transcultural psychiatry

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ARTICLE

Multicultural Mental Health Services: Projects for Minority Ethnic Communities in England

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Abstract Black and minority ethnic (BME) communities form 7.8% of the total population of the UK. Many of these communities face a variety of disadvantages when they access, or are forced to access, statutory mental health services under the National Health Service. Efforts have been made to address these problems by developing projects both within statutory mental health services and in the non-governmental ('voluntary') sector. This article describes some of these projects located in England, drawing out the themes and models that underlie their approaches, and discusses the lessons that can be learned from the U.K. experience.

Key words ethnic minorities • inequality • multicultural • NGOs • racism

The UK, comprising England, Scotland, Wales and Northern Ireland, has seen waves of immigration over the centuries. Until recently, immigration had been largely from other parts of Europe, but many of the immigrants during the post-war period were from South Asia, Africa and the Caribbean islands of the 'West Indies.' The terminology used to describe the different racial, cultural and ethnic groups now permanently resident in the UK has varied from time to time. The concepts 'race' and 'culture' have given way to 'ethnicity' for the purpose of categorization, the standards being set by the categories used in the national census (White, 2002). Ethnicity is usually self-ascribed to reflect self-perception in a

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British context. According to eminent British sociologist Stuart Hall (1992), the term ethnicity 'acknowledges the place of history, language and culture in the construction of subjectivity and identity, as well as the fact that all discourse is placed, positioned, situated, and all knowledge is contextual' (p. 257). In practical shorthand, ethnicity is taken to mean a mixture of cultural background and racial designation.

The current style in the UK is to describe all settled minority ethnic groups under one umbrella term 'black and minority ethnic (BME) communities.' This category excludes recent immigrants who are refugees and asylum-seekers. The main subgroups identified within the BME category are Asian (denoting people whose origins are from India, Pakistan, Bangladesh and Sri Lanka), Chinese (denoting people of Chinese ancestry from Hong Kong, Malaysia, Singapore and mainland China), black Caribbean/African-Caribbean (denoting origins from West Indian Islands and Guiana) and black African (denoting origins from sub-Saharan Africa). The terminology is complicated further because the term 'black' or 'black British' is often used to refer to people of both black African and black Caribbean/African-Caribbean origin, and people of Asian origin are referred to as 'Asian British.' And occasionally, all non-white ethnic groups are referred to as 'black.' All BME communities together amount to about 7.8% of the total U.K. population according to the national census of 2001, within which 3.9% are Asian/Asian British and 2% black/black British, the rest being from other minority ethnic groups (White, 2002).

Statutory mental health services in the UK are provided within the National Health Service (NHS), which is funded from general taxation and free to service users resident in the UK. Since 2002, responsibility for service delivery in England has rested with primary care trusts and NHS trusts, with 28 strategic health authorities forming the link between the (central) Department of Health and the trusts. The structure and delivery of mental health care has changed greatly over the past 40 years, first by shifting emphasis from hospital-based services to community care (Goodwin, 1997) and then by a steady change over the past 15 years that has shifted power over the organization of services from the professions to the government (Burns, 2004). Although the former change allows non-medical models of care to be used in some situations, statutory mental health services have continued to use a model that encapsulates most mental health problems as essentially medical illnesses based on traditional western European psychiatry. The latter change, whereby 'current practice is dominated by central prescription and risk assessment' (Burns, 2004, p. 275) means that the degree to which professionals can determine the style of care is limited.

The apparent failure of mental health services in England to meet the

needs of its BME communities has been a topic of interest and debate over the past 20 years, fuelled by reports on racial and cultural issues in the provision of services (Bhui, 2002; Fernando, 2002, 2003; Sashidharan, 2001), dissatisfaction with the services experienced by people of African and Asian descent (Keating, Robertson, McCulloch, & Francis, 2002; Parkman, Davies, Leese, Phelan, & Thornicroft, 1997) and two reports into deaths in psychiatric hospitals (Norfolk, Suffolk & Cambridgeshire Strategic Health Authority, 2003; Special Hospitals Service Authority, 1993) that highlighted institutional racism in psychiatric institutes. The main issues noted over the past 20 years show that BME communities (compared with other ethnic groups) are more often:

- diagnosed as schizophrenic (Bhugra et al., 1997; Harrison, Owens, Holton, Neilson, & Boot, 1988; King, Coker, Leavey, Hoar, & Johnson-Sabine, 1994);
- compulsorily detained in hospital (Audini & Lelliott, 2002; Davies, Thornicroft, Leese, Higginbotham, & Phelan, 1996; Harrison, Ineichen, Smith, & Morgan, 1984; Owens, Harrison, & Boot, 1991);
- admitted as 'offender patients' (McGovern & Cope, 1987);
- held by the police for observation for mental illness (Dunn & Fahy, 1990; Pipe, Bhat, Matthews, & Hampstead, 1991; Rogers & Faulkner, 1987);
- transferred to locked words from open wards when they are patients in hospital (Bolton, 1984);
- given high doses of medication when they are patients in hospital (Chen, Harrison, & Standen, 1991; Littlewood & Cross, 1980; Lloyd & Moodley, 1992);
- not referred for psychotherapy when suffering from mental health problems (Campling, 1989).

The need for changes to be initiated at a national level in order to confront these issues was proposed over 10 years ago in a government publication called *Dialogue for Change* (Mental Health Task Force, 1994). But little was achieved over the subsequent years.

In 1999, the National Service Framework for Mental Health (Department of Health, 1999) commented that 'black and minority ethnic communities lack confidence in mental health services' (p. 17). Subsequent discussions have led to two official reports outlining possible national plans for bringing about change, one issued by the National Institute for Mental Health in England (2003) and the other by the Department of Health (2003). Taken together, these two documents envisage ways of improving ethnic data collection, increasing the capability of service provision, addressing institutional racism and empowering and/or engaging BME communities to impact on decision-making in service

delivery. Nine 'Race Equality Leads' were appointed in mid-2004 to cover different regions of England but without any clear guidance on their remit. The Department of Health has announced a 'national race and cultural awareness training programme for all mental health professionals' (*Mental Health Today*, 2004, p. 7) but not specified how this training is to be delivered or what it will comprise.

While discussions were going on at a national level, a variety of projects have been developed in some parts of England designed to meet the needs of BME communities. This article presents descriptions of some of these projects. In most instances, they came about as a result of pressures from local BME communities and/or the enthusiasm and commitment of dedicated individuals. The projects in the statutory sector were entirely within the NHS. The initiatives in the voluntary (non-governmental) sector were partially or fully funded by resources from the state but controlled and organized by voluntary (non-governmental) organizations. Because there are no systematic studies of the projects described in this article, I present my personal impressions of the themes and models that underlie the projects. Then, I discuss what lessons can be learned from the experiences in England of trying to bring about multicultural mental health services. It should be noted that this article does not cover projects aimed at addressing mental health needs of refugees and asylum-seekers.

Statutory Sector Initiatives

Over the past 30 years, several projects have been developed within the NHS in different parts of England. Those described here have not been selected on the basis of any particular criteria except that they have been reported in one form or other in published literature and are known to me personally.

Transcultural Psychiatry Unit at Bradford

In the late 1970s and early 1980s, some statutory bodies (health authorities) promoted the formation of groups of people to 'specialize' in providing services for minority ethnic communities in their areas, usually by employing professionals who were conversant with minority languages and/or minority cultures. One such venture led to the formation of the Transcultural Psychiatry Unit at Lynfield Mount Hospital, Bradford (Yorkshire) in the late 1970s. This was the first attempt in the statutory sector to have a service that set out to be culturally sensitive. As such, it was both innovative and significant. The unit began when a psychiatrist, Dr Phillip Rack, who had developed a special interest in 'transcultural psychiatry,' gathered around him a team of professionals from various

cultural backgrounds in order to provide a linguistically and culturally sensitive service for East European (mainly Polish) and South Asian (mainly Pakistani) people living in the area served by Lynfield Mount Hospital (Rack, 1982). In effect, the staff attached to this unit acted as 'specialists' providing cultural consultancy to mental health services in the district either as individuals or as a team, occasionally taking over the care of people or families referred to it. The effectiveness of the unit depended on the expertise and dedication of members of the team developing cultural knowledge and, more importantly, being committed to adapting traditional European psychiatry to suit the needs of their minority ethnic clients.

The Transcultural Psychiatry Unit at Bradford thrived for several years. However, after Dr Philip Rack's successor Dr John Bavington retired because of illness in 1992, the unit appeared to lose support from the hospital organization and also came under increasing pressure because of excessive numbers of referrals (Daudjee, personal communication, 1998). Finally in 1999, the managers of the body responsible for the unit decided to close the unit on the grounds that its work would be absorbed into the general work of the service – 'mainstreamed.' In effect, transcultural approaches to clinical work that the unit had pioneered seemed then to disappear. However, this unit may well have inspired other centres to pursue a similar model of working, whereby a multicultural team provided specialist consultation to a district; indeed it was the model employed by a group of people in Enfield (Middlesex) working with me between 1986 and 1993.

Maudsley Outreach Support and Treatment Team

During the 1980s, it became apparent that black people might be more accepting of home-based psychiatric services than they were of hospital services, mainly because hospitals had a strong negative image among black people. The results of a survey carried out at the Maudsley Hospital in South London in the 1980s (Moodley, 1995) showed that: 'While white patients considered the social contacts made through hospital as being more important, African and African-Caribbean patients rated seeing a member of staff of their own colour, being understood and receiving help with finding jobs as more important' (p. 128). Based on this and other findings on the views of service users, a new community-based service that was set up in 1989, the Maudsley Outreach Support and Treatment Team (MOST), pursued a user-centred approach. Dr Parimala Moodley (1995), who was the director of MOST, writes: 'We believe that our success was a result of working *with*, rather than for or at, our patients. Our interventions were always made explicit and nearly always agreed upon

between the professionals and service users involved – with compromises on both sides' (p. 138). About 4 years after it was set up, MOST was 'mainstreamed' by the Maudsley Hospital. This meant that its functions were placed within the main mental health service structure of this hospital. The effect was that its activities as previously organized were disbanded. However, the approach of providing outreach care for black people pursued at MOST, where professionals worked closely with the users of the services, may well have stimulated other outreach teams working in the London area.

North Birmingham Home Treatment Service

A significant initiative within the NHS began in 1990 as the West Birmingham Home Treatment Service under the direction of Professor Sashi Sashidharan (Parveen, 1995). This service was made possible when a ward at a local mental hospital was closed allowing resources dedicated to that ward to be transferred into community work in the area previously served by that ward. The arrangement was initially a pilot project serving a population of 35,000. Later, the scheme was widened to serve a catchment area of 200,000 forming part of the services provided by the North Birmingham Mental Health Trust. Over 60% of the clients dealt with by the service were from minority ethnic backgrounds and the staff were committed to 'anti-oppression practice' (Parveen, 1995, p. 9). More recently, ethnospecific community-based services have been set up in north Birmingham to support the home treatment service – the Frantz Fanon Centre for African-Caribbean people and the Asian Resource Centre. The future of these services is at the time of writing (July 2004) in the balance for a variety of reasons.

Ipamo

In the early 1990s, several black activists interested in mental health issues conceptualized and obtained funding for what was called the 'Sanctuary Project' (Jennings, 1996) – essentially a sanctuary for black people who would otherwise be admitted to an ordinary psychiatric unit. Their aim was to develop appropriate alternatives to (psychiatric) hospital care run by black people for black people. Working groups were formed to develop a project in Hackney (north east London) and one in Lambeth (South London) – both areas with relatively high black populations. Initially, both groups envisaged 'partnerships' between statutory and voluntary sectors. The project for Hackney gradually changed into a voluntary sector project within a housing association contracting with the local social services department. It now functions as the Nile Centre – a voluntary sector

project described later. The group for Lambeth pursued the partnership pathway hoping to develop a project that would be within the statutory (mental) health service for the area but managed by a black-led voluntary organization called 'Ipamo.'

Having obtained special funding from the Department of Health, Ipamo was set up in mid-1995 as a voluntary organization with membership drawn from black and Asian professionals, black community groups and black churches. Ipamo planned to work in partnership with the two statutory bodies that were responsible for the statutory mental health services for the London Borough of Lambeth (which included Brixton with a relatively large black Caribbean population). These bodies held responsibility for the funds and capital development, while Ipamo, through its Board of Directors, was responsible for the service to be developed. A model and a detailed structure for a service were formulated; staff were to be mainly black people and a general ethos for the therapeutic approach was planned to combine traditional (western) approaches to mental health with ideas from black social and political movements, notions of spirituality using input from local black churches and an approach to counselling, called 'black therapy,' developed by the director of Ipamo, Malcolm Phillips, a psychologist and counsellor. This was a type of counselling that emphasized self-reliance and self-esteem, counteracting the realities of racism. It was based on the theories of Cross (1971, 1978, as cited in Nobles, 1986) for moving black people forward psychologically so that they may live in a racist environment while maintaining their self-esteem.

A building was purchased as the location for Ipamo but the statutory bodies concerned informed Ipamo of various practical problems, such as dismissal of the architects employed for re-designing the building, and a gradual diminution of funds available for service provision. Finally, after about three years of planning and negotiation between Ipamo and the statutory bodies, the latter decided that the project was not viable and stopped funding Ipamo in December 1998. The lessons for the black voluntary sector arising from this misadventure in partnership are discussed elsewhere (Fernando, 2003).

Discussion

A variety of approaches have been tried within the statutory (NHS) sector in projects aimed at meeting the needs of BME communities. In my view, many of these projects have been dependent on the commitment and enthusiasm of one or two persons; when they leave, the 'special service' has come up against difficulties and usually disappeared. The result has been that innovative projects in the statutory sector have been often marginal

to the main mental health service and when attempts have been made to bring them into the mainstream their innovative nature has disappeared. All too often, 'mainstreaming' has been a euphemism for 'abolishing.' In my view, the main approaches that have informed projects in the statutory sector are as follows:

- training professional staff in 'cultural sensitivity and 'anti-racist practice';
- cultural consultancy based on a multicultural multidisciplinary team;
- transcultural unit within a mental health service that promoted professional expertise in helping people from a variety of cultural backgrounds;
- service led by professionals from similar ethnic backgrounds to those of clients;
- anti-oppressive practice in dealing with people from BME communities;
- linking psychological support to housing;
- using 'black therapy' and emphasis on spirituality by linking up with black churches.

As far as I can make out, no clear-cut single 'good practice model' for multicultural services has emerged in the UK. However, some of the main approaches referred to above may amount to 'good practices.' Likewise, Watters and Ingleby (2004) have noted, in studying mental health and social care for refugees and asylum-seekers in European countries, that there are a variety of good practices but no overall consensus on a single good practice model. In my view, the situation in the context of the NHS is that, although local projects incorporating good practices result in short-term change, they cannot be sustained unless they are supported and validated by central authority. If that happens, then one could envisage that the good practices would be taken on board by the mainstream resulting in changes in the statutory services.

In my view, sustainable changes in the statutory sector require a national plan and strategy to promote innovation locally and then ensure that such local innovation (if successful) becomes incorporated in the mainstream and a model for other places to follow. So a national strategy needs to confront the fact that a variety of approaches may be required to bring about change that lasts, varying perhaps from place to place and guided by local conditions and (most importantly) local people. It is possible that recent government policies (Department of Health, 2002) opening up opportunities for primary care trusts, pursuing the aims of the National Service Framework for Mental Health (Department of Health, 1999), to commission secondary care projects may help in such a process. Yet, I believe that general guidelines may need to be set centrally to confront

both individual prejudice and institutional racism, and to enable local initiatives to face up to the conservatism of established systems that tends to prevent change.

Schon (1967) has described the resistance to change of a social system as 'not a matter of inertia but of dynamism' (p. 125). In my view, one of the main sources of 'dynamic conservatism' preventing change in mental health services emanates from psychiatry itself. Therefore, changes in the way psychiatry functions may be needed if innovative multicultural practices are to be brought about and institutionalized within statutory mental health services in general. First the main need is for greater flexibility than there is at present in ways of assessing people who present with mental health problems. Perhaps one approach is to consider mental *health* rather than illness, taking the service user viewpoint as a guide to what constitutes a 'problem' and what sort of services are required. In such an approach, someone can have symptoms and yet be mentally healthy (Secker, 1998); and the content of services depends on what people wish for themselves – what good outcome means to them, for their families and so on. This would inevitably bring into play the cultural diversity of what well-being is all about. And this diversity has to be respected. Cultural competence of professionals has to do with being able to go along with diversity and being sensitive to user needs, while bringing along an expertise derived from knowledge of services available and an ability to make judgements on when and to what extent the traditional medical model is applicable. Specific ways of achieving change in psychiatric clinical practice are discussed elsewhere (Fernando, 2003).

Voluntary Sector Initiatives

Since the early 1980s many counselling and psychotherapy services have come on the scene in what is generally called the 'black voluntary sector.' The projects described here, as a sample of the many ethnospecific projects now available in England, are drawn from those known personally to me at some period of their development.

Nafsiyat

Nafsiyat, set up in 1983, was probably the first centre set up in the UK that was specifically aimed at providing psychotherapy for BME communities. It was founded by Jafar Kareem, a clinical psychologist from Bengal (India) who had been trained in Europe and had been working for some years in the NHS. Some of the ideas promoted and developed at Nafsiyat were written up in chapters by Kareem in the book *Intercultural Therapy* (Kareem & Littlewood, 2000). At first, all the therapists recruited to work

at Nafsiyat had been trained in psychoanalytic psychotherapy; however, the approach fostered by Jafar Kareem was to modify psychoanalytic psychotherapy through learning from the BME clients seen at the centre and calling on cultural knowledge of the therapists from non-western cultural backgrounds who worked there. Jafar Kareem's aim was to develop a form – or forms – of psychotherapy appropriate to the needs of multicultural Britain. I recall him voicing the view that if therapy did not suit a client, it was the therapist who had to change and not the client.

Jafar Kareem personally supervised all the therapists at the centre and encouraged them to develop (what he called) a 'Nafsiyat style' of intercultural therapy. Tragically, Jafar Kareem died suddenly in 1992. The 'Nafsiyat style' was an innovation that was very personal to Jafar Kareem and possibly died with him. The lack of effective leadership and serious internal problems of management between 1997 and 1999, led to this project becoming a small fairly traditional psychoanalytic psychotherapy centre, although some of the therapists may attempt to carry on Jafar Kareem's style of working. In any case, many other centres offering counselling to BME communities have been developed in England since the mid-1980s.

Qalb Centre

The Qalb Centre was set up in Waltham Forest (East London) in 1993 by a group of mainly Asian professionals, including social workers, counsellors and a psychiatrist. The centre aims to provide counselling and complementary therapies for Asian people experiencing mental health problems (Gorman, 1995). Complementary therapies available at the centre include massage and yoga. The counsellors are mainly Asian and they have developed ways of liaising with the complementary therapists in order to maintain a 'whole-person' approach. More recently, Qalb has set up a daycare centre for Asian people with long-term mental health problems where a similar approach to that at the counselling centre is used, but with outreach and support. Most of the clients attending the day care centre are people referred to Qalb by the statutory (psychiatric) services. Each client has a programme drawn up which does not take psychiatric diagnosis into account at all, but is based on enhancing positive aspects of their life situation, including their skills, and community support.

Nile Centre

The Nile Centre opened in July 1997 as a mental health facility for African and African-Caribbean people. It is structured within a black-led housing association and funded by grants from various sources, mainly the

(statutory) social services department. The Nile Centre offers help during crisis with supportive housing, outreach crisis support and counselling. All the staff are of African or African-Caribbean origin and the clients are either self-referred or referred by professionals working in the statutory mental health service in the London Borough of Hackney situated in East London. Nearly all the clients have a psychiatric diagnosis attached to them usually indicating 'serious mental illness' but diagnosis is not taken as indicative of the type of interventions offered by the centre. Its approach is to help clients deal with racism that they face in both daily living and their interactions with the statutory services and to counteract social deprivation and exclusion by helping clients to access welfare services and training schemes in the community. The staff are trained to be 'culturally sensitive' and work in a 'holistic' framework.

The work of the Nile Centre is seen as complementing the 'medical model' approach of the statutory sector. In practice, the staff attempt to liaise with statutory sector workers who are nearly always involved with the clients of the centre, although their involvement is usually reduced once Nile Centre staff are involved. The latter endeavour to maintain communication between the workers in the two agencies at a grass-roots level although the project itself is entirely independent of the statutory sector. The work of the Nile Centre has not been critically evaluated but an audit of user satisfaction of the work carried out at the centre suggests that the services are greatly appreciated by its (black) users.

Harambee

The Harambee organization was formed in 1961 as a youth development/community development project for African-Caribbean people in Birmingham. By the late 1960s it had expanded into providing housing/hostel services, a nursery and an advisory service. Around the mid-1980s, Harambee had formed a novel service for African-Caribbean people designated as 'mentally ill' – usually 'seriously mentally ill,' within the Birmingham criminal justice system. Black people entering the service were assessed by a panel of professionals consisting of social workers, probation officers, psychiatrists and community workers, working for the service in a voluntary capacity. After assessment, those accepted were housed in the main centre (the 'core' of the residential project) where professional advice (including medication) was available and facilities were provided for supervision over basic activities of daily living.

After rehabilitation in the core facility, which included activities for daily living and social skills training, clients were sent to one of the outlying 'cluster' housing projects for long-term residential care, or helped to re-settle in the community, with linkage to training programmes. In the

early 1990s, the core and cluster system disintegrated, although some residual elements carried on in terms of hostel/independent living facilities for clients still remaining. The housing association still remains intact, being linked to the home treatment service in Birmingham referred to earlier.

Discussion

The general impression I have obtained about black voluntary sector projects is that the following approaches have been applied at the projects:

- adapting traditional counselling by learning from clients;
- using skills of therapists derived from their own cultural backgrounds and community links;
- using alternative therapies derived from Asian cultural traditions;
- supportive therapies linked to housing and social integration;
- advocacy to help clients to deal with statutory services;
- therapies aimed at community integration;
- guidance to clients on strategies to deal with racism.

The impression I have obtained in discussion with both therapists and clients at several black voluntary sector projects (including Nafsiyat, Qalb Centre and Nile Centre) is that the counselling practised at the centres is generally appropriate and helpful – something that is often not the case at statutory services. Most of the counsellors at these centres claim to provide counselling that is 'different' to that provided at traditional statutory services. In some instances the difference is obvious in that they provide a mixture of traditional counselling and complementary therapies derived from Asian cultural traditions. In other cases the difference is less evident. In my view, the following features represent where the main 'difference' may lie.

Many of the projects cater to a particular ethnic group or subgroup such as 'Black,' 'Asian,' 'Chinese' 'Somali,' etc. The staff in each project would mainly or exclusively belong to the designated ethnic group or one very similar culturally, or else have had close connections with people from the designated background. Therefore, when staff are being selected to work in the project, as much credence is given to their cultural understanding and connections with the designated ethnic group as is given to their training and past experience of working in community support or counselling services. Thus, the staff are in a position to bring to the therapeutic situation cultural knowledge and community experience from their own personal backgrounds and current life experience. In this sense many of the approaches in the projects resemble those advocated by Waldegrave (2003) in working with three communities in New Zealand.

The reception areas of the service usually have a 'multicultural' feel in terms of decoration on the walls, type of furniture, notices, etc. giving the location either a South Asian or African atmosphere as well as a local British one. However, what is often striking is the informality of approach by the staff towards clients and the tendency for staff to greet and converse with clients in languages that clients feel comfortable in.

Many of the services operate on a much less formal setting than do traditional counselling services. Practical arrangements are flexible both in relation to time keeping and venue at which clients and staff meet. For example, clients arriving late for appointments are usually accommodated and seldom made to feel guilty about being late. And lateness is not usually discussed as a psychological problem.

In many instances, clients are matched to therapists in terms of cultural background or, if that is not possible, the therapist provided is usually someone who is conversant with the cultural background of the client. In most projects each client is consulted about their wishes regarding ethnic and gender matching. In practice, the degree of ethnic matching of client and therapist is limited by the availability of staff but ethnic matching is something that is kept uppermost in mind when a therapist is allocated to a client.

The quality of the relationships made between the clients and the staff is very different to that seen in traditional ('white') counselling and psychotherapy services. Professionals working in many ethnospecific services for BME people are unlikely to draw firm boundaries between what is appropriate and not appropriate for discussion at therapy sessions. The restrictions on disclosing personal facts and beliefs by the therapist are much less rigidly applied than is the case in traditional counselling and psychotherapy services. Hence, clients are very likely to discuss personal problems of a social and political nature including racism and ways of dealing with racism. And in such discussion, the therapists would generally see it as their duty to place before the client their (the therapist's) own experiences and ways of dealing with problems of a social and political nature.

Although many of the projects tend to focus on the individual client, families are seldom excluded from involvement in the centres from which the projects operate. The general assumption is that families will participate in (for example) accompanying the client to the centre or the therapy session. However, it is rare for more organized family therapy to be undertaken, possibly because many of the professional staff working in the projects are not trained in family therapy.

Conclusions

This article provides an overview of the attempts that have been made in England to develop mental health services that address needs of black and minority ethnic (BME) communities. It does not cover services that are aimed at addressing needs of refugees and asylum-seekers. Unfortunately, there is a dearth of systematic study of the topic addressed in this article. Hence, the observations presented here are largely anecdotal based on personal experience of the author over many years in the field.

The presence of a large number of ethnospecific projects in the black voluntary sector has meant that mental health services as a whole in the UK give the appearance of a cultural 'plurality' of service provision in many places. However, the voluntary sector projects are really marginal to the main body of service provision that is accessed – more often than not on a compulsory basis – by BME people with mental health problems. Nationally, the bulk of the resources for mental health care is absorbed by the statutory sector. Therefore, pressure to bring about changes in the statutory sector is the main focus of expressed opinion of service users from BME communities and many professionals interested in their welfare. And I believe this should be the main thrust of activism in the mental health field over the next few years. Government seems to recognize the need for changes in the delivery of services to BME communities but unwilling to grapple with the problems in a consistent way.

In my view, a significant part of changing statutory sector mental health practice must be concerned with changing the clinical practice of psychiatry towards adopting a multicultural approach – both in terms of how mental health assessments are carried out and the scope of what goes for therapy. Clearly, such a change needs to be backed up by theory and research and this is where academic cultural psychiatry may have an important role.

Cultural psychiatry research and theory is now extensive, but as a body it is politically weak and has very little impact on training of professionals who by and large run the mainline mental health services in the UK. The challenge is to enable the knowledge and theory in cultural psychiatry to fit into the political and social context of service provision in the mainstream mental health services, especially into psychiatry and clinical psychology. The picture in the UK at present is of a few interested and committed individuals struggling at the grass roots (usually in the voluntary sector) to bring into being services that are responsive to and appropriate for a multicultural society. Meanwhile, interesting topics in cultural psychiatry are discussed elsewhere – mainly in journal articles and meetings attended by academics, psychiatrists and psychologists. The grass roots activists in the voluntary sector seldom attend such meetings while

the meetings that they do attend – largely to do with running services that BME communities find satisfying – are seldom attended by academics and professionals who carry some power to change clinical practice in the statutory sector. Clearly this is not a productive situation and the sooner the two worlds – the academic/professional and the voluntary sector service provision – come together the better.

References

Audini, B., & Lelliott, P. (2002). Age, gender and ethnicity of those detained under Part 11 of the Mental Health Act 1983. *British Journal of Psychiatry*, *180*, 222–226.

Bhugra, D., Leff, J., Mallett, R., Der, G., Corridan, B., & Rudge, S. (1997). Incidence and outcome of schizophrenia in Whites, African-Caribbeans and Asians in London. *Psychological Medicine*, *27*, 791–798.

Bhui, K. (2002). London's ethnic minorities and the provision of mental health services. In K. Bhui (Ed.), *Racism and mental health: Prejudice and suffering* (pp. 139–187). London: Jessica Kingsley.

Bolton, P. (1984). Management of compulsorily admitted patients in a high security unit. *International Journal of Social Psychiatry*, *30*, 77–84.

Burns, T. (2004). Psychiatry in the future. *Psychiatric Bulletin*, *28*, 275–276.

Campling, P. (1989). Race, culture and psychotherapy. *Psychiatric Bulletin*, *13*, 550–551.

Chen, E. Y. H., Harrison, G., & Standen, P. J. (1991). Management of first episode psychotic illness in Afro-Caribbean patients. *British Journal of Psychiatry*, *158*, 517–522.

Davies, S., Thornicroft, G., Leese, M., Higginbotham, A., & Phelan, M. (1996). Ethnic differences in risks of compulsory psychiatric admission among representative cases of psychosis in London. *British Medical Journal*, *312*, 533–537.

Department of Health. (1999). *Mental health national service frameworks*. London: Department of Health.

Department of Health. (2002). *National service frameworks: A practical aid to implementation in primary care*. London: Department of Health.

Department of Health. (2003). *Delivering race equality. A framework for action*. London: Department of Health.

Dunn, J., & Fahy, T. A. (1990). Police admissions to a psychiatric hospital. Demographic and clinical differences between ethnic groups. *British Journal of Psychiatry*, *156*, 373–378.

Fernando, S. (2002). *Mental health, race and culture* (2nd ed.). Basingstoke: Palgrave.

Fernando, S. (2003). *Cultural diversity, mental health and psychiatry. The struggle against racism*. Hove, UK: Brunner-Routledge.

Goodwin, S. (1997). *Comparative mental health policy. From institutional to community care*. London: Sage.

Gorman, G. (1995). Qalb. *Openmind*, *76*, 19.
Hall, S. (1992). New ethnicities. In J. Donald & A. Ratansi (Eds.), *'Race' culture and difference* (pp. 252–259). London: Sage.
Harrison, G., Ineichen, B., Smith, J., & Morgan, H. G. (1984). Psychiatric hospital admissions in Bristol. 2. Social and clinical aspects of compulsory admission. *British Journal of Psychiatry*, *145*, 605–611.
Harrison, G., Owens, D., Holton, A., Neilson, D., & Boot, D. (1988). A prospective study of severe mental disorder in Afro-Caribbean patients. *Psychological Medicine*, *18*, 643–657.
Jennings, S. (1996). Developing black mental provision: Challenging inequalities in partnership. *Journal of Community and Applied Social Psychology*, *6*, 335–340.
Kareem, J., & Littlewood, R. (2000). *Intercultural therapy* (2nd ed.). Oxford: Blackwell.
Keating, F., Robertson, D., McCulloch, A., & Francis, E. (2002). *Breaking the circles of fear*. London: Sainsbury Centre for Mental Health.
King, M., Coker, E., Leavey, G., Hoar, A., & Johnson-Sabine, E. (1994). Incidence of psychotic illness in London: Comparison of ethnic groups. *British Medical Journal*, *309*, 1115–1119.
Littlewood, R., & Cross, C. (1980). Ethnic minorities and psychiatric services. *Sociology of Health and Illness*, *2*, 194–201.
Lloyd, K., & Moodley, P. (1992). Psychotropic medication and ethnicity: An inpatient survey. *Social Psychiatry and Psychiatric Epidemiology*, *27*, 95–101.
McGovern, D., & Cope, R. (1987). The compulsory detention of males of different ethnic groups, with special reference to offender patients. *British Journal of Psychiatry*, *150*, 505–512.
Mental Health Task Force. (1994). *Black mental health – A dialogue for change*. London: Department of Health.
Mental Health Today. (2004, June). News: NHS mental health staff to get race training. *Mental Health Today*, p. 7.
Moodley, P. (1995). Reaching out. In S. Fernando (Ed.), *Mental health in a multi-ethnic society. A multi-disciplinary handbook* (pp. 120–138). London: Routledge.
National Institute for Mental Health in England. (2003). *Inside outside improving mental health services for Black and minority ethnic communities in England*. London: Department of Health.
Nobles, W. W. (1986). *African psychology*. Oakland, CA: Black Family Institute.
Norfolk, Suffolk & Cambridgeshire Strategic Health Authority. (2003). *Independent inquiry into the death of David Bennett* (Chairman: Sir John Blofeld). Cambridge: Norfolk, Suffolk & Cambridgeshire Strategic Health Authority.
Owens, D., Harrison, G., & Boot, D. (1991). Ethnic factors in voluntary and compulsory admission. *Psychological Medicine*, *21*, 185–196.
Parkman, S., Davies, S., Leese, M., Phelan, M., & Thornicroft, G. (1997). Ethnic differences in satisfaction with mental health services among representative people with psychosis in South London: PRISM Study 4. *British Journal of Psychiatry*, *171*, 260–264.

Parveen, T. (1995). Services for Black communities in general. In C. Harding (Ed.), *Not just Black and White. An information pack about mental health services for people from Black communities, Booklet 1* (pp. 9–10). London: Good Practices in Mental Health.

Pipe, R., Bhat, A., Matthews, B., & Hampstead, J. (1991). Section 136 and African/AfroCaribbean minorities. *International Journal of Social Psychiatry*, *37*(1), 14–23.

Rack, P. (1982). *Race, culture and mental disorder*. London: Tavistock.

Rogers, A., & Faulkner, A. (1987). *A place of safety*. London: MIND.

Sashidharan, S. P. (2001). Institutional racism in British psychiatry. *Psychiatric Bulletin*, *25*, 244–247.

Schon, D. A. (1967). *Technology and change. The new Heraclitus*. Oxford: Pergamon Press.

Secker, J. (1998). Current conceptualizations of mental health and mental health promotion. *Health Education Research*, *13*, 57–66.

Special Hospitals Service Authority. (1993). *Report of the committee of inquiry into the death in Broadmoor Hospital of Orville Blackwood and a review of the deaths of two other Afro-Caribbean patients: 'Big, Black and dangerous?'* (Chairman Professor H. Prins). London: Special Hospitals Service Authority.

Waldegrave, C. (2003). 'Just therapy' with families and communities. In C. Waldegrave, K. Tamasese, F. Tuhaka, & W. Campbell (Eds.), *Just therapy – a journey* (pp. 63–78). Adelaide, Australia: Dulwich Centre.

Watters, C., & Ingleby, D. (2004). Locations of care: meeting the mental health and social care needs of refugees in Europe. *International Journal of Law and Psychiatry*, *27*, 549–570.

White, A. (Ed.). (2002). *National statistics. Social focus in brief: Ethnicity 2002*. London: Office for National Statistics.

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