

AHPN

African Health Policy Network

Improving Health and Wellbeing

The Mental and Emotional Wellbeing of Africans in the UK

A research and discussion paper



AHPN: Improving Health and Wellbeing

The AHPN is the leading policy organisation that influences policy on the health and wellbeing of Africans in the UK.

We are a network of membership organisations and individuals with a common goal to improve the health and wellbeing of the UK's African population.

The AHPN acts as a focal point and catalyst for individuals and organisations in the African communities, providing platforms to share learning and experience, to influence policy and to speak with a collective voice.

Acknowledgements

This document was researched and authored by **Deryck Browne**, Research and Policy Officer, AHPN.

Thanks for additional input and support to: Jacqui Stevenson, Acting CEO and Head of Policy, and Rose Cook and Josh Babarinde, Policy Interns.

Feedback, additions and alterations were gratefully received from further colleagues and supporters.

Contents

Executive Summary	4
Introduction	6
Background	7
African Mental Health	8
Admission Rates	9
Ethnic Inequalities in the use of Mental Health Services	9
Difference, Disparity and Access	10
Policy and Strategy	11
The Myth of “Maladaptive Communities”	13
Psychiatric Models and Drivers of Inequality.....	13
Solutions	14
Discussion	14
Themes from the Research.....	16
Emotional well being.....	16
Seeking help.....	18
Determinants of Health and Wellbeing.....	19
Lived Experience.....	20
Favoured Terminology.....	21
Accessing Services	22
Improving Wellbeing	24
Conclusions and Recommendations	27
Bibliography	29

Executive Summary

The burden of mental health weighs heavy on society in general and on African and black people in the UK in particular. It is the largest single cause of disability in the UK at a cost of £105 billion each year (Her Majesty's Government/Department of Health, 2011). 1 in 4 people will experience some form of mental health problem (Mental Health Foundation, 2013a). Against this backdrop of general population risk, African people face even higher risk, with for example a significantly increased risk of suffering a psychotic disorder compared with non-Africans (Sharpley et al., 2001).

Differential treatment of Black and Minority Ethnic (BME) people coming into contact with mental health services has been well documented, as have the issues around access to services, coercive pathways, and negative experiences of care. These have been borne out not only by the monitoring reports of bodies such as the Care Quality Commission and the various Inquiry reports on the treatment and care of Black individuals who have passed through the hands of the mental health system, but also by the multitude of smaller studies which show bias, disproportion and discrimination (Nacro, 2007)

There has been some response. 'No Health Without Mental Health' the Government's mental health strategy has as its aim provision of high quality services accessible to all. It situates mental health squarely in the community as 'everyone's business' and focuses on well-being and prevention. And the NHS Commissioning Board has the objective of placing mental health on a par with physical health, thereby closing the gap between people with mental health problems and the population as a whole and achieving the goal of 'parity of esteem' for physical and mental health (Her Majesty's Government/Department of Health, 2011).

In parallel forums the debate continues as some authors persist in shifting the focus towards discussion of dysfunctional communities, away from the appropriateness and efficacy of services towards the failings of particular groups of service users. Authors such as Sewell have argued that health care service delivery systems which have as their focus symptoms and cures with little focus on disease manifestation arising from individuality are likely to have an adverse impact on those with protected characteristics, including those from African communities. Options such as the 'locked hexagon model' (Sewell, 2012) provide solutions for an altogether more holistic approach, which chimes with the responses from our completed questionnaires received from 100 individuals from the African communities.

This survey was conducted to explore the views and experiences of African people in relation to mental health. The survey was designed to allow a greater understanding of how mental health and wellbeing issues are interpreted by African people in order to provide a greater and more nuanced insight into how the challenges associated with mental health and BME communities might be better addressed. The findings of the survey are presented in this report, which also incorporates the findings of desktop research to present a baseline on African people and mental health.

The overall findings of our questionnaires indicate that:

- Financial concerns and worries were a principal trigger for individuals' mental health and wellbeing problems
- A high percentage of respondents (over 50%) said that they would look outside of the family (i.e. to work, community or faith colleagues) for mental health and wellbeing support
- Over 30% of respondents had lived experience of a personal mental health problem and over 60% had contact with someone with lived experience
- The term 'emotional health and wellbeing' was the term a high percentage (over 60%) of respondents chose to describe their feelings and emotions
- 68% of respondents had not accessed statutory services at all, and 77% had never utilised community services
- Respondents emphasised the importance of faith groups in supporting those with mental health and wellbeing issues

Based on these findings, we put forward these recommendations:

1. In line with its focus on patient-led services, the Department of Health should support access to a range of psychological therapies and support, based on individual need and cultural appropriateness, with a particular focus on the distinct needs of diverse communities and population groups.
2. There needs to be a keener focus on the risk factors for mental health in African communities, such as immigration issues, financial problems and employment. Addressing these factors should be a key element of any strategy to improve mental health and wellbeing.
3. Additional funding, resources and support for community and voluntary sector mental health and non-specialist organisations is necessary in order to support these to meet the diverse needs of Africans affected by mental health problems. This should include support to address cultural and religious beliefs about mental health. Provision should be made for support and therapies to be provided by non-traditional providers including community, third sector and faith groups.
4. Greater detailed research should be commissioned into the mental health needs of African people and the steps that need to be taken to address any emerging anomalies.

Introduction

This report is designed to both provide baseline information and to stimulate discussion on issues concerning mental health and emotional wellbeing in the UK's African communities. We were particularly interested to understand how individuals in the African communities interpreted, expressed and addressed mental wellbeing issues, what their views were and what they thought might be improved in respect of mental health service provision. Over a one year period African Health Policy Network member organisations encouraged individuals with whom they were working or were in contact to complete an online or hard copy survey on mental health issues. Participation was voluntary and anonymous and one hundred responses were received (online and hard copies).

In addition, and as an important backdrop, it was considered useful to contextualise these with desk based research and literature review, to enable discussion of current mental health issues in relation to African communities. The findings of this are presented in the background section of this report.

Information was distributed via the AHPN membership detailing the research and what it was hoped would be achieved through it. Online surveys (constructed on the web based research programme Survey Monkey) were distributed across the breadth of the membership. Hard copies were distributed where requested. Participation was voluntary and respondents were assured that their contributions would remain anonymous. Responses were analysed statistically and, where data was textual, verbatim text was considered.

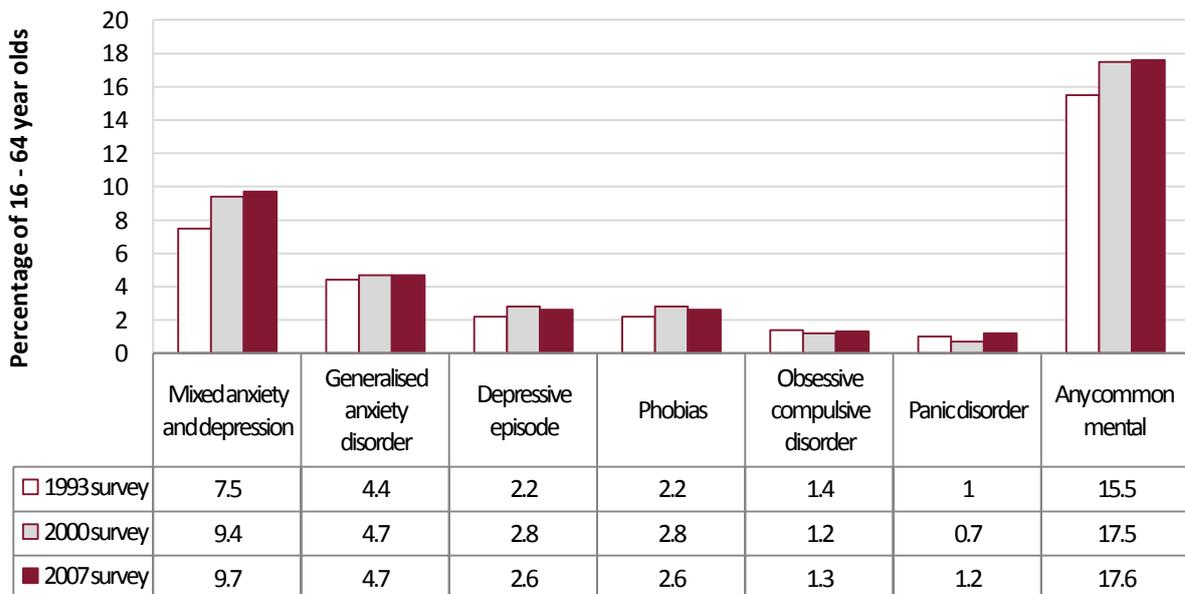
The research for this study was carried out over a one year period (August 2011-July 2012). As The African Health Policy Network is an umbrella organisation comprising of a membership of over fifty affiliated community based and charity organisations nationally, it was to these organisations that the research questionnaire was distributed. One hundred responses were received, although not all respondents answered all questions. We have made clear the actual numbers responding to each, although numbers of those abstaining questions were small and do not appear to significantly alter findings. Responses were completed online and through hard copy. Sixty-one hard copy responses were received, mostly from two localities (Leicester and Nottingham). Hard copy respondents were afforded the opportunity to provide greater detail on questions 6 and 7. They only chose to do so on question 6 and where these responses are being discussed this is made clear.

Background

Mental health is the largest single cause of disability in the UK. It constitutes almost 23% of the overall burden of disease. The economic and social costs of mental health problems are estimated at approximately £105 billion each year (Her Majesty's Government/Department of Health, 2011). Not surprisingly then, mental health problems are common. One in four people will experience a mental health problem each year with anxiety and depression being the most common mental illnesses (Mental Health Foundation, 2013a).

A wide range of conditions come under the label of 'mental ill-health' and consequently a range of interventions and treatments are necessary to address them, and in a range of settings. Most mental health symptoms have traditionally been divided into either neurotic or psychotic symptoms: the neurotic covers those symptoms regarded as extreme forms of normal emotional experiences such as depression, anxiety or panic. Previously called neuroses these are usually termed 'common mental health problems' (Mental Health Foundation, 2013b).

Prevalence of Common Mental Health Problems



(Adapted from Health and Social Care Information Centre, 2009, Adult psychiatric morbidity in England, Results of a household survey [Table 2.4, p.41])

Psychotic symptoms are less common, and encompass symptoms that interfere with an individual's perceptions of reality. While the more common anxiety and depression affect one in ten people at any one time the rarer and more severe forms of mental illness such as schizophrenia and bi-polar disorder will impact on one to two people in every one hundred in the UK (Mental Health Foundation, 2013b). Schizophrenia affects a persons' thinking and can consequently alter their perception of reality, emotions and behaviour. Onset for Schizophrenia usually occurs in late teens or early twenties (Mental Health Wales, 2013).

African Mental Health

A 2004 study of neurosis and psychosis in ethnic groups in Great Britain found that Africans were at significantly increased risk of a psychotic disorder compared with non-Africans (Brugha, Jenkins, Bebbington, Meltzer, Lewis, & Farrell, 2004). African and Caribbean men in particular are over-represented at the acute end of mental health services with disproportionate diagnoses of psychotic disorders or serious mental health problems (The Sainsbury Centre for Mental Health, 2002). Also, men in general may find it more difficult to seek help for mental health problems and African men are no different in this respect.

Mental health among young people is increasingly associated with life chances and linked to issues of deprivation and disadvantage. Unemployment amongst young black men is significantly higher than for other groups and is recognised as a significant risk factor for depression in men (Royal College of Psychiatrists, 2010a).

Specific elements of the immigration system, particularly immigration detention, can have severely negative impacts on mental health and wellbeing. The immigration process is inherently stressful, producing isolation, uncertainty and inactivity which can in turn lead to poor mental health. Research has highlighted that refugees and asylum seekers are poorly served by mental health services whilst simultaneously at greater risk from stress, anxiety and depression (Nacro, 2010).

Elders of African and Caribbean descent are also at an increased risk of suffering mental health problems and specifically dementia (Livingston et al., 2001). High blood pressure, diabetes, stroke and heart disease are risk factors for dementia and these are more common in African and Caribbean communities (House of Commons All Party Parliamentary Group on Dementia, 2013). Awareness of dementia and depression among African older people is low and assumptions may be made by medical professionals about family care leading to lack of appropriate information and support. The risk of dementia amongst BME elders who do not speak English appears to be higher than figures for the general community (Royal College of Psychiatrists, 2009) (AHPN, 2013).

The differential treatment of black and minority ethnic people who come into contact with the mental health system is generally well documented. These experiences are compounded by the fact that people of African descent in the UK are more likely than white counterparts to be considered in need of mental health treatment and care (Mind, 2013b). The links between discrimination, disadvantage and poor mental health have also been well documented in research (Sewell et al., 2012). And moreover, the pathways that African communities take to access that care are very often more of a coercive pathway than other communities, for example via the criminal justice system, the immigration and asylum process and the civil sectioning process (Nacro, 2007).

Admission Rates

Admission rates to psychiatric units and rates of mental health detention continue to be higher for Black African, Black Caribbeans and Black Other groups than for other population groups (Mind, 2013b). The 'Count me in' censuses showed men from these groups were three times more likely than the general population to be admitted to psychiatric units, and more likely to have been detained under the Mental Health Act (Mind, 2013b).

A 2007 study found that the age-standardised rate of trauma in adulthood varies by ethnicity but has been noted as highest in black men (45.7%, compared with 36.0% of white men and 29.3% of South Asian men). Black men are also more likely than men in other ethnic groups to screen positive for current PTSD. This is not just as a result of a higher rate of trauma: their conditional probability of PTSD has also been reported as high (16.3% compared with 7.5% of men overall) (National Centre for Social Research & Dept of Health Sciences, University of Leicester, 2007).

The age standardised prevalence of psychotic disorder has been found to be significantly higher among black men (3.1%) than men from other ethnic groups (0.2% of white men) (McManus S, Meltzer H, Brugha T et al, 2009).

Drug dependence varies with ethnicity and income. Amongst males, black men have been found most likely, and South Asian men least likely, to report symptoms of dependence. The same pattern has been seen for women (Health & Social Care Information Centre, 2007).

Mental health services for black men, especially young black men, represent a particular concern, especially given the impact of unemployment on mental health. More black men in the UK are unemployed than any other demographic group with black men being more than twice as likely to be unemployed than white counterparts (Trades Union Congress, 2012). According to a 2012 report from the Office of National Statistics; Labour Force Survey, the overall unemployment rate for all people in the UK was 8%; among black people it was 18% (Rhodes, 2012). When stratified by age, however, the numbers are even more telling: the unemployment rate among young Black/African/Caribbean/Black British men aged 16-24 is a full 45%, compared to the overall rate for this group, 22% (Trades Union Congress, 2012).

Ethnic Inequalities in the use of Mental Health Services

Recent studies have set out to explore whether the minority ethnic population is *less* likely to receive treatment for mental health problems than the white population, despite evidence of over-representation in admissions. An analysis of data from 23,917 participants in the 1993, 2000 and 2007 National Psychiatric Morbidity Surveys, found: "Black people were less likely to be taking antidepressants than their white counterparts were (Odds ratio 0.4; 95 % confidence interval 0.2-0.9). After controlling for symptom severity and socioeconomic status, people from black (0.7; 0.5-0.97) and South Asian (0.5; 0.3-0.8) ethnic groups were less likely to have contacted a GP about their mental health in the last year" (Cooper et al., 2012).

A 2002 report found that there were particular barriers (what were termed 'circles of fear') that came between African and Caribbean communities and mental health services (The Sainsbury Centre for Mental Health, 2002). These barriers prevent people seeking treatment and support, and thereby risk increasing severity of mental illness and compounding fear in accessing services. The main findings of the 'circles of fear' research are quoted in the table.

Breaking the circles of fear, (quoted from The Sainsbury Centre for Mental Health, 2002):

1. Circles of fear prevent black people engaging with services. Staff see service users as potentially dangerous and service users perceive services as harmful.
2. Mainstream services are experienced as inhumane, unhelpful and inappropriate: Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well integrated with the community.
3. The care pathways of black people are problematic and influence the nature and outcome of treatment and the willingness of these communities to engage with mainstream services: Black people come to services too late, when they are already in crisis, reinforcing the circles of fear.
4. Primary care involvement is limited and community-based crisis care is lacking.
5. Acute care is perceived negatively and does not aid recovery.
6. There is a divergence in professional and lay discourse on mental illness/distress: different models and descriptions of 'mental illness' are used and other people's philosophies or worldviews are not understood or even acknowledged.
7. Service user, family and carer involvement is lacking.
8. Conflict between professionals and service users is not always addressed in the most beneficial way: the concept of 'culture' has been used to attempt to address some of these issues, but can divert professionals away from looking at individual histories, characteristics and needs.
9. Black-led community initiatives are not valued: secure funding and long term capacity building initiatives are absent.
10. Stigma and social inclusion are important dimensions in the lives of service users.

Difference, Disparity and Access

According to the Mental Health Minimum Dataset 2011, the rate of access to mental health services, adjusted for age and sex, is 3733 per 100,000 population for the Black and Black British group, compared to a rate of 2789 for all groups. Black Africans had the highest rate of access to hospital inpatient care for those in contact with mental health services, at 16.5 per 100 mental health service users, compared to 8.5 in the White British Group. 19.5% of people on a Supervised Community Treatment order under the Mental Health Act at the end of 2011 were Black or Black British (NHS Information Centre, 2011).

In terms of individuals detained under the Act, all ethnic groups showed small increases between 2009/10 and 2010/11, but the Black and Black British group showed the largest increase (by 4.9%). According to the *Count Me In* census 2010, 23% of people receiving in-patient mental health care were ethnic minorities, with admission rates to hospitals at least two times higher for Black Africans in 2010 (Care Quality Commission 2011).

The report by the CQC, '*Monitoring The Mental Health Act in 2011/12*' found continued very high rates of detention for Black patients under the Mental Health Act. The Commission's third annual report focused on the dignity, involvement, care and recovery of people subject to the Act but like previous 'Count Me In' censuses and Monitoring Reports before it, found a continued trend of disproportionately high detention rates amongst Black communities (Care Quality Commission 2013). The key findings illustrated that:

- Detention rates were particularly high for Black African, Black Caribbean, Other Black and Other Asian groups with rates 2-13 times greater than expected
- Hospitalisation rates for voluntary patients were higher than average for Black African, Black Caribbean and Other Black groups

The report also showed that the broad group represented by the 'Mixed, Black and Other' category had higher rates of access to the full range of secondary mental health services, including those provided outside hospital compared to other groups. This makes the gross disproportions in respect of compulsory detention even more disturbing.

In addition, the figures for treatment under Compulsory Treatment Orders (CTOs) gave cause for concern with people from the Black and Black British groups making up 15% of the CTO population, compared with 2.9% of the general population and 9.7% of the inpatient population. (Care Quality Commission, 2013)

Policy and Strategy

The government's mental health strategy, 'No Health without Mental Health', published in February 2011, set out a strategy for both improving the mental health and wellbeing of the population in general, and improving outcomes for people with mental health problems through high quality services that are accessible to all (Her Majesty's Government/Department of Health, 2011). The

strategy outlines a new and more holistic approach to mental health that situates it squarely in the community and states that it is 'everyone's business'. It advocates focusing more on wellbeing and the prevention of mental illness than severe psychotic illnesses, and taking a 'life course approach'. (Her Majesty's Government/Department of Health, 2011)

Clearly treating mental and physical health conditions in a coordinated way, and with equal priority, is essential to supporting recovery. Yet people with mental health problems have worse outcomes for their physical healthcare, and those with physical conditions often have mental health needs that can go unrecognised. The recently established NHS Commissioning Board has as an objective to place mental health on a par with physical health, and to close the health gap between people with mental health problems and the population as a whole (Department of Health, 2013). The Commissioning Board has mapped out that by March 2015 it expects to see measurable progress towards achieving true parity of esteem, where everyone in need has timely access to evidence-based services. This will involve extending and ensuring more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people, and for those out of work. The IAPT programme has been set up to support services to deliver increased access to Cognitive Behavioural Therapy and other psychological therapies in primary care to tackle anxiety and depression (NHS, 2012). IAPT aims to provide universal access to psychological therapies in primary care. Political support and increased funding has led to an expansion of the programme. Uptake and access differs between communities, but generally there is low BME take-up and access to the programme remains problematic. Lack of adequate or effective collection or monitoring of ethnicity data, compounds an already difficult scenario.

The Commissioning Board has agreed to play a full part in delivering the commitment that at least 15% of adults with relevant disorders will have timely access to services, with a recovery rate of 50% (Department of Health, 2012).

Alongside government policy, there are the ongoing campaigns such as 'Time to Change', a national anti-stigma campaign, coordinated by MIND and Rethink Mental Illness, and funded by the Department of Health and Big Lottery Fund. The efficacy of such initiatives can often be difficult to gauge but in respect of mental health stigma TTC reports:

- There has been a 3% increase in the numbers of people with mental ill health reporting no discrimination in their lives, and a significant 11.5% reduction in the average levels of discrimination reported in 2011 compared to 2008
- There has been a 2.4% improvement in public attitudes towards people with mental health problems since the launch of Time to Change.
- According to evaluation of Time to Change by the Institute of Psychiatry, King's College London, there is a clear and consistent link between awareness of the Time to Change campaign and improved knowledge, attitudes and behaviour around mental health (Time to Change, 2013).

Recognising that stigma and discrimination play a significant part in the BME experience of mental health the Time to Change campaign has developed a focus on BME communities within its funding rounds, to support targeted projects.

The Myth of “Maladaptive Communities”

Environmental triggers for mental ill health in BME people with genetic predispositions have been given significant prominence by some mental health commentators. These may include absentee fathers, curtailed freedom for women, poor understanding of mental health issues and stigmatisation of mental illness. Taken together with relatively high poverty and urbanisation, such factors, it has been argued, conspire to increase stress, reduce coping strategies and eventually induce psychosis (Sewell, 2012).

But the “maladaptive communities” thesis is incomplete. It correctly emphasises the effect of stressful life events on one’s mental health, but it fails to take into account the impact of interactions between white and non-white communities. Furthermore, it does not address the notion that the effectiveness of healthcare professionals at engagement and service provision can vary according to the ethnicity and culture of end-users (Sewell, 2012).

It has been argued that the diagnoses of psychiatric disorders can be affected by the “dangerous other” stereotype i.e. that the beliefs and behaviours of non-white people are sometimes pathologised as a manifestation of mental illness. Racial disparity in diagnosis and compulsory treatment can be seen as an outcome of benign professionals, it is thought, working normally, but according to professional precepts that are inherently discriminatory (Sewell, 2012).

Psychiatric Models and Drivers of Inequality

Sewell also argues that service delivery systems in healthcare which focus on symptoms and cures, without reference to the variability in disease manifestation arising from individuality, are likely to have adverse implications for people with protected characteristics, including those from African communities. The use of traditional biological models in psychiatry is one such example. This practice has been subject to legal and cultural ‘pushback’ and a bio-psychosocial model of mental illness has burgeoned as a result (Sewell, 2012). The modern approach that has emerged is a combination of biology, psychology, social intervention, talking therapy and engagement with patients with regard to treatment decisions. The aforementioned “Improving Access to Psychological Therapies” programme has also played a part in contributing to this development (Sewell, 2012).

The Department of Health has conceded that there is an undue emphasis on coercive models of treatment on black patients with ‘organisational requirements, often taking precedence over their individual needs’. Historically, and currently, figures have shown that black people are over-represented at each heightened level of security in the psychiatric process from informal to civil detention and then in detention on forensic sections of the Mental Health Act within the criminal justice system (Nacro, 2010). There have been progressive developments, such as the Delivering Race Equality in Mental Health Programme that ran for five years from 2005, which proved useful in that it helped usher in a new focus in the race and mental health debate. In keeping with authors such as Fernando and Keating it debated issues such as disproportion not in terms of deviancy, dangerousness and genetics but looked to social and cultural explanations in line with concepts of institutional racism (Nacro, 2010).

And in February 2011 the aforementioned 'No Health Without Mental Health' stated that the focus of future work in this field should include the addressing of:

- Inequalities that lead to poor mental health
- Inequalities that result from poor mental health
- Inequalities in service provision (Her Majesty's Government/Department of Health, 2011).

This was welcome for, as Sewell points out, the evidence is that social disadvantage is the key driver of ethnic inequalities in mental health. (Sewell, 2012).

However, the overall general trend of BME disproportion and disadvantage persists. The final 'Count me in' Census showed that little progress had been made despite varying initiatives during recent years. In some cases there had actually been a widening of variations by ethnicity; compared to 2005 rates of detention have actually increased for Black African groups (Care Quality Commission, 2011).

Solutions

Sewell's 'Locked Hexagon' Model provides a six point treatment strategy for BME patients which can be successful when applied simultaneously and in the same locality (Sewell, 2012). When just one component of the 6-point treatment strategy is absent, care quality in that service delivery system will suffer disproportionately it is argued.

The Model Components (Sewell, 2012):

- **Specific targets for improvement in key areas**
- **Carer and community engagement**
- **Knowledge and skill development for staff and managers**
- **Promotion of employment, training, volunteering, education**
- **Use of narrative approaches**
- **Service users as experts in shaping services**

This theory is an evolution of the McKinzie 7S model, a popular and storied management strategy which is predicated on simultaneous improvement to seven key elements of business performance. This precedent is promising and the premise is plausible, but to substantiate the Locked Hexagon Model claim it is necessary to measure patient outcomes in service delivery systems which lack some of the components listed above. Statistical analysis can then establish whether or not the simultaneous application of every part of the Locked Hexagon Model causes additive or multiplicative improvements in treatment. Even if the Locked Hexagon Model amounts to more than the sum of its parts, the magnitude of the extra benefits available should be quantified and compared to the financial costs of implementation (McKinsey Quarterly, 2008).

Discussion

The relationship between racism, stress and mental ill health is well established in the literature. The manifestations of racism are varied, but they are all independently linked to negative health

outcomes. It amounts to a disease predictor and can be interpersonal, institutional or systemic (Sewell, 2012). It can be argued that remarks and violence do not necessarily need to be directed towards an individual for his/her mental health to be affected. The cumulative effect of low-level, intangible remarks and actions can also be damaging. Pervasive racism can cause people from the BME communities in question to identify “false positives”, exacerbating the problem (Sewell, 2012).

Even where staff members at a health service delivery system may have BME backgrounds, the perception that the institution itself is imbued with intrinsic racism in its policies, technology and decision making can cause meaningful health problems (Karlsen, 2002).

The evidence suggesting a link between racism and mental ill health is compelling, and we need to better understand the sometimes subtle nature of this health threat with greater sophistication. Institutional racism can invade interactions, it has been argued, between two non-racist parties. The result is that the non-white service user can indeed feel endangered. And amidst all of this the voice of the service user must be heard. The concept of user involvement is vital, and indeed lies at the heart of the Government’s vision for the strategic commissioning of services. By involving users, it is hoped and presumed that such commissioning will result in high-quality services that adequately reflect user need. However, listening strategies have to be thoughtfully put into place and sections of the community who historically have not been heard, for example African service users, must be reached (Schehrer & Sexton, 2010). A recent study by Mind (Mind, 2013a) explores the concept of ‘reverse commissioning’ which has at its cornerstone a need for real partnership between service users and commissioners, based upon commissioners being better informed and educated about BME service users, their needs and how to engage; and simultaneously BME service users being enabled, empowered and encouraged in the use of their knowledge when it comes to development and commissioning of services for them (Mind, 2013a).

Themes from the Research

Our research survey sought to elicit the views of people from African communities on the issues of mental health and well-being. It was completed anonymously in hard copy or online. The ten questions posed covered a range of issues. These included:

- The causes of emotional distress
- Where people turned for help
- What factors individuals associated with mental difficulties
- Whether individuals had lived experience
- What terminology individuals preferred to describe their feelings
- Whether individuals had used state-provided mental health services

There were also additional and open-ended questions about what factors could improve mental health and well being in the African communities.

Emotional well being

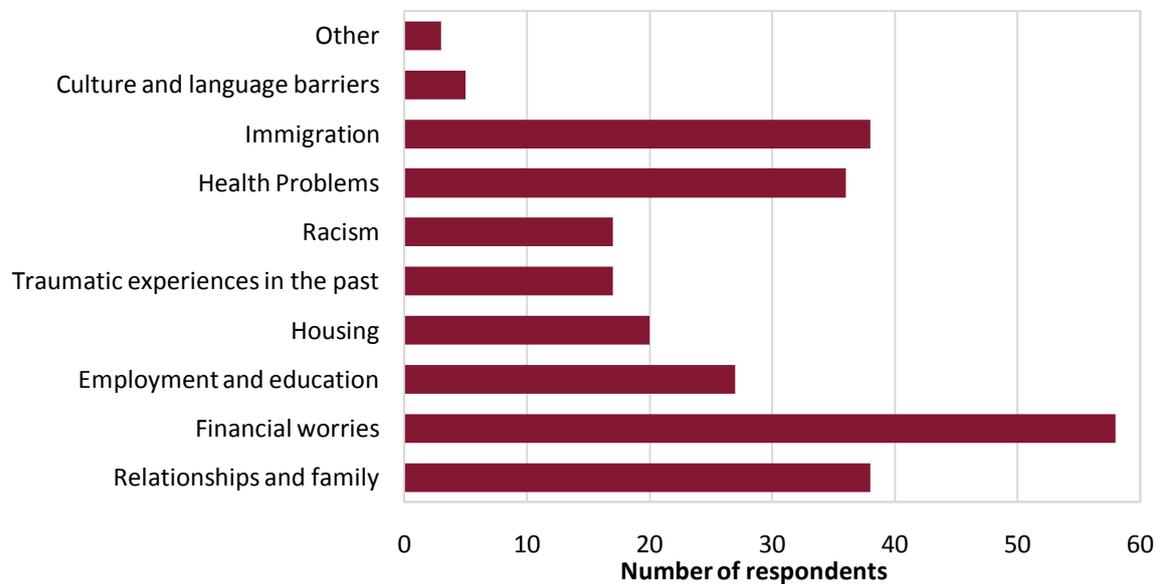
There are several wide ranging risk factors that may be associated with mental wellbeing and poorer mental health outcomes. These can be summarised as:

- The incidence or the impact of adverse life events and experiences e.g. abuse, relationship breakdown, long term illness or disability
- Social isolation and exclusion, economic disadvantage
- The impact of deprivation and structural inequalities in health

In keeping with the above our survey of one hundred individuals cited financial worries as the primary cause of emotional distress, with almost 60% of respondents identifying this (Table 1). Relationships with family, immigration and health problems were mentioned by just under 40% of respondents. The other significant causes of distress given were employment and education (28%) and housing (20%). Traumatic past experience, racism and cultural/language barriers were all mentioned although by less than 20% of respondents.

The interwoven nature of causal factors cited is instructive. Financial worries as a key determinant might stem from a range of sources to do with employment, immigration status, health status etc and so may be masking the preponderance of some or other of the factors cited less frequently. But that respondents choose to express the more common roots of distress in this way is significant as it speaks to the fears, insecurity and stress over money issues and the instability this can bring for individuals and families. There may also be complicating factors. The migratory experience may often have been a stressful one and perhaps one not easily re-visited; nonetheless it was a significant factor at almost 40%.

Table 1
In your opinion what are the most common causes of emotional distress?
 (Respondents selected two answers)



The risk factors for mental health for BME populations will of course for the most part be the same as for the general population, but with compounding factors. Studies show that racism contributes to mental distress and leads to feelings of isolation, fear, intimidation, low self-esteem, anger and an increase in negative life events which can in turn lead to greater stress (Karlsen et al., 2005). Numerous studies also show that the immigration detention process and the criminal justice system can act as a gateway to mental health services for black people and indeed the adverse routes sometimes taken will have implications for the type of services engaged and the levels of security imposed (Nacro, 2010).

Economic disadvantage has been described as involving some or all of the following:

- Material deprivation
- Exclusion and discrimination
- Educational attainment
- Employment/unemployment/security and quality of employment
- Environmental factors/quality of living and working surroundings
- Adverse life events, financial problems and debt worries

Historical data shows that African communities are more likely to be at risk of poverty and social exclusion and it is recognised that these, along with stigma, prejudice and discrimination create a hostile and stressful environment that can lead to an increase in mental health problems (Meyer, 2003). The strength of the causal relationship between risk factors and mental wellbeing will vary, so no relationship can be assumed. And generally risk factors are fluid and cross-cutting. However, the results of the survey bear out the breadth and complexity of the causal factors associated with emotional distress in the African communities.

Seeking help

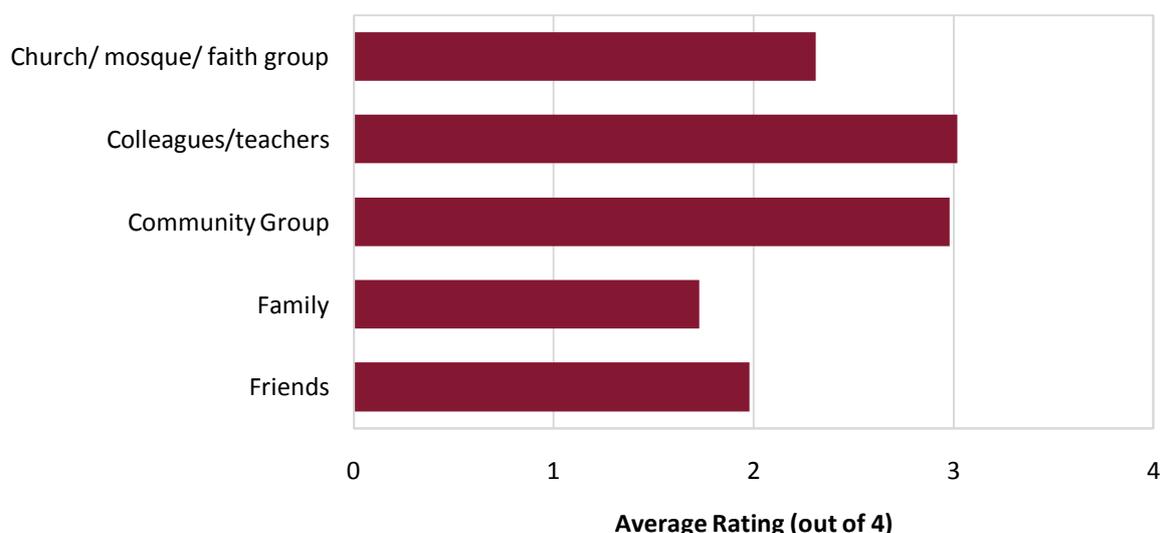
People suffering from mental health problems, even where these are severe, often do not seek professional help (Bebbington et al., 2000). There is little work done in this area (particularly in response to lay sources of help) and even less which breaks findings down by ethnicity. In a large scale study Bebbington found that study respondents' preferred sources of help were lay support networks such as friends or relatives (Bebbington et al., 2000).

The interesting factor relating to the responses from our survey was that individuals undoubtedly exhibited a preference for looking 'outside' of the family/friends network when looking for support for their well-being and emotional problems (Table 2). 60% responding said that they would 'most likely' turn to colleagues or teachers, and a similar percentage said that they would look toward their community group. Almost 50% said that they would look to their faith group, church or mosque for support. Less than 40% said that they would turn to friends and a smaller number said they would turn to family members.

Table 2

Who do you usually turn to when you are feeling low, anxious, or troubled? Rank the following sources of support from 1 to 4

(1 = most likely, 4 = least likely)



The results here show the potential isolation that exists for African individuals with mental health problems, and illustrates the impact of the problem of stigma and exclusion. The stigma attached to any suggestion of mental ill health can profoundly influence a decision whether to acknowledge, or indeed disclose, the problem and seek treatment, or to try to conceal it. The fear of being labelled 'mad' and consequently "shunned by family and friends leads some people to try to appear normal and untroubled" (BME Health Forum, 2013). In some communities psychological stress is seen as 'madness' and "madness' is seen as incurable", the implication here being that there is actually little to be gained from seeking treatment; and exclusion from community and wider society becomes therefore a very real possibility (BME Health Forum, 2013).

Qualitative research carried out at the local level has indicated that members of BME communities may not declare mental health problems for fear of being labelled or isolated, or even because they do not wish to bring shame upon families (The BME Health Forum and the Migrant & Refugee Communities' Forum, 2005).

Social exclusion can be both a risk factor for, and a consequence of, mental ill health, and have a significant impact on where individuals choose to seek the help that they need. As mentioned above, members of BME communities may often have their experiences compounded by poverty, unemployment, poor housing and a lack of support from statutory services (Bebbington, et al., 2013). Research has found that people living in the most economically deprived wards were more likely to consult their GP rather than others such as friends and family— possibly due to weaker support networks, or having more free time to do so perhaps due to lack of employment opportunities (Bebbington, et al., 2013).

Determinants of Health and Wellbeing

Stress is defined as the way one can feel when under abnormal pressure, and many types of situation can cause stress. The most common tend to involve work, money, relationships or major life events such as divorce, unemployment, moving house or bereavement (Mental Health Foundation, 2013c).

For some of those of African descent in Britain there may also be the compounding factors of immigration and, in many cases, poverty. In the findings of our survey nearly 70% of respondents claimed that excessive worrying was linked to mental health difficulties (Table 3). It is difficult to assume causal linkages here but certainly there remains a need to further interrogate these exploratory findings. A similar number cited sleeping problems as a connected factor. Almost 60% cited addiction, of one form or another, as being linked to mental health and similar numbers mentioned anger issues. Factors which were not considered as of similar significance were hallucinations and auditory hallucinations (at 40% and 30% respectively).

Although aspects of racism and discrimination cut across many of the responses raised, it was also sometimes raised as a 'stand alone' factor: When asked open ended questions about what might improve the mental health of individuals two respondents commented:

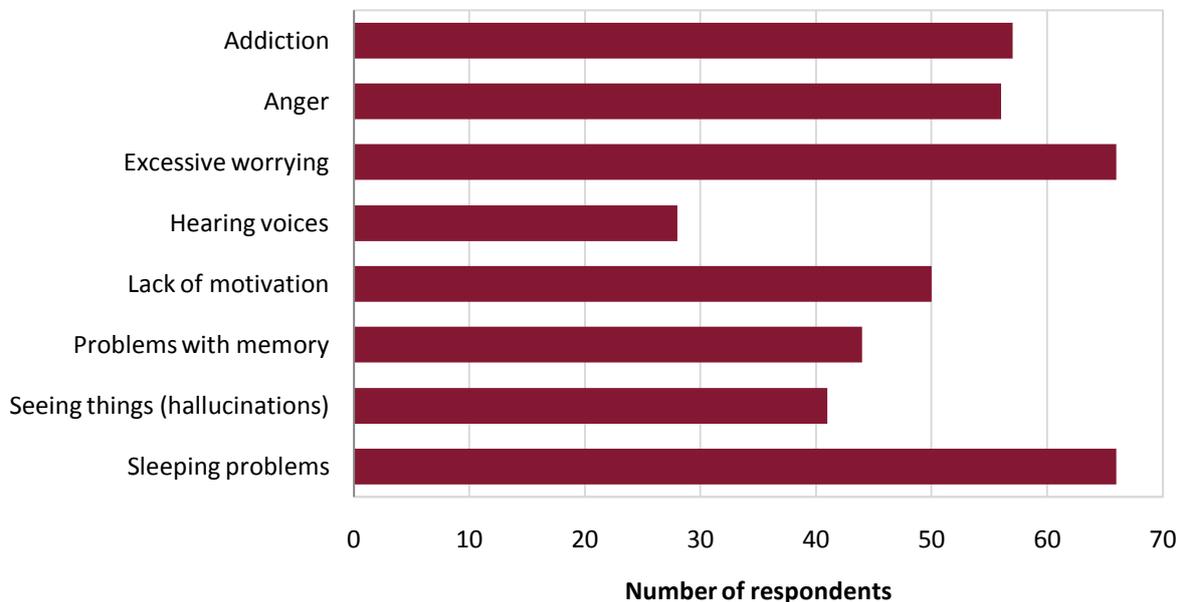
“a non-racist community and Government....less racism, sexism and homophobia”

“Acceptance as part of society...reduce racism and discrimination”.

Table 3

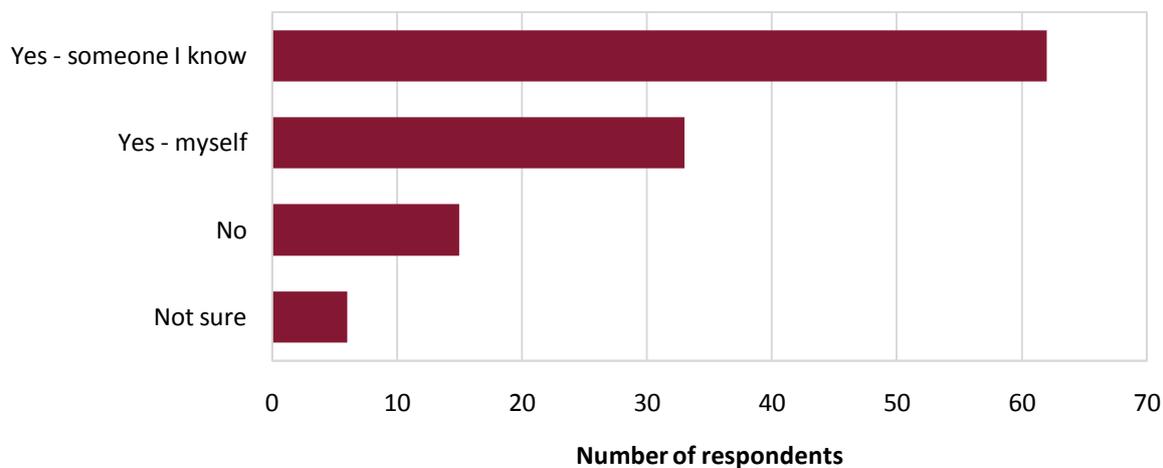
Which of these do you think could be connected to mental difficulties?

(Respondents selected all answers that were relevant to their understandings)

**Lived Experience**

The majority of respondents (63%) said that they knew of someone with a mental health or an emotional problem. 36% answered affirmatively but in relation to their own lived experience.

Table 4

Have you, or somebody you know, ever experienced mental or emotional difficulties?

Favoured Terminology

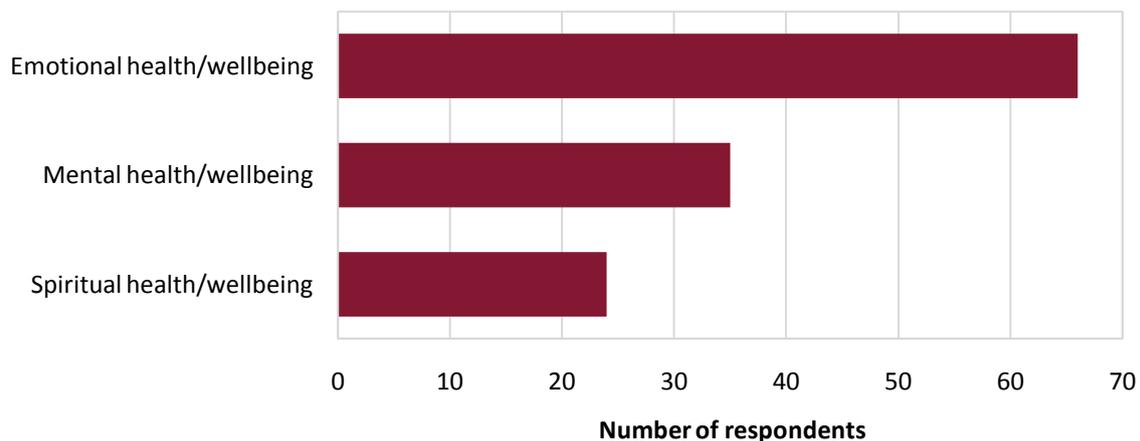
We asked people which phrase they felt most comfortable with when referring to their feelings and emotions (with the selection being mental health/wellbeing; emotional health/wellbeing; and spiritual health/wellbeing) (Table 5). The responses demonstrate that 66 respondents (68.04% of the 97 people who answered this question) prefer the term 'emotional health/wellbeing', just over double the amount that preferred 'mental health/wellbeing'. The popularity of the first choice may possibly suggest that 'emotional health/wellbeing' encompasses a wider range of problems, including more common emotional stresses, as well as more serious, medical mental disorders. To identify with the phrase 'mental health' is perhaps to imply something more serious and medical, whereas 'emotional health' might appeal as a more universal term. The stigma surrounding 'mental health' may also have an impact on this choice but the detail of the responses does not allow us to posit this with any certainty.

That about a quarter of respondents (24 people; 24.74%) would choose 'spiritual health/wellbeing', is perhaps telling of the importance faith and spirituality have in the life of many African people, particularly given the emphasis on faith and spiritual wellbeing in responses to later questions regarding factors which can improve mental health and wellbeing. This corresponds with the Royal College of Psychiatrists' recognition of the positive correlation between spirituality and improved mental health, but may also suggest a conflation between the two, where people are recognising mental health problems as a sign of spiritual deficit (Royal College of Psychiatrists, 2010b).

Table 5

When talking about your feelings and emotions, which of the following do you feel most comfortable with?

(Respondents selected all answers that were relevant to their understandings)



When interviewees were asked the more open ended question: 'What does mental health mean to you?' this elicited a wide range of responses. From the more holistic:

"To me personally, my mental health is the health of my emotional wellbeing which affect my ability to enjoy life and have a balance between my daily life activities and efforts to achieve psychological resilience (e.g. worries). When I have good mental health, I am able to express my emotions and

adapt significantly well to a range of daily life demands, such as missing a London bus, coping with my daughter”

To the almost clinical:

“A combination of depression and a chemical imbalance in the brain”.

Generally the tendency was towards equating mental health with a more holistic and wider appreciation of emotional and social as well as mental states.

Some mental health commentators suggest that the phrases ‘mental health and wellbeing’ and ‘emotional health’ overlap in many ways. The Mental Health Foundation recognises that “some people call mental health ‘emotional health’ or ‘wellbeing’”, stating that mental health problems “range from the worries we all experience as part of everyday life to serious long term conditions” (Mental Health Foundation, 2013b).

‘Emotional health’ often appears to be the umbrella term to refer to emotional issues that contains ‘mental health’ within its remit. However, spiritual health can be perceived slightly differently. The Royal College of Psychiatrists states that spirituality involves:

- A deep seated sense of meaning and purpose in life
- A sense of belonging
- A sense of connection of ‘the deeply personal with the universal’
- Acceptance, integration and a sense of wholeness (Royal College of Psychiatrists, 2010b).

Looking after spiritual health and harnessing this sense of belonging and meaning through individual and community activities can ‘offer real benefits for mental health’. However, spiritual health/wellbeing can be seen as something that is conducive to improving or maintaining mental health, rather than the two being synonymous: research has demonstrated a positive correlation between religious adherence and increased hope, decreased depression, fewer suicides, and decreased psychosis (Swinton & Parkes, 2011). Spiritual health can therefore be a coping mechanism for dealing with mental health problems.

Accessing Services

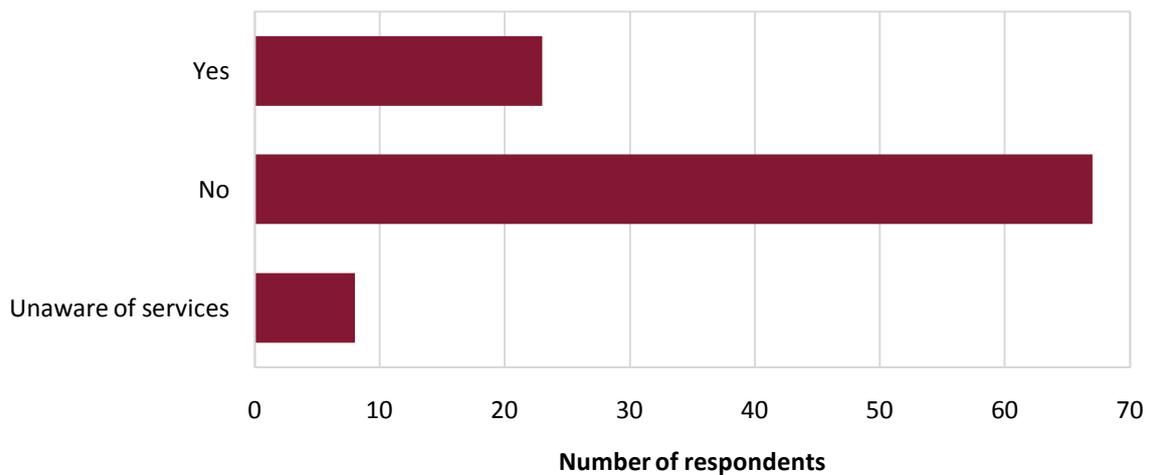
The question regarding accessing state-provided mental health services was answered by 98 of the 100 voices (Table 6). The survey found that 68.37% people had not used state-run mental health services, three times as many as those who have (23.7%). 8 people stated that they were ‘unaware of services’.

Out of the 33 people who answered that they personally had experienced mental or emotional difficulties, only 23 reported that they had used state-provided mental health services. It is unclear whether this fairly substantial gap between those reporting personal problems and reporting use of state services is due to the ambiguous and wide subject area of ‘mental and emotional’ difficulties in question 4, or because of barriers to accessing state-run care. In any event it is worthy of further investigation.

AHPN has previously reported that for cultural, religious or practical reasons (including lack of linguistic or cultural competency from staff) African people may be less likely to access services and support for psychological needs and this may be a factor at play here (African Health Policy Network, 2010).

Table 6

Have you ever used any state provided mental health services? (e.g. Gone to the GP for a mental health problem, had counselling or therapy, had inpatient treatment, been prescribed medication)



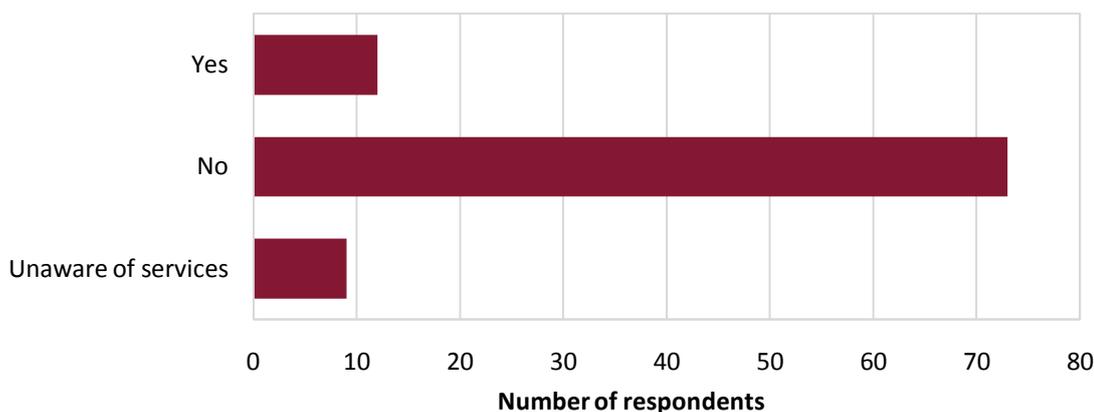
Whilst there are many barriers (including cultural) that obstruct African people's access to mental health services, a further factor is that African people appear less likely to go to mental health professionals over using support networks elsewhere. This mirrors the work of AHPN in HIV where we have found that African individuals interviewed would not necessarily go as a first port of call to receive psychological support from healthcare professionals, but would rather go to community support groups and networks, other peer networks, and faith leaders for psychological support (African Health Policy Network, 2010). This is conversant with the responses to question 9 of the survey ('What do you think could improve the mental wellbeing of the African communities in the UK?') for which very many answers advocated support systems through churches, community outreach, and support from the community and religious institutions, as well as those which implored mental health services to be culturally appropriate and sensitive.

We also asked whether respondents had accessed any non-state provided mental health services (Table 7). This question was answered by 94 people. 12.77% stated that they had used such services, whereas 77.66% had not and 9.57% were unaware of the services.

Given the broad historical research that has shown that community support groups and networks, faith groups and other peer networks are more likely to be the first port of call for African people in search of psychological support, it does appear counter-intuitive that there are fewer respondents who have accessed non-state provided services than those who have accessed state provided services (23.47%). But again this demonstrates the need for further detailed research in this area.

Table 7

Have you ever accessed any non-state provided mental health services? (e.g. those provided by a community group, charity or faith group)



Improving Wellbeing

Question 8 was an open question which asked 'In your opinion what can improve mental well being and happiness?'. Respondents could mention whatever factors came to mind. A range of diverse responses were received from 81 respondents in total. The presence of faith and spiritual belief was a popular response with eleven individuals mentioning this. Comments such as "*going to church more*", "*knowing God and believing in him*" and "*a physical and spiritual presence*" were fairly common although there was no particular analysis of *how* faith and belief could fulfil the role of improving mental wellbeing and happiness. One person said, however:

"...I wish I could have talked to someone when I was going through my depression...I was lucky I had my faith, a strength I never knew existed, and I knew I had to get well for my family".

Eleven individuals mentioned support factors and the need for a network of colleagues, community, friends and family. One mentioned the importance of:

"Getting support in both happy times and bad times and having a feeling of acceptance and belonging within your community".

Another said it was necessary to have:

"...a strong network of support from friends and family (amongst) whom you can be assured that you won't be judged".

Another said that it was helpful just to:

"share the problem with someone".

Several respondents mentioned financial concerns and the harsh reality of poverty being detrimental to one's mental health (which chimes with the information provided in Table 1). Wellbeing was connected to *'being able to have the basic necessities', 'financial stability'* and *'helping people to engage jobs to improve their financial status... helping people to be more productive in society'*. The link between poverty and mental health is well researched and is likely to be bi-directional: those experiencing low incomes and poverty are more likely to find themselves suffering mental health issues; and those with mental health problems are more likely to experience poverty. Once affected an individual's socio-economic status is likely to decline even further (Borton & Knott, 2011).

Question 9 focused solely on the African communities in the UK. It asked: 'What do you think could improve the mental wellbeing of the African communities in the UK?'. On this issue the key factor reiterated within many responses was 'support', whether this was mutual support from within the family and close community, or external support from faith groupings and leaders, and health/wellbeing agencies. It is interesting that when, in an earlier question, individuals were asked about where they would turn to for support they tended to shy away from family. But, as noted, in the open ended aspirational question family and community tend to come back into play, suggesting that individuals would at least want to seek support from family for their wellbeing if they felt able.

Clearly people also thought that the absence of barriers and what they perceived as 'obstacles' would be beneficial. One respondent said that the *'eradication of labelling, (more) equal treatment at work places, within schools and colleges and tackling racism'* would all contribute to enhanced mental wellbeing in the African communities.

Where people mentioned faith and religion this was largely from the perspective of the faith group being a supportive structure. However one *sole* respondent took the view that an: *'over dependence on faith and religions to address our problems''* was actually a barrier to wellbeing. It is of course recognized that faith can be a "source of support, strength and wellbeing to those who share it and being part of a group of people that share that faith can foster a sense of community and belonging". (African Health Policy Network, 2012). But it should also be noted that faith settings can sometimes foster stigma and misinformation. This is important given the extremely influential position that faith leaders hold in the African communities. Notwithstanding this, the overwhelming majority of those mentioning faith amongst our respondents saw it as a positive and an important spiritual dimension to the way in which they might overcome any lack of wellbeing. For example, one person said that what the African communities needed to enhance mental wellbeing was:

'A return back to community spirit and a much needed return to God'.

It was also clear that 'signposting', as a broad heading, was seen as favouring wellbeing in the African communities – indicating that perhaps sometimes people were in need of good quality advice but were unable to access it. One person spoke of the need for:

"...more awareness in the community, specific advocacy services to support and give people information in order for them to be able to make an informed choice".

Another said:

“GPs in the community (were needed) to signpost the person ASAP to the right place to improve their wellbeing”.

This need to access good quality information went in tandem with a need for heightened cultural awareness on the part of service providers. One respondent said what was needed was a:

“Better understanding of the African Caribbean people, early intervention and culturally appropriate services”.

Another said that African communities needed to be:

“Creating awareness of the causes, treatment and therapies and recovery methods associated with mental wellbeing”.

Conclusions and Recommendations

This exploratory survey has considered the views of one hundred African individuals in relation to issues regarding emotional health and wellbeing. This has been a timely exercise. The mental health needs of the UK African population have not previously been looked at in depth and this exploratory work provides some base line from which to move forward. Also, the proposed changes in the structure of the NHS and the way in which those with long term care issues are to receive services going forward, particularly with the advent of personalised budgets, means it is crucial that the needs of diverse service users are understood and therefore that African voices are heard by commissioners of services.

Emotional health and wellbeing is the term that the majority of respondents considered an appropriate one for what we often call 'mental health'. This suggests that those who responded do not see mental health as a medical phenomenon but one which encompasses wider determinants of wellbeing, social factors, economic factors and structural factors. Financial worries, immigration issues, other health and relationship issues were all considered to be significant in relation to one's emotional health and wellbeing. These are issues which require holistic and person centred approaches.

Perhaps due to complex issues surrounding family and shame or stigma, our respondents expressed a preference for looking outside of the close family when seeking support for emotional health and wellbeing issues. Individuals were more likely to go to community pillars such as faith groups than family members. This emphasises the central role that faith and spirituality play in the lives of very many within the African communities – and consequently faith leaders and faith communities have an important role to play in addressing issues of emotional health and wellbeing in the African communities. It is clear that further work needs to be carried out with African communities in respect of mental health treatment, care and support. These discussions will also need to be 'solutions-focused' including positive and bold ideas, such as Sewell's 'locked hexagon model' approach.

Our survey of 100 individuals found that:

- Financial concerns and worries were a principal trigger for individuals' mental health and wellbeing problems
- A high percentage of respondents (over 50%) said that they would look outside of the family (i.e. to work, community or faith colleagues) for mental health and wellbeing support
- Over 30% of respondents had lived experience of a personal mental health problem and over 60% had contact with someone with lived experience
- The term 'emotional health and wellbeing' was the term a high percentage (over 60%) of respondents chose to describe their feelings and emotions
- 68% of respondents had not accessed statutory services at all, and 77% had never utilised community services
- Respondents emphasised the importance of faith groups in supporting those with mental health and wellbeing issues

Recommendations:

1. In line with its focus on patient-led services, the Department of Health should support access to a range of psychological therapies and support, based on individual need and cultural appropriateness, with a particular focus on the distinct needs of diverse communities and population groups.
2. There needs to be a keener focus on the risk factors for mental health in African communities, such as immigration issues, financial problems and employment. Addressing these factors should be a key element of any strategy to improve mental health and wellbeing.
3. Additional funding, resources and support for community and voluntary sector mental health and non-specialist organisations is necessary in order to support these to meet the diverse needs of Africans affected by mental health problems. This should include support to address cultural and religious beliefs about mental health. Provision should be made for support and therapies to be provided by non-traditional providers including community, third sector and faith groups.
4. Greater detailed research should be commissioned into the mental health needs of African people and the steps that need to be taken to address any emerging anomalies.

Bibliography

- African Health Policy Network. (2012). *Faith 'Healing' and HIV: How Should We Respond? Summary Paper*. Available: http://www.ahpn.org/Upload/page/116_AHPN_Faith__healing__and_HIV_Research_Summary_114.pdf. Last accessed 25th July 2013.
- African Health Policy Network. (2010). *African Health Policy Network Submission to Consultation on 'Standards for Psychological Support for Adults Living With HIV'*. Available: http://www.ahpn.org/Upload/page/108_AHPN_submission_to_consultation_on__Standards_for_psychological_support_for_adults_living_with_HIV__195.pdf. Last accessed 25th July 2013.
- African Health Policy Network. (2013) *Policy Position 2013: Improving Health and Wellbeing*. Available: www.ahpn.org. Last accessed 25th July 2013.
- Bebbington P E, Meltzer H, Brugha T S, Farrell M, Jenkins R, Ceresa C & Lewis G. (2000). Unequal Access and Unmet Need: Neurotic Disorders and the Use of Primary Care Services. *Psychological Medicine*. 30 (0), 1359-1367.
- BME Health Forum. (2005). *Caught Between Stigma and Inequality; Black & Minority Ethnic Communities and Mental Well-Being in Kensington & Chelsea and Westminster: Recommendations for improved service delivery and partnership with local communities*. BME Health Forum and the Migrant & Refugee Communities' Forum
- BME Health Forum. (2013). *Mental Health*. Available: <http://www.bmehf.org.uk/index.php/about/previous-project/mental-health/>. Last accessed 25th July 2013.
- Borton C and Knott L. (2011). *Poverty and Mental Health*. Available: <http://www.patient.co.uk/doctor/Poverty-and-Mental-Health.htm>. Last accessed 25th July 2013.
- Brugha T, Jenkins R, Bebbington P, Meltzer H, Lewis G, Farrell M. (2004). Risk factors and the prevalence of neurosis and psychosis in ethnic groups in Great Britain. *Social Psychiatry and Psychiatric Epidemiology*. 39 (12), 939-46.
- Care Quality Commission. (2011) *Count Me In Census 2010: Results of the 2010 National Census of Inpatients and Patients on Supervised Community Treatment in Mental Health and Learning Disability Services in England and Wales*. National Mental Health Development Unit. Available: [http://archive.cqc.org.uk/_db/_documents/Count_me_in_2010_FINAL_\(tagged\).pdf](http://archive.cqc.org.uk/_db/_documents/Count_me_in_2010_FINAL_(tagged).pdf). Last Accessed 24th Jul 2013.
- Care Quality Commission. (2013) *Monitoring the Mental Health Act in 2011/12*. Available: http://www.cqc.org.uk/sites/default/files/media/documents/cqc_mentalhealth_2011_12_main_final_web.pdf. Last Accessed 24th Jul 2013.
- Cooper C, Spiers N, Livingston G, Jenkins R, Meltzer H, Brugha T, McManus S, Weich S, Bebbington P.. (2013). Ethnic inequalities in the use of health services for common mental disorders in England. *Social Psychiatry and Psychiatric Epidemiology*. 48 (5), 685-92.
- Department of Health (2012). *The Mandate: A Mandate From the Government to the NHS Commissioning Board: April 2013 to March 2015*. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf. Last Accessed 24th Jul 2013.
- Department of Health. (2013). *The Mandate A mandate from the Government to the NHS Commissioning Board*. Available: <http://mandate.dh.gov.uk/mental/>. Last accessed 24th Jul 2013.
- Her Majesty's Government/Department of Health. (2011). *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*.

House of Commons All-Party Parliamentary Group on Dementia. (2013). *Dementia Does not Discriminate: The Experiences of Black, Asian and Minority Ethnic Communities*.

Karlsen S, Nazroo J Y, McKenzie K, Bhui K & Weich S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England . *Psychological Medicine*. 35 (0), 1795–1803.

Karlsen, S. (2002). Ethnicity, Environment and Health: Putting Ethnic Inequalities in Health in their Place. *Social Science & Medicine*. 55 (9), 1647.

Livingston G, Leavey G, Kitchen G, Manela M, Sembhi S & Katona C. (2001). Mental health of migrant elders — the Islington study. *The British Journal of Psychiatry*. 179, 361-366.

McKinsey Quarterly. (2008). *Enduring Ideas: The 7-S Framework*. Available: http://www.mckinsey.com/insights/strategy/enduring_ideas_the_7-s_framework. Last accessed 24th July 2013.

McManus S, Meltzer H, Brugha T et al (2009) Adult psychiatric morbidity in England, 2007. Results of a household survey. Health and Social Information Centre, Social Care Statistics

Mental Health Foundation. (2013a). *Mental Health Statistic*. Available: <http://www.mentalhealth.org.uk/help-information/mental-health-statistics/>. Last accessed 24th July 2013.

Mental Health Foundation. (2013b). *What are Mental Health Problems?*. Available: <http://www.mentalhealth.org.uk/help-information/an-introduction-to-mental-health/what-are-mental-health-problems/>. Last accessed 24th July 2013.

Mental Health Foundation. (2013c). *Stress*. Available: <http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/stress/>. Last accessed 25th July 2013.

Mental Health Wales. (2013). *What is serious mental illness?*. Available: <http://www.mentalhealthwales.net/mhw/whatis.php>. Last accessed 24th Jul y2013.

Meyer, IH. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin* , 129(5):674-97.

Mind. (2013a). *Mental Health Crisis Commissioning Excellence for Black and Minority Ethnic Groups: A Briefing for Clinical Commissioning Groups*. Available: http://www.mind.org.uk/assets/0002/3541/CCG_crisis_care_briefing_BME_March_2013.pdf. Last accessed 25th July 2013.

Mind. (2013b). *Mental Health Facts and Statistics: Key Facts and Statistics on Mental Health Problems and Issues*. Available: http://www.mind.org.uk/mental_health_a-z/8105_mental_health_facts_and_statistics. Last accessed 24th July 2013.

Nacro. (2007). *Black Communities, Mental Health and the Criminal Justice System*. Mental Health and Crime Briefing. Available: <https://www.nacro.org.uk/data/files/black-communities-mh-1009.pdf>. Last accessed 24th July 2013.

Nacro. (2010). *Foreign National Offenders, Mental Health and the Criminal Justice System*. A Nacro mental health briefing paper. Available: <http://www.nacro.org.uk/data/files/mh-foreign-nationals-briefing-jun10-820.pdf>. Last accessed 24th July 2013.

National Centre for Social Research & Dept of Health Sciences, University of Leicester. (2007). *Adult Psychiatric Morbidity in England, 2007. Results of a Household Survey*. London: NHS Information Centre for Health & Social Care.

NHS Information Centre. (2011). *Mental Health Bulletin: Fith report from Mental Health Minimum Data Set (MHMDS)annual returns, 2011*. London: NHS Information Centre.

Rhodes, C. (2012). *Unemployment by ethnic background*. House of Commons Library.

- Royal College of Psychiatrists. (2009). *Psychiatric Services for Black and Minority Ethnic Older People*. College Report CR156. Available: <http://www.rcpsych.ac.uk/files/pdfversion/cr156.pdf>. Last accessed 24th July 2013.
- Royal College of Psychiatrists. (2010a). *No Health Without Public Mental Health: The Case for Action*. Royal College of Psychiatrists Position Statement PS4/2010. Available: <http://www.rcpsych.ac.uk/pdf/Position%20Statement%20of%20website.pdf>. Last accessed 24th July 2013.
- Royal College of Psychiatrists. (2010b). *Spirituality and Mental Health*. Exeter: Author. Available: <http://www.nhs.uk/ipgmedia/national/Royal%20College%20of%20Psychiatrists/Assets/Spirituality.pdf>. Last accessed 25th July 2013.
- Schehrer S & Sexton S. (2010). *Involving Users in Commissioning Local Services*. Joseph Rowntree Foundation. Available: <http://www.jrf.org.uk/system/files/user-involvement-service-commissioning-full.pdf>. Last accessed 24th July 2013.
- Sewell H. (2012). *Equality Act 2010 in Mental Health: A Guide to Implementation and Issues for Practice*. United Kingdom: Jessica Kingsley Publishers. 1-256.
- Sewell, H. (2012). Toxic Interaction Theory: One reason why African Caribbean people are over-represented in. *Ethnicity and Inequalities in Health and Social Care*.
- Sewell H., Waterhouse S. & H.S. Consultancy. (2012) *Making Progress on Race Equality in Mental Health*. NHS Confederation. Available: <http://www.nhsconfed.org/Publications/Documents/Making%20Progress%20on%20Race%20Equality%20in%20Mental%20Health%20FINAL%20SUBMITTED%2014%2005%2012.pdf>. Last accessed 24th July 2013.
- Sharpley M S, Hutchinson G, Murray R M, McKenzie K. (2001). Understanding the excess of psychosis among the African—Caribbean population in England: Review of current hypotheses. *The British Journal of Psychiatry*. 178, 60-68.
- Swinton, J, and Parkes M. (2011). Researching Spirituality: Evidence and Practice. In: Gilbert P *Spirituality and Mental Health*. Brighton: Pavilion. Chapter 3.
- The BME Health Forum and the Migrant & Refugee Communities' Forum. (2005). *Caught Between Stigma and Inequality; Black & Minority Ethnic Communities and Mental Well-Being in Kensington & Chelsea and Westminster. Recommendations for improved service delivery and partnership with local communities*. London: The BME Health Forum and the Migrant & Refugee Communities' Forum.
- The Health & Social Care Information Centre., Department of Health Sciences, University of Leicester. (2007). *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*. The Health & Social Care Information Centre, Social Care Statistics. Available: <https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf>. Last Accessed 24th July 2013.
- The Sainsbury Centre for Mental Health. (2002). *Breaking the Circles of Fear: A Review of the Relationship Between Mental Health Services and African and Caribbean Communities*.
- Time to Change. (2013). *Our impact*. Available: <http://www.time-to-change.org.uk/about-us/our-impact>. Last accessed 24th July 2013.
- Trades Union Congress. (2012). *Young black men have experienced sharpest unemployment rise since 2010*. Available: <http://www.tuc.org.uk/economy/tuc-21533-f0.cfm>. Last accessed 24th July 2013.
- Trades Union Congress. (2012). *Youth Unemployment and Ethnicity: TUC report*. TUC.

The Mental and Emotional Wellbeing of Africans in the UK



Contact us

Website: www.ahpn.org

Email: info@ahpn.org

Phone: 020 7017 8910

Address: Suite B5, New City Cloisters, 196 Old Street, London, EC1V 9FR

AHPN is a Company Limited by Guarantee. Registered in England and Wales No. 3979511. Charity No. 1088641