities that bring members of the community together
- high levels of interaction
- high levels of participation in community activity
- accessible local information
- influence over decisions affecting the community
- inclusive, participative, tolerant, caring and high levels of trust
- friendly and pleasant physical environment
- low levels of crime and anti-social behaviour
- robust local democracy and opportunities to participate
- representation

(Adapted from Department of Health 2001 and from Scottish Public Mental Health Alliance 2002)

SETTING: Primary Care

Primary care is an important setting for reaching and promoting the mental health of people from black and minority ethnic communities and all those working within the primary care team have a potential role to play.

Use of primary care by black and minority ethnic communities

Some black and minority ethnic communities are more likely than the white population to seek help for mental health problems through primary care, which is preferred to specialist mental health services. Irish people, for example, have particularly high rates of consulting GPs for psychological problems (Erens et al 2001). However, some groups of Irish people (older people especially homeless men, people with alcohol problems, Travellers) seem to prefer to use emergency services for general and mental health problems rather than primary care. This may be because they feel their problems are stereotyped, their mental health problems not addressed, they experience hostility or lack confidence or knowledge of what services are available. South Asian and Chinese communities seem less likely to consult GPs, in particular for anxiety and depression. Chinese groups tend to access their GP only after long delays, and less than 40% of them seek help firstly from their GP.

The capacity of general practitioners to recognise mental health problems in black and minority ethnic patients appears to be limited (Shaw et al 1999). Black and South Asian patients are less likely to have mental health problems recognised by their GP (Odell et al 1997; Bhui et al 2001) or the nature of their presentation wrongly attributed to mental illness (Wilson 1993). People from black and minority ethnic groups have higher levels of unmet mental health need (Goldberg and Huxley 1992). There is also evidence that GPs' decisions to refer patients with mental health problems to specialist services are influenced by the patient's ethnicity (Bhui 1998, Commander et al 1999).

Mental health and primary care

Primary care services, including social care services, carry the main responsibility for mental health care and treatment in the community. The majority of mental health problems are managed within primary care so it has a crucial role in promoting the mental and physical well being of people with mental health problems. Typically, people with mental health problems present to primary care with a mixture of social, psychological, medical, emotional, financial and family difficulties. People from ethnic minority communities may be less likely to distinguish between mental health and physical health problems and therefore present

with physical symptoms to their GP. They may also have belief systems that find the explanatory models of Western psychiatry difficult to understand. GP's are the gateway to other health and social care services, yet often they do not refer people with mental health problems appropriately.

Around one in four consultations in primary care involves a mental health problem (Goldberg 1991). The majority of people with common mental health problems and a significant number of people with severe and enduring mental illness are currently managed only in primary care (Kendrick et al 1991). Depression in people from African Caribbean, South Asian, and refugee and asylum seeker communities is frequently over looked, although these communities may be at 60% higher risk than the white population, with the risk being twice as high for men (Davies et al 1996). Black and minority ethnic people are also more likely to be detained under the Mental Health Act, and less likely to be offered alternatives to drug treatment (Gill et al 1996). People with severe mental illness also have poorer physical health than the general population, bringing them into contact with primary care (Singleton et al 2001).

Mental health promotion in primary care

Mental health promotion within primary care is important because of its potential to reach people from black and minority ethnic communities at an early stage before problems reach crisis point. It can also reach the wider black and minority ethnic community with interventions to promote their mental health and well being through, for example, parenting support or exercise on prescription. Primary care is the gateway to the health service but can also be the signpost to a range of community services, including those that promote mental health, support people with mental health problems and improve access to appropriate services.

Summary – Mental health promotion action plan for primary care

- Mental health care and treatment needs to be individually tailored to take account of a person's social and cultural background, lifestyle and personal preferences. People are experts in their own condition and should be involved in all decisions about the treatment they receive. When the patient and doctor are from different cultural backgrounds, it is especially important to listen to the experience and views of the service user.
- GPs and others working in primary care need to be aware of the importance of considering a range of options, for instance, Chinese medicine, arts and music therapy or considering the value of spirituality. Complimentary therapies should be available as effective treatments for mental health problems, and to help reduce some possible negative side effects of medication. They are particularly popular with some people from black and minority ethnic communities. Acupuncture, for instance, has been shown to be effective in reducing depression.
- Psychological therapies should be available to anyone who wants to try them, and there is a need for services that address the specific needs of black and minority ethnic groups, for example by providing counselling in appropriate languages. Culturally sensitive psychotherapy has been shown to be effective, but services are rarely available and GPs may not be aware of those that do exist.
- People with mental health problems from black and minority ethnic communities use a range of coping mechanisms, of which mental health services are only one. Being part of a community, friends, family, work and self help can all contribute to mental well being. Many patients with mental health or psycho-social problems could potentially benefit from services on offer within the voluntary and community sector, for example self help groups, arts and creativity and physical activity and this is especially true of people from black and minority ethnic communities. GPs need up-to-date information about local services and community groups to help patients access a range of options which could be helpful
- Partnerships between health services and social services, and services in the voluntary and non-statutory sector are essential to the delivery of effective primary care mental health. Primary care teams may have close links with Citizen's Advice Bureaux, benefits and housing agency workers, as well as partnerships with voluntary sector services that traditionally are good at engaging people from black and ethnic minority groups.

The NHS Plan contains proposals to strengthen primary care mental health by appointing new primary care mental health workers and community mental health 'gateway' workers (Department of Health/ NIMHE 2003). These workers have the potential to promote mental health with black and minority ethnic communities by:

- improving communication and information within primary care about effective and accessible services for patients within the statutory and voluntary sector, including those particularly relevant for black and minority ethnic service users
- helping patients from black and minority ethnic communities to access relevant services
- contributing to the promotion and support of self help groups and health promotion and mental health promotion activities
- developing practice-based mental health resources, including those specifically designed for black and minority ethnic groups, such as those in minority languages
- developing links with community groups and establishing reference groups for service users to provide feedback on services and have an input into planning.

SETTING: Faith Communities

Faith communities can contribute to the mental well being of their own communities and the wider community, through prevention, support and recovery. Religion and spirituality play an important role in the lives of a significant number of people from black and minority ethnic communities and therefore faith communities can make an important contribution to mental health promotion with these groups. There are many different religious traditions both within and between different communities, for example the Muslim faith can cut across all ethnic groups, and in some cases needs will be coloured more by religion than by ethnic background.

Religion, spirituality and positive mental well being

Systematic reviews have consistently found that religious involvement is associated with positive mental health outcomes (Ellison and Levin 1998). A recent Australian study has found a correlation between regular church attendance and measures of personal psychological well being (Francis and Kalder 2002). A growing number of studies also emphasise the importance of spiritual beliefs and the value of support from faith communities for people with mental health problems (Mental Health Foundation 2000, Bobat 2002). The cohesiveness provided by faith communities can contribute to mental well being.

A study of a Hindu temple in South India identified a significant improvement in the symptoms of people with psychotic illnesses, who received no psycho-pharmacological interventions during their stay, and proposed that part of the effect may have resulted from access to refuge in a supportive, non-threatening and reassuring environment (Raguram et al 2000).

Research into black families' survival strategies found that spirituality is a strong aspect within the lives of African, Caribbean and South Asian people, encompassing:

- wider feelings of sharing and community, not just religious adherence
- a source of personal strength, fostering both perseverance and forgiveness
- the ability to build and concentrate on self-knowledge without detriment to other ethnic groups
- inner contemplation and outer activities which lead to the building of positive individuals and communities, greater self-knowledge and understanding of others.

(Dutt & Ferns 1998)

In a study of twelve religious groups based in Luton and Peterborough, religious communities were found to provide an impressive range of valuable services and represent a local resource that is underused and little appreciated (Morris et al 2003). It concluded that faith communities are especially important in generating or supporting social capital in deprived areas where other social infrastructures may be absent. Faith groups are particularly skilled at identifying the needs of their communities as well as finding practical and innovative ways of fulfilling them. The benefits accrued through the activities of faith groups are also shared by the wider community.

In the consultation events for Inside: Outside (Real Voices 2003), Black and Asian people emphasised the importance of addressing spiritual aspects in relation to mental health.

'The spiritual aspect of mental health has not been mentioned. Alternative therapies such as herbal medicine, spiritual healing etc are also very important.'

(Asian male worker at Inside: Outside consultation event in Bradford, Real Voices 2003 p.33)

Negative links between religion, spirituality and mental health

The link between religion and spirituality and mental health can also be problematic. While the church can play a mediating and supporting role in managing mental health problems, it can also mask distress by casting it as demonic behaviour that needs to be exorcised. Such approaches may prevent early and appropriate professional intervention (Sainsbury Centre for mental Health 2002).

Studies have found a resistance to spiritual issues within mental health services, where religious beliefs are sometimes interpreted as symptoms of illness (Friedli 2000; Asian Health Development Project 1999). An increasing number of studies demonstrate that many people who use mental health services feel that their spiritual needs are not understood and valued.

Diagnosis and treatment of mental illness

In many cultures, a diagnosis of mental illness can take into account wider social and religious factors. These include spiritual possession, witchcraft, the breaking of religious taboos, divine retribution and the capture of the soul by a spirit. These factors need to be considered if different treatments for mental illness are to be accepted. While mental health services do not specifically deal with the spiritual dimension, faith communities can offer that dimension and have a role to play in providing a more holistic approach to treatment.

Mental health promotion and faith communities

Mental health promotion should encourage an approach that identifies, values and celebrates the whole person, and recognises the individual within their family, community (including faith community) and neighbourhood environment. Mental health service providers need to be made aware of the importance of people's religious and spiritual beliefs.

Advocacy support can help to ensure that black and minority ethnic service users have their views known and their cultural and religious beliefs respected. This may be important if people's religious beliefs, lifestyle choices and expressions of their cultural identity are not to be pathologised into a diagnosis of psychosis.

Faith communities possess valuable resources and social capital in terms of networks, buildings, voluntary activity and leadership skills and can make an important contribution to mental health promotion with black and minority ethnic groups. Faith groups may also represent one of the only local organisations able to reflect the views of particular ethnic groups.

Faith communities can contribute to improved mental well being by offering an important source of friendship, belonging and support. They can also provide spiritual guidance, counselling and emotional support, and support for carers and families of mental health service users from black and minority ethnic communities. Religion or spirituality can act as a part of the holistic healing process that gives calmness and peace that is so vital to recovery (Hussein 2001).

Some black and minority ethnic communities face barriers to accessing mental health services. For some people with mental health problems, faith communities may be the first point of contact and can act as a link and referral system to statutory mental health services and other sources of support in the community. Mental health promotion can play a role in forging partnerships between faith communities and other mental health service providers.

Summary – Mental health promotion action plan for faith communities

- Raise awareness among mental health service providers of the important role of spiritual and religious beliefs for some mental health service users
- Contribute to the improved mental well being of the community served by offering friendship, spiritual guidance, counselling and other emotional support
- Offer support to carers and families of mental health service users from black and minority ethnic communities
- Increase access to mental health services by providing a link or referral system and working in partnership with service providers
- Provide advocacy and raise awareness of the views and beliefs of people from black and minority ethnic groups

Case Study

Council of Sikh Gurudwaras in North Birmingham have developed a mental health initiative. It provides a befriending/advocacy service on the in-patient unit, and has developed a central resource library for alternative therapies. See Chapter 8.

SETTING: Mental Health Services

Mental health services are an important setting for mental health promotion with black and minority ethnic communities because:

- the high numbers of people from black and minority ethnic communities in touch with services provides an opportunity for reaching these groups with mental health promotion
- poor quality mental health services that are inappropriate, inaccessible and culturally insensitive for black and minority ethnic communities will have an impact on the mental health of people who use them, their carers and the wider community (O'Connor and Nazroo 2002; Bhui et al 2003). Improving the way mental health services are experienced, so that people feel valued, respected and listened to, will in itself have an impact on mental well being.

Inequalities in mental health service experience and outcomes for black and minority ethnic groups are a result of a combination of institutional and individual discrimination, poor planning, inadequate training of professionals and lack of resources. Barriers to mainstream health and social care services include language barriers for non-English speakers, insensitivity to cultural and religious needs, and discrimination and poor practice (Kings Fund 2000). Often, mental health needs are not met and service responses and approaches are not always relevant or appropriate (Bhui 2002). The Race Relations Amendment Act (2000) requires listed public authorities to promote race equality, including making sure the public have access to information and services and carrying out ethnic monitoring (see information about the RR(A)A in Appendix 1), so that there is now a legal framework for ensuring services meet the needs of black and minority ethnic service users and their families and carers and take these needs into account during needs assessment, health care planning, delivery and review. There are provisions in the Act that deal with the barriers identified below.

Experiences of mental health services

Research shows that black and minority ethnic communities face inequalities within the mental health system in terms of low take-up of services, lack of information about services, over-diagnosis and mis-diagnosis of mental illness, poor referrals, over representation in acute services, fewer psychological therapies, excessive use of medication, and inappropriate detention under the Mental Health Act (Mental Health Act Commission 2001; Bhugra and Cochrane 2001).

Barriers to care and negative experiences of mental health services include:

- inadequate provision for non-English speakers
- service insensitivity to cultural and religious needs
- institutional discriminatory behaviour and poor practices
- racial stereotyping by mental health professionals who view black and minority ethnic groups as being unable to express their emotions, hostile in attitude, not motivated for treatment and not susceptible to treatment by psychological therapies and talking treatments (Fernando 1995; Robinson 1995)
- people feeling misunderstood because they are feared, stereotyped or ignored, leading to a lack of trust and unwillingness to engage with mental health services (Wilson & Francis 1997)
- higher levels of dissatisfaction with services, greater use of detentions under the Mental Health Act and more frequent experiences of being forcibly restrained (National Schizophrenia Fellowship 2000)
- mainstream services experienced as inhumane, unhelpful and inappropriate, and care pathways being problematic, with primary care involvement limited and community crisis care lacking (Keating et al 2002).
- the untherapeutic environment of psychiatric wards and its negative impact on the experience of mental health services (Department of Health 2000).

With the current level of investment in health and social services, there are opportunities for real improvements to be made, transforming the quality of services by raising standards, tackling inequality, becoming more accessible and flexible, and designing services around the needs and choices of the people they serve. *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England* (Department of Health 2003) recognises the need to improve the service experience and service outcome for black and ethnic minorities communities, and proposals also aim to improve the overall mental health of people from black and minority ethnic groups living in England (see Policy Context in Appendix 1).

Inside Outside 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.

The following initiatives and practices can make a contribution to improving mental health service experience and outcome for black and minority ethnic communities and promoting mental health and well being for service users, carers, families and the wider community.

Cultural sensitivity audit

Services are developing a greater awareness of the cultural diversity among the populations they serve, are consulting more often and more widely to try to identify their mental health needs, and are beginning to plan how to meet these needs (Keating et al 2003). All of these steps should begin to impact on service delivery and provision. Improving the ethnic sensitivity of existing services needs to recognise how black and minority ethnic groups perceive services, and how they would like services to meet their needs. Cultural identity is an integral part of an individual's self and crucial to the psychological well being of individuals. Key concepts of cultural identity include religion, attitudes to family, leisure activities, rites of passage, food and language (Bhugra et al 1999). Cultural sensitivity audits can be used by services within the national health service, by local authorities and by voluntary organisations to establish the needs of service users from black and minority ethnic groups, to assess how well these are being met, and make recommendations on how services can improve.

In order to develop culturally sensitive services the following data about the local community and current services needs collating:

Data needed to develop culturally sensitive services includes:

Local population data

- General population
- Ethnic profile of general population
- Community languages spoken
- Religious diversity
- Housing types, including homelessness
- Unemployment
- Key vulnerable groups

Service data

- Ethnic, linguistic, religious, age and gender breakdown of service users
- Linguistic, religious, age and gender breakdown of staff
- Race equality scheme in place
- Representation of ethnic groups on committees and boards, and among senior management and other staff levels within the organisation
- Availability of interpreting services and the range of languages
- Training received by interpreters and by health staff in how to work with interpreters in mental health settings
- Service users' views of the cultural and religious aspects of service
- Advocacy services for people from black and minority ethnic groups
- Staff training needs
- Anti-discriminatory policy and monitoring
- Partnerships with voluntary and independent providers

The Sainsbury Centre for Mental Health is developing a **Cultural Sensitivity Proforma** (currently in draft form). For more information, contact Graham Durcan, Senior Consultant, The Sainsbury Centre for Mental Health on 020 7827 8313 or email g.durcan@scmh.org.uk

Consulting and engaging with black and minority ethnic communities

A key to achieving necessary changes in mental health services is the development of effective partnerships between services and black and minority ethnic communities. Strategies are needed that ensure the active participation and representation of black and minority ethnic communities in needs assessment, service development, delivery and monitoring. At present, there are significant barriers to engaging fully with black communities (Bitel and Hill 2001), including the short term funding arrangements of many black and minority ethnic voluntary and community groups, problems around performance management arrangements and the need to build sustainable capacity within communities.

The most popular approach to community engagement has been consultation but this on its own does not necessarily transfer a sense of engagement- especially where there is a history of consultation that does not result in desirable change and sustainable impact. Developing effective engagement means revising partnership culture- moving away from a view of black and minority ethnic communities as an issue or problem to be solved and embracing race equality as fundamental to all aspects of their work. For more on consultation, see Chapter 4.

Information needs

In a study into the mental health information needs of black and minority ethnic communities in Manchester (Ghafoor 2002), service users identified the need for multi-lingual information in a wide range of formats (leaflets, videos, audiotapes) on diagnosis, medication and other treatments, and on the availability of self help groups. They also identified the need for better information exchange between service providers, and improved understanding of specific cultural, religious and gender issues. The Race Relations Amendment Act (2000) requires listed public authorities to publish a **Race Equality Scheme**, part of which is to make sure that the public have access to information and services.

A study into the side effects of drugs prescribed for mental health problems highlights the need for better information about medications and treatments (Mind 2001). Black and minority ethnic people's experiences are in common with those of all service users but some particular issues stand out:

- having no information at all
- not knowing their diagnosis or treatment
- having no access to an interpreter
- Not knowing their rights of appeal.

People want more choice about their treatment and provision of a wider range of treatments, more information and access to alternative treatments, and mental health promotion can contribute to this.

Physical health needs

Research has shown that people who use mental health services have high rates of physical illness, much of which is undetected, resulting in increased rates of morbidity and mortality (Koran et al 1989). Reasons for this include socio-economic factors, increased social exclusion, lifestyle and life experiences, all of which may affect people from black and minority ethnic communities even more. There is an increased risk of a range of illnesses, including coronary heart disease, diabetes, various infections and respiratory disease. People with mental illness are twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease (Phelan et al 2001; Harris and Barraclough 1998). A person with schizophrenia can expect to live for ten years less than someone without a mental health problem (Brown et al 2000) and again this will have a particular impact on young African Caribbean men who have an increased risk of schizophrenia.

Generally mental health service users are less likely to be offered blood pressure, cholesterol, urine or weight checks, or to receive advice on smoking cessation, alcohol, exercise or diet (Cohen and Hove 2001). Data recorded for health promotion is also significantly less than normal, and health promotion information rarely makes clear its relevance for people with severe mental illness (Sherr 1998). For some mental health service users from black and minority ethnic communities there may be additional barriers to health checks and health promotion advice such as language barriers and discrimination.

Ethnic Monitoring

Ethnic monitoring is a process for collecting, storing and analysing data about individuals' ethnic (or racial) background and linking this data and analysis with planning and implementing policies. Ethnicity data has been identified by the Mental Health Commission and NIMHE as a key building block of effective delivery. Organisations

are currently at very different stages, for example acute psychiatric hospitals have had to collect ethnicity data on in-patients since 1994 but data is still very incomplete; many PCTs still do not carry out effective monitoring.

You can use ethnic monitoring to:

- Highlight possible inequalities
- Investigate their underlying causes
- Remove any unfairness or disadvantage

Most public authorities that have to meet the statutory general duty relating to the Race Relations Amendment Act must monitor the ethnic backgrounds of their staff, and of applicants for jobs, promotion and training. If the authority has more than 150 full-time staff) or the equivalent) it must also monitor the ethnic backgrounds (and numbers) of staff who receive training, are involved in grievances or disciplinary action against them, benefit or suffer as a result of performance appraisals, or leave their jobs with the authority (for whatever reason). Authorities have to publish the results of their employment monitoring every year.

Organisations now must be able to demonstrate that they are not discriminating and that they are positively promoting equality. In order to do this, they need to be able to show that:

- the ethnic origin of service users is in proportion to the ethnicity of the population in the service's catchment area
- there are no discrepancies of service experience between different ethnic groups.

Ethnic monitoring can tell you which groups are using your services, and how satisfied they are with them. You can then consider ways of reaching under-represented groups and making sure your services are relevant to their needs and provided fairly. Organisations engaged in ethnic monitoring should ensure that the data collected is easy to read and understand, that the reasons for collecting the information are clear, and that the data can be readily used within their wider planning process. For more information, see www.cre.gov.uk/gdpract/em

Training

Training is not a solution on its own but it can contribute to an organisation's overall strategy for meeting the needs of black and minority ethnic communities. It should be informed by the needs of users, families and carers, involve people from black and minority ethnic communities in its design and delivery, and equip staff with the skills, knowledge, attitudes and awareness to meet these needs. Training should be short, focussed and built around the needs of each group of staff and the communities they serve (Keating et al 2002). It should be regularly reviewed and updated.

Health and social care organisations need to establish:

- staff induction procedures that include information and raise awareness of their equal opportunities and related diversity policies
- staff training policies to equip staff to provide mental health care to a multi-racial and culturally diverse population, consistent with their wider staff development and training strategy
- training to equip staff to provide a culturally competent service to all users and carers
- training on race and equality issues for staff at all levels.

'Transcultural mental health and counselling training ... need to be offered. GPs need training in dealing and giving appropriate advice to patients so prevention work can happen rather than ending up in psychiatric care.'

(Asian male at Inside: Outside consultation event in London, Real Voices p. 36)

Cultural awareness training

Rather than providing separate services for black and minority ethnic communities, possibly reinforcing marginalisation, mainstream services need to improve their ethnic sensitivity and understanding of the needs of black and minority ethnic communities through cultural awareness training. Services that can demonstrate this understanding are better able to effectively engage the communities they serve (Birtwhistle 2002). Culturally sensitive training should be part of the core of professional and continuing education training for all professionals across statutory and non-statutory providers of mental health care, and people from black and minority ethnic communities should be included in its design and delivery. Some mental health trusts have incorporated training on cultural awareness into their race equality strategy (Keating et al 2003).

Culturally competent services

A culturally competent service is one that is able to provide an appropriate high quality professional service to all those who wish, or need, to use that service. A person's racial, ethnic, cultural or religious background should not be a barrier to their being able to make full and proper use of that service.

Advocacy services

Advocacy services that help members of black and minority ethnic communities say what they want, obtain their rights, represent their interests and gain the services they need can significantly improve ethnic minorities' general experience of the mental health system. For advocacy to be effective for black and minority ethnic communities, advocates must be able to relay linguistic, cultural, religious and social messages about clients to professionals and where necessary challenge discrimination and racism (Kapasi and Silvera 2002). According to a report by the Mental Health Alliance (2002).

'staff competencies need to be sector specific, deal with issues of racism, the complexities of culture, and understanding of the context in which the user is approaching the service, combined with an ability to communicate with the users.' (Mental Health Alliance 2002, p 8).

In many mental health units the advocacy service has no staff from minority ethnic backgrounds, and many of these services recognise their own limitations in understanding or representing the views of their minority ethnic clients. Often, the specialised advocacy projects that work with black and minority ethnic communities are smaller and less formal, and their funding is often more short term.

The accepted view of advocacy is that the advocate should work with the service user wholly separately from family and friends, based on the recognition that there can be conflict of views between what the service user wants and what family members want. Some argue, however, that in some black and minority ethnic communities, the community's views are of equal importance and cannot be divorced from those of the service user. The challenge is to ensure that advocacy is both responsive to cultural difference, while ensuring the advocate is putting forward a service user's view, when it is at odds with the rest of the family or community.

Advocacy services need to:

- employ a diverse range of people at all levels of the organisation
- be accountable to communities and funders for delivering a sensitive and appropriate service
- include training on cultural awareness, equality and valuing diversity for all their advocates, no matter what their ethnic background
- involve black and minority ethnic communities in developing local advocacy structures, including black and minority ethnic specific mental health forums
- provide bilingual workers where needed, and use interpreters who are knowledgeable about mental health, advocacy and cultural issues
- explore ways of developing advocacy services in partnership with local communities
- where possible services should be run by people with experience of using mental health services.

(Acknowledgement: Mental Health Alliance, July-September 2002)

Summary – Mental health promotion action plan for mental health services

- Train staff in their duty under the Race Equality Scheme, anti-discrimination, cultural awareness and the use of interpreters
- Build links with black voluntary organisations and involve them in developing services on wards so they become more culturally sensitive
- Designate a staff member with the role of improving and co-ordinating services for users from black and minority ethnic groups
- Set up hospital-wide support groups, such as an African Caribbean group
- Provide information about the services and treatment on offer, including side effects of medication and the availability of complimentary therapies
- Provide information about services provided by the black voluntary sector, and involve these organisations in planning discharge
- Offer the choice of a key worker from the same ethnic group and gender where possible

- Designate a room to be used for prayer and other religious activities
- Ensure that culturally acceptable food is available
- Provide bilingual workers
- Provide female-only wards
- Integrate non-medical and social models of care
- Ensure physical health needs are met and providing regular health checks and health promotion information
- Consult with black and minority ethnic service users to ensure that services are meeting their needs.

Based on an audit of the cultural sensitivity of the hospital based psychiatric services provided by City & Hackney Community NHS Trust (Sathyamoorthy et al 2000)

SETTING: The Workplace

Overall, working has a positive effect on people's mental health. In addition to financial benefits, work is an important source of support, providing social and information networks, a sense of purpose and personal identity (**mentality** 2002). As well as providing positive benefits for all of us, employment is a key goal for many people with mental health problems, and they identify exclusion from mainstream activities, notably employment, as one of the areas that most concerns them (Bates 2002). This is equally true of mental health service users from black and minority ethnic communities, the majority of whom say they want paid employment in the ordinary job market (Seebohm et al 2003). The workplace is therefore an important setting for mental health promotion work because encouraging and supporting the employment of both people from black and minority ethnic communities as a whole, and people from these communities who have used mental health services, can make a big impact on overall mental health.

Value of employment for mental health

Meaningful occupation, including paid employment or study, provides mental stimulation, the opportunity to interact with others, and the chance to make a contribution to society. Work plays a central role in people's lives, providing a structure and purpose to the day, self-esteem and self-confidence, relationships and social support, money, and independence and participation in society. We all need a role that is valued and acknowledged by others,

and for many of us this is provided by paid employment. One of the social factors leading to mental distress amongst black and minority ethnic communities is poverty and unemployment. There is also a strong relationship between unemployment and mental health problems.

Barriers to employment

Many people from black and minority ethnic communities live in areas with relatively few job opportunities, limited access to transport and childcare, with considerable implications for employability. Employers need to operate an equal opportunities policy to ensure that people from black and minority ethnic groups have equal access to jobs available. Organisation workforces should reflect the communities they serve. This is equally true for health and mental health organisations that are major employers within any local area, and where the employment of people from different black and minority ethnic groups can enhance the cultural awareness and sensitivity of services provided. The NHS should take the lead as an example to other employers through their employment of people from black and minority ethnic communities, including people from these communities who have used mental health services. The Race Relations Amendment Act (2000) gives public authorities a new statutory duty to promote race equality. The aim is to help public authorities to provide fair and accessible services, and to improve equal opportunities in employment, taking account of racial equality in employment practice.

The benefits system creates a barrier to paid employment. Paid work can lead to a disruption of benefits, and can have particular impact on people from black and minority ethnic communities because their access to welfare rights advice is more limited, and because they are more likely to live in supported accommodation.

Voluntary work and work experience placements can be tailored to individual interests and abilities and involve no risk to benefits but what many people want ultimately is paid employment.

Job centres are often not perceived to be relevant for people from black and minority ethnic communities, or for people with mental health problems from these communities. Job centres need to be able to work with people with mental health problems from black and minority ethnic communities who need support with work and mental health issues. Some studies indicate that job centres are failing to provide equality of opportunity for black and minority ethnic groups (Pathak 2000). A lower proportion of ethnic minority people than white people move into sustained employment (25% compared with 33%) and a higher proportion into education and training (59% compared to 44%) despite being better qualified.

For people from black and minority ethnic communities who do obtain employment, there is widespread risk of racism in the workplace (O'Connor and Nazroo 2002). Racial harassment and discrimination can leave people feeling stressed, depressed, suicidal and isolated (Cabinet Office 2002). Employers and employees therefore all have a responsibility to address racism. The stigma of mental illness is also a barrier to getting and keeping employment. People from black and minority ethnic communities have to deal with discrimination resulting from stigma on top of the racism they face. People have to overcome the low expectations within the services set up to help them.

Help with getting employment

People with mental health problems are entitled to help with getting employment. The NSF for Mental Health (Department of Health 1999) recognises employment as a key contributor to recovery and the promotion of health. Care plans for people on enhanced CPA (Care Programme Approach) must include plans to secure suitable employment or other occupational activity. However, there is evidence that people from black and minority ethnic communities are under-represented in specialist mental health employment schemes (Pozner et al 1996) and yet they need particular help in overcoming the many barriers to employment.

Summary – Mental health promotion action plan in the workplace

- Inequalities and prejudice make it very difficult for people from black and minority ethnic communities to gain employment, and mental health service users from these communities have additional problems accessing support and work opportunities. Professionals, carers and users of services need to know that work is a real possibility for all, given the right opportunity and support. Employment and mental health professionals need to foster black service users' potential and provide the support they need.
- Job Centres need to improve the way they address the needs of people from black and minority ethnic communities, and mental health service users from these communities, and one way is to recruit more black and minority ethnic staff and improve cultural awareness.

- Employers need to recognise the waste of potential resulting from a failure to tap into the skills and resources available within the black and minority ethnic community. Partnerships with a range of organisations in the local community, including religious or faith organisations, sports centres and colleges, as well as local employers, can be fostered to produce a range of options for people seeking employment or preparing for work. Potential employers need information about what they can gain in terms of support and benefits if they take on a mental health service user.
- Mentoring schemes and work support groups can be valuable in helping people access and keep a job. There are a variety of models of support from mentors, buddies or befrienders that can be offered including:
 - Individual support, sometimes from a peer with previous experience of mental ill health or from a black and minority ethnic group
 - Influence on the employer to put in place reasonable adjustments, such as variations in hours, that help an individual cope with work
 - Contact with mental health services so support can be accessed if needed
 - Support groups within the workplace, including black survivor groups, can help cope in an environment of institutionalised racism
- Mental health in the workplace needs to consider the following elements, and ensure they work equally for people from black and minority ethnic groups:
 - **Promotion:** promoting the mental health and well being of staff
 - **Support:** offering assistance, advice and support to people experiencing mental health problems in the workplace. Also support for staff returning to work
 - **Employment:** adopting a positive approach to employing staff with a history of mental health problems

Case Study: AWAAZ Asian Advocacy and Employment Project – Manchester

AWAAZ is a user-led self-advocacy project working with Asian people experiencing emotional problems, helping them access health, social and other services and employment. The AWAAZ employment project was set up in November 1997, with an initial three-year funding from the National Lotteries Charities Board. It targets service users aged 18-64 years and develops co-operatives as a way forward to encourage Asian service users into jobs that match their skills.

A range of services are offered including:

- Advice and support to make the right choice in career development and further education
- One-to-one employment counselling
- Assistance with CV preparation
- A specialist job club
- Accompanying clients to interviews if needed
- Access to computers and computer training
- A bank of job placements and vacancies gathered from newspapers, health authorities, housing, council offices and other sources
- ESOL courses
- Support for setting up a small business or support with a business

Funding has recently been received from the Basic Skills Agency to be involved in piloting their ESOL syllabus. AWAAZ are now a learn direct provider for the community in North Manchester, with links to job centre plus and the city college.

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SETTING: Criminal Justice system

Black and minority ethnic groups within the criminal justice system

Black and minority ethnic groups (including foreign nationals) make up 19 per cent of the male prison population and 25 per cent of female prisoners (Nazroo 1997; Nazroo 1998; Alexander 1999). In 1997 there were 11,500 people from ethnic minority groups in prisons in England and Wales, far higher than numbers from the indigenous population. The experience of people from minority ethnic backgrounds in the criminal justice system is markedly different from that of white people. Within the system as a whole, including stop and search, arrest, police custody, probation and in prison, there is a disproportionate number of people from black and minority ethnic communities, and people involved in the criminal justice system are at risk of having higher than usual rates of mental health problems (Home Office 2000a; Rutter et al 1998).

Pathways to mental health services

An alarmingly high number of people from black and minority ethnic groups, including the Irish community, are in contact with the police as a result of mental health problems, and have the criminal justice system involved in their referral to specialist mental health services compared to the white majority. This is true for both compulsory and voluntary admissions to hospitals. Conversely, referral to specialist services for minority groups is less likely to be through primary health care than for the white majority population (Sashidharan and Francis 1991; Bhui 2002; Sainsbury Centre for Mental Health 2002). Service users often describe police interventions as being characterised by the unnecessary use of physical force. Unfortunately, police involvement is associated with criminality rather than therapy, and this impacts negatively not only on service users but on black families and carers (Sainsbury Centre for Mental Health 2002 p.48).

Mental health and the criminal justice system

The prison population has some severe and complex physical and mental health problems. Whilst in prison, there is an opportunity to influence prisoners' mental health and well being for the duration of their sentence and for the future. For many, prison may be their first opportunity to learn about their health and mental health, have support to manage some of their problems and develop skills for the future which might help promote their mental health. It is also a chance for them to take mental health messages back into their communities.

The health of prisoners is generally much worse than that of the rest of the population. Prison health data shows:

- 90% of all prisoners have a diagnosable mental health problem, substance use problem or both
- around 2% of remand prisoners attempt suicide in any given week
- prisoners have about a two to four-fold excess of psychotic illnesses and major depression compared with the general British population of similar age, both potential risk factors for suicide
- prisoners have about a ten-fold excess of anti-social personality disorder (Jenkins et al 1997).

Risk factors that lead to offending, such as deprivation, living in a poor area and family stress are linked to mental health problems, and offenders are more likely to have experienced stressful life events (Lader et al 2000). Interactions with the criminal justice system are also stressful and may lead to anxiety and depression, especially for those in custody (Paulus and McCaine 1983; Zamble and Porporino 1988).

Women and prison

A disproportionate number of women prisoners (25 per cent) are from black and minority ethnic groups. Nearly twice as many women prisoners suffer from mental ill health than male prisoners. Of women imprisoned for the first time, 55 per cent have a mental health problem, with the majority suffering from depression (Revolving Doors Agency 2002). Their survey of women prisoners found that 64 per cent of women who are known to be mentally vulnerable are going to prison and leaving dependent children on the outside. 3 per cent of those women did not know where those children were, affecting the mental health of both the children and their mothers. The report states: 'Placing women with a mental health problem in prison on a sentence of less than a month wreaks havoc on employment, housing, social inclusion and most importantly, children.'

The Government's *Strategy for Women Offenders* (Home Office 2000b) highlights the specific needs of women and the *Women's Offending Reduction Programme* promotes an holistic response to the range of factors that impact on women's offending eg. mental and physical health, caring responsibilities, experience of abuse and violence. Availability of and confidence in community alternatives to custody need to be improved if the female prison population is to be reduced.

Mental health promotion in the prison setting

At present, the mental health needs of people within the criminal justice system are not being met by existing services, and there is a lack of expertise and resources, inadequate screening and assessment, lack of staff training, limited treatment options and a lack of research. Meeting these needs is a multi-agency responsibility requiring increased understanding and better communication between key players.

Both the Department of Health and the Prison Service support a whole prison approach to health promotion in prisons as reflected in their recently published report (Prison Health Policy Unit and the Prison Health Task Force, June 2002). This encourages prisons to develop and implement a health promotion strategy, policy and practice to improve the health and well being of staff and prisoners. With the transition of responsibility for prison health services from the Home Office to the Department of Health, there will be greater emphasis on ensuring that prisoners and prison staff have access to similar health promoting opportunities as people in the community. Over the next five years, prison health will become part of the NHS, with Primary Care Trusts being responsible for the commissioning and provision of health services to prisoners in their area. As part of this process, the mental health promotion needs of prisoners from black and minority ethnic communities will need to be assessed and addressed.

The World Health Organization (WHO) in their consensus statement on mental health promotion in prisons states that prisons should not compromise the physical or mental well being of prisoners or staff (WHO 1999), and recommend that prisoners should:

- feel safe
- be helped towards insight into their offending behaviour
- be treated with positive expectations and respect.

Imprisonment, especially for first time prisoners or those on remand, is a stressful time. Home and family worries can assume a special significance and the loss of personal control over one's daily life can be very difficult to cope with. There needs to be recognition and acceptance that prisoners will at times feel under stress and need extra support. The 'whole prison' approach means that staff also needs the best possible environment and support in order to work most effectively.

Some benefits of successful mental health promotion in prisons

- *For the prison:*
Improved security, safer environment, improved staff-prisoner relations, easier recruitment/retention of staff, lower sickness absence.
- *For staff:*
Improved job satisfaction, higher morale, lower stress, improvements in physical and mental health.
- *For prisoners:*
Increased emotional and physical well being, better able to confront offending behaviour, increased confidence and social skills, ability to use time well and plan for the future, social inclusion and better rehabilitation prospects, reduced likelihood of developing mental health problems or the degree of mental health problems experienced.
- *For families:*
Better family relationships, safer environment for children to grow up, less risk of family members developing mental health problems.
- *For the community:*
A more socially inclusive society, with more likelihood of successful rehabilitation of released prisoners, fewer mental health problems among released prisoners, increased safety.

Summary – Mental health promotion action plan for prisons

- Provide opportunities for physical activity, education and work or purposeful activity to promote physical and emotional well being.
- Effective mental health awareness training for prison staff to develop competencies and confidence to identify anyone showing signs of stress and anxiety and offer appropriate support.
- Have in place policies and practices to prevent bullying, including involving prisoners in the identification of bullying risk.
- Make available counselling and other support groups – access to NHS Direct could help individual prisoners identify appropriate help and useful organisations.
- Social and life skills training and mental health awareness.
- The ‘listener’ schemes that operate in most prisons where prisoners are trained by local Samaritans branches.
- Give prisoners as much personal autonomy as possible to promote mental health and prepare prisoners for taking individual responsibility again on release.
- Contact with families and friends to provide support and contact with the outside world.
- Projects addressing substance misuse, including alcohol.
- Staff need information about their own mental well being and stress management, and awareness that they can contribute to prisoners’ health and well being.

Acknowledgement to Leeds Prison Health Promotion Framework: Promoting Physical and Mental Wellbeing in the Prison Community

6 A Framework for Evaluation

This Chapter sets out a range of issues for consideration when developing an evaluation framework for mental health promotion. These include:

- How to plan your evaluation
- How to undertake your evaluation
- How to use the information that you collect
- How to share and publicise your findings
- How to design an evaluation timeplan.

Mental health promotion projects and initiatives are crucial for people from minority ethnic communities. These programmes offer the potential not only to sustain and enhance the positive mental health of these communities as a whole, but also to enrich the lives of people who use mental health services. Programme impact can only reasonably be assessed however through a planned process of evaluation.

Planning your evaluation

It is important to anyone undertaking monitoring or evaluation to be able to answer the following questions:

- Why are we doing an evaluation?
- Who is the evaluation aimed at?

Evaluations are most often undertaken to support a bid for new or further funding or as part of the feedback process to funding agencies. Another important stimulus for evaluation is to meet the community's needs for information on mental health promotion programmes and initiatives of worth. Evaluation also provides an opportunity to augment the project team's learning by enabling reflection on what has gone well – and not so well!

Whatever the main reasons for the evaluation a few general principles apply.

- Build the evaluation in right at the start of your project, the earlier the better. Even if a programme or intervention has already started it's not too late to consider an evaluation. As long as the aims and objectives of the project are clear and agreed, then an evaluation can be taken forward within that framework.

- Be clear about your aims and objectives.
 - **Aims** are statements that express what the project intends to do, for example 'set up a culturally sensitive advice service for young Irish men' or 'develop a way of accessing the views of Somali elders on community safety'.
 - **Objectives** are statements about what the project wants to achieve within a specific timeframe. So a 'culturally sensitive advice service for young Irish men' might have as some of its objectives to get accurate information on the numbers of young Irish men in the area; carry out a needs assessment with these young men; map local appropriate voluntary and statutory services; offer that information to the target group; and monitor, review and evaluate the project work.
- Bring together members of the project team to discuss and plan the evaluation and to spell out why and for whom an evaluation is being done. Your target audience will influence the form and content of your evaluation, as will the length of time and the resources and skills available.
- Map out a timeplan for each stage of the evaluation. (See the sample plan at the end of this Chapter.) You will need to decide what it is you are measuring, what information you are going to collect to demonstrate that the project is meeting its aims and what methods you are going to use to gather your information.
- Observe ethical principles and ensure that lay people are clear about the terms of the evaluation and the limits of their involvement. Try to reassure them that their anonymity is guaranteed and that if possible their time and costs such as travel or childcare will be reimbursed. Some evaluation projects use a written agreement between the project and community members which sets out details of the evaluation, how the information collected from them will be used and pledges to feed back any outcomes from the research such as the final report and recommendations.
- Involving lay people – Government policy has increasingly laid emphasis on public involvement through consultation on the design and delivery of services as well as in research to inform those developments. Community development research has revealed that lay people sometimes resent only being the objects of research and never being in the driving seat. So you will need to decide how you want to involve lay people in contributing to the evaluation.

Involving lay people in research

There is already a wealth of experience to draw on if you want to involve lay people. For example **INVOLVE** (formerly **Consumers in NHS Research**) aims to ensure that consumer involvement in research and development in the NHS, Public Health and Social Care improves the way that research is prioritised, commissioned, undertaken and disseminated. Strategic objectives include promoting greater consumer involvement in health and social care research and empowering members of the public so that they can be more involved in research and development. (<http://www.conres.co.uk>) **INVOLVE** can also advise on training for members of the project team, if you find that the skills you think you might need are in short supply.

Another similar group is Folk.us (<http://latis.ex.ac.uk/folk.us/whoweare.htm>) which aims to promote a research culture which is meaningfully controlled and influenced by service users, disabled people and informal carers. They have produced guidance on how to involve lay people in the evaluation process.

- At the planning stage consider how you want to involve the project's stakeholders. These will include the target group for your mental health promotion project, but also more broadly are likely to take in the funding organisation as well as local voluntary sector organisations which work with the identified ethnic minority community. Their views on what would constitute the success of your project will be valuable, as will their help and co-operation when you are publicising the evaluation findings at the end of the project.

Undertaking your evaluation

How you carry out your evaluation will depend on the time, skills and resources that are available to the project. Be mindful of the 'hidden costs' of an evaluation, especially the staff time necessary to collect and write up the information.

A critical issue when working with minority ethnic communities is to ensure that the evaluation takes the unique cultural issues of the specific community into account. Of course members of the project team may come from the target community and have in-depth understanding of relevant concerns and topics. Even so it will be important not to make assumptions based only on a shared cultural background as age, gender and socio-economic status will all play a critical part.

At the planning stage the project team will have decided what was being measured and this will influence the research methods used to collect information. So for example, in order to ‘develop a way of accessing the views on community safety of Somali elders’ you will be measuring the impact of one or several ways of engaging with older people from the Somali community.

You may need to try several different approaches and there will be a range of issues to consider, for example:

One to one interviews can be very useful in ascertaining individual views. Issues to consider are the possible need for interpreters, sensitivity to times of year which may conflict with religious festivals and the need to test out the interview questions before using them for real, in order to ensure that they’re easy to understand and yield useful information.

Focus groups of people from the community you want to target are also a useful tool; the ideal size is between 8 – 10 people and it’s preferable to have two facilitators. Issues to consider are the need for interpreters, time of day, venue and ease of access, reimbursement for people’s time and provision of appropriate refreshments. It can also take a long time to get the right number of people together so allow enough time to organise the meeting. You will have to give more thought to how you recruit participants if you are aiming to include more hard to reach people. Facilitators should be clear about what topics they want to cover during the group that should be no longer than 2 hours.

Comparison of these approaches may reveal that one method worked better than the other because it yielded more information from community members. Perhaps both methods worked well but one was less resource intensive than the other. The final evaluation report would ideally have observations about these issues as well as a series of recommendations, based on the views of Somali elders, on how to improve community safety.

Before you begin to collect your information you will need to have some idea of how you will know if your project has met its aims and objectives. In other words you will need some concrete way of showing that you did what you set out to do. Measures will vary depending on what your project is setting out to achieve. Remember to revisit your aims and objectives because these will determine how you will measure your achievements.

One way of deciding what your measures will be is to ask the project’s stakeholders what success might look like for them. Using the example of accessing the views of Somali elders once more, measures might include some of the following:

Somali elders

- Having their concerns listened to
- Having a say in what their community should be like
- Making contact with other members of their community
- Being treated with respect

Project workers

- Learning new skills
- Making a difference to the local community
- Creating new models of involving lay people

Project commissioners

- Gaining new information for planning purposes
- Meeting a neglected area of community need
- Improving community mental health and building social capital

Whatever community is the subject of an evaluation there is a varied 'toolbox' of data collection methods. In addition to interviews and focus groups, which were described earlier, community projects could use some of the following evaluation tools:-

Questionnaires: Useful in terms of collecting information from a large number of people, but make sure it's well-designed and the information it provides will be easy to understand. You could get advice and guidance from the local health promotion unit or university research department. Online advice is available from **INVOLVE**. (<http://www.conres.co.uk>) or **Folk.us** (<http://latis.ex.ac.uk/folk.us/whoweare.htm>)

Case studies: Ideal for showing in detail the effect of a particular activity on one person or a group of people; case studies can be useful if you want to highlight an issue of specific concern.

Diaries: These can be written or audio-taped and offer an opportunity for people to record their thoughts and experiences as they are involved with your project. But you will need to negotiate with people so they make the commitment to keep the diary and are reassured about issues of confidentiality and how the information will be used.

Creative activities: Recording information through activities such as creative writing, poetry, artwork or cartoons can be very powerful and give a very rich impression of the impact of your project on its participants. Such tools can be used to record the process of a project, or one point in time during the project such as a major event. These records can serve as an adjunct to other methods of data collection you may be using.

Visual tools: Photographs, collages or videos are all valid evaluation tools and can provide a deeper sense of what impact participation in your project has had on community members. You may want to get advice and guidance on how to produce these sorts of material. The local Further Education College or Adult Education provider may be able to help. Local amateur photography clubs may also be able to give some direction. This type of evaluation can be a lot of fun and everyone will learn new skills, which in itself is mentally health promoting!

Underpinning all of these methods is the necessity to keep good, accurate, complete project records. A log book or project diary is a good way of tracking what happened and when, copies of relevant correspondence and any other important details. One or two members of the project team should take responsibility for this important area of work.

A mixed method of evaluating mental health promotion programmes offers the best opportunity of capturing the clearest possible picture of the process of an initiative and which elements were most effective in delivering on project aims.

The *MELLOW Campaign* is a powerful mental health network that aims to stimulate and develop creative and sustainable solutions to reduce the over representation of young African and Caribbean men in psychiatric services. This unique project is a partnership between the East London and City Mental Health Trust and an independent steering group of African and Caribbean service users, carers, mental health practitioners, youth and community development agencies, a pharmacist, a GP and faith organisations.

In order to develop an evaluation framework that includes indicators that are meaningful and valued by all relevant groups, mentality undertook a consultation process with:

- Mellow staff and steering group members – through a meeting to identify and agree a range of indicators for each key objective
- Mellow stakeholders, through telephone and face-to-face interviews
- Mellow users, through a consultation event ‘Chat Back’ attended by seventeen service users. User consultants were recruited and supported to run focus groups with users at this event and identify indicators of success of the Mellow Campaign and desired user outcomes

This process yielded a number of indicators which were agreed as measures of success of each of the four key objectives of the Mellow Campaign. For example the objective on Empowering service users had some of the following indicators:-

- Service users gained the resources and support to identify their own needs;
- Mellow programmes resulted in the establishment of user-led initiatives;
- Services users were less dependent on in-patient and community services.

Specific Mellow activities were evaluated to identify their contribution to Mellow objectives and to identify lessons learnt for future Mellow work. Workshop and programme providers and performers were asked about the impact of each activity on service users, on services and on the wider community. Mellow service users were interviewed to identify particularly enjoyable and positive features of Mellow events and projects, and to assess how far Mellow helps to promote the factors that are known to have a positive mental health impact such as participation, empowerment and friendship networks. (**mentality** 2002)

Using the information that you collect

What happens after you've collected all the information? You need to come to some conclusions and demonstrate the extent to which the project has met its stated aims and objectives. Your evaluation information should help you answer those questions. You also need to be able to describe the process of how the project developed, which members of the team were responsible for different tasks and perhaps what their perceptions and views were.

Make sure that more than one member of the project team is responsible for analysing and explaining the research findings. It can be very lonely writing up research findings on your own and a second point of view is always valuable. Think together about how to present your results and who will be reading your report. Do this during the course of the project and don't leave all the writing up until the very end.

As a team it's important to build in thinking time. You should allow yourself the space to think about 'How are we doing so far?' This process will help in pulling together your evaluation findings.

A variety of ways to present results is always a good idea. For information describing numbers (people attending an event, frequency of responses to a particular question) try using tables, bar charts and pie charts.

Information from interviews and focus groups should be classified according to themes and illustrated with anonymous quotes. This method gives more colour and richness to what might otherwise be a rather dull account of the project.

You may want to include other ways that you have recorded information such as photographs of project participants or the area where the project took place; poems or other pieces of writing that research subjects may have produced or stills from a project video.

Make sure that your report addresses the aims and objectives of the project and provides criteria to illustrate how these were met. In essence your report will be a history of the project and will explain what you set out to do, how you did it, what happened and the impact of your project on local people.

Making best use of your findings

Once you have completed your evaluation report you will want to publicise your findings. What are some of the issues to consider?

You may need slightly different versions of your report for the different target audiences. Your funding agency, perhaps the local primary care trust, may want a complete evaluation report with detailed descriptions of the project, its process and findings and how the budget was managed. Local people who were involved in the project and other members of that community should also receive a full report. Both these sets of stakeholders may benefit from a presentation by the project team to talk through the report and answer any questions.

Once the report has been fed back to a funder or the project's management committee it is worth considering wider publicity for the findings. This is especially true if the project has addressed issues of gaps in services or persistent problems facing members of an ethnic minority.

You might want to consider some of the following:

- publicising your findings in the local newspaper
- approaching a local radio station to share your findings
- speaking at large meetings or conferences which focus on the specific community with which you have been working
- putting your findings and information about your report onto a relevant website.

It's important to remember that the final report from your project can serve several important functions. You can use it to secure renewed funding for your project, to ensure a service improvement for a specific ethnic minority and to inform future project work with this community. The bottom line however is to demonstrate that the project has had an impact on mental health promotion for the community members.

Sample plan for a 12 month evaluation project

Month 1

- Hold a meeting to review the project's aims and objectives and to consider evaluation in the light of these.
- Hold a meeting to plan the evaluation – what methods will you use?
- Discuss how to involve community members and how to respect their needs

Month 2

- Work out what advice you need on monitoring and evaluation
- Get the necessary advice and guidance
- Decide which members of the team will be doing what
- Start to organise your evaluation

Month 3

- Review your progress using information you have already collected
- Think again about the project's aims and objectives
- Does anything need to change at this point? If so, how?

Months 4 and 5

- Continue to think about progress, using the information you are collecting
- Review the involvement of community members, either as subjects or objects of the evaluation
- Continue collecting your information

Month 6

- Hold another major review meeting
- Consider if changes are necessary and why
- Continue to collect your information for the evaluation

Months 7 and 8 (As Months 4 and 5)

Month 9

- Hold another major review meeting
- Make decisions on how you will present and share your findings
- Final stages in information gathering

Months 10 to 12

- Finish collecting your information
- Write up your final report
- Finish work on other aspects of the project as appropriate i.e. video production
- Talk with funders about how to share the learning
- Give feedback to people taking part in the project
- Share the learning as widely as possible and as appropriate

(Adapted from McKie et al 2002)

7 Examples of Mental Health Promotion with Black and Minority Ethnic Communities

This Chapter provides examples of projects taking place around the country and working with different black and minority ethnic communities in a range of settings. The projects illustrate examples of effective practice for promoting mental health and well being, both through the services provided and the way in which they are delivered. Activities provided include awareness raising about mental health issues, advice and information, challenging stigma, promoting self esteem, providing emotional and social support, befriending, advocacy, counselling, opportunities for physical activity, arts and creativity, day care, and initiatives to improve access to appropriate services and provide training for workers. All of the work is delivered in a culturally sensitive and accessible way.

Summary of key approaches used in the projects included

Areas of Work	Project Number
Access, uptake of services	2, 5, 6, 7, 8, 9, 10, 11, 13, 15, 16, 17, 18, 21, 25
Advice, support, information	1, 3, 6, 7, 9, 10, 11, 12, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 26, 27, 28, 30
Advocacy	1, 3, 8, 9, 11, 12, 16, 26
African Caribbean	1, 2, 3, 4
Alternative therapies	1, 4, 19, 22, 23, 26
Arts, drama, creativity	1, 4, 7, 9, 15, 19, 29, 30
Awareness-raising	1, 2, 4, 6, 7, 12, 14, 15, 16, 17, 18, 21, 23, 24, 25, 29
Befriending, promoting friendships	1, 4, 14, 16, 24, 27
Black and minority Ethnic groups – all	27, 28, 29, 30
Capacity building	4, 6, 11
Carers support	1, 2, 3, 7, 17, 26
Chinese, Vietnamese	5, 6, 7
Community input to service planning	4, 12, 16, 17, 22

Counselling, talking therapies	3, 7, 8, 9, 21, 24, 25, 28
Culturally, linguistically sensitive services	4, 7, 8, 9, 10, 11, 12, 17, 19, 20, 25, 27, 28
Day-care, drop-ins	1, 7, 10, 17, 19, 20, 26
Education, training	1, 2, 3, 4, 10, 19, 27
Employment opportunities	3, 4, 10, 27
Family activities, support	1, 2, 12, 17, 24
Helplines	2, 7, 9, 28
Housing, refuge	1, 3, 7, 8, 10, 21, 27, 28
Irish	8, 9, 10
Life skills, parenting skills	1, 14, 16, 27, 29
Mainstream services more culturally sensitive	2, 4, 5, 7, 11, 12, 17, 27
Mass media	6, 22, 23, 24
Men	4, 29
Outreach	1, 2, 3, 4, 7, 10, 17, 19, 30
Physical activity	1, 2, 17, 29
Physical health	1, 10, 16, 17, 23, 26, 29
Prison setting	1, 3
Refugees, asylum seekers	11, 12, 13, 14, 15
Resource development	2, 4, 5, 6, 7, 21, 23
School setting	2, 14, 15, 29
Self esteem, self confidence	1, 4, 9, 14, 15, 17, 20, 22, 26, 27, 29
Self help	4, 16, 22
Social activities, networks	1, 4, 9, 10, 16, 17, 19, 20, 22, 24, 26, 27, 29, 30
South Asian	16, 17, 18, 19, 20, 21, 22
Training, support for workers	2, 4, 5, 7, 13, 15, 17, 18, 21, 24, 25, 27, 29
Women	9, 16, 17, 19, 20, 21, 27, 28, 30
Young people	2, 3, 4, 6, 7, 14, 15, 20, 21, 24, 29
Volunteering	12, 19

African Caribbean

Project 1: African Caribbean Community Initiative

ACCI offers a holistic and culturally sensitive day care and advocacy service to the African Caribbean community in Wolverhampton.

Target Group: African Caribbean people with mental health needs.

Setting: Community

Funding: Wolverhampton City Council, Wolverhampton Health Care Trust, Mental Health Grant, Beacon Award. The outreach posts were initially funded through the Community Fund, and now by Wolverhampton Primary Care Trust. The gardening group has received a grant from Wolverhampton Health Action Zone.

Timescale: 1987 – on-going.

Aims and objectives

- To provide a wholly holistic and culturally sensitive, specialist advocacy service to the African Caribbean community, who are subject to rejection, isolation and marginalisation
- To enable members to experience a sense of well-being and self worth, using a person-centred approach
- To develop, co-ordinate and deliver a superior quality, member oriented structured and unstructured day care service as well as a proactive outreach service to meet the needs of members
- To provide interactive educational and recreational activities, health promotion and good living practices, life and social skills and emotional support

Rationale: ACCI was set up in response to concerns about the growing numbers of young African Caribbean people suffering or at risk of mental ill health; the visibly disproportionate numbers in psychiatric institutions; and the lack of aftercare and day care provisions offered to the African Caribbean community by mainstream services.

Project Description: ACCI is a resource centre providing day care, outreach and supported housing for African Caribbean people with mental health needs. It includes a number of different areas of work:

- **Real Fathers Real Men Project** – this project was set up in response to the recognition that black men have many issues around sexual health, relationships and fatherhood and find it hard to talk about these areas. Initially, a men's group was set up, but subsequently a family group was also started because of the need for men to deal with issues together with their partners and families. Both groups meet once a month to discuss and support each other around a range of topics including teenage pregnancy, attitudes of young men towards children, the effect of absent fathers on their children, sexual health and drugs.
- **Carers Group** – the group aims to provide a forum for carers to share their experiences and discuss ways in which members can be supported in their caring role. It works to highlight the serious consequences that carers face in their caring role and the stigma, shame, ignorance and cultural indifference they experience. The group helps to reduce isolation and aims to raise awareness of mental health issues. Carers gain access to a specialist, culturally sensitive service, practical help, advice, information and training and a network of local and national carers.
- **Befrienders** – volunteers are trained and supported to befriend members, visiting them at home, working with them in the day centre, going out with them or joining in social events.
- **Health Advisory Clinic** – offers regular health checks such as weight, blood pressure, urine and blood sugar tests, together with a quit smoking service for both staff and members.
- **Outreach** – the outreach team visits members in a variety of settings including people's homes, hostels, day centres, CPA meetings, outpatient appointments, police stations and prisons, and their role includes:
 - Supporting people suffering or recovering from mental illness
 - Facilitating a smooth transition from hospital back into the community, including helping to obtain appropriate housing
 - Empowering African Caribbean people to take control of their lives, helping them recognise and understand their illness and improve their long term health and well being
 - Raising awareness in the community and dispelling stigma surrounding mental illness

- **Activities** – a wide range of activities are offered to members, with the aim of increasing their quality of life and empowering and enabling individuals to interact socially. Activities include a drop-in, computers, life skills, arts and crafts, relaxation sessions, therapeutic support, trips and visits, and a men's therapeutic group that includes drumming and poetry. Acupuncture sessions are held twice a week, and there are opportunities for physical activity through swimming, walking, bowling and football sessions. The Adult Education Centre provides input to many of the activities, and some of the sessions are held off-site.

Partnerships: ACCI has partnerships and links with a range of organisations including the Wolverhampton Drug Action Team, the Local Implementation Team, Wolverhampton Race Equality Council, Wolverhampton Health Care, BME Sexual Health Services and BME Housing, Community Mental Health Teams across Wolverhampton, Rethink Befriending Service and other voluntary agencies such as Mind.

Evaluation/outcomes: A survey of members is used to get more formal feedback in addition to the regular verbal feedback, suggestions and requests from members. The survey identifies how long they have used the service, how often they use it, what they like most, what they dislike and why, and any improvements they feel are needed.

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Project 2: Antenna Outreach Service

Antenna provides a culturally sensitive outreach service to young people aged 15-25 years, advice and support to families and carers, and awareness raising within the black community and to a range of service providers.

Target Group: 15-25 year old Black African, Black Caribbean and mixed heritage young people with mental health needs.

Setting: Community

Funding: Initial two-year funding from the Sainsbury Centre for Mental Health, the Kings Fund and the NHS Executive (as part of the Working Together in London Initiative). Now funded by Barnet, Enfield and Haringey Mental Health Trust, New Deals for Communities (for the Home Tuition Programme) and Sport for All (for activity weekends).

Timescale: October 1999 – on-going.

Aims

- To develop an accessible and sensitive mental health service to cater for the needs of young black people aged 16-25 years so they achieve a better quality of life
- To deliver a service that reflects both the mental health and aspirational needs of the clients and parents/carers
- To raise awareness about mental health in the black community
- To develop a culturally sensitive outreach service to the client's family and community
- To enhance the quality and level of integration of the outreach service with mainstream care agencies in Haringey and Edmonton.

Rationale

A study commissioned by Enfield and Haringey Public Health Department and Haringey Race Equality Council in 1998 highlighted community concerns about hospitalisation of young people from African Caribbean communities diagnosed with mental health problems, and the need for prevention and early intervention with this group.

Antenna was set up to pioneer proactive and preventative work to address the disproportionate number of black people experiencing mental ill health. It aims to engage those clients who, because of their lack of engagement with existing support services, are considered to be at risk of breaking down or are in need of hospitalisation. The entire Antenna team is drawn from the African and African Caribbean community, in order to enhance the level of sensitivity and understanding of the psychosocial, socio-economic and cultural needs of the target client group. Research has demonstrated the need for early intervention and Antenna targets clients in the early stages of their illness with complex health and social needs.

Project Description

Antenna works with around 50 young black African and Caribbean people aged 16-25 years to provide a culturally sensitive service, with staff recruited from the communities. Clients likely to be targeted are those who regularly miss appointments or who have a history of non-compliance with medication, excessive use of recreational drugs or alcohol, or due to their chaotic lifestyle have been identified as at risk. Referrals come from hospital wards, community mental health teams, the police or probation service, for example. The project offers a holistic service to meet a range of different needs, for example help with housing and benefit advice.

Around 50% of Antenna's clients at any one time are in some sort of active training programme. Antenna visits them during lunch times and supports them to complete their training. Five young people have gone on to university or to study for NCVQs or other qualifications. A 24-hour telephone helpline is available to provide information and support around mental health issues to young people and their parents.

Antenna tackles the stigma of mental illness within black and ethnic minority communities. The project visits schools, churches and mosques, youth services and educational centres in the borough to raise awareness about mental health issues with people from ethnic minorities, to tackle stigma and to cultivate a more accessible, sensitive approach to mental health issues. It works in one school to contribute to the health mentoring programme.

A community event attracting 400-5000 people is held annually to raise awareness about mental health issues within the local community. A number of videos have been produced, including 'Heavy Mental', shot, directed and edited by the Antenna Young People's Group and including street interviews, mental health facts and signposts to available help. The youth group also works in youth clubs, sixth form colleges and community centres to promote the work of Antenna.

Antenna runs training for mainstream service providers within health and social services, with the police, and within nurse and social work training courses. It contributes to a 12 week self development programme for Prince's Trust volunteers to enable them to work better with young people with mental health problems. Work takes place with 5 churches in the borough, and young people are offered work experience doing, for example, administrative work and catering. Training is also provided for parents around how to do assessments, what signs to look for, the effects of medication. The Family Support Co-ordinator works with families and encourages their involvement.

Partnerships: Barnet, Enfield and Haringey Mental Health Trust, Bell Youth Action, The Prince's Trust, Pyramid (a black counselling service), a range of other statutory and voluntary agencies working in the area of education, training, employment and leisure services, local churches and the local community.

Consultation: From the early stages of the programme, the views of users and carers have been actively sought and used to inform the service. The Antenna Young People's Group reflects the wider community, including both young people who use mental health services and those who do not, and helps shape the service with their ideas and to share their experiences of youth culture and current trends. It meets regularly to have input into the project around issues such as staff selection, use of language in client information packs, logo and publicity design.

A meeting for families is held every 6 months at the centre – it is an enjoyable social event and provides an opportunity to discuss how they want the service to improve and themes they would like to cover – for example stress management and conflict resolution management.

Evaluation: Evaluation of Antenna was carried out by the Sainsbury Centre for Mental Health and the Centre for the Economics of Mental Health as part of the overall evaluation of the 'Working Together in London' programme in 2002. The report 'Out of the Maze' highlights areas that have worked well – including the use of a psycho-social model of care, the family/parent support service, the telephone referral system, the 24-hour helpline, engagement with the wider community, and the Antenna Youth Group. It also identifies areas for improvement, including the need for a better understanding of how services can respond to cultural issues in both black services and youth services, and the need to bring an understanding of culturally specific approaches into mainstream services.

Pointers used to measure success:

A number of pointers are used to measure the impact of Antenna, including:

- Improved partnership working – co-operation and collaboration between key stakeholders
- Early treatment and prevention of admission/readmission
- Young people who use Antenna, and their parents/carers, feel they have been helped positively in a way not experienced before
- Young people who use the service feel better about their lives and feel more independent
- Black voluntary groups are actively involved in service development

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Project 3: Frantz Fanon Centre

The Frantz Fanon Centre provides dedicated and accessible mental health care for North Birmingham's African Caribbean community.

Target group: All African Caribbean adults aged 16-65 years. Support for younger children is also provided as part of their work supporting families.

Setting: Community

Funding: Mainstream funding from Birmingham and Solihull Mental Health Trust, plus the People's Learning Partnership for the Learndirect training project.

Timescale: 1997 – on-going.

Rationale: The centre was set up in response to distress amongst the African Caribbean community following a specific incident in Birmingham City Centre involving an African Caribbean man, together with the large number of African Caribbean people, especially men, using psychiatric services in the Birmingham area.

Aims:

- To reduce the over-representation of African Caribbean people in the acute mental health services; to provide a high quality mental health service to the African Caribbean community in Northern Birmingham and to retain their involvement and confidence in all aspects of the service.
- To provide real alternatives to hospital and traditional Western psychiatry through developing the following areas:
 - Outreach and community support
 - Crisis and residential care

- Psychotherapy and counselling
- Vocational training and work opportunities
- Children, young adults and families
- Support for service users and carers
- Advocacy, advice and mediation
- Prison 'in-reach' programme

Project description: The Centre offers a variety of services specifically designed to address the mental health needs of the Black community.

Outreach and community support

The Centre provides a dedicated team of nurses and support workers who provide care and support in the community for people with acute and long-term mental health needs, including preventative work for those at risk and appropriate networking with home treatment teams, primary care and social services. It is based around assertive outreach models but has been tailored to the social needs of the Black community in relation to advocacy and cultural issues. A key innovation is the integration of users, advocacy workers and unqualified support workers within a team also including nurses and social workers.

Crisis and residential care

Specific support will be provided for people in crisis using a variety of methods such as family placements and crisis beds to provide alternatives to admission to hospital settings.

Psychotherapy and counselling

Counselling is provided by external private contractors but the Centre is keen to address the needs of patients who are seeking an alternative to medication, regardless of whether they have been diagnosed as suffering from a 'psychosis'.

Vocational training and work opportunities

The Centre has its own training unit with access to a jobs database and help in arranging job placements in virtually any field. The Centre also operates a Learndirect Training Centre that provides internet-based training using the latest information technology.

Children, young adults and families

The Centre's social worker liaises with Social Services and legal agencies to ensure that children's needs are addressed, whilst also endeavouring to keep the family together and provide support during stressful times.

Support for service users and carers

The Centre employs a 'service user consultant' and a number of volunteers to coordinate support groups for in-patients as well as people who are receiving care in the community.

Advocacy, advice and mediation

A specially trained advocacy worker provides help, advice and mediation around mental health procedures and related legal areas. The Centre can also provide representation on Mental Health Review Tribunals and complaints to hospital managers.

Prison 'in-reach' programme

The Centre provide a prison 'in-reach' programme to Birmingham Prison in line with Government policy to provide mainstream NHS services within prisons. They are able to deliver follow-up care for people who have been using community services and are subsequently detained within the prison system, and continue their involvement if the person is released into the north Birmingham area.

Consultation: This is done through regular discussions with clients when talking about their care plan. It is based on a process of feedback and review looking at the clients' perceptions and perspectives on what they need. Clients are also asked for feedback on the referral process at three main stages – their initial feedback is sought after pre-assessment and again after discussions with them. This process is ongoing and the final feedback is sought on completion of assessment.

Partnerships: Different teams within Birmingham Mental Health Trust; Voluntary Sector providers of services for African Caribbean people; Servol; Handsworth Community Care, Rethink's Advocacy Service; privately contracted counsellors.

Evaluation: Evaluation was undertaken 2 years ago through focus groups with users and staff. Evaluation of the counselling service is planned.

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Project 4: Mellow

Mellow is based in East London and uses music, arts, sport and drama to promote mental health and raise awareness of mental health issues. It delivers a range of services including personal development programmes, outreach and employment/training opportunities to enhance the quality of life of young black men.

Target Group: Young African & Caribbean men aged 11 – 34 years living in the boroughs of City and Hackney, Newham and Tower Hamlets.

Setting: Community

Funding: Through East London and City Health Action Zone Programme; with financial support from London Arts, local Primary Care Trusts and Lord Mayor's Square Smile Appeal Fund.

Timescale: October 2000 – on-going.

Aims:

To reduce the overrepresentation of young African and Caribbean men in mental health services and to develop alternative responses to mental distress among this target group

Objectives:

- To increase opportunities for young African and Caribbean men who use services to achieve their potential and hold on to, or regain, a life that has meaning for them
- To promote and develop a range of support services for young African and Caribbean men across the Health, Social Care, Youth and Education sectors
- To facilitate the development of self help and user-led initiatives
- To identify employment and training opportunities for the target group
- To influence service delivery and policy development at a local and national level
- To increase awareness of mental health issues and their importance among the wider African and Caribbean community
- To facilitate the empowerment of the target group to participate in the design, planning and delivery of mental health services
- To increase awareness of the concerns of the target group amongst mental health practitioners and other professionals

- To provide training and information for professionals to improve service delivery to the target group

Rationale: Mellow was set up in response to the over-representation of young African and Caribbean men in mental health services. Mental health service users commonly report that mental health assessments and service provision take place from a perspective that does not respect or engage with cultural difference, and the programme recognised the need to develop alternative responses that would better meet the needs of the target group.

Project description: Mellow's approach is very holistic in that the spiritual, emotional and creative well being of service users co-exist with employment opportunities, training and personal development. The campaign links with education, regeneration agencies, faith communities and the business community to ensure a holistic approach to mental health care. Mellow reaches out to the wider community to raise awareness, holding events in community venues from art galleries to night clubs. A range of services and projects include:

Mellowship – Creative expression programmes including both performing and visual artists that promote mental well being

Support without Borders – this programme pilots innovative therapeutic services that will improve client engagement with mental health services and enhance mental well being. Following user/community consultation, Mental Health Resource Centres are being developed across East London to provide a range of support and therapeutic services. These centres will aim to reduce hospital admissions and promote earlier interventions.

Unlocking Potential – a programme to promote meaningful employment and training opportunities

Community engagement – providing outreach, befriending and personal development programmes for adolescent African and Caribbean men (in City and Hackney) and young Somali men (Tower Hamlets) through community engagement workers.

Research and development – needs assessment, service reviews and audits to improve mental health services and highlight best practice, including how to improve the care and support of young African and Caribbean men with dual diagnosis.

Training – Mellow delivers a range of seminars, training and conferences to disseminate best practice and improve understanding.

Partnerships: This programme is a partnership between the East London and City Mental Health Trust and an independent steering group of African & Caribbean service users, carers, mental health practitioners, youth and community development agencies, a pharmacist, a GP and faith organisations.

Consultation: Mental health service users are listened to, their contribution recognised and they are central to all planning processes and to the delivery of key elements of programmes and events where they have the opportunity to participate actively and take on responsibility for organisation. Mellow has supported and built the capacity of user-led organisations to ensure that their voice is heard, listened to and acted on.

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Chinese & Vietnamese

Project 5: Endurance

Endurance is a training/resource pack for mental health professionals. It aims to improve the accessibility to mental health services for people from the Chinese Community.

Target group: Chinese community

Setting: Different mental health settings for mental health workers and training settings for undergraduate and postgraduate students undertaking health and social care courses.

Funding: Merseyside Health Action Zone funded the research project and the production of the resource/training manual. Liverpool City Council contributed to the dissemination stage.

Timescale: February 2002 – July 2002 (6 months)

Aims:

- To reduce inequalities by promoting equality of access to mental health services for Chinese people

Objectives:

- To raise awareness among mental health workers of the experience and needs of Chinese people so that they can deliver a culturally sensitive service to them.
- To develop a training/resource pack for the mental health workers

Rationale: A need was identified to raise awareness of mental health workers of the mental health needs of the Chinese community.

Project description: The first phase of the project involved preparation and consultation, which included a literature review and consultation with different focus groups. The focus groups included mental health workers from day centres, Community Mental Health Teams, psychiatric wards, training officers and Chinese Community Workers. Interviews were also carried out with service users and carers. The second phase included writing up the training/resource manual and holding two workshops for different mental health workers to try out the materials in the manual.

Consultation: Mental Health workers (psychiatrists, community psychiatric nurses, social workers, day centre, nurses working in psychiatric units), training officers, Chinese community workers, mental health service users from the Chinese community and their carers.

Evaluation/outcomes: Evaluation is currently being carried out, using a questionnaire to evaluate whether the Endurance training/resource manual has any impact on the practice of mental health workers. Verbal responses about the publication have been extremely positive. Many mental health professionals and related professionals have asked for a copy, and 1000 copies of Endurance have been disseminated.

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The Endurance resource was produced in partnership with Merseyside Health Action Zone and a copy can be downloaded from <http://www.mhaz.org.uk/mhaz/achieving/fellowships.html>

Project 6: National Chinese Mental Health Project – Wah Sun Project

Wah Sun is a national project to raise awareness and challenge the stigma about mental health among the Chinese community, using the media and an educational approach.

Target Group: Chinese communities across the UK.

Setting: Community, schools

Funding: Lloyds TSB

Timescale: January 2002 – December 2003.

Aims

- To encourage positive accurate beliefs about mental health
- To challenge stereotypes and myths about mental illness
- To encourage people with a mental illness and their carers to develop a voice to speak for themselves
- To help users access quality treatments and services through information dissemination
- To allow professionals to explain their services to users and carers through national media

Objectives

To develop:

- a TV programme highlighting Chinese mental health issues
- a video adapted from the TV programme for dissemination
- a bilingual website on Chinese mental health issues and services
- a user-led newsletter
- a national directory of Chinese mental health services
- road shows in Chinese community centres
- capacity building with projects in the Chinese community locally, regionally, and nationally to develop mental health promotion initiatives e.g. Children Artwork Project
- enhanced use of existing services provided within the Chinese Mental Health Association for the benefit of the service users, carers, and their families.

Rationale: People with mental health problems experience prejudice and discrimination that can be as debilitating as the illness itself. This is particularly acute for users from the Chinese community, who face discrimination from their own Chinese community on top of that from the wider community. There is little material to promote and raise awareness of mental health issues with the Chinese community. The Chinese Mental Health Association has received consistent demand from users and carers across the UK for information about mental health in the Chinese language.

Project description: The project uses a multi-media approach to achieve comprehensive coverage of mental health messages and sustainability. A series of TV programmes will be developed with Chinese Channel TVB Satellite Europe, and the programmes also produced as videos for wider dissemination through road shows and other routes.

Partnerships: North Birmingham Mental Health Trust – Asian Services

Evaluation/Outcomes: A monitoring and evaluation framework has been agreed and North Birmingham Mental Health Trust will provide a key lead to monitor and evaluate the project.

- Consumer satisfaction surveys with service users, carers and the wider community will be undertaken
- Any materials produced will be evaluated through focus groups consisting of a range of stakeholders
- Evaluations and community consultations are/will be conducted in workshops, launches, focus groups, and road-shows on a continuous basis
- Independent evaluation will be undertaken to assess the outcomes of the overall project.

Pointers to be used to measure success

- Following the TV broadcast, the number of calls to a hotline number will be monitored to indicate audience response
- The hit rate on the CMHA website will be monitored
- Written feedback in response to the newsletter and TV programmes
- Numbers of referrals to CMHA
- Development of new projects and services as a result of mental health awareness and promotion campaigns

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Project 7: Vietnamese Mental Health Service

The Vietnamese Mental Health Service provides a range of services to Vietnamese people with mental health problems, their families and carers, including outreach, counselling, drop-in, information, support for carers and children, and raises awareness about mental health among the Vietnamese community as a whole.

Target Group: People from Vietnam with mental health difficulties and their families living across the UK.

Setting: Community

Funding: The Department of Health, Lambeth, Southwark and Lewisham Primary Care Trust, Lambeth Social Services, Tower Hamlets Social Services, Hackney Social Services, South London and Maudsley NHS Trust, and a number of charitable trusts.

Timescale: 1989 – on-going.

Aims:

- To increase access to adequate and appropriate health and social care for all people from Vietnam who have mental health difficulties and their carers
- To promote quality and culturally sensitive services to these people

Objectives:

- To work in partnership with health and social care and other agencies to promote culturally sensitive mental health services
- To provide outreach and counselling services
- To provide drop-in day centres
- To provide support for carers and children of mentally ill parents
- To offer supported accommodation for people from Vietnam
- To provide training and support to Vietnamese community organisations to develop local mental health services
- To provide training and education about mental health issues, and health and social care systems to people in the Vietnamese community; and about Vietnamese culture and beliefs in mental health to health and social care professionals

Rationale: The Vietnamese Mental Health Project was established in 1989 following a two-year research project on mental health problems amongst people from Vietnam in London. Since then, the project has grown to employ ten workers, and provide services to people from Vietnam with mental health difficulties and their families living across the UK.

Project description: The Vietnamese Mental Health Services provides a service for people with mental health problems and their families and carers, and also works to raise awareness about mental health among the Vietnamese community as a whole. Areas of work include:

Outreach services – Visits are made to mental health service users, carers and their families in their homes to provide emotional support, advise on housing and welfare issues, and provide information about health and social care systems. The service works in partnership with Community Mental Health Teams, assesses mental health needs and promotes early intervention. An advocacy service is also provided. The service does not operate a waiting list but responds to need almost immediately.

Counselling – Both individual and family counselling is provided

Drop-in centres – These are provided in 3 different areas of London and offer opportunities for service users to socialise and provide mutual support. A range of activities is on offer, including English classes, creative and leisure activities and outings.

Support for carers and children – The service provides emotional support, practical help, advocacy, information and encouragement to get involved in Care Programme assessment. Informal meetings are held fortnightly and an annual day for carers is organised. Children of mentally ill parents are offered special care and support, monitoring their education and development- physical, mental, psychological and emotional.

Newsletter and information leaflets and booklets – A health newsletter is produced every 2 months and distributed to more than 500 people throughout the UK. A range of health information leaflets and booklets is also produced to raise awareness and understanding about mental health issues among the community.

Training and education – Training and education on mental health issues and health and social care systems is offered to Vietnamese people through meetings at drop-in day centres and home visits. Training is also provided for health and social care professionals on Vietnamese culture and beliefs in mental health through seminars and conferences, and by working in partnership with other agencies. The VMHS also responds to enquiries seeking advice on practical issues in working with people from Vietnam.

Partnerships: The VMHS works closely with health and social care and other agencies, and with community organisations of people from Vietnam and other ethnic groups working in the mental health field.

Evaluation/outcomes: An independent evaluation was carried out in 2000. It included group meetings with patients at drop-in sessions, meetings with community organisation staff and interested community members; questionnaires to Vietnamese community organisations, statutory service providers and GP practices. Overall, the service is seen as a greatly valued, competent, professional and responsive organisation. However, the evaluation highlighted the problem of under funding, both for its current services and those it wishes to develop to further meet the needs of the very vulnerable people it serves.

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Irish

Project 8: Cara Irish Housing Association Specialist Support Team

Cara Irish Housing Association provides support to vulnerable tenants who have mental health and dual diagnosis (alcohol and substance abuse) support needs.

Target: The Irish community – tenants of Cara Irish Housing Association with mental health problems, substance misuse and emotional health issues, in nine London boroughs.

Setting: Community setting, including people's homes, day centres, and the office base.

Funding: A Charitable Trust up to June 2003. From April 2003, mainstream funding from 'Supporting People' (a funding regime for supported housing).

Timescale: The pilot scheme started in 1995. The Specialist Support Team started in 1999 – ongoing.

Aims:

- To meet the needs of Cara's tenants in a culturally orientated manner
- To provide a comprehensive service to Irish people living in Cara property who experienced mental and emotional ill health, and/or substance misuse
- To provide users with real choices and control over their lives; help them access mainstream provision where appropriate and improve their overall health and quality of life

Objectives:

- To support Cara tenants access and sustain contact with appropriate services through the provision of culturally sensitive support
- To offer a range of integrated support services addressing a range of needs
- To empower tenants to maintain independence and successfully maintain long term tenancies

Rationale: A pilot project to work with problem drinkers was evaluated and found to be very helpful but limited in its brief. When people are homeless, before they come into the Cara Housing Association, their primary need for shelter is pressing. Once people are housed, then underlying issues come up, for example around substance misuse, mental health issues and family breakdown. In response to the evaluation, the current project was established to help people address these issues.

Project description: The Specialist Support Team provides mental health and dual diagnosis (alcohol and substance abuse) support to vulnerable tenants within Cara Housing Association, including survivors of sexual abuse and people with mental illness such as depression or schizophrenia. The Team seeks to facilitate more independent living and provides a floating support service. Referrals come from the Supported Housing Officers working with Cara's tenants, and the project also sends information direct to all tenants so that they can self refer. CPA workers occasionally refer clients on discharge from hospital inpatient treatment. Support may be offered for as long as is needed, but because of the demand for the service, there are plans to implement some short-term support. The team provides an integrated care package, organising GP appointments, attending CPAs, liaising with psychiatric services, mental health advocacy, motivating tenants to access and sustain contact with statutory services and the Irish community. In providing a culturally sensitive service they act as a bridging service between the individual and mental health services. They use a range of tools including cognitive behavioural work, motivational interviewing, person centred counselling skills and basic brief solution focused therapy.

Consultation: With tenants, and with Supported Housing Officers.

Evaluation/outcomes: The initial pilot was evaluated externally by Alcohol Concern. Evaluation now takes place with users of the service when they leave – through face-to face interview using a questionnaire. There are also plans to do a periodic review with current users. Monitoring and evaluation takes place through analysis of data and update reports for the Board. 'Supporting people' will also be organising a review of work.

Pointers used to measure success

- Reduction in alcohol use
- Improvement in health status
- Improvement in mental health status
- Better able to manage mental ill health/live independently
- Reduced drug use
- Improved family and social circumstances

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Project 9: London Irish Women's Centre

The London Irish Women's Centre offers a one-to-one advice and information service and counselling service, and campaigns on behalf of Irish women's needs.

Target Group: Vulnerable Irish women from across London.

Setting: Community

Funding: Association of London Governments, the Community Fund, the Irish Government, London Borough of Hackney, Irish Youth Foundation, Ireland Fund of Great Britain.

Timescale: 1983 – on-going.

Rationale: The London Women's Centre was set up in 1983 as a vibrant venue offering a range of support groups, cultural events and Irish music. It was widely used by women to combat isolation and gain support. Gradually there has been a shift to more practical advice such as housing and benefits rights based on the needs being identified by the women themselves, and more recently the counselling service has been established in response to women's mental health needs. There is a clear need for a culturally sensitive service that meets the specific needs of Irish women, and there is no other such service in London.

Aims:

- To reduce isolation and social exclusion and ensure Irish women have the support and confidence they need to play a full part in British society
- To increase access to supportive culturally sensitive services particularly for vulnerable Irish women such as those with mental health problems, disabilities or facing domestic violence.
- To ensure that disadvantaged Irish women understand the benefit systems and have equal access to benefits, housing and social support

- To bring together and empower Irish women from across London to formulate and address their own needs
- To inform, influence and lead policy debates on exclusion, empowerment, gender, cultural identity, service provision and discrimination in all forms.

Project description: The Irish Women's Centre provides advice, advocacy and mental health support services to Irish women from across London. Clients are mainly between the age of 18-65 years plus. It identifies the needs of Irish women and represents their interests in networks, service development and policy forums. The advice and information service works to increase access to benefits and other support services, and provides one-to-one advice sessions for women through a drop-in, appointments and telephone advice. The counselling service offers assessment followed by counselling for up to a year depending on need. Women can self refer, and are also referred to the service by GPs and from local agencies including other Irish agencies.

The Centre has planned a number of groups providing opportunities for women to become involved in different activities and spend time together. So far, a creative writing workshop has taken place and was well attended.

Consultation: The Irish Centre gets feedback about the services it provides from women who use the centre. Consultation also takes place through its membership of a number of forums, for example the Federation of Irish Societies which identifies new policies that should inform service delivery.

Evaluation: Both verbal and written evaluation takes place with women who have used the service. Monitoring and evaluation takes place regularly by collecting statistics on the uptake of various services provided and through feedback from staff.

Pointers used to measure success:

A range of pointers are used to measure success, including:

- Increased user access to and uptake of benefits entitlement, housing and support services
- Reduced isolation, vulnerability and ill health among women using the service
- Increased uptake of the counselling service
- Increased user confidence and social capital so that women are able to play a more active part in their community
- Increased confidence both in terms of women's perceptions and staff observations

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Project 10: The Suaimhneas Project

Suaimhneas is a Gaelic word which translates as 'tranquillity' or 'peace of mind'. The project provides a support service to homeless Irish men and women in Liverpool who are experiencing problems around mental health and substance misuse.

Target Group: Homeless Irish men and women in Liverpool who are experiencing problems around mental health and substance misuse.

Setting: Community, in people's homes, hostels, on the street, prisons, hospitals.

Funding: Liverpool NHS Trust, Tudor Trust, Crisis, John Moores University.

Timescale: 1999–2005.

Rationale: There is a large number of homeless Irish people in Liverpool. The Irish community is dispersed and does not have a high profile and this is a relatively invisible group within it. Homelessness results from an accumulation of problems, and it causes even more, yet it is extremely difficult for people who are homeless to get the sort of support they need.

Aims:

- To describe and identify the needs of homeless Irish men and women in Liverpool who are experiencing problems around health, mental health and substance misuse.
- To review the work carried out by other agencies providing services for the homeless and make links with them
- To offer a culturally sensitive service and a safe environment to explore the possibility of change

- To provide support to clients to enable them to achieve their goals and realise their potential
- To provide support for clients to repatriate to Ireland, with housing support

Project description: The Suaimhneas Project is part of Irish Community Care Merseyside that works to identify and respond to the needs of Irish people, offering professional and culturally sensitive services. Services include drop-in information and advice, welfare benefits advice and advocacy, outreach support, youth work, social groups for older people, research and training, and work with Irish travellers.

The Suaimhneas Project is part of the work of Irish Community Care Merseyside and offers an assertive outreach service to Irish people who are homeless and experiencing problems around mental health and alcohol or drug misuse. The majority of clients are men aged between 18-34 years. Clients are reached through the drop-in, in their homes (in housing, hostels, day centres or on the streets) and are also visited in hospital and prison. Referrals are received from GPs, social services, hospitals, prisons, hostels and voluntary organisations.

The project helps clients focus on ways to deal with the many problems they face and aims to engage and empower clients to look at the options available to them. It often acts as a vital link between clients and the services that may be able to help resolve their problems, attending meetings and interviews with them. Needs of clients vary greatly, from the fundamental need for somewhere to sleep, to access to basic services such as a general practitioner, dentist or a phone to call home. Where there is an identified mental health need, community psychiatric nurses help clients access mental health services. Through the project, clients can pursue training and work related opportunities, receiving travel expenses and working three days a week without loss of benefits. This is a way of getting back into society and having some meaningful occupation. An adult placement programme places young adults within a family environment – possibly for the first time for many years – helping them fit in to a family routine.

Consultation: The project works closely with individual clients to help them identify their needs.

Partnerships: The project works closely with a range of agencies, including the Homeless Forum, Rough Sleepers Forum, Big Issue, YMCA, Young Persons Advice Centre and social services.

Evaluation/outcomes: Information such as number of clients seen and whether they have moved on is collected regularly. The project keeps in touch with clients long term and follows up their progress. An external evaluator is looking at how funding is used.

Pointers used to measure success:

Examples of measures used are:

- Clients have accessed the services they need, for example drug and alcohol services, education
- Housing circumstances have improved, for example clients have moved from street to hostel

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Refugees and Asylum Seekers

Project 11: Bi-Cultural Support Project

The Bi-Cultural Support Project is a London based project providing a casework service to refugees and asylum seekers.

Target group: Asylum seekers and refugees

Setting: Community

Funding: The Camelot Foundation initially funded the project for three years. The project has now received Lottery funding for the next 3 years.

Timescale: Established in April 2000 – on going

Aims:

- To raise awareness of mental well-being needs of refugees and advocate for appropriate services
- To facilitate the development of mental well-being services
- To ensure vulnerable people can be identified early during the assessment process

Objective:

- To provide a culturally sensitive assessment, referral and casework service to asylum seekers regarding their mental health needs.

Rationale: The Refugee Council and The Medical Foundation for the Care of Victims of Torture approached Camelot with a joint bid to run a mental health project for refugees which led to the Breathing Space Project. The Bi-Cultural project is part of this work.

Project description: A team of three bi-cultural workers and a full time development worker are based at the Brixton One Stop Service who provide a casework service to clients experiencing mental distress. Workers help clients to assess appropriate services through advocacy and work with all aspects of the client's case including housing, healthcare and benefits. Clients access this service through the Refugee Council.

The Bi-Cultural Team is a London based project that takes referrals from the Refugee Council and the Medical Foundation to provide an effective casework service to support individual refugees who have mental well-being needs. They also facilitate the capacity building of refugee community organisations that provide mental health services to

community members. Research is undertaken to identify the impact of settling in the UK on the mental well being of refugees. The Bi-Cultural Project is now developing the casework side of its work.

Partnerships: Refugee Council, The Medical Foundation for the Care of Victims of Torture

Consultation: Local community, other professionals and mental health organisations. The Refugee Council and The Medical Foundation for the Care of Victims of Torture.

Evaluation/outcomes: An external evaluation on the first 3 years of the project has been carried out by the Tizard Centre at the University of Kent. Funding is being sought to evaluate the next stage. Within the Bi-Cultural team they have devised a Quality of Life questionnaire that is used when clients are seen, at the beginning and end. These questionnaires are compared to other services results, around the country. A client feedback service is also available.

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Project 12: MAAN Somali Mental Health

The Somali Mental Health has succeeded in fulfilling and bridging the gap between the community and service providers. The organisation is celebrating its 10th year of continuous service delivery to the Somali community.

Target group: Somali community in Sheffield

Setting: Mainly in the community and hospital (psychiatric wards) and occasionally in primary care settings.

Funding: The core funding comes from local Primary Care Trusts and the project also fundraises.

Timescale: 1992 – ongoing

Aims and objectives:

- To empower the community to improve their mental health and well-being and reduce the anguish, pain and suffering currently experienced by many Somali refugees in Sheffield.
- To address the mental health needs of Somali people, many of whom are experiencing severe post traumatic stress disorder, by establishing community based facilities in a linguistically and culturally sensitive environment and enabling the Somali people to access both statutory and voluntary services.
- To train Somali volunteers in counselling and other skills so that they can provide basic counselling and other support to address immediate needs where possible
- To bridge the language and cultural gap between Somali people experiencing mental health problems and mental health service providers.
- To provide information, advocacy, welfare rights advice, language and other valuable support to Somali people experiencing poverty and other problems due to mental health problems so they can access and benefit from the social welfare services
- To develop and improve communication channels with statutory health and other relevant organisations and other black and minority ethnic communities, to enable an on-going process of community participation in the planning, commissioning, delivery and evaluation of health care.
- To help Sheffield Primary Care Trust's and Sheffield Social Services access the community and deliver appropriate and culturally sensitive services.

Rationale: The organisation was set up because of a failure of existing mental health services to deliver appropriate and culturally sensitive services to the Somali community. This was due to the absence of a dedicated service policy geared towards the needs of a refugee community who do not speak the language and have no idea what services are available to them.

Organisation description:

The organisation works with community psychiatric nurses, social workers, hospital doctors and nurses and GP's. The Somali Mental Health Projects activities can be summarised as:

- Escorting clients and interpreting
- Supporting clients in hospital and in the community
- Outreach work and advocacy.

- Support for families, children and carers
- Resource centre for organisations and the community
- Information provision and awareness raising for the community and a range of organisations.

Partnerships: The Somali Mental Health works in partnership with the Somali Community Mental Health Project, Black Health Forum, Universities, Black Drug Service and Community Halfway Homes.

Consultation: The organisation consults with women's groups, representatives of community associations, community based projects, voluntary organisations, community mental health teams and individuals.

Evaluation/outcomes: The organisation uses qualitative and quantitative methods of monitoring and evaluating their work and progress. They keep confidential records of all the individuals with enduring and acute mental health problems with whom they work, the numbers of clients they are providing intensive support to, a breakdown of the clinical diagnoses and treatments and their progress. They also keep records of attendance at group sessions and other activities of the project.

They collect the views of people who use the service in an informal way through the on-going and day-to-day work of the project. The Somali community has a very strong oral tradition and way of doing things and a questionnaire evaluation would not work very well. There are plans to develop research using a semi-structured interview carried out by Somali people independent to the project, in the next phase of work.

Outcomes include:

- increased awareness of available services
- increased uptake of the existing services
- reduction of fear of medication
- reduction of mistrust in the system
- increased referrals and self-referrals
- reduction of taboos around mental health.

Pointers used to measure success:

The Somali Mental Health use the following measures:

- number of referrals
- number of telephone calls
- take up of the service by the individual
- community involvement
- Community Mental Health Teams involvement
- enquiries, information, signposting and resource provision.

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Project 13: Mental Health Needs of Asylum Seekers and Refugees in Plymouth

The project works with asylum seekers and refugees referred to Plymouth Mental Health Services to identify their needs and ensure they access appropriate services. It offers support and advice to Plymouth Mental Health Services and other statutory and non-statutory organisations working with asylum seekers and refugees to help them develop to meet the mental health needs of this group.

Target group: Asylum seekers and refugees with mental health problems.

Setting: Community

Funding: Plymouth NHS Primary Healthcare Trust – secondment of two of their workers for 18 hours/week for 1 year, with a recommendation for a permanent service to be set up.

Timescale: 2002 – initially for one year.

Aims:

- To promote fair access to mainstream mental health services
- To co-ordinate initial access to appropriate services when asylum seekers and refugees are referred to mental health services
- To provide guidance and support to health professionals working with asylum seekers and refugees
- To support asylum seeker and refugee organisations on mental health issues
- To act as a resource of information on accessible services and best practice
- To develop mental health services in Plymouth for asylum seekers and refugees in relation to identified need

Rationale: It was identified that asylum seekers and refugees in Plymouth had mental health issues that needed addressing, access to mental health services needed to improve, and the discrimination and social exclusion of asylum seekers and refugees needed to be tackled. In response to the National Service Framework for Mental Health, it was important to ensure that services for asylum seekers and refugees, including mental health promotion, access to services and effective services for people with severe mental illness, are safe, sound and supportive. A need for dedicated staff to work with this client group was identified, and the project was set up to establish the mental health service requirements of asylum seekers and refugees in Plymouth, so that future service planning would be based on identified need.

Project description: Two mental health workers have been seconded to work part time, to assess asylum seekers and refugees who are referred to Plymouth's Mental Health Service, to identify their needs and to identify services that they can access. The workers have a liaison role, linking in with all areas of Plymouth Mental Health Service and identifying areas in the service that need further development to meet the needs of asylum seekers and refugees. They also work closely with other statutory and non-statutory organisations that work with asylum seekers and refugees, and advise and support asylum seeker and refugee organisations. Recommendations are made for identified service developments, and where possible these developments are initiated.

Partnerships: The work is delivered by Plymouth NHS Primary Care Trust, in many cases in partnership with asylum seeker organisations in Plymouth.

Consultation: On-going liaison and discussion takes place with statutory and voluntary sector organisations.

Evaluation/outcomes: The project is monitoring referral routes and access to mainstream services, identifying the outcome of assessments, and carrying out an audit of views about current service provision for asylum seekers and refugees by Plymouth Mental Health Services. A report of the six-month review and recommendations is due in May 2003.

Due to the specific needs of asylum seekers and refugees, such as cultural and language barriers, dedicated services are needed as a 'stepping stone' to mainstream services and community networks.

Pointers used to measure success:

- Improved access to mainstream mental health services
- Development of existing mental health services to include mental health promotion and dedicated counselling time
- Further training on mental health issues for individuals working with asylum seekers and refugees
- Agreement to fund full-time permanent posts to continue the project

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Project 14: North Sheffield Young People's Mental Health Project

The North Sheffield Young People's Mental Health Project promotes positive mental health in young people. New In Our Nation is a resource pack that was produced by the project in collaboration with education. The resource pack offers activities to promote self-esteem and resilience in young asylum seekers.

Target group: Young asylum seekers

Setting: School

Funding: North Sheffield Young People's Mental Health Project was initially funded by Health Action Zone and is now funded by the Child and Adolescent Mental Health Services.

Timescale: April 2000 – ongoing

Aims and objectives of the resource pack:

- To provide some useful resources and practical activities to promote the emotional well being and resilience of young asylum seekers in either a school or youth work setting

Objectives of the programme:

To allow young asylum seekers to:

- Raise self-esteem
- Improve listening skills
- Increase insight and awareness
- Build confidence
- Enhance friendships
- Encourage problem-solving skills
- Develop individual coping strategies
- Increase knowledge of external support agencies
- Facilitate working together co-operatively
- Offer understanding
- Explore feelings
- Have fun!

Rationale: The Young People's Mental Health Project identified the need to explore models of service delivery that would address the mental health needs of young people. It was set up to enable the provision of more integrated care systems promoting mental well-being and early intervention for young people, particularly vulnerable groups. One strand of the project was to address the needs of Black and Minority Ethnic young people, and an interest group asked that Asylum Seeker young people be one of the priorities.

Resource Pack description: The New in our Nation programme was developed for use in schools, providing some useful resources and practical activities. Points to consider in running a group are set out in the resource, for example how to develop safety and

security by meeting with the young people beforehand to give them information and reassurances about being involved in the group. Each young person is provided with a parental consent form.

Groups provide a setting for personal change and enable young people to understand themselves and how they interact with others. Groups can provide certain direct personal experiences unavailable through other methods and can be very valuable in personal education development or personal support. Sharing common experiences can often be a very empowering process. By listening to and learning from other group members young people develop a greater sense of themselves. There are few environments where cultural minorities can be empowered to express and share perceptions.

The programme consists of eight sessions as follows:

- Opening the group – introduction
- Exploring our feelings about who we are
- Role models
- Poetry and painting
- Historical session/Bill of Rights
- Agony Aunt
- My shield of strength
- Hopes, fears and dreams

Partnerships: The resource pack was developed in partnership with the NSPCC Young People's Centre, Fir Vale School and the Northern Refugee Centre.

Consultation: The project aimed to consult with young asylum seekers and those working with young people (school staff, teachers, head teachers and other professionals) to identify current services and common concerns and explore opportunities for collaboration and multi-agency working. From this consultation a support group for asylum seeking young people was set up and the resource pack produced. This also led to the development of a multi-agency steering group in the city to look at the wider needs of young asylum seekers.

Evaluation/outcomes: The project was evaluated using a short questionnaire. This asked workers to rate the usefulness and impact of the work of the project on them and their work. Respondents were also asked about their current work, their confidence in working with young people, which included asylum seekers and their views about the future work of the project.

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Project 15: Turkish and Kurdish Drama Project

The Turkish and Kurdish Drama Project is a self-empowerment project for volunteers, activists and workers to work through social issues affecting mental well being through drama and other art forms.

Target group: Turkish, Kurdish and Cypriot communities in London and outside.

Setting: Community Centres, workplaces, schools and primary care settings.

Funding: The Local Network Fund in Hackney is currently providing a small amount of funding to enable the project to involve and reflect on the experiences of young people from the Turkish, Kurdish and Cypriot communities. Previous one-off funding for individual projects has come from NHS Trusts, Department of Health, New Deal and Sure Start.

Timescale: 1998 – on-going.

Aims and objectives:

- To inform and influence services to provide better and more resources for Turkish, Kurdish and Cypriot communities through using the magic power of art, culture and drama (for example bilingual plays)
- To provide knowledge, information and awareness raising in an accessible, culturally friendly way
- To facilitate positive opportunities for two way inclusion and integration of the Turkish, Kurdish and Cypriot communities by presenting cultural norms and practices in aesthetic and accessible forms to local communities.
- To contribute to challenging racism and discrimination within institutions

- To help develop creative and artistic potential within the Turkish, Kurdish and the Cypriot communities.

Rationale: The project was initiated at the East London and the City Health Authority as part of a health promotion programme for the Turkish, Kurdish and the Cypriot communities. It was developed in response to a need to raise awareness, highlight issues and empower community members using drama activities and role-play.

Project description: Through drama workshops and other artistic activities, community members, volunteers and activists are trained in acting skills and voice training and they reflect on their past and present experiences and discuss their issues and needs. Following the workshops, a play is produced to highlight issues of concern that have been raised, and the play is performed to professionals and community members at the community centres, cafes, festivals.

The project secured funding from the Department of Health in 1998, and produced activities such as Anatolian Wedding (Bride on the Horseback), folk dancing, and sketches that have been a major attraction at local festivals (Church Street Festival, Islington International Festival and Hoxton Festival).

Since September 1999 the project has been based with Social Action for Health and has developed a project to involve Turkish, Kurdish and Cypriot refugees in the Shoreditch New Deal Programme (Life in Shoreditch). Another project has developed around Dalston and Queensbridge Sure Start Programme in partnership with three other community organisations (Halkevi, Daymer, Minik Kardes Day Nursery) to produce educational drama on parenting and access to services.

Partnerships: The Turkish and Kurdish Drama Project produces and delivers its work in partnership with other arts organisations, community groups, and local communities

Consultation: Local community members, frontline workers, health and social care professionals.

Evaluation:

Evaluation is done in various ways:

- One-to-one open ended interviews with the performers-participants on the benefits of the project on their self empowerment in terms of skills gained, positive impact on self confidence, social networks developed

- Feedback from the audience-participants in order to measure their participation, information received, issues covered, points made in relation to the issues covered in the plays
- Number of participants in the events.

Outcomes:

Experience gained from the Turkish and Kurdish Drama Project could easily be passed on to other areas of work and with other population groups. The following are some benefits to the participants and the community.

- The project increases awareness about access to health and social care services and approaches to different issues and needs in a holistic and causal way, putting issues in their cultural and social context.
- The project promotes self-empowerment. Drama workshops and other activities are fun to be part of, humorous to the participants and the audience, challenging, empowering, triggering questions in participants' minds and in the minds of those watching, and helps improve participants' skills.
- An opportunity is provided for building partnerships and joint working with local art projects, professionals and a range of organisations in a supportive environment.
- Drama workshops and other activities increase self-confidence of the participants and help them gain new skills.

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South Asian

Project 16: Himmat Project

Himmat is one of nine projects within a Healthy Living Initiative, 'Cottoning On', in Oldham. It empowers local South Asian women through a befriending and advocacy service to reduce social isolation and improve access to services.

Target Group: South Asian women with emotional difficulties

Setting: Community

Funding: National Lotteries, New Opportunities Fund, Oldham Primary Care Trust, West Pennine Health Authority, Oldham Borough council.

Timescale: 2002 – 2006.

Aims

- To promote health and well being for South Asian women
- To enable South Asian women to influence services that affect health
- To network with statutory, voluntary and community organisations to promote the project
- To improve understanding of mental and physical health needs
- To develop and improve social networks to reduce isolation and improve health skills
- To reduce stigma attached to mental health and physical health
- To reduce health inequalities

Objectives

- To raise awareness through information giving sessions
- To support groups to promote health and well being
- To develop health skills such as food hygiene and first aid
- To promote healthy lifestyles e.g. physical activity, relaxation
- To develop parenting skills
- To signpost to other services

Rationale: Suicide rates among young Asian women are double the national average. This initiative took off the ground in response to the lack of opportunities for South Asian women within the area to be actively involved in all aspects of their development. The project is situated within one of the most deprived wards of the city where there is a limited infrastructure to meet the needs of these women.

Project Description: This is one of a number of projects that make up the overall “Cottoning-On” Healthy Living Initiative within Oldham. Himmat focuses on primary prevention and does not explicitly emphasise mental health because of the stigma attached. A number of staff are able to speak and communicate in the languages of the local communities. A lot of emphasis is placed on the creation of healthy sustainable communities for future generations. Himmat links with other community based organisations to promote its activities and recruit befrienders and advocates.

Consultation: With local community organisations and agencies working with women.

Partnerships: “Cottoning On” has been developed through a multi-agency partnership of key stakeholders in Oldham, with a wide range of statutory and community organisations working together to address inequalities.

Evaluation/outcomes: The project is in its early days and this is an ongoing process. It will be expected to collect demographic information about participants and baseline health data, and to produce quarterly and annual progress reports to assess milestones achieved.

The Partnership hopes to achieve the following outcomes over the lifetime of the initiative:

- Increase in number of women entering health and social care employment
- Increased understanding of health issues within the community and amongst professionals
- A better understanding of mental health issues
- Improved physical and mental well being
- New evidence identified for delivering health promotion to black and ethnic minority women
- Increased participation/engagement in decision-making, delivery, management and research within Cottoning On.

Pointers to be used to measure success

In a full year of the project:

- 4 self help groups supported
- 170 Black and minority ethnic women attend mental health awareness training
- 30 women working in the community as befrienders
- 60 women to receive support from befrienders or advocates
- Increased uptake of services
- Support networks developed to reduce isolation
- More accessible services

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Project 17: Longsight/Moss Side Community Project

Longsight/Moss Side Community Project provides practical and emotional support to older Asian people and their carers, and Asian women with mental health problems. It also works to improve the availability of culturally and religiously appropriate services.

Target Group: South Asian Communities including those from India, Pakistan, Bangladesh and East Africa. Asian women with mental health needs.

Setting: Community

Funding: Manchester Mental Health Joint Commissioning Executive, Manchester Social Services.

Timescale: 2002 – 2005.

Rationale: Manchester has a diverse population, and professionals are reporting increasing levels of isolation among South Asian communities locally. The project came about as a result of trying to raise awareness within this group of what services are available and how to access them. Older South Asian carer communities were marginalized and so this project was established to meet their needs.

Aims:

- To reduce isolation and loneliness
- To encourage people with mental health problems to access other services
- To raise awareness of mental health issues and reduce stigma within Asian communities
- To increase understanding among mental health professionals of the importance of cultural and religious issues to Asian service users
- To improve the provision of culturally and religiously appropriate mental health services
- To improve service users' understanding of mental health and illness

Objectives:

- To organise drop-ins which provide
 - a safe environment for service users
 - access to information
 - an opportunity to acquire interests/skills through participation in various activities, including physical exercise, and discussions on coping with stress, healthy eating
- To assist service users improve their confidence, self belief and self esteem through a Personal Development Programme
- To influence appropriate service provision through participation in policy/strategy groups
- To raise professionals' awareness of cultural/religious issues through joint working and organising special events
- To undertake outreach work with carers and families of service users

Project Description: The project works with and on behalf of older Asian people and their carers. It takes a holistic and integrated approach to assessing service users' health and social care needs, providing information on a range of issues from housing to immigration. It provides practical and emotional support and helps people access services. By working

with those responsible for commissioning and providing services, it attempts to improve the availability of culturally and religiously appropriate services. This principle is extended to its work with Asian women with mental health needs. The women are assisted through drop-ins and outreach work, their carers are encouraged to participate in the Asian Carers' Group organised by the project, and their families are engaged through outreach work. Outreach work is undertaken by paid staff, social work students on placement, and volunteers.

Partnerships: Manchester Social Services, Manchester Mental Health Joint Commissioning Executive, Manchester Mental Health Social Care Trust and other voluntary sector organisations.

Evaluation/outcomes:

- Participation in activities
- Learning new skills
- Improved confidence, self belief and self esteem
- Better understanding of mental health issues
- Improved social networks
- Access to training and jobs
- Better informed professionals
- More appropriate services

Pointers to be used to measure success:

- Regular attendance at drop-ins
- Service users reporting improvements in physical and mental well being
- Service users developing new interests and taking up training and jobs
- More referrals from mental health professionals and others
- Availability of culturally and religiously appropriate mainstream services

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Project 18: Mental Health Training for the Bangladeshi Community

Mental health training courses for Bangladeshi community/health workers were provided initially to develop a basic level of knowledge of mental health, illness and mental health promotion and build the capacity for mental health promotion with the Bangladeshi community. Six-week courses for Bangladeshi women are now provided to raise awareness of mental health issues, promote mental health and improve access to and uptake of services.

Target Group: Bangladeshi community/health workers; women from the Bangladeshi community in Camden.

Setting: Community centres

Funding: Camden Health Action Zone, Camden PCT.

Timescale: The original two courses to train Bangladeshi community workers took place in summer 2000. Mental health courses for Bangladeshi women started in summer 2002 and are ongoing.

Rationale: There has been increasing concern from statutory and community organisations about the existence of inappropriate health provision for ethnic minority communities, and in particular the Bangladeshi community in Camden. It was felt that community organisations could act as a valuable resource of cultural knowledge and be intermediaries between health services and the Bangladeshi community. Many community workers felt that if they had sufficient knowledge of mental health issues and where to refer people for advice and help, they could assist in improving the community's access to mental health services. The 6-week mental health course for community members has been set up because of the recognition that one-off sessions on mental health awareness are limited in the impact they can have.

Aims/objectives:

The training course for community/health workers aimed to:

- Raise awareness of mental health and illness and mental health promotion among Bengali workers
- Gather in-depth information about the community's needs
- Develop a network to provide on-going support for the workers
- Provide information about existing services and how to access them
- Support workers in learning how to recognise early signs and symptoms of illness and clarify their roles
- Support workers in learning how to deal with their personal emotional and psychological effects of supporting clients in distress
- Enable workers to act as a bridge between the Bengali community and mental health service providers

The training for community members aims to:

- Raise awareness of mental health and illness
- Promote their mental health and well being
- Reduce the stigma around mental health
- Provide information about services and how to access them
- Increase uptake of services

Project description: The mental health training courses for Bangladeshi community/health workers in Camden ran for 8 weeks and workers from diverse backgrounds participated in the programme, including health advocates, doctors, community workers, outreach and youth workers, welfare rights advisors, parent education workers and football coaches. The course covered mental health theory, definitions of mental health, different cultural manifestations of mental illness and an overview of treatments. A key element was to develop the individual awareness and skills of workers in dealing with personal emotional and psychological needs when supporting clients in distress.

The mental health course for Bangladeshi women in Camden is two hours per week for six weeks and is facilitated by a bilingual trainer/counsellor. Around 10-15 women can attend each course, and community workers help identify women who they feel are at a stage

where they can benefit from the programme. The course helps raise knowledge and awareness about mental health by providing information, including the use of bi-lingual videos and written information, but perhaps more importantly, attending the group helps reduce social isolation and allows women to offer mutual support.

Consultation: Community/health workers were consulted about their needs and expectations and from this the 8 week course was developed. The training programme for community members has developed over time with input from workers in day-to-day contact with the community.

Partnerships: Camden Bengali Women's Health Project; Camden Health Promotion Service; Primary care workers, including some health visitors and general practitioners.

Evaluation/outcomes: The training course for community workers was evaluated formally through focus group discussions with an external consultant. Training for community members is evaluated more informally through discussion and verbal feedback at the end of the course.

Outcomes include:

- Feeling more empowered to promote mental health within their work role
- Having a better understanding of mental health issues
- Improved listening/talking and problem solving skills
- Better knowledge of different treatments, care options and services available
- Reduced stigma around mental health
- Better able to articulate their mental health needs
- Better able to act as advocates for the community or family members
- A Bangladeshi Mental Health Forum for community workers meeting quarterly to provide an opportunity to network, support each other and share concerns and issues.

Pointers used to measure success: There are no formally agreed criteria to measure success, but a key one will be an increase in access to and uptake of mental health services by the Bangladeshi community.

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Project 19: Naye Subah (New Dawn) Project

Naye Subah provides day care and a range of services for Asian women with mental health difficulties, including support and drop-in groups, activity-based groups, educational classes, information, outreach and advocacy, alternative therapies, and opportunities for Asian women to do volunteering with the project.

Target Group: Asian women with mental health difficulties.

Setting: A community-based project, providing an outreach service and facilitating groups in different geographical areas

Funding: Bradford Social Services.

Timescale: 1996 – on-going.

Aims:

- To provide a wide range of services for Asian women experiencing mental health difficulties and distress
- To improve access to and provide a better service for Asian women in Bradford with mental health difficulties

Rationale: The project was set up in response to the identification of unmet needs of Asian women experiencing mental health difficulties and distress. The aim was to bring together a number of independent sector providers to work in partnership with statutory agencies and provide a culturally sensitive and appropriate service to meet the needs of Asian women.

Project description: Naye Subah provides a day care and support service for Asian women with mental health difficulties. It provides a range of services, including therapeutic, support

and drop-in groups, activity-based groups, educational classes, information, outreach and advocacy, emotional support, alternative therapies such as aromatherapy, massage and relaxation, and opportunities for Asian women to do volunteering with the project. In 1997 Naye Subah received the 'Sir Graham Day' award for innovation and good practice.

Consultation: The work of the project is guided by consultation with the service users, Naye Subah management group and team, and other agencies that the project links with to do joint work eg. Bradford Mind Drop-in group, and the Helios Centre Relaxation Group.

Evaluation/Outcomes: Research was carried out in 1998 to evaluate achievements of the first two years of the service. Regular review meetings are held to monitor progress and reports submitted to the funding body. The project has been successful in providing a specialist service for Asian women and meeting their needs in a culturally sensitive way, and in raising awareness of mental health issues within the Asian community.

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Newham Asian Women's project

Newham Asian Women's Project provides a range of services including advice, research, training, counselling, specific mental health projects, and input into national policy.

Rationale: Newham has a high population of young Asian women who, according to epidemiological studies, are three times more vulnerable to suicide and self harm between the ages of 15-35 than their non-Asian counterparts. The Research Report 'Growing up young, Asian and female in Britain' (1998) identified and documented the mental health experiences of young Asian women in Newham. A range of issues were identified including:

- community and cultural oppressions preventing young women exploring and expressing their individualities
- the duty of women to maintain the family izzat (honour)

- violence and physical abuse being used as a community sanctioned method of curbing young women's independence
- inadequate and often inappropriate service responses
- a general lack of understanding of mental health issues and interactions between culture, gender and self-harm.

In response to this, Newham Asian Women's project has identified a range of services and areas of work. It works to shape national policy and research, influence regional advocacy and deliver local services to support and improve women's lives. Services include:

- The **advice service**, offering advice on a range of issues such as safe-housing, welfare or income benefit claims, health concerns and legal advice
- A **national research and policy project**, Imkaan, that profiles and advocates on behalf of the specialist refuge sector nationally through training, publications and strategic liaison with government, statutory and community organisations
- A **mental health project** offering clients who experience mental distress a complete and individualised care package, advocacy, a support group and one-to-one counselling
- **Training programmes**, including personal and professional development, childcare, ESOL and keep fit
- **Counselling** both at NAWP Resource Centre and at a local GP surgery, local schools and colleges
- **Zindaagi**, working to promote the positive mental health and well-being of Asian women vulnerable to suicide and self harm through a holistic approach to healing and expression
- **Refuge services** in both Newham and Haringey; and
- **Teens@NAWP**, a project providing a range of services for young Asian women.

Project 20: Teens@NAWP

Target group: Young Asian women aged 10-19 years.

Setting: The community: Primary and secondary schools, NAWP Resource Centre, other community venues.

Funding: The Neighbourhood Support Fund and the Children's Fund.

Timescale: From 2000 – on-going.

Aims:

- To provide a culturally sensitive and pro-active service where young women and girls can access advice, support, information and new opportunities in a safe and confidential space.
- To increase self esteem and empower young Asian women

Project description: Teens@NAWP is a youth project for young Asian women and girls between 10-19 years old, providing an opportunity for young women from the community to meet, learn, share and grow. It offers an environment that is non-threatening, confidential and non-judgmental. It provides a social space that allows young women to escape the pressures of home, school and society and gain both peer and professional support.

- Teens works in two primary and two secondary schools to provide lunch time drop-in sessions where girls and young women can find out about the project, and get information and one-to-one support. They also provide a 6-week programme, two hours a week during school time, to cover a range of issues raised by the girls, including self harm, domestic violence, sexual abuse, coping strategies, pressures at home, peer pressure, bullying, and to offer a range of activities.
- Teens also runs a support group at NAWP for 13-19 year olds, including workshops on a variety of issues identified by the young women, and a range of social activities and trips. The group provides a space for young women to talk about their experiences and fears, build their self esteem and confidence, and challenge behaviour that is not acceptable.
- Once a year, a five-day residential is organised out of London for up to 12 young women, providing the opportunity to try different activities, develop independence, spend time with their peers and receive more intensive support from the project.

- Twice a year, Teens offers a 12-week training and development programme, two days a week, for 13-19 year olds. The target is socially excluded young women who may be prone to exclusion from school, may have left school and be in transition, or may have mental health problems. The programme aims to raise self esteem and covers issues such as identity as young women, as Asian young women, racism, phobia, sexual health, relationships, stress management, anger management, as well as careers development.

Consultation: All project activities and the range of issues covered are based on consultation with the girls and young women involved, as well as with key contacts within the schools.

Partnerships: Newham Youth Service; Connections.

Evaluation: Consultation with the young women who use the project provides the opportunity for feedback and helps ensure services are designed to meet expressed needs. For each of the project services, evaluation takes place through written evaluation forms, group evaluations and video diaries to put forward their views. Feedback is also received through regular meetings with key contacts in schools.

Pointers used to measure success: A range of criteria is used to measure the success of the project, for example the young women:

- show increased self esteem and confidence
- engage better in school
- are more vocal in identifying their own needs and asking questions
- engage more with their peers
- participate more actively in workshops and activities

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Project 21: Zindaagi

Target group: Young Asian women aged 15-25 years.

Setting: Community

Funding: East London and City Health Action Zone.

Timescale: February 2000 – on-going.

Aims:

Meaning ‘life’, this project aims to promote the positive mental health and well-being of Asian women vulnerable to suicide and self harm, and to deliver an ethos of hope and inspiration to the young Asian women who may access the services that are developed, supported and shaped by the project.

- To develop and co-ordinate support services for young Asian women vulnerable to suicide and self-harm in east London
- To develop specialist counselling services
- To offer support and information for Asian women’s voluntary sector organisations providing support to young Asian women in distress
- To provide training and awareness raising workshops for frontline health, social care and educational professionals
- To establish a specialist crisis refuge for young Asian women vulnerable to suicide and self harm

Project description: Zindaagi works to develop and deliver a holistic approach to healing and expression by integrating mental, physical and emotional health. It promotes community education and awareness and challenges taboos and stigma associated with self-harming behaviour. It liaises with mainstream mental health care providers to ensure that genuine access is afforded to Asian women experiencing mental distress and that appropriate interventions are developed to understand and meet their needs.

Zindaagi has developed ‘A guide to East London support services for young Asian women’ in response to expressed need for more information and better access to services providing advice, support, counselling and somewhere to talk. The directory also provides information about services to professionals who are not always aware of what is available, and aims to promote partnership working between voluntary and statutory agencies.

The project is developing a training pack to raise awareness of mental health issues and Asian women among mental health professionals, including attempted suicide, cultural issues, signs to look out for, how to engage with young Asian women. It is also setting up training sessions for practitioners in Newham, Hackney and Tower Hamlets.

Consultation: Zindaagi organised the first East London conference on Asian women, suicide and self harm in 2001, and the event was used as a consultation event around future service planning. Women who use the services developed by Zindaagi are regularly consulted to ensure the project is meeting their needs.

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North Birmingham Asian Services

North Birmingham Asian Services work to break down barriers so that people from the Asian community understand mental health and where to go for help. There is a focus on a community development approach and service development, training programmes addressing issues of race, ethnicity and culture, an advocacy service, a volunteering programme and awareness raising with the Asian community.

Rationale: The high rate of social deprivation in the Asian community, together with evidence of multiple barriers to access of appropriate services, lack of preventative care, and evidence that services are only accessed at a point of crisis made it important for North Birmingham Mental Health Trust to address the issue of mental health and Asian communities. Asian communities make up more than 16% of North Birmingham and in some wards this rises to 40-50% of the local population.

In response to this, North Birmingham Asian Services were established in 1998 with a 3-year grant from the Health Authority. Two consultation days were held in October 1998 and views of the community in general and service users in particular were fed into a conference in November 1998. The outcome of these events formed the basis of a service development strategy.

The Asian Services is committed to user and carer involvement, working in collaboration with the community based sector, challenging discrimination in existing mainstream services, raising awareness of mental illness in the community and providing a holistic response to the needs of the Asian community.

A key area of work for the Asian services is raising community awareness about mental health. A number of different approaches have been used to achieve this:

- Use of innovative means such as videos and interactive plays to get the message across to the community and professionals. Nationwide, 'Talking about suicide' sold 1000 copies, 'Mann Ki Baat' sold 2000 copies, and 'In the Kitchen' drama toured the West Midlands. The first national Asian mental health 'Mela' was attended by over 5000 people.
- Organising community awareness days in relevant languages
- Enabling and supporting local agencies to develop their own methods of awareness raising with particular user groups
- Developing effective links with the media to promote positive messages

Project 22: Dosti

Target Group: Anyone from the Asian community with mental health problems.

Setting: Community – the group currently meets at the Asian Services but is seeking an alternative partner agency that can provide a venue that is more central and accessible

Funding: Mind Millennium Awards, North Birmingham Mental Health Trust, Nationwide Foundation. The Digberth Trust has provided funding for a 6-week training programme. Further funding is being sought to support group activities and travel expenses.

Timescale: From 1999 – on-going.

Rationale: The Asian Services identified a lack of help and support available to the Asian community and wanted to provide information about where people can access help. There is a need to tackle stigma and make it more acceptable to be open about a mental health problem and seek help. Both service users and carers have a wealth of knowledge and experience which are invaluable to service providers.

Aims:

- To give Asian users and carers a voice in the development of services for South Asian communities

- To provide an opportunity for people to meet others from the same culture and background and take part in social activities
- To provide support and information about services available and sources of help
- To promote positive self esteem and a sense of empowerment
- To provide an opportunity to influence services and the way professionals work

Project description: ‘Dosti’ – meaning friendship – mental health user forum is a self help group with around 25 regular members, meeting weekly to talk, offer each other support, and take part in a range of activities. The group provides an opportunity to find out more about mental health issues and to discover that others share similar problems. Dosti organises different activities, for example alternative therapy sessions, yoga, regular outings to the cinema or for a meal, annual trips and community events for Valsakhi, Eid and World Mental Health Day. Members attend and contribute at conferences, and participate in consultation events about the needs of the Asian community. They have taken part in recovery training with the University of Central England and have contributed to training for professionals run by the Asian Services. Mental health training has been provided for the group by West Midlands Counselling Service. Members received media training as part of the West Midlands Mela which they were involved in, and have since contributed to local radio programmes, putting across positive messages and conducting live debates on different issues through phone-ins.

Dosti supported the Trust and the Department of Health in the production of a mental health awareness video ‘Mann Ki Baat’ and worked with Carlton TV to produce ‘lifeline’ – a programme about Asian women and depression.

Consultation: Members of the group are fully consulted about what they want from the group, and identify the issues and activities they would like to cover.

Evaluation: An evaluation was carried out by Asian Services in 2002, and identified that service users found ‘Dosti’ very useful, with comments including ‘It’s good that we can talk to each other’ and ‘we can speak in our own language and talk and share issues.’ The same was not so true for carers, who were much less involved.

Pointers used to measure success:

These include:

- An increase in the number of Asian service users and carers involved in the work of the Trust and influencing service development
- Active members of Dosti have gained employment within the Trust

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Sikh Community Healthy Living Project

Target Group: Birmingham's Sikh community, with a particular focus on young people in the Shanti project

Setting: Community

Funding: Community Fund.

Timescale: 1999 – 2005.

Rationale: Mental health problems within the Sikh community are due in part to broken links with previous families and country ties, and differences in social and cultural values leading to a lack of respect. Young people often experience high levels of stress, in part due to the high expectations placed on them by parents. The Sikh Council of Gurdwaras in Birmingham identified gaps in services which were affecting the spiritual, social and economic life of the Sikh community, and developed the project to meet the needs of the community.

Project 23: Tandustri

Tandustri works to improve the physical health of the Sikh community by providing information about a range of health topics and opportunities for health checks and screening.

Aims:

- To introduce the Sikh community to alternative therapies
- To research and re-introduce traditional cures
- To provide information in Punjabi and English
- To give personal advice and health checks
- To provide workshops and training for healthier living

Project description: During the months of April and November, daily radio health slots cover a wide range of health topics including cancer, diabetes, reiki, depression, schizophrenia, domestic violence and environmental issues. A variety of health professionals contribute to the programmes which are taped and made available for loan.

Health awareness days are held in voluntary, public and educational settings and in Gurdwaras on a Sunday when most families attend, and professionals provide health checks and screening as well as one-to-one advice and information. A wide range of written information (in Punjabi and English) is available.

Project 24: Shanti

Shanti works with students from the Sikh community to promote mental well being.

Aims:

- To help the Sikh community with the ever increasing stress and tension of life and to promote mental well being.
- To provide education and raise awareness about mental health in the community
- To promote traditional Sikh exercises and yoga sessions across Birmingham
- To organise regular family trips to strengthen community ties
- To provide support and befriending to Sikh patients in hospital
- To work with other organisations to provide better mental health for the Sikh community.

Project description: The project links with three universities within Birmingham and works with students from the Sikh community to promote mental well being, linking with Sikh societies within the universities. The project contributes to training sessions provided by the Asian Services to professionals, to raise awareness of mental health issues for the Asian community, cultural perspectives, how people deal with mental health problems and where they go for help.

Residential and day camps for young people under 16 years offer fun activities, sports, traditional exercises and meditation, and raise health issues. These events are promoted through the Gurdwaras and by word of mouth. Support groups for young people provide group counselling and the opportunity to talk about problems and develop friendships. A helpline will be set up during March and April 2003, open 24 hours a day, for young people to seek advice around stress and mental health issues such as bullying. The local Sikh Times has given half a page a week free for the project to promote health messages and let the community know about forthcoming events.

A website will be launched in late February 2003, and will provide a forum for people to request information and put forward their views.

For both Tandustri and Shanti:

Consultation: User forums provide the opportunity for people to voice their ideas and share experiences.

Partnerships: The Sikh Healthy Living Project works in partnership with many organisations, including North Birmingham Asian Services, Naujawn Academy (a charitable organisation), North Croft Hospital, Sikh Women's Forum, and there are plans to work with Sure Start in the near future. Many professionals work in partnership with the project, including those providing complimentary therapies such as reflexology, reiki, acupuncture, homeopathy, and GP's, the Primary Care Trust, hospitals and social services.

Evaluation: Each element of the project is evaluated with those who use it through feedback forms and verbal feedback.

Pointers used to measure success:

A range of criteria is used, for example:

- The level of response to radio programmes via phone calls, letters or visits to the centre
- Number of people visiting the centre, requesting information, attending health awareness days

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Project 25: Pennine Care Primary Mental Health Service

Pennine Care primary Mental Health Service provides a culturally-specific counselling service in primary care.

Target Group: The Rochdale South Asian community, including Pakistani Asian, African Asian, Bangladeshi Asian, Kashmiri Asian, Pathan Asian, Asylum Seekers and people of mixed race. The project works with the whole population, as well as with vulnerable groups and people at risk, for example women experiencing domestic violence, young Asian women at risk of suicide, and with people with moderate mental health problems.

Setting: Community, including GP practices, health centres, community centres, hospitals, social services premises and voluntary sector bases throughout the Borough.

Funding: NHS funding (mainstream), but there is very limited funding available for community projects and events or to develop the work in response to community needs.

Timescale: March 1997 – on-going.

Aims and Objectives:

- To offer both culturally sensitive and linguistically sensitive one to one and group therapy to clients suffering from primary mental health and emotional difficulties
- To support people through emotionally holding them and to enable people to develop better ways of coping with the problems that are currently disabling them.
- To promote mental health awareness, reduce the social stigma related to mental health problems and break down mythical barriers within local black and minority ethnic communities.

- To offer training in trans-cultural mental health and anti-discriminatory practice to mental health staff and other professionals within health, other statutory services and the voluntary sector.
- To provide culturally sensitive clinical supervision to mental health workers working with ethnic minority individuals and needing insight into working with difference.

Rationale: The project was set up in response to evidence suggesting that people from ethnic minority communities were not using mental health services, and in particular were not accessing ‘talking therapies’ such as therapeutic counselling, groups and other treatments. Since the work started in 1997, counselling in primary care has become well established and this has only been possible through having both a culturally and linguistically sensitive therapist available and also through development work, working in partnership with a range of agencies.

Black and minority ethnic communities, especially those from the Sub-continent, have set ideas, beliefs and views about mental health which include many myths, and challenging these and providing accurate information about mental health has been a central part of the project.

Project Description: The Primary Mental Health Service responds to and engages with people from the Asian community in Rochdale who are suffering from specific emotional and psychological problems. Mental health facilitators from the Pennine Care Team work with clients with mental health problems at a primary care level, both on a one-to-one and group basis, and offer culturally and linguistically sensitive services. The team also works within the wider Asian community to raise the profile of mental health and reduce the social stigma linked to mental health problems through proper awareness, information and education. This is achieved by proactively working in the community, seeking out Asian people with mental health problems, as well as through clients accessing the service. The project also offers transcultural mental health training to health service staff, including cultural awareness, anti-discriminatory practice and self-reflection.

Awareness of the service is raised in the community through open days, workshops, and links with community centres, and through liaison with GP’s and other workers within health, social services and the voluntary sector.

Partnerships: Work is delivered and offered in partnership with various agencies, in particular the Roshni Project, Rochdale Mind, Age Concern, Rochdale Race Equality Council and Social Services. This ensures care packages can be offered to clients with multiple needs.

Consultation: Mental health service users and the wider Asian community of Rochdale are consulted for views about the service. Also involved is the mental health sub-committee (which includes Rochdale Race Equality Council, Mind, Social Services, Age Concern, Community Mental Health Team and various community organisations). Other groups with an input to the work include Rochdale Primary Care Group, Clinical Psychology, The Alcohol and Drug team, Psychiatry, and various service managers and health professionals.

Evaluation/Outcomes: The project currently uses the CORE evaluation system from Leeds University, which provides a standardised tool for evaluative-audit and outcome measurement for use with services providing psychological therapies to adults. (For more information, contact CORE System Group, Psychological Therapies Research Centre, 17 Blenheim Terrace, University of Leeds, Leeds LS2 9JT). Statistical data regarding the number of clients from ethnic minorities and treatment delivery will be received in March 2003.

The project has enabled ethnic minority clients to access primary mental health care. Although this has been a major achievement, a great deal more development work is needed to respond to the diverse needs and influx of referrals from ethnic minorities.

- Over the last 5 years, counselling has been established and provided for the Rochdale Asian community. It is well accessed and we have moved from a point of no referrals to having to work with waiting lists
- This has happened in conjunction with developmental work to promote mental health and reduce stigma.
- A range of professionals has been offered in depth trans-cultural mental health training that has improved overall service delivery

Pointers to be used to measure success:

- The Primary Care Mental Health Service has been accredited as a practice development unit by Leeds University, and this is reviewed every 2 years.
- Core Evaluation results – Leeds University
- Verbal feedback from community events and programmes
- Clients who self-refer through ‘word of mouth’ from within the community
- Verbal and written feedback from service users, providers and managers.

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Project 26: Raabta and Deeplish Mental Health Projects

The Raabta and Deeplish groups are part of Rochdale and district Mind and provide a day care centre approach with structured activities including advice and advocacy, as well as offering breaks for carers, training and awareness-raising activities.

Target Group: Members of Rochdale South Asian community, including Pakistani, Kashmiri and Bangladeshi communities, who are or have been experiencing mental health problems, and their carers.

Setting: Community – Rochdale and District Mind Office base and a range of community centres, plus day care centres for black and minority ethnic communities.

Funding: Rochdale Metropolitan Borough Council (for the full time Ethnic Minority Community Mental Health Development Worker), Single Regeneration Budget has funded equipment through the small grant scheme, donations from Rochdale Primary Care Mental Health Services, Mind provides venue, volunteer expenses, creche facility and other on-going needs.

Timescale: January 2001 – ongoing.

Aims and objectives:

Raabta and Deeplish Groups:

- To reduce social isolation and increase social contact for people from Asian and other ethnic minority communities who are using or have used mental health service users
- To offer a safe, non-oppressive environment for people to enjoy themselves
- To offer information and general advice relevant to individual and group needs

- To help members develop the confidence to enable them to use other resources in Rochdale

Mind Ethnic Minority Community sub Committee

- To consult service users from ethnic minority communities locally
- To advise Rochdale and District Mind on appropriate service developments for ethnic minority service users
- To contribute to the development and management of Rochdale and District mind

Rationale: The need for the project was identified because people from ethnic minority communities were failing to access other services such as primary and acute mental health service, Mind advocacy and counselling service, day care and benefits advice services. These communities were also not participating in mainstream social groups organised by Mind. A number of surveys (Rochdale and District Mind's survey of Asian Communities and Mental Health – 'Mashvra' Report, February 2000; Asian Black Communities Mental Health project; East Lancaster University Report) identified a need for specific services for people from ethnic minority communities with mental health problems. Mind's ethnic minority community committee also identified the need through their developmental role and expertise and through contact with service users. Statutory day care services have referral-only criteria, whereas the Mind project provides open access.

Project Description: Rochdale and District Mind has been undertaking specific work with people from ethnic minority communities experiencing mental health problems for the last two years, including:

- Mind Raabta Support group (for men and women, but mostly used by men)
- Mind Deeplish Women's group
- Mind Ethnic Minority Community sub Committee
- Occasional training, awareness raising and recreational activities

The groups have been meeting weekly, but are now open on more days and are opening their doors to more people. The project also signposts members to other services. The groups provide a day care centre approach with structured activities including advice and advocacy, as well as offering breaks for carers.

Group members are asked about activities they would like – these have included aromatherapy and massage sessions, yoga and relaxation, healthy eating, and sessions on physical health such as diabetes and coronary heart disease. Mind also use Eid parties and

events such as World Mental Health Day to raise awareness of mental health issues and break down barriers through media such as poetry and drama.

Partnerships: Mind has extensive links and good networking relationships with other local providers and work jointly wherever possible. The projects work in partnership with a number of local organisations, including the Health Promotion Service, Rochdale Learning Network, Rochdale Employment Development Services, Age Concern Rochdale, Cartwheel Community Arts, Hopwood Hall College, Rochdale Metropolitan Borough Council and Rochdale NHS Trust.

Consultation: Consultation takes place regularly with service users, their carers and families, as well as with all relevant stakeholders within local statutory agencies- both the NHS and Rochdale Metropolitan Borough Council.

Evaluation/Outcomes: Evaluation takes place through regular supervision, through surveys and questionnaires, quarterly discussion meetings with project group members, Rochdale Mind consultation with all service users, and evaluation carried out by the Social Services Department of Rochdale Metropolitan Borough Council.

Outcomes include:

- Mental health awareness days/seminars
- Improved access to community members
- Facilities and services have been available to the Asian community that have previously not been offered locally
- Enhanced service provision through working in partnership with other agencies
- The needs of target groups have been met within the resources available at a very local informal level

Pointers used to measure success:

- Increased attendance of groups
- Feedback from members
- Co-working with other organisations
- Verbal and written feedback from users and providers
- Self referral of clients through 'word of mouth'
- Numbers accessing the service through referral from different agencies

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Projects working with a number of black and minority ethnic communities

Project 27: Culture Works

The project provides emotional and social support, raises awareness of mental health issues and improves self confidence and self esteem. It enables service users to gain life skills, introduces them to leisure and social outlets and offers friendship and advice.

Target Group: People with mental health problems from the local black and minority ethnic communities, including Bangladeshi, Indian, Chinese, Black, Vietnamese and mixed heritage.

Setting: Community, including schools, GP practices, community centres.

Funding: Community Mental Health Team (mainstream funding).

Timescale: Started in June 1997 – remodelled in 2003 – on-going.

Rationale: Local research has demonstrated that people from black and ethnic minority communities are currently unable to access mainstream community services for a variety of reasons including language, cultural barriers and lack of knowledge about services available. The project was launched in June 1997 to fill a gap in the already wide range of services available and to ensure that people who are at risk receive face-to-face contact and support in order to prevent family breakdown, social isolation, loss of housing/tenancy and more severe relapse or hospital admission.

Aims:

- To improve the mental health of individuals who are experiencing serious and/or enduring mental illness, symptoms of stress and/or social dysfunction that are culture specific
- To combat discrimination against individuals and groups with mental health problems and promote their social inclusion
- To prevent family breakdown and loss of housing/tenancy
- To provide training to all staff in the CMHT on cultural competencies and black and minority ethnic issues
- To raise the profile of mental health among the local and national black and minority ethnic communities hence empowering the community
- To develop a skilled team and encourage black and ethnic minority workers into voluntary/paid work within mental health services.
- To mainstream black and minority ethnic mental health and facilitate already existing services to be more culturally sensitive

Project description: Home Support provides social, emotional and practical support to clients by the provision of a support structure that is appropriate to the needs of culture, family structure, language and gender. A team of 7 support workers are bi-lingual and from ethnic minorities themselves. Two support workers facilitate the Harmony drop-in for women and Shanti, a mixed group, both of which meet weekly. Both groups aim to provide people with a relaxed social environment and to signpost those who are interested on to other social support, educational and other outlets. Other workers provide one-to-one support, for example advice on benefits, debt management, or support to take part in educational or recreational activities. People who can self refer or can be referred by GP's, health visitors, community psychiatric nurses or social workers. The project also provides training and consultation in partnership with other key services, for example 'cultural attitudes towards sexual health' is provided with the Sexual Health Nurse.

Consultation: Both service users and service providers from mental health and other agencies are consulted and involved in shaping the service. Dialogue also takes place with community leaders, for example the local mosque and welfare associations.

- A consultation workshop for service providers in the voluntary and statutory sector was delivered to identify what local mental health services need in terms of support to help them mainstream their individual services.

- Some research is taking place within residential services, with a support worker conducting an audit around cultural sensitivity in seven units.
- An audit of past and present black and minority ethnic service users satisfaction and needs is taking place using structured interviews.

Partnerships: Jointly managed by Portsmouth Primary Care Trust and adult mental health social services. The Race Equality Scheme and other policies from both organisations are being built in to the project. Partnerships are also taking place between community development teams, the Richmond Fellowship, Portsmouth counselling service, Sure Start and Women's Refuge.

Evaluation: Initially evaluation was carried out by a steering group. Statistics are gathered on how the service is used and feedback is gained through consultation with the community. Local Implementation Groups for suicide prevention, women's strategy and housing, together with the Mental Health Working Group are involved in reviewing progress.

The project has implemented a performance assessment framework monitored by the Balanced Scorecard to enable them to self evaluate. The team's development is evaluated by conducting team reviews, benchmarking against the 'Drexler Sibbet' team performance model.

Pointers used to measure success:

A number of criteria are used, including:

- How many people use the service
- The quality of the service and service user satisfaction
- The number of agencies who are provided with training or consultation
- The extent to which the project has influenced policies across Portsmouth County Council
- The number of self referrals from community members
- Minority ethnic groups are mainstreamed into mental health services
- Social events organised, for example a comedy night and a cultural awareness event on World Mental Health Day.

Contact details:

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Project 28: Muslim Women's Helpline

The Muslim Women's helpline provides confidential emotional support to Muslim women and gives advice and information about mental health issues from an Islamic perspective.

Target Group: Muslim women, whatever their culture, ethnicity or linguistic background.

Setting: Community; face-to-face work takes place in a neutral venue that is comfortable for the client and counsellor, for example a local Mosque.

Funding: A variety of private funding, a one-off grant from the Lord Chancellor's Department for the year 2002-2003.

Timescale: 1989 – on-going.

Aims and objectives:

- To provide confidential emotional support to Muslim women of any ethnicity
- To advise and give information about mental health issues from an Islamic perspective
- To work in a preventative way in order to promote the mental health of Muslim women
- To promote professional training for Muslim women in communication and counselling skills as a way of reaching those women who may find it difficult to seek outside help
- To network with Muslim/non-Muslim organisations in order to ensure a better service is provided to Muslim women
- To collate statistical data to identify major problems facing Muslim women and highlight those issues so that they can be addressed appropriately by community leaders

Rationale: The helpline was set up to respond to the difficulties that many Muslim women face in this country, coming from overseas, unable to speak English, being completely isolated and having problems fitting into the community here. Outside organisations from whom Muslim women seek help may not understand the sensitivity of religion. The service is now considering broadening their remit to provide a family helpline. They already receive some calls from men who seek advice and support to deal with trauma or stress experienced by their wife or mother.

Project Description: The service provides a national telephone helpline and, where appropriate, face-to-face counselling to all Muslim women. The main languages offered are Arabic, Urdu, Punjabi, Gujarati and Farsi. Women requiring help in other languages may be referred to other appropriate projects. Women present with a range of emotional and mental health issues, many of which are linked to marital breakdown, problems within marriage, depression and loneliness. Having provided information and advice, the project may refer women on to a community organisation that can provide more on-going support.

Information about the helpline is available through the a variety of directories, including the Muslim Directory, via the Muslim Women's Helpline website, and women may also receive information via word of mouth or be referred through NHS Direct or through professionals such as health visitors, community psychiatric nurses and others.

Consultation: Through contact with women using the service who identify their needs, and by asking women where they have been helped, what has been successful/less successful, and what more could be done to help.

Evaluation/outcomes: Feedback about the helpline is gathered by telephoning clients at some point after a consultation to ask them how useful the service has been. However, this has limitations because many women do not want to give their names or contact details. Some women telephone to volunteer feedback and to ask for further help.

Pointers used to measure success: A range of criteria is used to measure success, including repeat calls from clients, and the number of referrals received through statutory agencies.

Contact details:

Najma Ebrahim
Helpline Co-ordinator
Muslim Women's Helpline
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Tel (Helplines): 020 8904 8193/020 8908 6715
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Project 29: Positive Vibrations

Positive Vibrations is one of nine projects within a Healthy Living Initiative, 'Cottoning On', in Oldham. It offers black and ethnic minority young men a range of opportunities and activities that promote psychological well being, based on effective mental health promotion practice.

Target group: Young men with mental health problems from black and ethnic minority communities in Oldham.

Setting: Community, including schools and local businesses.

Funding: National Opportunities Fund Grant, SRB 4, Oldham Primary Care Trust, Oldham Metropolitan Council.

Time Scale: October 2002 – December 2005.

Rationale: It is well documented that black and African Caribbean men are more likely to be sectioned under the Mental Health Act, are less likely to be offered complementary and talking therapies and are also less likely to be given the opportunity to work within a peer led support structure.

Aims:

- To introduce a range of activities to promote mental health for black and ethnic minority men.
- To raise awareness of mental health issues and reduce stigma in the wider community.
- To network with other agencies to promote mental health and to share good practice

Objectives:

- To create social networks
- To increase physical activity
- To create access to art and creative activity.
- To create opportunities to develop life skills through workshops.
- To offer support and training to other community organisations.

Project Description: Positive Vibrations has developed a range of innovative and holistic activities that do not always make explicit the aim of promoting and fostering mental well-being amongst the target group. The fact that Positive Vibrations does not heavily promote the term “mental health” as its core aim is well received by the client group.

A number of activities aim to improve the social and personal development of the participants, and enables them to take part in activities which otherwise would not have been possible. These include a Parenting Skills course (which reduces teenage pregnancy rates), St. John’s Ambulance life saving course, healthy Caribbean and Asian cooking courses (in partnership with local Tesco thereby involving local businesses through the Chamber of Commerce), and a music course. The member of staff has a marketing background rather than a traditional mental health background and this benefits the project.

Consultation: Project activities have come about as a result of extensive consultations with the client group who feel part of the whole initiative.

Partnerships: African Caribbean Project in Oldham; “Cottoning On” has been developed through a multi-agency partnership of key stakeholders in Oldham, with a wide range of statutory and community organisations working together to address inequalities.

Evaluation/outcomes: The project is in its early days and this is an ongoing process. It will be expected to collect demographic information about participants and baseline health data, and to produce quarterly and annual progress reports to assess milestones achieved. Staff are developing the processes to define evaluation and outcomes which the client group can own.

Pointers to be used to measure success:

In the first year of the project:

- Four groups supported
- Mental health awareness raising sessions reaching 160 black and minority ethnic men
- Increased number of referrals to Positive Vibrations
- Written feedback via community newspaper
- Increased confidence by client group
- Encouragement to go into music business/number of CD’s marketed

Contact details:

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Project 30: Women of Colour Project

The Women of Colour Project aims to offer a culturally appropriate and supportive space to ethnic minority women, including women of mixed parentage, experiencing any form of mental illness or emotional distress.

Target Group: Ethnic minority women, including women of mixed parentage, experiencing any form of mental illness or emotional distress in the Oxford area.

Setting: Community – in a community centre

Funding: Oxfordshire Mind (which receives funding from statutory services in Oxfordshire), Single Regeneration funding up until 2004.

Timescale: July 2002 – ongoing.

Rationale: Acorn, managed by Oxfordshire Mind, has been running for more than 15 years and is a centre for the promotion of wellbeing and mental health, welcoming all cultures and actively celebrating diversity in the community. When Beth Brown-Reid joined Acorn as manager four years ago she was the only black worker in Oxfordshire Mind, and was aware that the centre was not attracting people from different cultures and backgrounds. Changes began to be introduced, such as different food on the menu and different pictures representing different cultures, and slowly people began to come in.

From this, it was decided that the needs of ethnic minority communities, and women in particular, would be better met by providing a specific space for women of colour, and the Women of Colour project was established. One reason for a woman-only space is that women are less likely to access services, especially those catering for men and women, and they often experience extreme disadvantage. There are no services providing culturally specific talking therapies or preventative outreach care in Oxfordshire. Patients from black and minority ethnic communities are less likely to access drop-ins when they are discharged from hospital.

Aim:

To offer a culturally appropriate and supportive space to ethnic minority women, including women of mixed parentage, experiencing any form of mental illness or emotional distress.

Project description: The Women of Colour Project meets one day a week, providing a woman only space and free and confidential support and information, at present available in English, Urdu and Punjabi. Women do not need a referral or a specific diagnosis – the group is for anyone who is feeling lonely, isolated, depressed or who wants some support in a welcoming, culturally aware environment. Lunch is prepared by members of the group and is available at minimum cost. A number of activities are planned, including art and creativity, day trips, cooking together. One group member is planning to write and present a play around women's experiences in the African Caribbean community. Support with child care costs is available. For women unable to leave their home, the project also provides an outreach service, visiting women at home. Project workers go into local colleges to work with young people and let staff know about the service, and also visit hospital wards and link up with ward staff so that women hear about the project before they are discharged.

Consultation: Consultation took place with statutory organisations and with the local community to identify need.

Contact details:

Farah Zeb (Women of Colour) or Beth Brown-Reid (Manager, Acorn Team)

Acorn

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Appendix 1

The Policy Context

This section reviews a range of policy initiatives that have broad implications for mental health and mental health promotion with black and minority ethnic groups. It also sets out the legal framework provided by the Race Relations Act 1976 and the Race Relations (Amendment) Act (2000) which informs these policies. It includes policies that create a framework within which mental health promotion with different black and minority ethnic groups has more of an opportunity to be effective. The thrust of recent Government policy has been modernisation, public involvement, user-centred services and reducing inequalities. Policies have been informed by an acknowledgement that mental distress is shaped by a wealth of life experiences such as poverty, unemployment, poor educational attainment, bad housing, trauma, racism and abuse. They have at their core the aim of tackling inequalities and ensuring that the needs of the individual are addressed with respect and understanding of diversity. Mental health promotion can contribute to supporting this agenda, and many of the policies that have been put in place can enable this process.

Despite the clarity and coherence of Government policy on health inequalities, achieving change on the ground has been more difficult. While there have been significant policy developments within the NHS, and specifically in mental health services over the last ten years, many initiatives have so far failed to adequately address the particular needs of black and minority ethnic communities or to yield positive outcomes for these groups.

General health

Saving Lives: Our Healthier Nation (Department of Health 1999b): The Government's public health strategy recognises, together with *Inequalities in Health (Acheson 1998)*, that solutions to major public health problems such as mental health are complex. Both acknowledge the need for interventions that cut across sectors to take account of the broader social, cultural, economic, political and physical environments that shape people's experiences of health and well being. Mental health promotion can make an important contribution to achieving this agenda. Proposals are put forward for concerted partnership working to improve people's living conditions and health, and to address inequalities by focusing on prevention rather than cure. Mental health is one of four priority areas, and the strategy includes a target to reduce the death rate from suicide and undetermined injury by at least a fifth by 2010.

The NHS Plan (Department of Health 2000a): This identifies that people in minority ethnic communities are less likely to receive the health services they need, and sets out the Government's intention to set national health inequalities targets. The NHS Plan makes the commitment to reduce inequalities and develop a comprehensive health service designed around the needs and preferences of individual patients, their families and carers, which will respond to the different needs of different populations, including black and minority ethnic groups. The modernisation agenda, outlined in the NHS Plan, includes key themes on engaging communities, building partnerships, developing person centred services and delivering a whole systems approach.

The Vital Connection – An Equality Framework for the NHS (Department of Health 2000b): One of the aims is to recruit, develop and retain a workforce that is able to deliver high quality services that are fair, accessible and appropriate and responsive to the diverse needs of different groups and individuals, and that is representative of the population it is serving. This will ensure that:

- minority ethnic groups are not disadvantaged in recruitment and employment
- shared ethnic and cultural background between staff and patients can contribute to understanding of mental health needs and cultural requirements.

Inequalities

The inequalities targets in the NHS Plan are backed by a series of strategies and related initiatives within local government. Consultation and participation are central to this agenda. The requirement to consult with, engage and involve communities will mean addressing the psychological and emotional impact of deprivation and exclusion, as well as a greater focus on quality of life indicators that measure the impact on how people feel. These policies are at the heart of a new agenda for public services and regeneration and have the potential to have a huge impact on the mental and emotional well being of black and minority ethnic communities.

Disability Discrimination Act (1995): This aims to end the discrimination which many disabled people face and gives them rights in a number of areas including employment, access to goods, facilities and services. The Act defines a disabled person as someone with 'a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities.' The employment provisions apply to employers with 15 or more employees. They include situations where an employer may unlawfully discriminate by treating someone less favourably than other employees or job applicants because of their disability; or by not making reasonable adjustments.

Inequalities in Health (Acheson 1998): This report makes the case for action on health inequalities. It emphasises the importance of the wider social and economic determinants of health, including poverty, poor housing and unemployment, all of which disproportionately impact on black and minority ethnic communities. It highlights the way in which increasingly between the mid 1970's and the early 1990's, overall improvements in life expectancy benefited the most disadvantaged social classes less than others. The report recommends the development of services that are sensitive to the needs of minority ethnic people and which promote greater awareness of their health and proposes that the needs of minority ethnic groups be specifically considered in assessment, resource allocation, health care planning and review.

Health Improvement Programmes and Health Action Zones: These were introduced within the NHS in 1998. Most health authorities identified the needs of black and minority ethnic communities as an area to be addressed within their Health Improvement Programmes. Health Action Zones brought together all the key stakeholders contributing to the health of the local population to develop and implement a locally agreed strategy for improving the health of local people. They had key objectives of reducing health inequalities and improving services. The need to improve services for black and minority ethnic communities was identified as a cross cutting theme in many Health Action Zone programmes.

National Strategy for Neighbourhood Renewal (Social Exclusion Unit 2000): This aims to arrest the decline of deprived neighbourhoods and to narrow the gap between deprived areas and the rest of the country. Because black and minority ethnic communities are found disproportionately in areas of deprivation, this will have a particular impact on the health, and mental health, of these groups.

The Neighbourhood Renewal Unit's ***Race Equality Action Plan*** makes a number of proposals to engage and include black and minority ethnic communities and organisations in delivering the National Strategy for Neighbourhood Renewal. It recognises that this will require the involvement of the voluntary and community sector to ensure local responsiveness, representation and accountability (Social Exclusion Unit 2000a).

Community Strategies (Local Government Act 2000): These aim to improve quality of life and promote economic, social and environmental well being in order to contribute to sustainable development. They are co-ordinated and delivered by a Local Strategic Partnership, a multi-agency umbrella partnership across all sectors, involving partners from primary care, NHS Trusts, education, police and the voluntary sector. Local authorities are expected to take the lead and have a responsibility to ensure consultation, engagement and inclusion.

The Best Value Programme (Department of the Environment, Transport and the Regions 2002): This provides an opportunity to tackle inequalities, including a focus on visible minorities, to ensure large sections of the population have equity and equality, and includes 'fair access' as a specified performance indicator in many of its core standards.

Strong Local Leadership – Quality Public Services (Department of the Environment, Transport and the Regions 2002): This White Paper places quality of life and greater community engagement at the heart of the reform of local government, with key themes of consultation and renewed local democracy, community cohesion, civic renewal and sustainable development, including building social capital.

Tackling Health Inequalities: the results of the consultation exercise (Department of Health 2002): This consultation invited feedback on the national health inequalities targets announced in the NHS Plan. The results highlight a number of key issues that have been overlooked, including mental health and the promotion of positive mental well being, which is closely linked to poverty and social exclusion. The following key areas of concern emerge, all of which have a particular impact on the mental health of black and minority ethnic communities:

- access to good primary health care services has been poor for many of the most disadvantaged communities. Communities most at risk of ill-health also tend to have the least satisfactory access to a full range of preventative services such as screening and health promotion
- some communities face multiple problems of material disadvantage that are associated with poor health. The quality of the social and physical environment is worst where financial deprivation is greatest such as in the inner cities
- there is a need to acknowledge that some inequalities are larger in relation to certain ethnic groups than between social groups, and a need to narrow the health gap between the majority population and ethnic minority communities.

Mental health

Modernising Mental Health Services (Department of Health 1998) and Modernising Social Services (Department of Health 1998): These are strategies outlining the future of health and social services. They set out a range of measures to improve quality and reduce variations, with services responsive to individual needs, regardless of age, gender, race, culture, religion, disability or sexual orientation. Both state a commitment to tackling inequalities in the way services are delivered to people from black and minority ethnic

communities. This includes the training and education of mental health professionals to become 'culturally competent', including promoting cultural awareness, knowledge and sensitivity.

The National Service Framework for Mental Health (NSF) (Department of Health 1999a): This sets out national *standards* of care and measures for monitoring performance, with a focus on the mental health needs of working age adults up to 65 years. There is no specific standard set for ethnic minority mental health within the NSF.

The NSF incorporates a number of guiding principles upon which service standards should be based, including:

- user involvement
- high quality, accessible services that do not discriminate
- choice of services
- good co-ordination between all agencies involved in delivering services.

It highlights the insensitivity of existing services to people from African and Caribbean communities and identifies that mental health assessment for South Asian communities is inadequate. It also stresses that minority ethnic groups, including refugees, suffer from social exclusion that damages mental health and compounds their mental health problems.

The NSF has brought about the integration of social services and health services, meaning people in distress should now be assessed for all their health and social care needs together, and these can then be met by a comprehensive, regularly monitored care plan. Everyone on enhanced CPA (Care Programme Approach) must have a plan that addresses their occupation, housing and benefit needs, thus creating a framework for looking more holistically at people's broader needs, and this may be especially beneficial for people from black and minority ethnic communities.

Standard One of the National Service Framework for Mental Health concerns mental health promotion and aims to ensure that health and social services promote mental health and reduce the discrimination and social exclusion experienced by people with mental health problems. Standard One outlines the need to develop health improvement programmes and local mental health strategies targeting identified vulnerable groups, including mental health promotion for black and minority ethnic communities. It identifies a number of key settings, including schools, workplaces and neighbourhoods, for mental health promotion to take place.

Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England (Department of Health 2003): There has been no national strategy or policy specifically intended to improve the mental health of minority ethnic groups or the care and treatment they receive from mental health services. This Government report is the first step towards this and anticipates a National Plan for Ethnicity and Mental Health as part of the Government's Modernisation Programme, outlined in the NHS Plan launched in 2000. *Inside Outside* recognises the need to improve the service experience and service outcomes for people from black and ethnic minorities who experience mental ill health, especially those coming into contact with mental health services as users or carers. It also makes proposals that aim to improve the overall mental health of people from black and minority ethnic groups living in England. The recommendations, together with the results of a consultation process taking place with black and minority ethnic communities from around the country, will form the basis of the Department of Health's Black and Minority Ethnic Mental Health Implementation Framework to be released for consultation later in 2003.

Inside Outside sets out three overarching strategic objectives:

- reducing and eliminating ethnic inequalities in mental health service experience and outcome
- developing a Mental Health Workforce that is capable of delivering effective mental health services in a multicultural context
- enhancing and building on the capacity within black and minority ethnic communities and in the voluntary sector for dealing with mental health and mental ill health.

Proposals for developing a culturally capable service include:

- actively promoting and supporting the attitudes, behaviours, knowledge and skills necessary for staff to work respectfully and effectively with people from minority ethnic communities
- statutory mental health providers working collaboratively with the local voluntary sector to develop ways to meet the needs of minority ethnic groups
- ensuring services are congruent rather than conflicting with cultural norms
- ensuring language access for people who prefer a language other than English

National Suicide Prevention Strategy for England (Department of Health 2003):

This aims to support the achievement of the target set in the White Paper: Saving Lives Our Healthier Nation, and reinforced in the National Service Framework for Mental Health, to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010. The strategy includes an objective to promote mental well being among the wider population, and specifies work with black and minority ethnic groups, including Asian women.

Draft Mental Health Bill (Department of Health 2002): The Government has a comprehensive programme to modernise mental health policy and a Draft Mental Health Bill was published by the Department of Health in June 2002. It contains a number of proposals that are welcome in principle and can support and build on existing policy as set out in the National Service Framework for Mental Health and the NHS Plan. These include the further development of advocacy, an enhanced and speedier Mental Health Review Tribunal system, and an emphasis on developing care plans.

However, there is widespread concern about the Draft Mental Health Bill as it stands. It will have particular implications for people from black and minority ethnic communities because of the way they currently access mental health services and the increased rates of detention under the Mental Health Act for some black and minority ethnic groups.

Race

The Human Rights Act (1998): The adoption of The Human Rights Act in England provides an imperative to improve the experience of people from black and minority ethnic communities who use mental health services, and to respond more directly to the needs of minority ethnic groups.

The Stephen Lawrence Inquiry Report (MacPherson 1999): Following the murder of Stephen Lawrence and the failure of the criminal justice system to bring his murderers to justice, the MacPherson Report highlights institutional racism which it defines as: 'The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.' The NHS, along with other public bodies, is expected to examine its structures and services in the light of the report to eradicate racism.

The Race Relations (Amendment) Act (2000): This is a statute passed by Act of parliament in 2000 and is the legislative response to the Stephen Lawrence Inquiry, aimed at tackling institutional racism. It amends and does not replace the Race Relations Act 1976. Section 71(1) places the general race equality duty on listed public authorities, which include Primary Care Trusts, Mental Health Trusts, Secure Psychiatric Hospitals, Strategic Health Authorities, Health Regulatory bodies such as Inspectorates, Police Forces, The Prison Service and Local Authority Social Service Departments. All of these institutions must ensure that in exercising their functions they do not discriminate unlawfully and actively promote race equality. The aim of this is to mainstream race equality into the thinking, policy and practice of public authorities. Organisations need to demonstrate positive action. Public bodies are charged with the responsibility to ensure that their interventions or services do not result in disparities in outcome, and to monitor outcomes and take steps to eradicate racial discrimination. The first 3 year phase of implementation of the race equality duty comes to an end in May 2005.

The duty to promote race equality

The amended Race Relations Act gives public authorities a new statutory duty to promote race equality. The aim is to help public authorities to provide fair and accessible services, and to improve equal opportunities in employment.

The aim of the duty is to make the promotion of racial equality central to the work of the listed public authorities. The general duty also expects public authorities to take the lead in promoting equality of opportunity and good race relations, and eliminating unlawful discrimination. In practice, this means that listed public authorities must take account of racial equality in the day to day work or policy-making, service delivery, employment practice and other functions.

Certain public authorities (see Appendix 2 of the Code of Practice) have to undertake ethnic monitoring of employment practice and prepare and publish a ***Race Equality Scheme*** that sets out how they will meet both their general and specific duties. Under the Race Equality Scheme, public authorities must:

- assess whether their functions and policies are likely to affect people differently, depending on their ethnic group
- monitor their policies to see how they affect race equality
- assess and consult on the impact that policies they propose to introduce are likely to have on promoting race equality
- publish the results of their assessments, consultations and monitoring

- make sure that the public have access to information and services
- train their staff on the new duties
- review the scheme at least every 3 years.

The ***Commission for Racial Equality*** works with organisations in the public, private and voluntary sectors to reduce racial discrimination and promote equal opportunities for employees, customers and service users. It provides advice and assistance on a range of issues including equal opportunities policy and practice, ethnic monitoring and employment. The Commission for Racial Equality has produced a statutory code of practice (***The Code of Practice on the Duty to Promote Racial Equality, Commission for Racial Equality 2002***), and four non-statutory guides, to help authorities in England and Wales meet their duty to promote race equality (see www.cre.gov.uk/duty.) These set out clear guidelines about how to implement a race equality scheme within health organisations. A successful health organisation will:

- identify functions and policies that are relevant to the duty to promote race equality
- assess and consult on the impact its policy proposals are likely to have on this duty
- monitor the effects of its policies on different groups
- publish reports on its assessments, consultations and monitoring every year
- ensure access to information about its work and to its services
- publish a race equality scheme
- set race equality objectives for all its partnership work, and for work carried out under contract
- train its staff on the duty to promote race equality
- monitor staff, applicants and employment processes by ethnic group.

The CRE section 44 grants programme ***Getting Results*** provides funding for local racial equality service providers, with more than £3.8 million made available to 93 providers in 2004. For more information, contact gettingresults@cre.gov.uk.

The Home Office Community Funding Team manages the ***Connecting Communities Grant Scheme*** that funds projects to promote race equality and give minority ethnic communities greater access to and influence over policy makers and service providers. Three main areas of support have been identified – community networks, access to jobs and services, and positive images and £15 million has been allocated up to the end of 2006. Application forms can be obtained from the Home Office website: www.homeoffice.gov.uk

Refugees and Asylum Seekers

UN Convention relating to the status of refugees (1951): The UK is signatory to this convention and its 1967 Protocol. All applications for asylum made at UK ports of entry or within the country are considered in accordance with the obligations under the Convention. The Convention states that a refugee is a person who ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country’.

Fairer, Faster and Firmer – A Modern Approach to Immigration and Asylum (July 1998): This sets out a range of proposals to modernise and integrate the immigration and asylum system, with the overall aim of developing a more flexible and streamlined system.

The Immigration and Asylum Act (1999): This included provisions which address conditions applying to persons before they come to the UK, the way they are dealt with at ports when arriving in the UK, and how they are dealt with once here. It contained new support arrangements for asylum seekers in genuine need.

National Asylum Support Service (April 2000): Before the Immigration and Asylum Act 1999 was implemented, the Benefits Agency or local authorities provided support to asylum seekers. From April 2000, that became the responsibility of the new National Asylum Support Service. Asylum seekers are entitled to apply for accommodation in the UK on a ‘no choice’ basis, outside of London and away from the South East. They are also entitled to apply for cash support. Advice for asylum seekers is available from immigration law advisers and firms of solicitors contracted under the Community Legal Service Fund.

Accommodation may be provided by a local authority, housing association or private landlord. The provider is responsible for advising the asylum seeker on how to access services, including local health care and getting their children into school.

Refugee Integration Strategy (November 2000): This has established a Challenge Fund designed to promote projects that address specific social needs amongst refugee communities, with a budget of £2 million for 2003/04. The Fund is open to any organisation that has an innovative project to offer or wishes to consolidate an existing project.

Secure Borders, Safe Haven: Integration with Diversity in Modern Britain (February 2002): This set out the key challenges facing the Government on nationality, immigration and asylum policy and the measures that would be taken to develop a coherent strategy. Reform of the asylum system is based on the principle that we should have a humanitarian process which honours our obligations to those feeling persecution while deterring those who have no right to asylum from travelling here.

Nationality, Immigration and Asylum Act (2002): This is a major landmark in the reform of nationality, immigration and asylum policy. It establishes an end-to-end asylum process with a system of induction, accommodation and removal centres, and aims to speed up the asylum process.

Appendix 2

Useful National Organisations

Sources of further help and information – Black and Minority Ethnic Groups

The Afiya Trust

27-29 Vauxhall Grove

London SW8 1SY

T: 020 7582 0400

F: 020 7582 2552

E: neemamandalia@afiya-trust.org or Rosemarywallace@afiya-trust.org

Web: www.afiya-trust.org

Generates, supports and maintains national and local networks concerned with the promotion of black and minority health and community care equality issues.

Asian Family Counselling Service

Suite 51, The Lodge

Windmill Place

2-4 Windmill Lane

Southall

Middlesex UB2 4NJ

T: 020 8571 3933

F: 020 8571 3933

E: afcs99@hotmail.com

Hours of opening: 9.30am-4.00pm

Provides marital, family and individual counselling for the Asian community.

Chinese Mental Health Association

2nd Floor, Zenith House

155 Curtain Road

London EC2A 3QY

T: 020 7613 1008

F: 020 7739 6577

E: info@cmha.org.uk

Web: www.cmha.org.uk

Chinese mental health promotion, bi-lingual counselling, mental health assessment, befriending, group and daytime activities for Chinese mental health service users and their carers.

Chinese National Healthy Living Centre

29-30 Soho Square

London W1D 3QS

T: 020 7534 6546 or 020 7287 0904

F: 020 7534 6545

E: general@cnhlc.org.uk

Web: www.cnhlc.org.uk

Information service, health promotion, preventive care and primary care for Chinese people.

Commission for Racial Equality

St Dunstan's House

201-211 Borough High Street

London SE1 1GZ

T: 020 7939 0000

F: 020 7939 0001

E: info@cre.gov.uk

Web: www.cre.gov.uk

A publicly funded, non-governmental body set up under the Race Relations Act 1976 to tackle racial discrimination and promote racial equality.

Confederation of Indian Organisations (UK)

5 Westminster Bridge Road

London SE1 7XW

T: 020 7928 9889

F: 0207620 4025

E: cioheadoffice@aol.com

Web: www.cio.org.uk

Umbrella body which aims to represent the needs of the South Asian community in the UK. Vishvas Project (in Southwark and Lambeth) aims to ensure that Asian women with mental health problems have access to appropriate information and support services.

Diverse Minds

Mind's Black and Minority Ethnic Unit

15-19 Broadway

Stratford

London E15 4BQ

T: 020 8215 2218

F: 020 8522 1725

E: s.sardar@mind.org.uk

Web: www.diverse minds.org.uk

Works to ensure that mental health services are responsive to the needs of people from black and minority ethnic communities.

Federation of Irish Societies

The London Irish Centre

50-52 Camden Square

London NW1 9XB

T: 020 7916 2725

F: 020 7916 2753

E: federationfis@msn.com

Web: www.irishsocieties.org

A national umbrella organisation which draws together Irish clubs and societies in Britain. It promotes the interests of Irish people through community care, education, culture and arts, youth and sports activities and information provision.

Nafsiyat Intercultural Therapy Centre

3rd Floor, 262 Holloway Road

Islington

London N7 6NE

T: 020 7686 8666

F: 020 76868667

E: nafsiyat-therapy@supanet.com

Web: www.nafsiyat-therapy@supanet.com

Offers counselling and therapy to black and minority ethnic people.

Refugee Council

3 Bondway

London SW8 1SJ

T: 020 7820 3000

F: 020 7582 9929

E: info@refugeecouncil.org.uk

Web: www.refugeecouncil.org.uk

Hours of opening: 9.30am-5.30pm

Gives practical help to refugees in the UK and promotes the rights of refugees worldwide.

Refugee Support Centre

47 South Lambeth Road

London SW8 1RH

T: 020 7820 3606

F: 020 7820 3606

E: rsctherapy47@hotmail.com

Hours of opening: 9.30am-5.30pm (appointments needed)

Provides free services in counselling and psychotherapy to refugees in their language of choice, activity groups for refugees who are 50+ and live in the boroughs of Lambeth, Lewisham and Southwark, family therapy for refugee families or couples. Also provides training for professionals who work with refugees, especially those working within community organisations.

Vietnamese Mental Health Services

Thomas Calton Centre

Alpha Street

Peckham

London SE15 4NX

T: 020 7639 2288

F: 020 7639 0008

E: vietnamese.mhs@aol.com

Hours of opening: 9.00am-5.00pm (Mon-Fri)

Provides services and support to Vietnamese people in London and beyond who are suffering from mental health problems, and to their families. Work in partnership with health and social care agencies, provide outreach and counselling services, drop in day care centres and supported accommodation. Also provides training and education about mental health issues, health/social care systems for people from Vietnam and about Vietnamese culture and beliefs in mental health to health/social care professionals.

Sources of further help and information on mental health – General

Depression Alliance

35 Westminster Bridge Road

London SE1 7JB

T: 020 7633 0557

F: 020 7633 0559

E: information@depressionalliance.org

Web: www.depressionalliance.org

Provides information, support and understanding for those affected by depression and their carers. Also provides a network of local support groups as well as campaigning to raise greater awareness of the condition.

Manic Depression Fellowship

Castle Works

21 St. George's Road

London SE1 6ES

T: 020 7793 2600

F: 020 7793 2639

E: mdf@mdf.org.uk

Web: www.mdf.org.uk

A national user-led organisation that aims to enable people affected by manic depression (bi-polar) to take control of their lives through the services offered, including self help groups, information and publications, employment advice, the MDF Self Management Training Programme, 24-hour Legal Advice Line for employment, legal, benefits and debt issues and a travel insurance scheme.

mentality

134-138 Borough High Street

London SE1 1LB

T: 020 7716 6777

F: 020 7716 6774

E: enquiries@mentality.org.uk

Web: www.mentality.org.uk

The first national charity dedicated solely to the promotion of mental health. **mentality** works with the public and private sector, user and survivor groups and voluntary agencies to promote the mental health of individuals, families, organisations and communities. **mentality** can assist you with planning, implementation and delivery of NSF Standard One including policy support and development, advice on what works, development of criteria/measuring success and through mental health promotion training.

Mental After Care Association (MACA)

1st floor
Lincoln House
296-302 High Holborn
London WC1V 7JH
T: 020 7061 3400
F: 020 7061 3401
E: info@maca.org.uk
Web: www.maca.org.uk

Provides community services including advocacy, assertive outreach schemes, community support, employment schemes, forensic services, information, respite for carers, social clubs and supported accommodation. MACA also works for positive change in mental health legislation and practice.

Mental Health Foundation

83 Victoria Street
London SW1H 0HW
T: 020 7802 0300
F: 020 7802 0301
E: mhf@mhf.org.uk
Web: www.mhf.org.uk

A UK organisation, incorporating the Foundation for People with Learning Disabilities, with main offices in London and Glasgow. Provides research and practical projects to help people survive, recover from and prevent mental health problems.

Mental Health Matters

9-10 Enterprise House
Kingsway, Team Valley Trading Estate
Gateshead
Tyne & Wear NE11 0SR
T: 0191 497 1600
F: 0191 487 7945
E: rharris@mentalhealthmatters.co.uk
Web: www.mentalhealthmatters.com

A national registered charity providing support and services to people suffering from enduring mental ill health and their families and friends. Services include a helpline, supported accommodation, day services and employment opportunities, advice and information.

Mental Health Media

356 Holloway Road

London N7 6PA

T: 020 7700 8171

F: 020 7686 0959

E: info@mhmedia.com

Web: www.mhmedia.com

Produces and sells videos and multimedia resources which educate and inform about mental health and mental distress. They also provide media skills training and support to users and professionals.

Mind

15-19 Broadway

London E15 4BQ

T: 020 8519 2122

F: 020 8522 1725

Information helpline: Open Mondays to Fridays 9:15am to 5:15pm

telephone: 0845 766 0163

E: contact@mind.org.uk

W: www.mind.org.uk

A mental health charity based in England and Wales. Mind works to create a better life for everyone with experience of mental distress.

National Institute for Mental Health in England (NIMHE)

Blenheim House

West One

Duncombe Street

Leeds LS1 4PL.

T: 0113 254 3811

E: Ask@nimhe.org.uk

Web: www.nimhe.org.uk

Aims to improve the quality of life for people of all ages who experience mental distress. Working beyond the NHS, they help all those involved in mental health to implement positive change, providing a gateway to learning and development, offering new opportunities to share experiences and one place to find information.

Rethink

Registered Office

28 Castle Street

Kingston-Upon-Thames

Surrey KT1 1SS

T: 020 8547 3937

F: 020 8547 3862

E: info@rethink.org

Web: www.rethink.org

National Advice Line Tel: 020 8974 6814 (open 10am to 3pm, Monday to Friday)

Dedicated to improving the lives of everyone affected by severe mental illness, whether they have a condition themselves, care for others who do, or are professionals or volunteers working in the mental health field.

Sainsbury Centre for Mental Health

134 Borough High Street

London SE1 1LB

T: 020 7827 8300

F: 020 7403 9482

E: contact@scmh.org.uk

Web: www.scmh.org.uk

Work to improve the quality of life for people with severe mental health problems. It aims to influence national policy and encourage good practice in mental health services.

Samaritans

The Upper Mill

Kingston Road

Ewell

Surrey KT17 2AF

T: 020 8394 8300

F: 020 8394 8301

E: admin@samaritans.org

Web: www.samaritans.org

Offer confidential emotional support 24 hours a day to those in crisis and in danger of taking their own lives.

Sane

1st Floor

Cityside House

40 Adler Street

London E1 1EE

T: 020 7375 1002

F: 020 7375 2162

Saneline: 0845 767 8000 open from 12 noon until 2am every day of the year
(calls charged at local rate)

E: london@sane.org.uk

Web: www.sane.org.uk

Seeks to change attitudes about mental illness, campaigning for improved rights and care and conducting research through the SANE research centre.

Appendix 3

Feedback Form

We continue to welcome your comments on this publication and would welcome your feedback.

Please complete and return this form to **mentality** (see address over). You do not have to include your name and address if you would prefer not to.

Name

Organisation

Address

Telephone

Email

Did you find this publication useful?

Which chapters or sections were most useful?

Is there anything else that you would like to see included?

Are there any other comments you would like to make?

Thank you for completing this feedback form.

Please return to:

mentality

134–138 Borough High Street

London SE1 1LB

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