

Mental Health Inequalities Facing U.K. Minority Ethnic Populations

Causal Factors and Solutions

Tracy Grey, MSc, BA (Hons), Hári Sewell, CQSW, DMS, Gillian Shapiro, PhD, and Fahmida Ashraf, MRes, PGCHEP, PgCert, BA (Hons)

Black and minority ethnic (BME) communities continue to experience inequalities within the U.K. mental health system despite major government policy initiatives. The authors examined the literature for causal factors for continued mental health inequalities facing BME groups and potential solutions. The authors selected 53 articles from 1991 to 2012 based on inclusion criteria encompassing all major policy initiatives and relevant literature detailing explanations of mental health inequalities. Although ethnic inequalities in mental health have been of concern for decades in the United Kingdom, a still-significant gap exists between policies and methods of implementation. In comparison to White people, more BME people are diagnosed with mental health issues every year. BME communities are also facing barriers in terms of accessing culturally appropriate services, including lack of cultural understanding, communication issues, and where and how to seek help. Service providers need to work closely with people from BME communities prior to service design and delivery. Information should be made available in appropriate languages to support understanding about their illnesses and how they can seek help. Frequent reviews may further help assess BME communities' needs and make required changes and implementations.

Introduction and Background

Before considering the causal factors for ethnic inequalities in mental health cited in the literature, it is important to understand the nature of these inequalities and the terms typically used within the literature to describe the populations and groups affected.

Much of the policy and literature covering inequities in health in the United Kingdom uses the term *Black and minority ethnic (BME)* when referring to populations and groups who are in a racial or ethnic minority. The term represents people who as individual racial or ethnic groups are very diverse and includes White ethnic minorities, such as Irish. The term *BME*, despite its widespread use, has severe limitations and usually follows nonspecific quantifiers, such as “most” or “some.” For example, a study of ethnic utilization of newly devised mental health services highlights the diversity of patterns across different groups (Glover & Evison, 2009). Given the accepted use of the term *BME* and the fact that research and government papers typically use this term, this article uses it.

Ethnic inequalities in mental health continue to be a cause for concern within numerous policy documents and reviews published or commissioned by the U.K. government. The U.K. policy initiative “Delivering Race Equality in Mental Health Care” (DRE; Department of Health, 2005) promised an ambitious strategy to address mental health inequities. Despite the government’s positive review at the conclusion of the program (Department of Health, 2010a), evidence presented from the final annual national census of inpatients in England and Wales painted a different picture. The final Count Me In census sponsored by the Department of Health suggested that the policy directive had very little impact on narrowing the health gap at the national and local levels (Care Quality Commission, 2011).

Research shows that many BME groups experience significant variation when accessing mental health care pathways in the United Kingdom. This is reflected in some BME groups being less likely to enter and be referred to mental health services through their general practitioner and

more likely to be arrested by the police following a crisis, which inevitably results in poorer health outcomes and often-coercive forms of care in locked wards.

Research evidence shows that BME communities accessing mental health care services do not always experience the quality of care to which they are entitled (Department of Health, 2003, 2005; Fernando, 2010; Sewell, 2012). Evidence of inequality in mental health outcomes is well documented and referred to frequently in policy documents and reviews (Johnson et al., 2004). Ethnic inequalities have been highlighted as a cause for concern within many government policies, including the National Health Service (NHS) plan (Department of Health, 2000), the National Service Framework for Mental Health (Department of Health, 1999), “Inside Outside” (Department of Health, 2003), and the DRE (Department of Health, 2005).

Research Methods

A comprehensive literature review of articles from 1991 to 2012 was undertaken utilizing MEDLINE, CINAHL, and PsycINFO databases. NHS, government, and other relevant but not formally published reports were also reviewed for causal explanations cited in literature for ethnic inequalities in mental health. A total of 53 articles was chosen; the inclusion criteria encompassed all major policy initiatives and relevant literature detailing explanations of mental health inequalities. Excluded were papers that did not offer causation for mental health inequalities and potential solutions. The search terms used to retrieve articles were: Black and minority ethnic communities, health inequalities, mental health, racism, policy and practice, equality legislation, discrimination, service delivery, and cultural competency.

Mental Health Inequalities Across Different Ethnic Groups in the United Kingdom

African Caribbean people (Black people with heritage from the Caribbean) are diagnosed with severe mental health problems (Cooper, Morgan, Byrne, & Dazzan, 2008; Department of Health, 2003; Fernando, 2003; Vernon, 2011) at two to eight times more often compared with the White population. Moreover, these communities experience more restrictive measures within the health system, including being subjected to forensic services and locked wards (Tarbuck, Topping-Morris, & Burnard, 1999). At the same time, many within these groups lack access to alternative forms of interventions, such as psychological therapies, to reduce their mental ill health and distress (Glover & Evison, 2009).

Higher rates of mental illness are also reported among the White Irish population, but statistics for this particular group are often ignored in analyses of inequalities. The Irish population in the United Kingdom has a significantly higher rate of suicide than other BME groups (Vernon, 2011).

Research conducted by Mind (2011) details comparisons across ethnic groups regarding mild, moderate, and severe mental ill health. It shows that women from Black groups experience higher-than-average rates of detention within mental health services, and, as a whole, the Black community is less likely to be diagnosed with mild to moderate mental health conditions, such as depression and anxiety, relative to their White counterparts. Overall, the findings from the study point to the importance of gender and class considerations, as the research shows that they are key determinants influencing and exacerbating the rates of detention in BME communities.

Based on a review of reports and research into service utilization data, Sewell (2012) identifies five domains in which inequalities occur for various BME groups:

1. Disproportionate experience of factors that are linked to poor mental health
2. Higher rates than average for utilization of services or for particular diagnoses
3. Lower rates than average for utilization of services
4. Poorer outcomes derived from the treatments and interventions in mental health services
5. Poorer experience of relationships with mental health service professionals

The groups to which these domains apply most are highlighted in Sewell's review and include Roma, Gypsy, and Indian groups. It is striking, however, that Black groups are most frequently highlighted as facing inequalities. The African Caribbean group is most prominent in terms of service use inequalities. Consequently, the analysis of possible causes of ethnic inequalities in mental health most frequently focuses on the experience of African Caribbean people. The conclusions are sometimes erroneously applied generally to all BME groups in literature.

Underlying Causal Issues and Explanations for Inequalities in Mental Health

The scale of ethnic inequalities is largely known, and various hypotheses about the causes have been offered in the literature. Given that the inequalities differ according to gender and ethnicity, no single explanation can be reliably applied to

all groups. Research into ethnic inequalities in mental health is intended to aid the development of solutions; consequently, papers include a section on issues for practice. The science of problem solving in organizations focuses significant attention on understanding root causes of problems (see Bicheno & Holweg, 2009). Health and social care systems that wish to correct patterns of poorer outcomes for BME groups will need to have a good understanding of why the care and treatment they provide has less impact on these groups.

Western Model of Psychiatry

Fernando (2003) argues that psychiatry in the United Kingdom operates within a Eurocentric paradigm, which may influence the way people from BME communities are diagnosed. Fernando calls for greater cultural competence among staff working with BME service users and stresses the importance of health professionals examining their own worldview and that of the patient to combat unconscious and implicit bias, particularly in the assessment of mental illness. Fernando reminds us that perception of illness and disease and their causes varies by culture and that culture influences how people seek health care and how they behave toward health care providers. Moreover, mental health and illness are a taboo in some communities, and in the face of increasing socioeconomic uncertainty and income inequality, mental well-being may not be considered the priority that it should be. This taboo of mental ill health and the economic uncertainty can lead to people not appreciating the need for early intervention and reluctance in engaging with mental health services until a crisis point. Elsewhere, mental illness may be considered a personal issue; therefore, seeking professional help could be perceived as being embarrassing.

Communication Barriers

In the United Kingdom, many BME communities do not speak English as their first language. As diagnosis is contingent, in large part, on individuals being able to explain and articulate their experiences, this may have a bearing on the outcome of any such diagnosis (Fountain & Hicks, 2010). Lack of proficiency with the English language is one of the main barriers to accessing mental health services for many BME service users. Satisfaction with mental health services is higher where service users and service providers speak the same first language (Fountain & Hicks, 2010).

Racial Disadvantage and Discrimination

The deaths of Black men in detention have been critiqued for decades. For example, Sivandan (1991) suggests that the death of Black men in detention is not confined to the psychiatric system alone but is evident in other public service settings, such as police and prison. He argued that the public bodies have in common a fear of Black men in particular and stereotyped views of BME people being more aggressive and dangerous, particularly for those of African and African Caribbean background.

Although Black Caribbean people are more likely to be treated for psychosis, they may not be any more likely to have such an illness (Keating, 2007). Rather, the diagnosis of psychosis may be a result of a culturally biased interpretation of symptoms (Vernon, 2011). Cooper et al. (2008) report that based on detailed controlled studies, evidence has emerged to suggest that the incidence of psychosis is higher, but this is largely related to the impact of discrimination and social circumstances.

In addition, although there is no evidence that African Caribbean groups are more frequently aggressive than other groups, mental health staff

members are more likely to regard them as being potentially violent (Mind, 2012). These findings concur with those of Fernando (2010) and the Department of Health (2003).

Records of higher levels of diagnoses of schizophrenia among second- and third-generation Black Caribbean communities point to factors other than recent migration as a stressor (Pinto, Ashworth, & Jones, 2008). It is acknowledged that the effects of racism are subjective and can have a detrimental impact on mental health, but for others the impact of discrimination may be minimal (Karlsen, 2007).

BME males are less likely to self-identify that they have a mental health issue; they also have less awareness of the services that are available to help with such issues (Men's Health Forum, 2006). There may be a variety of reasons for these facts, including fear of consequences of reporting a mental health problem (White, 2006). These issues are compounded for African and Caribbean men (Keating & Robertson, 2004).

Research by the Sainsbury Centre for Mental Health (2002) called *Breaking the Circles of Fear* still resonates today. The report highlighted the perpetual fear that can exist in BME communities as well as with mental health professionals due to the fact that some professionals fear getting diagnoses wrong at best; at worst, others may have ideas about BME communities that are fueled by prejudice and stereotypes of dangerousness. Black clients are equally fearful that they will experience punitive forms of care.

Failures and inadequacies of mental health services and partner agencies have been ascribed to multiple factors (RAWOrg, 2010). Some argue that the DRE failed to deliver its objectives, which is attributed partly to it being insufficiently resourced or supported in a sustained way by national agencies. One potential problem is the focus on

the problem in BME communities rather than on the systems that often reinforce inequalities (see Guardian, 2010). A number of studies have the notion that mental illness is more prevalent within racialized groups because of their "inferior culture," genetic predisposition, or inherent behaviors (Cooper et al., 2008; RAWOrg, 2010); these assumptions often serve to fuel racism and ignore systemic social problems.

Social Model of Health

Providing services for BME communities fosters a strong appreciation of the social model of health. The importance of addressing the wider determinants that affect physical and mental well-being has been recognized by the Department of Health (2011) in its recent policy, *No Health Without Mental Health*. Socioeconomic factors are key determinants of mental well-being (Wilkinson & Pickett, 2010), and the income equality gap between BME communities and their White counterparts is widening (Office of National Statistics, 2010) with BME communities experiencing significant socioeconomic inequalities. Although there is a growing cohort of educated, Black, middle-class people, research shows that across the private and public sectors, Black communities tend to peak at middle management levels with very few concentrated in the more senior levels of organizations, including the NHS (Esmail, Kalra, & Abel, 2005).

There are several examples of social inequalities and vulnerability to mental ill health by sections of the BME community. For example, Keating (2007) found that Black men are more likely to be excluded from school, experience economic and social hardship, experience greater exposure to criminal cultures, and be the subjects of racial abuse.

Concerning mental ill health, limited research exists for other ethnic groups, specifically for

Roma, Gypsy, and Traveller communities. It is important that research at the local and national levels be undertaken to address the knowledge gap. The physical, psychological, and health needs of asylum seekers are complex, as many are arriving from countries with high prevalence of infectious diseases or after having been tortured, which is exacerbated further by poor living conditions once they arrive in England (Keating, 2007).

Solutions Offered in Policy and Practice

When considering solutions, it is important to note that issues of continuing inequalities in mental health reside within the wider changing NHS context. The recent Department of Health White paper *Equity and Excellence: Liberating the NHS* (2010b) calls for a radical transformation of the NHS. Subsequent legislation called the Health and Social Care Act was passed in Parliament in 2012. The policy emphasis is on equitable outcomes and higher standards of care across the entire system. The rhetoric of the policy directive appears to synergize well with the Equality Act of 2010, which places a duty on public sector bodies to eliminate discrimination within service provision. However, findings from service data point to a significant disconnect between the policy intent and the reality, arguing that the two can be divorced. The Count Me In census (Care Quality Commission, 2011), which was an analysis of performance against key objectives of the DRE policy (Department of Health, 2005), illustrates this point well.

2005 Policy: Delivering Race Equality in Mental Health Care

The DRE 5-year action plan launched by the Department of Health in 2005 set out on an ambitious strategy to eliminate discrimination. This

program specifically aimed to address mental health inequalities experienced by minority ethnic groups, including people of Irish, Mediterranean, and East European origin.

The DRE built on an earlier strategy, “Inside Outside” (Department of Health, 2003), which reported that BME groups do not receive equal treatment from mental health care services in any area of the United Kingdom. The recommendations from “Inside Outside” are still relevant today. They call for a culturally competent workforce, elimination of race discrimination, and a focus on the wider determinants, such as poverty and race discrimination, within services and within wider society.

The DRE policy initiative was precipitated by the death of a Black man of Jamaican heritage named Rocky Bennett, who died after being forcibly restrained by several nurses as a psychiatric inpatient. The RAWOrg (2010) study highlighted the case of two other Black men who died while receiving mental health care services, 23-year-old Olanseni Lewis and 52-year-old Colin Holt. The issue of detention was highlighted as an important area to address, including the reduction of BME patients in locked wards and seclusion. A key measure in the DRE initiative was that deaths in mental health settings must be reduced.

The role of psychological therapies as an important intervention in promoting mental well-being was also salient in the DRE initiative. DRE asserted that BME communities should have a greater range of psychotherapy and culturally appropriate therapeutic interventions, including counseling. To improve mental health service, it was made clear that BME people need to be actively involved in service design and training and development policy.

Significant investment was made as part of DRE (Department of Health, 2005) in funding 500

community development workers to engage local BME populations in shaping the implementation of race equality in mental health service provision. Although many examples of positive practice exist at the national and local levels, campaigners are concerned about the future of the work of community development workers (RAWOrg, 2010). At the end of the DRE strategy, there was a widespread reduction of the numbers of community development workers by local commissioning bodies (National Mental Health Development Unit, 2011).

The Count Me In census (Care Quality Commission, 2011) was designed to synergize with the Department of Health's Action Plan (Department of Health, 2005). This psychiatric inpatient census was an annual snapshot data-capture and analysis with specific reference to BME patients. Count Me In was intended to help local mental health commissioning and provider organizations have a more in-depth understanding of mental health inequalities and, as such, enable local action plans to be well informed and specific. The sixth and final census showed that the DRE had very little impact or traction on the disproportionate number of Black people experiencing the more punitive aspects of the mental health system (Care Quality Commission, 2011).

The Count Me In census uses the 2001 national population census categories and population projections; as such, it was limited in its scope for identifying other BME groups. The data about the mental health needs of those of Mediterranean origin and East European migrants are scant, as are the data for Roma communities and Gypsy and Traveller communities. The population census data showed that concerning their physical health, these communities experience significant health inequalities and have higher rates of morbidity and mortality, with one report suggesting

life expectancy for Gypsy and Travellers was 50 years (Parry et al., 2004). In addition, evidence from other studies (Karlsen, 2007; Karlsen, Nazroo, McKenzie, Bhui, & Wiech, 2005) shows that these groups experience significant social and economic disadvantage.

Current Policy and Solutions

In the past, policy initiatives have been explicit about what needs to be done to reduce ethnic and race inequalities in mental health (Department of Health, 2005). Although the current national strategy, "No Health Without Mental Health" (Department of Health, 2011) acknowledges the multiple levels of disadvantage that BME communities experience and highlights that members of BME communities have historically experienced poorer access to services and health outcomes, the document is lacking in detail and specificity in identifying what success looks like. However, the strategy's emphasis on early intervention is important for people from BME groups. BME communities are more likely to access mental health services at various crisis points and in many cases have had negative experiences regarding the forms of care that they have received (Department of Health, 2005; Vernon, 2011).

The sector regulator, the Care Quality Commission, suggests that awareness and understanding about the factors leading to ethnic variations in mental health care are needed. To reduce hospital admissions, the commission stresses the need for early intervention and collaboration across all agencies, specifically among education, police, criminal justice systems, and statutory or outside agencies. It recognizes that to make any real progress, a holistic approach is required (Care Quality Commission, 2011).

Vernon (2011) advises on the need to change the discourse and language that suggest that Black communities are the cause of their misfortune, suggesting that a more systemic analysis is required that takes account of inequalities within wider society: He asserts that communities' assets and resilience need to be recognized alongside appropriate data analysis to assess the trends. RAWOrg (2010) also argues that an overemphasis on the failures leads to deficit thinking that can reinforce low expectations of BME communities and misses the systemic social factors that perpetuate inequalities.

Given the social factors influencing the experience of BME groups in mental health care settings, the relative importance of staff members from the same ethnic backgrounds as service users has been explored in great depth. There is evidence to suggest that many service users acknowledge that the cultural competence was more likely to be present in staff from similar backgrounds, particularly from those whose first language is not English (Fountain & Hicks, 2010). A large percentage of those surveyed from the University of Central Lancashire study of community engagement projects also said that being empathetic and sensitive irrespective of ethnic background was more important than having somebody from the same ethnic background (Fountain & Hicks, 2010).

It is evident at national and local levels that inequities remain within the system. These inequities not only have a negative impact on the communities but can be costly to the NHS (Sainsbury Centre for Mental Health, 2006). However, it is noteworthy to report early wins from pilot interventions, such as focused implementation sites, which show best practice in eliminating discrimination in mental health underpinned by an evidence base (Department of Health, 2010a).

Conclusions and Implications for Practice

Based purely on the evidence from the final national psychiatric inpatient census (Care Quality Commission, 2011), the attempts to close gaps in equality have failed. As the "Inside Outside" strategy (Department of Health, 2003) acknowledged, ethnic inequalities in mental health have been of concern for decades. There appear to be four conclusions that can be drawn:

1. The inequalities are irresolvable.
2. The interpretation that *variation* equates to *inequality* is wrong.
3. Solutions need a longer time frame to have the desired impact.
4. The wrong solutions or combination of solutions is applied.

Accepting defeat in addressing inequalities is politically improbable, and politicians, whether national or local, are unlikely to suggest that the status quo is acceptable and should be maintained.

There is, however, a developing argument based on published research that some variations are misinterpreted as inequalities in the mental health system. Cooper et al. (2008) argue, for example, that the incidence of psychotic conditions in African Caribbean people is genuinely higher and the variations seen in mental health services are indications of inequality and discrimination in society. Singh, Greenwood, White, and Churchill (2007) highlight from their meta-analysis that the representation of BME people increases in the cohorts of people who have successive repeat admissions. This finding indicates that the variation increases once inside the mental health system, suggesting that the mental health system drives some form of inequality.

The possibility that the solutions need a longer time frame was explored in relation to DRE in the 5-year review at the end of the initiative (Department of Health, 2010a). Taken in isolation, there may be merit in the suggestion that DRE itself needed longer to have an impact; other commentators have supported this argument (RAWOrg, 2010). The wider context remains true, however, that given the acknowledgment that ethnic inequalities have persisted for decades (Department of Health, 2003), it is reasonable to expect that some sustained, perhaps incremental improvement in inequalities might be evident following a 5-year national program.

The possibility that the solutions offered are not yet at their optimum was explored by a major think tank. In its report "Completing the Revolution" the Centre for Social Justice (2011) recommended that the organizational development approach described as the locked hexagon model (Sewell, 2009) should be implemented nationally. Informed by the learning from DRE, the locked hexagon model suggests that each service delivery system in mental health should, in relation to race equality, combine locally based outcome targets; service users shaping services; use of narrative approaches; promotion of education, employment, training, and volunteering; staff and manager knowledge and skill development; and carer and community engagement (Sewell, 2009). ♦

References

- Bicheno, J., & Holweg, M. (2009). *The lean toolbox: The essential guide to lean transformation, 4th edition*. Buckingham: PICSIE Books.
- Care Quality Commission. (2011). Count Me In 2010 census. Retrieved from <http://www.cqc.org.uk/organisations-we-regulate/mental-health-services/count-me-2010-census>
- Centre for Social Justice. (2011). *Completing the Revolution: Transforming Mental Health and Tackling Poverty*. Retrieved from <http://www.centreforsocialjustice.org.uk/publications/completing-the-revolution>
- Cooper, C., Morgan, C., Byrne, M., & Dazzan, P. (2008). Perceptions of disadvantage, ethnicity and psychosis. *British Journal of Psychiatry*, 192, 185–190.
- Department of Health. (1999). *National service framework for mental health: Modern standards and service models*. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4077209.pdf
- Department of Health. (2000). *The NHS Plan: a plan for investment, a plan for reform*. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf
- Department of Health. (2003). *Inside outside: Improving mental health services for black and minority ethnic communities in England*. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019452.pdf
- Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services and the government's response to the independent inquiry into the death of David Bennett*. Retrieved from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773
- Department of Health. (2010a). *Delivering race equality action plan: A five year review*. Retrieved from

- <http://www.nmhdu.org.uk/silo/files/race-equality-action-plan-a-five-year-review.pdf>
- Department of Health. (2010b). *Equity and excellence liberating the NHS*. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
- Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf
- Equality Act. (2010). Retrieved from <http://www.legislation.gov.uk/ukpga/2010/15/contents>
- Esmail, A., Kalra, V., & Abel, P. (2005). *A critical review of leadership interventions aimed at people from black and minority ethnic groups*. Retrieved from <http://www.csip.org.uk/silo/files/bme-leadership.pdf>
- Fernando, S. (2003). *Cultural diversity, mental health and psychiatry: The struggle against racism*. Hove, England: Brunner-Routledge.
- Fernando, S. (2010). *Mental health, race and culture*. London, England: Palgrave Macmillan.
- Fountain, J., & Hicks, J. (2010). *Delivering race equality in mental health care: Report on the findings and outcomes of the community engagement programme 2005–2008*. Lancashire, England: ISCRI. Retrieved from http://www.uclan.ac.uk/schools/school_of_social_work/files/DRE_CE_full_report.pdf
- Glover, G., & Evison, F. (2009). *Use of new mental health services by ethnic minorities in England*. Durham, England: North East Public Health Observatory. Retrieved from <http://www.nepho.org.uk/publications/782/>
- Guardian. (2010, February 2). Poor research or an attack on black people? [Letter]. Retrieved from <http://www.guardian.co.uk/society/2010/feb/03/mental-health-bme-schizophrenia-letter>
- Johnson, M., Biggerstaff, D., Clay, D., Collins, G., Gumber, A., Hamilton, M., . . . & Szczepura, A. (2004). *“Racial” and ethnic inequalities in health: A critical review of the evidence*. Retrieved from http://www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/research/homher_draft.pdf
- Karlsen, S. (2007). *Ethnic inequalities in health: The impact of racism*. Better Health Briefing 3. London, England: Race Equality Foundation. Retrieved from <http://www.better-health.org.uk/briefings/ethnic-inequalities-health-impact-racism>
- Karlsen, S., Nazroo, J., McKenzie, K., Bhui, K., & Wiech, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine*, 35, 1–9.
- Keating, F. (2007). *African and African Caribbean men and mental health*. Better Health Briefing Paper 5. Retrieved from <http://www.raceequalityfoundation.org.uk/>
- Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle. *Health and Social Care in the Community*, 12(5), 439–447.
- Men's Health Forum. (2006). *Mind your head: Men, boys and mental wellbeing*. London, England: Men's Health Forum.
- Mind. (2011). *Mental health fact sheet*. Retrieved from <http://www.mentalhealthmatters.com/fact-sheets>
- Mind. (2012). *Statistics 3: Race, culture and mental health* [Fact sheet]. Retrieved from <http://www.mind>

.org.uk/help/people_groups_and_communities/statistics_3_race_culture_and_mental_health

National Mental Health Development Unit. (2011). *National evaluation of the community development workers*. London, England: National Mental Health Development Unit.

Office of National Statistics. (2010). *Income and wealth*. Social Trend 40: 2010 edition. London: Office of National Statistics. Retrieved from <http://www.statistics.gov.uk/hub/index.html>

Parry, G., Cleemput, P., Peters, J., Moore, J., Walters, S., Thomas, K., & Cooper, C. (2004). *The health status of Gypsies and Travellers: Report of Department of Health inequalities in health research initiative*. Retrieved from http://www.shef.ac.uk/polopoly_fs/1.43714!/file/GT-final-report-for-web.pdf

Pinto, R., Ashworth, M., & Jones, R. (2008). Schizophrenia in black Caribbeans living in the UK: An exploration of underlying causes of the high incidence rate. *British Journal of General Practice*, 58(551), 429–434.

RAWOrg. (2010). *The end of delivering race equality? Perspectives of frontline workers and service users from racialised groups*. Retrieved from http://www.mind.org.uk/assets/0001/3140/DRE_LZ.pdf

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*. London, England: Sainsbury Centre for Mental Health. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/breaking_the_circles_of_fear.pdf

Sainsbury Centre for Mental Health. (2006). *The cost of race inequality: Policy Paper No 6*. London, England:

Sainsbury Centre for Mental Health. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/costs_of_race_inequality_policy_paper_6.pdf

Sewell, H. (2009). Leading race equality in mental health. *International Journal of Leadership in Public Services*, 5(2), 19–27.

Sewell, H. (2012). Race and ethnicity in mental health care. In P. Phillips, T. Sandford, & C. Johnston (Eds.), *Working in mental health: Policy and practice in a changing environment*. Oxon: Routledge. pp. 104–115.

Singh, S., Greenwood, N., White, S., & Churchill, R. (2007). Ethnicity and the Mental Health Act 1983. *British Journal of Psychiatry*, 191, 99–105.

Sivandan, A. (1991). Black struggles against racism. In Curriculum Development Project Steering Group (Eds.), *Setting the context*. London, England: CCETSW.

Tarbuck, P., Topping-Morris, B., & Burnard, P. (1999). *Forensic mental health nursing: Policy, strategy and implementation*. London, England: Whurr Publications.

Vernon, P. (2011, March 1). Put race equality in mental health back on the agenda. Retrieved from <http://www.guardian.co.uk/society/joepublic/2011/mar/01/race-equality-mental-health>

White, A. (2006). Men and mental wellbeing—encouraging gender sensitivity. *Mental Health Review*, 11(4), 3–6.

Wilkinson, R., & Pickett, K. (2010). *The spirit level: Why equality is better for everyone*. London, England: Penguin Books.

Tracy Grey, MSc, BA (Hons), is regional business partner for Innov8NHS leading with the organisational development team at Yorkshire and Humber SHA. Tracy's post is in public health. Tracy has a diverse portfolio, working in regeneration, community development, and mental health, and is currently working toward an MBA.

Hári Sewell, CQSW, DMS, is director of HS Consultancy and honorary senior research fellow at both University of Central Lancashire and Buckinghamshire New University, UK. He has been published widely on race, ethnicity and equalities in mental health. He may be reached at hari.sewell@hsconsultancy.org.uk.

Gillian Shapiro, PhD, is managing director of Shapiro Consulting Ltd, which for 13 years has been consulting to organisations in both the public and private sectors on diversity, inclusion, and workplace engagement. She regularly leads and publishes research on inclusion and

diversity. She may be contacted at g.shapiro@shapiroconsulting.co.uk.

Fahmida Ashraf, MRes, PGCHEP, PgCert, BA (Hons), is a lecturer/researcher at the Centre for Inclusion and Diversity, University of Bradford, England. She has previously worked as a research project officer on many research projects including *Corrective Action to Redress the Ethnic Imbalance in Senior Management: Experiences of BME Leaders/Managers in the NHS; Community Facilitators project; Positive Action Research in Health and Education* (funded by the European Social Fund and the University of Bradford); and *Supporting Family Carers of People with Dementia* (Health Action Zone and the University of Bradford funded project). She is actively involved in many equality and diversity publications, forums, and committees at the University of Bradford. Her research interests include workforce diversity, ethnicity, race, gender, disability issues, and research methods. She may be reached at f.a.ashraf@bradford.ac.uk.