

Black and minority ethnic parents with mental health problems and their children

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Key messages

- Black and minority ethnic (BME) parents with mental health problems are likely to experience poverty, unemployment, and homelessness.
- Some common family structures, such as lone parenting, can increase the risks arising from isolation and lack of support for both parents and their children.
- People from BME communities are poorly served by mental health services.
- BME parents with mental health problems are often reluctant to use existing services because these are often not culturally sensitive to their needs.
- Reluctance to access services may result in mental health problems becoming more severe before diagnosis, treatment and support is obtained.
- Mental health problems among BME parents, compounded by lack of treatment and support, can have enduring effects upon their children and contribute to their over-representation in the child care system.

Introduction

For the purpose of this briefing, black and minority ethnic (BME) groups in the United Kingdom include people from Black African, African–Caribbean, South Asian, and Chinese heritage. These also include other white and non-white minority groups whose cultural heritage differs from that of the majority population.^{1,2,3,4} This briefing covers research that helps to understand the experiences of BME families where one or both parents have severe or enduring mental health problems and where children are under the age of 18. The briefing does not include older people (those aged 65 and over), dementia, detailed evaluations of services and interventions, or experiences of particular services.

While there are some valuable studies into the effects of parental mental health problems upon their children,^{5,6,7} the amount of directly relevant research is rather limited and coverage of different minority groups is patchy. However, it is possible to generalise from the greater body of research into mental health problems in BME communities, where this establishes the wider context and where the findings may reasonably

be taken as being relevant to the circumstances of BME parents with mental health problems.

What is the issue?

The prevalence of mental health problems in the general population is high with one in every six people in England having a mental health problem at some point in their life.⁸ While no official figures exist, it is estimated that around 30 per cent have dependent children and seven per cent live in lone-parent households.⁹ Mental health problems include psychotic disorders and, more commonly, anxiety, depression and fear of not being able to cope with life.¹⁰ While there are considerable differences between the experiences of different BME groups, and differences arising from individual as well as from more general factors like socio-economic position, some social problems such as poverty and discrimination are more commonly experienced¹¹ and there are also some shared difficulties in accessing effective and appropriate mental health services.^{1,2,3} It is well-established that there are higher rates of hospital admission and compulsory detention for some BME communities, especially people of Black Caribbean, Black African, White/Black Caribbean mixed and White/Black African mixed heritage, than for other groups in the general population.^{12,13} For example, people from African and African–Caribbean groups are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with depression.¹⁴ Although the reasons for these differences are complex and not fully understood, it is likely that they arise from, and are exacerbated by, experiences of social injustice and oppression^{15,16} and that these stressors may increase vulnerability to mental health problems.^{17–20} People from BME communities are more likely to experience inequality and social exclusion, including direct racial discrimination, poverty, unemployment, and insecure housing.^{3,21–8} One study into

poverty among different ethnic groups found that poverty rates for people from BME communities were much higher in inner London, the north of England, and the Midlands than elsewhere. In inner London 70 per cent of those living in poverty were from BME groups.²⁷ Higher levels of chronic illnesses such as diabetes (in some communities), and higher levels of infant mortality, also contribute to stress within families. In addition, some BME families face higher levels of stress because of their uncertain immigration status as asylum-seekers and refugees and seem to be more vulnerable to mental distress than the general population.^{1,29} A study based on a community-led research project, involving refugees and asylum seekers in one London borough, reported that two thirds of asylum seekers and refugees in the sample have experienced anxiety or depression.³⁰

In the UK, approximately four per cent of all parents with dependent children have mental health problems, with lone parents being particularly vulnerable and women being more vulnerable than men.¹⁰ But it is unclear how many of these are from BME communities – there is little reliable data about the number of BME parents treated by mental health services.³¹ The vulnerability of lone-parent families to mental ill health is not specifically related to family structure but to associated factors such as poverty, lack of family support and lack of supportive services in general.^{7,27,32,33} A study of African–Caribbean communities in the UK and a study of African–Americans in the US both noted that loneliness and isolation were factors contributing to increased vulnerability.^{1,34}

For a number of reasons many people from BME communities are often reluctant to seek help from mental health services and may delay contact until a situation has reached a crisis point.³⁵ For instance, African–Caribbean people are twice as likely as white people to be

diagnosed with a mental health problem, but they are less likely to access treatment and care.²⁴ Although a lack of awareness and information about mental health problems within some BME communities, such as black African and African–Caribbean groups, may be a factor,^{36,37,38} it is evident that many BME service users and their carers are dissatisfied with mainstream services which they often perceive as misunderstanding and/or misrepresenting their situation.¹⁵ Unfortunately, delay in accessing support can result in higher rates of hospital admission and more complex and intrusive interventions, including compulsory detention and seclusion.^{15,21}

Why is it important?

Generally, people from BME communities are poorly served by mental health services.¹¹ Treatment and supportive services are often based upon inaccurate assumptions and prejudicial stereotypes including, for example, 'aggressive black men',^{13,18} as policy-makers and service providers fail to understand the cultural and social circumstances of BME communities and thus their reluctance to seek help.^{39,40}

As well as being exposed to the general consequences of their parent(s) possible social exclusion,^{18,26,24,41} these children may be more vulnerable to a range of other negative experiences and outcomes including bullying, high levels of stress, an increased risk of mental health problems, and the risk of being admitted into care.^{5,6,10,32,42} Parental mental health problems can have a range of negative effects for children⁶ such as developmental delays,^{5,43} failure of parent/child bonding (with adverse effects in functioning for younger children), and even an increased risk of child abuse.⁴⁴ Children who undertake caring responsibilities are more likely to have an interrupted and incomplete

education.^{5,33,42,44–7} Consequently opportunities for further and higher education, and for employment, are often adversely affected, as these children and young people experience problems with schoolwork and attendance. In the UK some 30 per cent of children who are carers are supporting parents with mental health problems, and more than 15 per cent of these carers are from minority ethnic communities.⁴⁸ While a range of professionals, such as teachers, social workers and primary care workers, are well-placed to identify potential problems, some young carers are wary of revealing their difficulties, feeling stigmatised by teachers and other children, and, when their circumstances are known, finding that little support is forthcoming.⁴⁸ Poor communication between children's and adult services further increases the vulnerability of children in situations where coherent and co-ordinated support is needed.^{49,50}

What does the research show?

Parental role, family structure and the effects of mental health problems on children

Many studies focus on maternal mental health and specifically on depression, but research concerning psychotic illness and anxiety disorders is also included.^{20,33,45,51} As there is a lack of research into the effects of men's mental health problems upon parenting capacity and upon their children, some relevant studies from the USA have also been included.

Depressed parents are more likely than well parents to cope poorly in managing their children's behaviour.^{6,10} Generally, maternal mental health problems have been identified as a risk factor for children,^{32,46,47} affecting the bonding process and the ability of the mother to

cope with her parenting responsibilities. One US study suggested that screening mothers at risk of mental health problems in primary care clinics might be useful for early detection of children with emotional problems.⁶ Studies from both the UK and the USA show consistent and significant associations between a supportive mother/child relationship and improved child functioning, and indicate that maternal depression is often a risk factor for difficulties in parenting which effects both the cognitive and physical development of the child and increases the risk of abuse.^{5,6,47,52,53} While maternal depression associated with poverty jeopardises the development of both young boys and girls, chronic maternal depression seems to have an especially strong effect on girls.⁵⁴ Social and economic problems increase the negative effects of such problems upon children's development^{6,44,47,52} and upon the likelihood of children developing mental health problems.¹¹ Consequently, children whose mothers are receiving treatment for mental health problems are also more likely to need help themselves.

In some instances the negative effects of poor maternal mental health upon children can be counteracted by the presence of a supportive father.⁶ While lone maternal parenting is commonplace in some BME communities, one qualitative British study showed that fathers who were not living with the children still supported them and their mothers in a range of ways, to the extent that they were not considered absent.⁵⁵ BME men, especially those of African–Caribbean descent, are more likely to be involved in coercive mental health interventions and are also over-represented in the criminal justice system, from which there is a high level of referral to mental health services.^{18,41} Unfortunately, the role of these men as fathers and their relationships with their children has not been explored in UK research. However a large-scale study involving more than two

thousand school-aged children and their parents explored links between father figure involvement and children's later mental health outcomes. It noted that the involvement of fathers with children at age seven protected against psychological maladjustment in adolescents from non-intact families.⁵¹ Generally however, the negative experience for the child is increased and perpetuated by the absence of a father or other support systems.^{7,53}

For lone mothers, a lack of family support that impacts upon the mother's parenting capacity can also lead to the 'loss' of a child to the care system; there are a disproportionate number of BME children involved with children's services.^{56–8} The likelihood of child loss is greatest for unmarried women in households with an income at or below the poverty line, and with a history of persistent mental health illness, as evidenced by psychiatric hospitalisation.^{33,32,43} With regards to parents who are hospitalised, a review of services that included BME populations found that the anxiety that their children would be taken into care was a source of great stress for parents.⁵⁹ This review evaluated policies, processes, and facilities to enable quality contact between parents and children when a parent is in hospital. The research found that parents worried about the potential of over-burdening of their children, about the adequacy of their parenting and about the anxiety their children could be taken into care. It also found that parents with mental health problems experience discrimination and suspicion and fear that their children will encounter similar prejudice. These concerns are well-founded, as noted in an earlier study which reported that children do experience discrimination and embarrassment related to their parents difficulties and that this can lead to the concealment of problems.⁶⁰ Prolonged stays in hospital, repeat admissions, and coercive interventions are also associated with high levels of anxiety within families.¹¹

Family structures and the level of support they provide is an important issue in the context of cultural impacts on mental health. While some studies have shown a close association between lone parenting, lack of support and parental mental ill health^{10,61} it should not be assumed that more extended family structures necessarily provide adequate support, as these may present problems too.^{2,7} For example, one study of three-generational Asian families in the UK, found that there was an increased risk of mental health problems.² Tensions within the family, such as disagreements over child-rearing practices between mothers and grandmothers, were very strongly associated with maternal depression and anxiety; other contributing factors included having responsibility for a larger number of children, and the lack of adequate parenting knowledge and values when compared with an appropriate reference group.

Barriers to service

While mental health problems are widely stigmatised generally within the UK, there is evidence that this is more commonplace in some BME communities including African, African–Caribbean and South Asian communities, where mental health problems remain a taboo issue.^{22,57,62} Feelings of shame and denial are likely to deter early engagement with mental health services, which in turn is likely to lead to poorer outcomes, such as longer stays in hospital.^{35,63–5} A reluctance to visit a general practitioner is reflected in comparatively low referral rates for further treatment from BME populations.^{66,67} Research undertaken for the Delivering Race Equality strategy¹³ indicates that a majority of the Africans and African–Caribbeans surveyed thought that mental health problems were something to be ashamed of, and felt that they themselves were perceived negatively by society in general.¹⁴ The strategy is a framework for action which sets out what those planning,

delivering and monitoring local primary care and mental health services need to do to improve services for users, relatives and carers from black and minority ethnic communities.⁶⁸ A wide-ranging review of research and practice into mental health services for BME populations undertaken by the National Institute for Mental Health found that the stigma associated with mental health problems can be made worse by racial discrimination, and that the access to appropriate assessment and treatment may be impaired as a result.¹¹ Consequently, parents from BME communities are more likely than others to be referred to mental health services through social services and the criminal justice system.^{24,39,41} Delays in access to care are risky for children who are likely to be negatively affected by parental mental ill health, who may themselves be suffering from mental health problems or, in some cases, may be at risk of neglect or abuse.^{7,10,46}

The reports into institutional racism in public services^{11,69} and the numerous inquiries into the deaths of black men with mental health problems in police or health custody (such as the inquiry into David Bennett’s death), combined with existing fear and apprehension of mental health problems, can be major deterrents to the use of mental health services by BME people.^{36,40} The experience of contact with mental health services of men from BME communities, especially African–Caribbean communities, are often very negative. They may be perceived stereotypically by mental health and other professionals as aggressive and dangerous, and this may lead to a reluctance to seek help, particularly given the increased likelihood of coercive interventions, such as detention under the Mental Health Act and seclusion.^{18,20}

However, there are other reasons why, access to mental health care has been problematic for people from ethnic minorities.^{18,62,70,71} A number

of studies have found that social care and medical services for BME people with mental health problems are perceived by them as being culturally insensitive with assumptions, misunderstandings, and misdiagnoses hindering treatment and support.^{1,4,13,14,18,19,35,72–8} Religious preferences related to service provision are often misunderstood or ignored,^{77,79} as are cultural expectations of gender roles.^{35,77} Research studies undertaken for the Delivering Race Equality strategy have found that among Bangladeshi communities there are concerns relating to high levels of stigma, to religious issues such as provision of a prayer corner or halal food, to interpretation services; and to a preference for Asian staff.⁷⁴ Other South Asian groups were concerned about racist practices by some mental health staff, the lack of choice in treatment for BME people, inappropriate therapies and generally 'Euro-centric' approaches to treatment.⁷³ One study investigating the needs of Arabic-speaking communities concluded that more parenting advice was needed on issues such as education, culture relating to alternative health therapies, safety and general health.⁷² (There were no findings in this study directly linking mental health problems to deficiencies in parenting skills among this community.) BME parents and families living in poverty with restricted access to support services are less likely than the majority white population to access them. For instance, a retrospective analysis of case notes in a child and family consultation service found that Bangladeshi children and families were underrepresented in the clinic population, and that those who were referred were less likely to remain engaged in treatment.⁶⁵

Access to appropriate language services can be a crucial factor in promoting access to mental health services.⁸⁰ One large survey of minority language provision in social services within local authorities and larger voluntary sector agencies

showed considerable variability in the local availability of interpretation and translation.⁸¹ Another study of asylum-seekers found that access to all types of services was hindered by language barriers and lack of information.⁸² Although neither of these studies focused specifically upon BME parents, it is likely that their results can be generalised.

Children's experiences and involvement with services

Disruption to parenting capacity has been found to have profound and persistent implications for children and their parents.⁸³ The needs of children and young people who play a vital role in caring for a parent/s with mental health problems also appear to be under-recognised.^{50,84} There is evidence that children and young people who have been caring for a parent for some time are themselves at risk of developing mental health problems, and also that having mental health problems in childhood indicates a higher risk of continuing difficulties in adulthood.^{85,86}

Workshops and consultations with children and young people have found that many of them have insight and understanding of their parent(s)' problems and, though they would like to be active participants in treatment, recovery and care-giving there are few systems in place to enable this.^{10,87} Typically, they feel excluded from decisions about their parent's care and treatment,^{10,88} though the Children Act 2004 makes some provision for inclusion. For children from BME families, feelings of exclusion may be exacerbated by broader perceptions of racism and discrimination in services.^{10,18} One study, for example, found that some BME children who cared for a mentally ill parent thought that they were being treated in a discriminatory way because although school officials knew of their situation they did not make allowances for it.¹⁰

The complexity of establishing an effective relationship between BME groups and services is revealed in another study which established that service providers and teachers were sometimes uncertain of whether to intervene because of their fears of being seen as racist for doing so.⁴⁰

Research into the circumstances of children who are asylum-seekers has concluded that a failure to understand their often complex backgrounds and experiences leads to poor take-up of services, inappropriate interventions, and loss of engagement with services.⁸⁶ Even when culturally appropriate services exist, they are not always accessed by the intended target group.⁶⁵

Implications from the research

For the policy community

Throughout this briefing the interlocking relationship between poverty, BME populations and mental ill health has been noted. Poverty is not only a predisposing factor to mental health problems, but it also affects the individual development of children whose parents have mental health problems.^{27-9,32} In addition, family structures like lone mothering, predominant in some BME communities, are closely associated with poverty, with lone mothers constructed as problems and stigmatised in policy discourses.¹⁷ If the negative effects associated with poverty and BME families are to be tackled, then the response to the problem has to involve all relevant agencies and stakeholders both at the policy development and implementation stages. To date, many of the policy responses to BME mental health service provision have been ad hoc and reactive^{1,13,89,90} and have still not met the diverse needs of BME populations.^{1,90} The provision of mental health and related support services for BME populations is a complex issue, which needs to be carefully researched, planned,

and implemented with the involvement of parents from BME communities, including in setting the research agenda.¹¹ The benefits of such participation in research have been illustrated by the example of community projects with BME populations, which have displayed very positive outcomes. In these interventions, it is not just the leaders but the BME community itself which became involved.^{76,90-3} Unfortunately, despite the fact that many policy documents have made reference to empowerment, the general situation for people from BME communities in terms of access to appropriate services remains largely unchanged.^{11,15} Indeed, the findings of nine case studies of community partnerships in Wales have shown that the structural design of any policy instrument developed to promote community empowerment does not in itself guarantee the achievement of that empowerment.⁹⁴ There is also a need to investigate the influence of individual socio-cultural environmental factors, and disparities and overlaps between various BME groups.^{62,90,92}

It remains the case that more research into the circumstances and needs of BME parents experiencing mental health problems is required. There are significant gaps in existing research, especially with regard to the effects of mothers' and fathers' mental health problems upon their children and the effects of absent fathers, while the more general question about why there are such high rates of compulsory orders and detention among some BME groups also remains largely unanswered.⁹⁵

For organisations

The Race Relations (Amendment) Act 2000, in addition to prohibiting racial discrimination, also placed a positive duty upon local authorities to promote race equality, so they have a statutory obligation to provide fair access to their services.

However, the problems and challenges associated with ethnicity and mental health are influenced by a complex web of factors which are not amenable to simple solutions or a single approach.¹¹ This briefing has highlighted a widespread reluctance by BME parents to use mental health services and their perceptions of cultural insensitivity, exclusion, patronising behaviours and a general lack of understanding of the needs of BME mental health clients.^{19,24,41,76,90,96} Thus, the main task for service organisations is to understand the reasons for parents' low self-referral and other barriers to accessing services, and to develop an effective set of responses to these factors. Service providers will need to ensure a safe and empowering environment where assumptions and stereotypes are reduced or non-existent, and where oppression and racism are recognised and responded to.^{18,26,96–8} This will require closer cooperation with other services and with BME communities to:

- better understand local BME communities and improve staff awareness and knowledge
- where possible, recruit staff who are representative of local communities and have specific linguistic skills or cultural knowledge that can support appropriate practice^{1,96}
- enable those from BME communities using services to participate in service planning and development
- address problems of lack of knowledge and reluctance among prospective service users through outreach and educational programmes^{27,57}
- develop multi-disciplinary responses to enhance access to services and avoid fragmentation and gaps in service⁶⁶
- develop strategies to reduce high attrition rates in treatment programmes⁹²

- develop culturally appropriate forms of family support
- develop practices that allow children an appropriate voice in decision-making and discussion of their parent(s)' problems.^{88,99}

Service organisations need to recognise that BME communities have a long history of self-help and support,⁶⁷ so that tackling the reluctance by some people in BME communities to acknowledge mental health problems within families^{76,90} will require a sensitive and informed engagement with these communities as they try develop ways of reducing stigma and enhancing the prospects of treatment and support.

For practitioners

The implications for practitioners largely mirror those for their employing organisations. Nearly all of the changes required in service organisation and delivery depend upon practitioners supporting or changing their awareness and understanding of BME communities, and recognising their own pivotal position as the point of contact with BME parents with mental health problems. It has been noted that non-BME staff often lack confidence and are wary of criticism in their dealings with BME communities;³⁶ accordingly a critical professional self-awareness and an acknowledgement that they cannot possibly be well-informed about all BME communities should stimulate a willingness to learn from and engage with individuals and existing organisations from within BME communities, especially in exploring the prevailing myths and realities, and militate against participation by those using services.⁶⁷ Training to enhance cultural, linguistic, and participatory sensitivity is essential.^{1,10,22,35,77}

Direct family support and assistance may be the most immediate and practical means of helping

BME parents with mental health problems and their children,^{18,26} but a longer-term goal should be to enhance the capacity of people to advocate, influence and direct services themselves.^{100,101} The current policy emphasis upon personal choice and a rights-based approach to service provision, evident in the development of direct payments and personalised budgets for services, offers the prospect of services tailored to meet particular needs and cultural circumstances. There is some general evidence that those using services value the ability of social workers to provide non-stigmatising help and access to services,¹⁰² and the analysis of the 'essential capabilities' required to practice in mental health emphasises the importance of a professional value base which promotes dignity, human worth and social justice, and includes a commitment to the principles and social perspectives of the recovery model.¹⁰³

There may be many unidentified families where children are potentially at risk from their co-residency in a household where one or both parents have mental health problems.^{10,42} Research has also identified that many of these children are informal carers, while others face school exclusions and some are abused by their parents.^{44,88,99,104} Safeguarding such children is a primary responsibility of all practitioners, including carers who come into contact with them, but prior to identification this is a 'hidden problem'. There is, therefore, a need for increased awareness of its effects, firstly on children and subsequently on the community and wider society.⁸

Working with communities to ameliorate deeply embedded cultural and social practices that negatively affect them, such as the stigma of mental health problems in some BME communities, is a complex issue – as the findings from the Welsh study of community projects has shown.⁹⁴ Efforts at developing mental health

services to help and support BME parents and their children should therefore be culturally sensitive, and should recognise the potential role or significance of religious beliefs and spirituality for individuals and communities. One study noted a positive link between better mental health and practices such as attending mosque,¹⁰⁵ while another identified a positive association between church attendance and lower levels of depression.¹⁰⁶ For BME populations who are at risk of social exclusion, religious practices and other forms of community contact are likely to be important sources of psychological support and advice.

For people using services and their carers

There have been a number of reports of BME-led initiatives in the provision of mental health services. Many of these are typically based upon the assumption that people from BME communities are more likely to seek help from within their own communities, and most of these projects have been positively evaluated by users.^{28,90,92,100} Organisations like MIND have developed a range of services for Asians with mental health problems.¹⁰⁷ These include befriending schemes, drop-in centres, and groups for women with anxiety and depression. Initiatives such as these demonstrate the value of working in partnership with the local community.¹⁰⁷ Unfortunately, many of them are small in scale and short of resources, and consequently struggle to provide the levels of service needed by their communities.^{96,100,108} Generally though, services are improved by raising the participation and profile of black and minority ethnic user and advocacy groups in service planning and development.¹⁰¹ For instance, a key finding from a number of studies has been the strong preference for receiving services from staff from a similar ethnic and cultural background.^{24,96–8}

It is evident that BME parents and their families need to be fully involved in service planning, development and review at both individual and structural levels. This will ensure that services are relevant, accessible, and acceptable. For instance, initial assessments should be undertaken in partnership with parents and their children, and where necessary with the support of an interpreter.¹¹ While broader developments might be explored and 'tested' with BME community organisations. Children themselves may help with identification of mental health problems in parents, and although distrustful of 'official' mental health workers, may be more likely to talk to teachers or voluntary sector staff.^{85,88,99} BME parents and their children need a safe

environment in which to receive care and to discuss problems which they may feel render them vulnerable.

Those using services and their carers have a vital role in promoting and developing the knowledge and research base. User participation and user-led research will need to be supported by appropriate training in research skills, including critical appraisal. The inclusion of BME service users who are particularly susceptible to exclusion from participation due to ill-informed or oppressive practices will require the continuing development of research methods and practices that are sensitive to this diversity.

Useful links

Care Services Improvement Partnership (CSIP)

Supports positive changes in services and in the well-being of vulnerable people with health and social care needs.

www.csip.org.uk

Department of Health (DoH)

The Department of Health runs the English NHS. Its work includes setting national standards and shaping the direction of health and social care services.

www.dh.gov.uk

Depression Alliance

Provides information and support services to those who are affected by depression via publications, supporter/volunteer services and network of self-help groups. The Alliance is a user-focused organisation with offices in England and a sister organisation in Scotland.

www.depressionalliance.org

Equality and Human Rights Commission

From 1 October 2007 the Equality and Human Rights Commission took over the role and functions of the Commission for Racial Equality (CRE), the Disability Rights Commission (DRC) and the Equal Opportunities Commission (EOC), with new responsibilities for sexual orientation, age, religion and belief, and human rights.

www.equalityhumanrights.com

Family Welfare Association

A leading UK family charity, supporting over 45,000 families every year. The FWA tackles some of the most complex problems facing families including domestic abuse, mental health problems, learning disabilities and severe financial hardship.

www.fwa.org.uk

Joseph Rowntree Foundation (JRF)

The Joseph Rowntree Foundation is a leading charity supporting research on social issues, particularly the effects of poverty and the building of strong, cohesive communities.

www.jrf.org.uk

Mental Health Foundation

A UK charity that provides information, carries out research, campaigns and works to improve services for anyone affected by mental health problems.

www.mentalhealth.org.uk

MIND

The leading mental health charity in England and Wales provides a variety of services, including campaigning, publications and a confidential information line for users, carers and practitioners.

www.mind.org.uk

National Institute for Mental Health England (NIMHE)

A part of the Care Services Improvement Partnership, with the specific aim of improving mental health services and knowledge for both staff and people using services.

www.nimhe.csip.org.uk

Refugee Council

The largest organisation in the UK working with asylum seekers and refugees via direct and community support, and lobbying and campaigning.

www.refugeecouncil.org.uk

Runnymede Trust

An independent policy research organisation focusing on equality and justice through the promotion of a successful multi-ethnic society.

www.runnymedetrust.org

Sainsbury Centre for Mental Health

Works to improve the quality of life for people with mental health problems. The Centre carries out research, policy work and analysis to improve practice and influence policy in both mental health and public services.

www.scmh.org.uk

SANE

SANE raises awareness of mental illnesses and campaigns for better services for those affected, as well as undertaking research and providing information and support.

www.sane.org.uk

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Related SCIE Publications

Research briefing 23: Stress and resilience factors in parents with mental health problems and their children (2008)

Research briefing 24: Experiences of children and young people caring for a parent with a mental health problem (2008)

Resource guide 10: Commissioning and providing mental health advocacy for African and Caribbean men (2008)

Race equality discussion paper 01: Will community-based support services make direct payments a viable option for black and minority ethnic service users and carers? (2006)

Report 14: Doing it for themselves: participation and black and minority ethnic service users (2006)

Poverty, parenting and social exclusion (E-learning resources)

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