

Black-Led Initiatives in Mental Health: An Overview

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Abstract

The contributions of Black-led initiatives to mental health service provision in the United Kingdom have not been documented fully and go largely ignored despite the history of failure of mainstream mental health services to meet the needs of Black (1) and minority ethnic communities. Against this background, this paper analyses the models of service provision in relation to mental health services for Black and minority ethnic communities. The aim is not to present a comprehensive analysis of these initiatives, but to offer an illustrative account of some of the key issues facing Black-led initiatives in mental health.

Introduction

Mainstream mental health services in the United Kingdom have a longstanding history of failing the needs of Black and minority ethnic communities. Sashidharan and Francis (1999) suggest that the most glaring example of racial inequality in health and social care provision can be found in psychiatry. Evidence shows that services are not able to detect mental health problems across all minority ethnic communities (Bhui, 1997), they are not effective in engaging members of these groups (Bhugra and Bahl, 1999; Gunaratnam, 1993; McGovern and Hemmings, 1994), and they are not effective in gaining the confidence of Black communities (Gray, 1999; Hirsch and Powell, 1998). Inequalities within mainstream are also evident in the following: Black people are less likely than white people to have contact with a general practitioner, are three times more likely to be detained compulsorily, and are more often diagnosed as violent or aggressive (Christie and Smith, 1997; Fernando, 1995; Raleigh, 2000; Wilson, 1993).

Even though there have been numerous calls for these criticisms to be taken seriously (see, for example, Department of Health, 1994), the situation has not changed greatly. There is growing recognition of the importance of redressing inequalities within recent government proposals for the modernisation of health and social services. There has also been some acknowledgement that Black voluntary sector agencies better meet the needs of Black communities (Home Office, 2001). The last decade has seen a proliferation of reports and policy initiatives to draw attention to the plight of Black people with mental health problems (see Table 1 at the end of this article for a summary of these initiatives).

Three key developments noted in Table 1 are worth mentioning. Firstly, the government's modernising agenda is calling for partnerships between private, voluntary and statutory sector agencies to address social inequalities. Secondly, a Task Force has been established to develop a strategy for improving mental health services to Black communities. The launch of the strategy is imminent. Thirdly, the Race Relations Amendment Act 2000 now places a responsibility on public bodies to work towards the elimination of unlawful discrimination and promote equality of opportunity. These initiatives are all recent, so we have to date no evidence to attest their success. It is therefore unsurprising that efforts to redress these imbalances are still largely located in Black-led initiatives operating in the voluntary sector. A black-led initiative has been defined as "an organisation which is led and managed mainly or entirely by Black or other minority ethnic people, which serves mainly Black or minority ethnic people" (Home Office, 1999: 13). Although the importance of the voluntary sector is established (Atkin, 1996), the contributions of Black-led initiatives to mental health service provision have not been documented fully. Hirsch and Powell (1998: 110) suggest that "the work of the Black voluntary sector is rarely evaluated and publicised and the contributions to theory and practice in health and welfare largely ignored".

Descriptions and examples of mental health services in the Black-led initiatives have been offered (see, for example, Christie and Smith, 1997; Harding, 1995; Smaje, 1995). However, the ideological and philosophical bases of the models of service provision in such initiatives have not been articulated and theorised. This area of service provision has not been the subject of research and study in health and social care. For example, a large-scale study to examine the scope, structure, history, legal position and role of the voluntary

sector paid no attention to issues for Black and minority ethnic voluntary sector agencies (Kendall and Knapp, 1996). A more recent mapping exercise of the black and minority ethnic voluntary sector by the Joseph Rowntree Foundation (2001) also paid no particular attention to this area of service delivery.

It is against this background that this paper aims to offer a description and analysis of the service models that have evolved in the genesis of mental health services to Black and minority ethnic communities. It will particularly explore the strengths and weaknesses inherent in each model, though it should be noted at the outset that these models of service provision are not necessarily theorised or conceptualised in this manner by those who use them. This paper draws on the limited literature in this area and data from a review of mental health services to African and Caribbean communities under the auspices of the Sainsbury Centre for Mental Health (SCMH) in London (Keating and Robertson, 2002; Keating et al, 2002). This review, titled 'Breaking Circles of Fear', collected written evidence from a wide range of sources and carried out in-depth interviews with staff, carers and service users in Black-led initiatives. I will also draw on my experience as a Board member on the management committees of two Black-led initiatives and as a consultant and trainer on issues of 'race', culture and mental health over the last ten years.

Black-led Mental Health Initiatives in Context

Black-led initiatives are usually small, geographically dispersed (Francis and Jonathan, 1999), are generally under-resourced and have much shorter histories than their mainstream counterparts (Kemp et al, 1998). They have their roots in the communities they aim to serve and their organisational cultures and structures reflect this. Staff are usually drawn to them because of political and ideological commitments and compassion. Ethnicity or racial background is an important criterion in recruitment and selection. Under-resourcing means that these agencies can not afford highly trained and skilled staff. Implications of these factors for organisational development will be explored later, but first let us consider the historical origins of Black-led

initiatives.

It has been argued that the origins of initiatives to respond to the mental health needs of Black and minority ethnic communities can be traced back to the post-war reconstruction era when Black people were recruited to Britain to supply cheap labour (Yee and Mussenden, 2000). When Black people attempted to take part in society in general they met with utmost prejudice and social exclusion. In response, they gradually set up their own social groups and welfare organisations (Sivanandan, 1991). Ahmed and Webb-Johnson (1995) suggested that these initiatives and projects developed in response to local demands from the community to fill the gaps in mainstream service provision. However, the Institute of Race Relations (1993) posit that the growth of Black-led initiatives is a conscious reaction to the racism of the system. Traditionally, these projects have always had a political and campaigning thrust and have been the main protagonists in the struggle against a range of social and legal injustices against Black and minority ethnic communities (Hirsch and Powell, 1998). Yee and Mussenden (2000) suggest that self-help and self-reliance are part of the history of the presence of Black communities in Britain. Black-led initiatives have been created by people directly affected, whereas the wider voluntary sector emerged from philanthropic ideas where wealthier people were taking an interest in the plight of the disadvantaged. It is unfortunate that the new contract culture and depoliticization of the voluntary sector in general, are diverting Black-led initiatives from their campaigning and advocacy role (Hirsch and Powell, 1998). Voluntary sector agencies have now taken over state functions for welfare and are inextricably linked to Local Authority funding structures (Ahmed and Webb-Johnson, 1995). This poses major dilemmas for these Black projects in terms of retaining sufficient autonomy to set their own agenda.

Features of Black-led Initiatives

A key feature of Black-led initiatives is that they articulate the conditions of welfare for Black and minority communities. They challenge universalist assumptions of health and welfare provision: a philosophy that treats everyone the same regardless

of origin or status (Williams, 1993). This assumption legitimates non-recognition of the service needs of Black and minority ethnic communities (Atkin, 1996) and therefore Black-led initiatives play a critical role in identifying gaps in service delivery, in particular, inconsistencies and failings in social policies. They make the needs of Black people visible and provide examples of good practice in relation to these.

Another distinguishing feature of Black-led initiatives, according to Gray (1999), is that they are generally considered to be the only source of culturally appropriate practice. It can, therefore, be argued that they are subsidising mainstream services to Black and minority ethnic communities. Whilst this is true to a large extent, we should also acknowledge recent attempts to address racial inequalities in the mainstream. One such example is the recent initiative in the National Health Service (NHS) to widen access of local communities to the NHS workforce and to tackle inequalities in terms of recruitment, retention and training (Hammond, 1999). Other examples of policy initiatives include the National Service Framework for Mental Health (DOH, 1999) which places a duty on mental health services to make an accurate assessment of the mental health needs of Black and minority ethnic communities. It would be interesting to see what impact the Race Relations Amendment Act 2000 will have on this. Some mainstream voluntary agencies, for example national Mind, have also joined the quest to challenge racial inequality in services by establishing a unit to focus specifically on mental health issues for Black people. These concerns can also be found elsewhere in services: for example, I recently facilitated a stakeholder conference for a Mental Health Trust to develop a strategy to meet the mental health needs of Black and minority ethnic communities in their catchment area. Even though there have been these initiatives at national and local level, there is still little evidence that these have yielded any positive outcomes for Black people.

A further feature of Black-led initiatives is that the agenda is client-led (Ismail, 1996) and determined by historical as well as current disadvantage (Jamdagni, 1996). For example, in an interview with the co-ordinator of a Black-led project, the

response given to a question about the services they provide was: "what the client needs." Service delivery is essentially situated in the reality of the lives of service users, because these services have deep roots in the community. A service manager in a community based African-Caribbean mental health centre talked about their struggle for survival and stated, "we survived because we are owned by the (Black) community." This rootedness in the community seems to lessen the impact of racism and discrimination and inadequate service provision in the lives of Black service users. These organisations embrace a philosophy of care that is holistic (Institute of Race Relations, 1993; Philips, 1997). Their primary emphasis is to retain identity, collectively and individually and to acknowledge the experience and impact of racism on the lives of Black people. This is perhaps one of the most significant strengths of Black-led initiatives.

The size and life histories are distinctive features of Black-led initiatives. A review by the London Borough of Grants (Kemp, et al, 1998) which aimed to build a picture of support needs of Black voluntary sector organisations, surveyed 212 organisations across all sectors. They found that on average these organisations have no more than two paid staff and depended largely on volunteers. These organisations have shorter life histories, therefore they are sometimes referred to as 'new voluntary' sector organisations.

Black-led initiatives make critical observations about psychiatry and offer a perspective that involves an understanding of the political reality of Black people's experiences, the hardships that they endure, and is therefore appropriate for their cultural and racial identity needs (Gray, 1999: 206, Bhui, 2002). Definitions of mental illness that do not pathologise behaviour are preferred. The shift is from management of mental illness to promotion of health (Philips, 1997). Diagnostic categories are ascribed limited value and the focus is more on psychosocial support. For example, one organisation's stance is to focus on the healthy aspects of a person's life rather than their illness. The premise is that by strengthening the well-functioning components of a person's life, one may enable her/him to deal with those parts that are not so well. The problem with this is that these

projects are often not able to meet the needs of people with severe or acute mental health problems (Ismail, 1996). Furthermore, focussing on social support and less developed theoretical approaches, also means that services are often viewed as 'sub-standard' or what Hirsch and Powell (1998) term, driven by 'subjective compassion' as opposed to 'objective professionalism'. This poses a major challenge in a climate of competitive tendering and mixed economy of welfare. Also, the dominance of the mainstream discourses on mental health obscures the significance of this contribution to the discourse on 'race' and mental health.

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Organisational cultures in Black-led initiatives are distinct from those of mainstream voluntary sector organisations. The cultural traditions of the communities they serve are reflected in the structure and practice of the organisation (Iglehart and Becerra, 1996). They are less bureaucratised, more flexible and open. The agenda is therefore more social rather than market driven (Phillips, 1997). Roles are less clearly defined and communication structures less formalised. This strength however, can also be a source of weakness. Less formalised structures and procedures can lead to a blurring of boundaries and unclear lines of accountability: factors known to impact on organisational efficiency and effectiveness.

Challenges for Black-led Initiatives

A major challenge is the marginalised status of organisations in this sector. Voluntary sector organisations in general are not central to mainstream budgets. Black-led organisations suffer particularly in this respect (see, for example, Butt and Box, 1998; Christie and Smith, 1997, Sia, 1993; Walker and Ahmad, 1994, Watters, 1996). Funding is usually short term and linked to contracts. Constant threats of under-resourcing have serious implications for survival. Moreover, in the contract culture, the voluntary sector is expected to professionalise to realise potential (Atkin, 1996). It often does not have the capacity or infrastructure to meet this demand and therefore finds it difficult to survive (Yee and Mussenden, 2000). Numerous small Black agencies have folded due to this phenomenon. One particular organisation interviewed in the SCMH review

described how they were forced to reduce opening hours due to contracts being cancelled. Another organisation lost its contract for funding and was eventually taken over by a mainstream white voluntary organisation. One implication of limited and insecure funding is that these organisations do not have a strong asset base (Home Office, 1999).

Most of the organisations interviewed in the review did not own their premises, a factor that causes continual insecurity. One director comments, "we never know whether we are going to be in the same building next year...". Wenham (1993) argues that the funding constraints are largely due to the fact that these organisations do not have the same access to information about funding sources and networks as their white counterparts and where they apply for funding they are less likely to succeed. Sia (1995) reports findings from an analysis of Lottery funding applications that found that less than 4% of the Lotteries Charity Board funding were allocated to Black communities. A direct consequence of a lack of resources is that it limits the capacity of Black organisations to develop organisationally. They have to negotiate more barriers with fewer resources (Walker and Ahmad, 1994). Such agencies encounter difficulties in developing effective systems of management, supporting staff development, contemplating service development, or introducing monitoring and evaluative procedures. The following quote sums this up:

"It is a constant struggle to develop our services, lack of sufficient funding being our main drawback." (Project Manager)

Black-led initiatives are subjected to unreasonable expectations from the mainstream. They are expected to survive with minimal resources and limited support to develop organisationally. A significant dilemma is the inappropriate use made by them of mainstream services. One particular organisation interviewed as part of the 'Breaking Circles of Fear' review, found it difficult to turn referrals away, because as one worker commented, "where will they go if we cannot see them?"

Survival in Black organisations depends to a great extent on personal goodwill, commitment to the ideals of the organisation, and positive working

relationships. When asked how they have survived in the face of perennial financial difficulties, a common response was, “the true commitment and compassion of staff members and volunteers...”. An example of this level of commitment is one organisation that recognises the high levels of social isolation experienced by services users. At key times when this may be heightened, e.g. Christmas and Easter, they organise a shared lunch for service users, their families and friends and staff as well. Both service users and staff have evaluated these social events positively.

A potential tension in the reliance on personal commitment and goodwill is that problems and differences are more often dealt with in personal terms rather than through rigid procedures and guidelines. Conflict is often difficult to manage or address and there can be a tendency to avoid conflict until it reaches critical proportions. The disastrous effect of this is that unresolved conflict becomes political and ordinary measures to resolve it are no longer useful. In such conflict individuals align themselves according to personal loyalties and often fail to view the difficulties in the broader organisational context. Conflict resolution may become incredibly difficult and painful. As a board member of a particular organisation, I was involved in a protracted case of unfair dismissal, which started with basic questions by the board to the director about structures and procedures of accountability. This sparked a rather acrimonious period in the life of the organisation. An independent reviewer of this case suggested that this would never have happened in a mainstream organisation.

In summary, Black-led initiatives are distinct from the mainstream in their genesis, agenda, culture, and philosophy. Such characteristics may be similar to those of, for example, women’s organisations.

Models of Service Provision

The philosophies and theoretical perspectives in Black-led initiatives are often implicit, therefore, the classification or categorisation of the models proposed here has mainly been derived from the social work literature.

Ethno-Specific Agency

This type of organisation offers services to a specific minority ethnic community. It aims to provide a culturally appropriate service through its practice and staffing arrangements (Christie and Smith, 1997). Staff are more likely to be knowledgeable about local needs and social traditions (Butt and Box, 1998). This model of provision is underpinned by a philosophy that argues that mainstream society or the dominant culture is racist and therefore Black service users need a ‘safe’ space where they can reclaim their culture and build a network that reflects their cultural traditions. The ethno-specific agency is driven by ideas aimed at developing Black consciousness, a sense of identity, and unifying respective communities (Sivanandan, 1991; Alexander, 1987). hooks (1994) refers to this kind of separation or splitting as seeking ‘a sanctuary.’ The ethno-specific agency is also, perhaps more implicitly, informed by a conflict model that is aimed at altering service provision by removing a eurocentric stance to affirm Black people in terms they define and present (Dominelli, 1988). A central organising feature or tenet of this model is ideas of self-help and self-organisation and how they have been used to establish alternative forms of service provision. Main themes or foci in services are anti-racism, cultural identity, empowerment, advocacy, support, participation and self-determination. One of the organisations interviewed in the SCM review held the view that a positive ‘Black identity’ is key to emotional well-being and this agency places considerable emphasis on providing opportunities for service users to explore and validate their identity. For example, they organise study tours to Africa and the Caribbean for service users to explore African history and traditions. These activities have been evaluated positively by both service users and staff as the following comment illustrate,

“It felt good to be in a place where I was no longer in the minority...”

Another service user comments,

“I like to come here, because I do not have to explain myself.”

Non-western thinking and ideas typically inform

the ideological and philosophical core of these types of services. The Fanon Trust in South London (now sadly taken over by a mainstream voluntary agency), for example, has adopted the ideas of Franz Fanon to inform its services (Keating, 1998). It aims to enhance social well being and offer a nurturing environment. The starting point in the service is recognition and validation of the individual's social and cultural context, thus providing an opportunity to incorporate the unique socio-historical experiences of individuals into service responses. Overall, the focus is on empowerment rather than problem solving.

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Another example is Isis, a name that was chosen because of its philosophical meaning and qualities that attempt to overcome stigma. Isis symbolises "independence, caring, power, nurturing, majesty and wisdom." The organisation works within an African-Caribbean framework that involves an "understanding and awareness of the history of African-Caribbean people, the effects of institutional racism, lifestyles and cultural awareness, a consciousness of the interactions between African-Caribbean people and the Black child in its psychological development." (Isis, undated: 1)

The ethno-specific agency typically faces some dilemmas. First, because of the bias towards social support and less traditional treatment approaches, their services are perceived as inferior to more traditional mainstream services. A member of staff in an interview commented, "...they (white organisations) see us as less professional and do not trust what we do." This means that these services are continually struggling to prove themselves and justify their style of working. Second, short-term funding is a perennial problem and leaves the organisation particularly vulnerable. Indeed, most organisations interviewed in the SCMH review reported that they have to adjust their services according to constantly changing funding criteria and availability. Third, separate service provision can contribute to a 'ghettoisation' of services, where all the solutions for meeting the mental health needs of Black communities are located in separate provision. This can lead to an insider culture where Black people are considered to be the only ones who can meet the needs of

other Black people. A particular drawback of this is that these services often function in isolation from mainstream services and their value is obscured. Working in isolation is also not a good position from which to support service development and evaluation. I would therefore argue that separate service provision should be viewed as one component of the spectrum of services available to Black people.

Multi-Cultural Agency

The defining characteristic of this type of organisation is that it is run by people from different ethnic and cultural backgrounds for a range of ethnic and cultural traditions. One such example is Nafsiyat Intercultural Therapy Centre in North London. Underpinned by notions of pluralism, the premise of the multi-cultural agency is that Britain is multi-ethnic and services should be configured to reflect this. It is informed by a belief in human universality (Kareem, 1992). Difference is viewed as a central characteristic in society, but this has to be understood in the context of universality, therefore, practitioners should be able to work with anyone (Kareem, 1992).

Kareem (1992: 20) further suggests that:

"...external social factors such as prejudice, racism, sexism, poverty, social disadvantage – all of which cause profound pain, perhaps most especially for Black and ethnic minority patients because of the situation they find themselves in – are real and must be taken into account as vital clinical concerns."

Central themes in service delivery are: working with experiences of racism on inter- and intra-psychic levels as well as in the broader societal context; valuing of difference, cultural sensitivity and empowerment. This type of organisation therefore offers an element of inclusivity and accommodates diversity. The level of diversity makes it easier to challenge stereotypes and counter the view that ethnic groups are homogenous. Multi-cultural agencies can also respond to a variety of needs by providing a wider choice of worker/therapist and a range of theoretical perspectives. Shared background by therapist and user may also serve to equalise power based on shared understandings, but can also be a

source of tension. The late Kareem (1992), a psychotherapist from an Indian background, for example, cites a case of an Indian man who, because they shared cultural and ethnic backgrounds, expected that he (the therapist) would solve all his problems.

A major dilemma for this type of agency is the continuing danger of marginalisation. For example, Nafsiyat has been operating for over ten years, yet there has been no indication that mainstream services will incorporate its services into its remit. As this service does not operate in the mainstream, it is not central to mainstream budget decisions.

Multi-agency Partnership

A more recent trend in service provision to Black and minority ethnic communities is to seek to establish partnerships across statutory and voluntary sectors and local Black communities. It has been suggested that partnerships can offer new ways of thinking about delivering services (Jennings, 1996). There are however, to date few examples of attempts at such partnerships between statutory services and Black communities and one can therefore only postulate about the merits of this model. Partnerships have been defined as "...a particular means of achieving the desired end, a means where aims, work, responsibility and power are shared." (Kemp et al., 1998:197). Ismail (1996) suggests that partnerships are the way forward in the current era of a mixed economy of care. The multi-agency partnership is usually seen as a collaborative project between mainstream services, the voluntary sector, users, families, carers, and representatives from the Black community to develop a service that will be responsive to the needs of Black and minority ethnic communities. The multi-agency partnership is underpinned by an ideological commitment to pluralism and theoretically informed by the mixed economy of care perspective as espoused in the NHS and Community Care Act (1990). It incorporates a world view that validates the socio-historical and cultural context of Black people. This is pertinent when one considers that mainstream service responses to Black and minority ethnic communities have been derived from the discourse of professionals (Williams, 1993). It can be argued

that central themes in this model of service are: partnership (joint working), consultation, citizenship, and consumerism and user involvement (Jennings, 1996).

Partnership can offer the opportunity to challenge inequality in the mainstream, because it locates the problem and its solution in a much broader organisational and societal context. Working in partnership means pooling resources and it can allow the building of a vision that is shared more broadly. Now that there are statutory requirements for user and carer involvement in planning care, partnerships can be used to facilitate this. Partnerships offer a situation of permanency, because funding is derived from central budgets. Through partnership arrangements one can ensure that the expertise of the voluntary sector is integrated locally and nationally (Bhui, 1997). It also offers opportunities for shared training, an area of particular need in the voluntary and mainstream sectors. Training can serve as a vehicle to share knowledge and information. In a climate of best value and quality, working in partnerships can help to develop uniform standards. Partnerships can also reduce the level of duplication and can help to map service need more effectively and match service responses accordingly (Ismail, 1996). Mapping service need should take account of demographic variations, user perspectives on need and response, carers' and family perspectives on need and also staff perspectives on need (Bhui, 1997). Overall, partnerships imply shared responsibility for service development, delivery and evaluation. Jennings (1996) and Phillips (1997) both offer descriptions of such multi-agency partnership initiatives. Jennings (1996), for example, describes the Sanctuary project that aims at providing 24 hour crisis services for African and Caribbean communities. The service was developed in consultation with Black service users, carers and a range of mental health professionals. A key challenge for this project was to develop a shared vision. According to Jennings (1996), this was attained by involving all identified partners in writing a business plan. The service is run independently, but works collaboratively with local primary, secondary health and social care professionals to offer appropriate services to Black people.

Partnerships unfortunately bring their own dilemmas. They are frequently flawed by fundamental inequalities pertaining to budgetary responsibilities and decision-making structures. Phillips (1997) demonstrates how a partnership was undermined when decisions were made outside formal decision-making channels. Balancing the demands of conflicting agendas of stakeholders can be problematic. For example, the challenge for Black communities, users, families and carers is how to get their voices heard and yet retain the autonomy and freedom from bureaucracy to continue the quest for services that will respond effectively to the particular needs of Black and minority ethnic communities.

Concluding Comments

The models outlined above each speak to different needs and constituencies, but I would argue that overall they make a contribution to meeting the needs of Black and minority ethnic communities. I believe that they all make valid contributions to challenging institutional racism and collectively can offer services that are accessible, available, flexible, and appropriate. These should be the standards to achieve.

Service developments addressing the profound and damaging impact of racism on the lives of Black people with mental health problems can largely be found in the Black voluntary sector. This paper reviewed some of the models of service provision that evolved in the process. It is clear that Black-led initiatives make a vital contribution to improving the plight of Black people with mental health problems and make a crucial contribution to the discourse on 'race' and mental health. Black-led initiatives in mental health are sources of examples of good practice in relation to Black people. However, a great deal of work still needs to be done to achieve a situation where Black people can have confidence in mainstream service delivery. Black services users; their families and carers continue to offer negative commentaries on mental health services (Keating and Robertson, 2002).

I would recommend that the way forward seem to develop partnerships between Black communities, voluntary and mainstream sectors. Partnerships

should help to reduce inequalities, not only those based on racial discrimination, but those on gender and other sources of inequality as well. Working in partnership can also provide opportunities for sharing skills, knowledge and competencies to overcome these inequalities. There are, however, a number of areas that need further research and exploration with regard to Black-led initiatives before we can proceed to develop effective partnerships. For example, our knowledge about the dimensions along which Black organisations vary is limited, service effectiveness has not been evaluated, and the constraints of practice in them have not been examined fully. Furthermore, whilst we lack a coherent strategy at national and local level (currently being developed by the Mental Health Task Force, DOH, 1999) to address issues of 'race' and mental health across all areas of health and social care there can be no real progress.

- (1) The term 'black' in this article refers to people from African, African-Caribbean and Asian backgrounds

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Table 1 Recent reports and initiatives relating to mental health needs of Black and minority ethnic groups in Britain

<p><u>1993: Mental Health and Britain's Black Communities report</u> Showed where Black and ethnic minority service users were dissatisfied with services.</p> <p><u>1994: Ritchie report</u> Highlighted a series of errors and omissions in the care of Christopher Clunis, a Black man with schizophrenia who stabbed Jonathan Zito to death. (The report found that his ethnicity had affected the assessment and management of his care.)</p> <p><u>1994: Mental Health Task Force</u> (London project and regional race programmes). Demonstrated dissatisfaction with services, as well as highlighting good practice.</p> <p><u>1994: Black Mental Health: A Dialogue for Change</u> Advocated a new way of integrating voluntary and statutory sector practice. Voluntary sector seen as valuable in managing mental illness among Black and minority ethnic service users.</p> <p><u>1994: NHS Executive letter EL (94) 77 on collecting ethnic group data</u> All service providers to collect data on service users' ethnic origins, to help assess which groups were using particular services and whether these groups' needs were being adequately considered.</p> <p><u>1994: Ethnic health unit established</u> Attempted to address the needs of Black and other minority ethnic users for physical and mental health care services. The unit had a short lifespan but initiated some important work.</p> <p><u>1995: Learning the Lessons</u> (Zito Trust report) Looked at all the homicide inquiries where the perpetrator was mentally ill and attempted to identify common lessons. Emphasised role of race and ethnicity of mentally ill people and looked at service shortfalls for minority ethnic groups.</p>	<p><u>1995: Mental Health: Towards a Better Understanding</u> (Health of the Nation public information booklet for ethnic minorities and their carers). Highlighted the plight of carers and their needs.</p> <p><u>1998/9: A First Class Service (Dept. of Health)</u> Advocated national service frameworks, which set standards of care with best quality and fair access. Highlighted inequalities in health care.</p> <p><u>1999: MacPherson Report</u> (Following the murder of Black teenager Stephen Lawrence and the failure of the criminal justice system to bring his murderers to justice). Highlighted institutionalised racism. The NHS (along with other public bodies) expected to examine its structures and services in the light of the report to eradicate racism.</p> <p><u>1999: The National Service Framework for Mental Health</u> (Department of Health). Set out national standards of care and measures for monitoring performance. It gave special emphasis to the cultural sensitivity of services for African and Caribbean ethnic groups, the assessment of Asian ethnic groups and the plight of socially excluded groups, such as refugees.</p> <p><u>2000: The NHS Plan</u> A key aim is to address inequalities in health, especially for people from minority ethnic communities.</p> <p><u>2002: The Race Relations (Amendment) Act 2000 and the EC Article 13 Race Directive</u> The Act places a general duty on public authorities to work towards the elimination of unlawful discrimination and promote equality of opportunity and good relations between persons of different racial groups.</p> <p><i>Adapted and updated from Olajide (1999).</i></p>
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