**Title:** Race Equality and Cultural Awareness Programme handout booklet  
**Date:** April 2010  

**Document purpose:** Participants handbook to support the exercises set within the RECAP training package

**Background:**
- RECC training materials were commissioned by the Delivering Race Equality Programme in 2004. Peter Ferns was originally commissioned to produce this material by the NIMHE New Ways of Working Team (with other contributors being: Premila Trivedi, Suman Fernando & Dominic Makuvachuma Walker)

- RECC training grew out of Module 5 of the 10 Essential Shared Capabilities (ESC) training materials (free to download from [www.lincoln.ac.uk/ccawi](http://www.lincoln.ac.uk/ccawi))

- The ESC are a set of 10 descriptors of values and behaviours that Service Users and Carers consider to be the essential prerequisites of high quality mental health care.

- RECAP is a programme which like the ESC asserts that service change and improvement is only possible when you examine and reflect on the values bases of practitioners and recipients of services.

- This RECAP roll out programme has been commissioned by the national Delivering Race Equality Programme and will be governed and evaluated nationally

**Acknowledgements:**
Thanks to the following individuals for participating in the RECAP pilot phase by supporting and influencing the changes required to make this a valuable training package; Ian Mcgonagle, Olivia Nuamah, Adetoun Adefioye, Johnson Oyedeji, Shahana Ramsden, Edmund Thong, Linn Davies & Dorin Varza

Thanks to Caroline Hounsell and Karen Velasco for supporting, developing and delivering key aspects of the RECAP programme, as commissioned by Delivering Race Equality Programme.

Thanks to Poppy Jaman for coordinating the over all development of the RECAP, development of the RECAP national training team and the RECAP train the trainer package and the initial roll out programme.

**The RELATE model:**
The RELATE model has been developed and designed by Caroline Hounsell as part of the design of the new Race Equality and Cultural Awareness Programme.

The RELATE model has been devised as a tool to support individuals address discrimination.
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Handout 1 - The ‘seven dimensions’ of the Cultural rainbow

The Cultural Rainbow

© adapted from Trompenaars & Hampden-Turner (1997)
<table>
<thead>
<tr>
<th>1. Feelings (Red)</th>
<th>1. Feelings (Red)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(EXPRESSIVE) It is perfectly alright to show what you are feeling in public sometimes even when it is with people you don’t know very well.</td>
<td>(RESERVED) It is always best to contain your emotions when you are in public otherwise people will feel that you are 'melodramatic' or excitable.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Rules (Orange)</th>
<th>2. Rules (Orange)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(FLEXIBLE) Rules and regulations in organisations are all very well but you can’t take them literally. You have to take into account the person and their situation when applying them and be prepared to bend them where you feel it is necessary. Fairness is about being flexible.</td>
<td>(STANDARDISED) Rules and regulations in organisations must be applied to everyone in exactly the same way if they are going to be seen as fair – exceptions must be kept to a minimum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Individuality (Yellow)</th>
<th>3 Individuality (Yellow)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(GROUP) It is better for individuals to see themselves first as part of a family, community or work team even when it is not in their personal interests. In this way these groups will help them in future when they require it and they will get their needs met.</td>
<td>(INDIVIDUAL) Looking after your immediate family and yourself is definitely the highest priority, other wider social group interests would be of secondary importance. A good community or group is where individuals have the most personal freedom, take their own decisions and have opportunities for personal development and individual prosperity.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Problems (Green)</th>
<th>4. Problems (Green)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(HOLISTIC) The best way to approach a complex problem or situation is to first step back from the detail and take a ‘bigger picture’ view to get a feel of what is happening by looking for patterns and relationships between the different elements of the situation and then get more accurate information.</td>
<td>(ANALYTICAL) The best way to approach a complex problem or situation is to first break things down first into the most important elements and get some accurate information about each element so when you put it all together again you will have a better understanding of what is going on in the ‘bigger picture’.</td>
</tr>
<tr>
<td>5. Status (Blue)</td>
<td>5. Status (Blue)</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Everyone has a right to a basic level of respect but we often give extra respect and reward to some people in society.</td>
<td>Everyone has a right to a basic level of respect but we often give extra respect and reward to some people in society.</td>
</tr>
<tr>
<td>(ASCRIBED) It is better for people to be valued and rewarded in society on the basis of their importance and reputation in their family, community and work rather than just going on recent performance in their social roles or job-related roles. This brings stability and continuity to society and organisations.</td>
<td>(ACHIEVED) It is important for people to be valued and rewarded in society on the basis of how they perform in their roles and what they actually accomplish at present rather than who they are in the community, their past reputation or their job title.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>6. Environment (Indigo)</th>
<th>6. Environment (Indigo)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ACCEPTANCE) We are far from being able to control our situation and what may happen to us in the future. We need to focus on being in harmony with our environment and within ourselves and calmly accept things that we cannot change and actively work for inner peace of mind.</td>
<td>(CONTROL) We are quite capable of taking charge of our own destinies and shaping what happens to us. We need to focus on changing things by analysing our situations and engaging in determined action. We should never sit back and accept things.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Time (Violet)</th>
<th>7. Time (Violet)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(PAST-PRESENT) We cannot understand the present or go into the future unless we look back to understand, value and celebrate our past. It is fine to spend time and resources doing this.</td>
<td>(PRESENT-FUTURE) We should not dwell on the past and waste resources celebrating the past but look ahead to what we want in the future. We should look for and take up potential opportunities in the present and make plans for that desirable future.</td>
</tr>
</tbody>
</table>
### 1. Feelings

<table>
<thead>
<tr>
<th>Expressive</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Reserved</th>
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### 2. Rules

<table>
<thead>
<tr>
<th>Flexible</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Standardised</th>
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### 3. Individuality

<table>
<thead>
<tr>
<th>Group</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Individual</th>
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### 4. Problems

<table>
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<tr>
<th>Intuitive</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Analytical</th>
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### 5. Status

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Achieved</th>
</tr>
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</table>

### 6. Environment

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Control</th>
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</thead>
</table>

### 7. Time

<table>
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<th>Past-Present</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Present-Future</th>
</tr>
</thead>
</table>
‘Culture’ is rather like an iceberg; you can only see around ten percent of it above the water line and the vast majority of our cultural values are hidden below the surface.

Visible Culture (Superficial, explicit, taught…)
Art
Music
Literature
Drama
Dance
Games
Cooking
Dress

Invisible Culture (Deeper, habits, assumptions, understandings, values…)
Facial Expressions
Religious Beliefs
Religious Rituals
Importance of time
Paintings
Values
Literature
Child-raising Beliefs
Ideas about leadership
Gestures, Body Language and Facial Expressions
Ideas about Fairness
Ideas about Friendship
Ideas about Modesty
Courtships Practices
Eating Habits
Understanding of the Natural World
Definitions of Sin
Theory of Disease
Concept of Cleanliness
Patterns of Group Decision - Making
Attitudes towards the Dependant
Approaches to Problem Solving
Roles in relation to Age, Sex, Class, Occupation, Kinship….
Definition of Insanity
Ordering of Time
Notions about Logic and Validity
Concept of Self
The Importance of Work
Concept of Personal Space
Rules of Social Etiquette
Housing
Attitude to sexual behaviours
AND MUCH, MUCH MORE…….
Products, food, clothes, symbols, rituals, buildings etc.

Decisions and behaviours

Norms and values

Core beliefs and assumptions
Diagram 1: The Social Context of Mental Health Work

Social factors:
- political expediency
- social pressures
- traditions

Model of ‘illness’
- Psychological theories
- Clinical observations

Individual Factors
- ‘common sense’
- racial stereotyping
- cultural assumptions

DIAGNOSIS
Our personal values and the values of society will always play a part in determining the judgements that are made during the diagnostic process in mental health. The diagram above is adapted from Suman Fernando (2002) and summarises the wider process of diagnosis.

The issues surrounding personal values of practitioners are focused around the ‘individual factors’ box in the diagram. Practitioners will be strongly influenced by their sense of ‘what feels natural’ to them or what feels like ‘common sense’ when faced with making judgements about social situations. Underlying these natural preferences are the practitioner’s own cultural assumptions gained from a variety of sources, including their ethnic background and the cultural ‘norms’ of the society and/or professional group within which she or he operates. Racial stereotypes are liable to influence a society’s cultural norms and so perceptions of Black people tend to be negative in the context of a discriminatory society.

In the ‘social factors’ box the political agenda will also have a big impact on the diagnostic process. For example, if there is a public panic about a specific group of people such as those with a diagnostic label of ‘personality disorder’ there will be pressure on authorities to ‘do something’ about that group and the perceived threat ‘they’ present to the public. This group effectively constitutes an ‘out-group’ in society which is discussed later in this session. The impact on diagnosis may then be to have a greater focus on ‘dangerousness’ and the issue of ‘treatability’ and the person’s ‘best interests’ may then be side-lined. Traditional views of mental distress will also influence the purpose, process and outcomes of diagnosis as it is essentially a value-based process.

Diagnosis in mental health is not purely a ‘scientific’ or ‘technical’ process - it always involves value judgements by practitioners.

Whenever there is a major change in legislation or policy affecting BME people ask ‘why’ it is happening to uncover the underlying values being promoted. Make a judgement about what is ‘good’ or ‘bad’ about the change to uncover your own values and where you stand.
Even before Hitler came to power in 1933, the ideology of eugenics was gaining in popularity in Germany, the United States, and other countries. Eugenics is the belief that the human species can be improved by controlling reproduction among people with undesirable genetic traits. The story of groups targeted for racial hatred by eugenicists in Germany is well known, and includes Jews, people with mental illness, people with disabilities, homosexuals, criminals, Gypsies, and foreign workers. The fate of people with mental illness is also fairly well known; in 1933, a law was enacted making it legal for doctors to sterilize people with mental illness against their will, resulting in the sterilization of mass numbers of them (Friedlander, 1995). Eugenics advocates of the time did not necessarily support the idea of killing people with disabilities, but believed that their sterilization was sufficient to prevent their undesirable traits from being passed on to future generations. In this “genetically dominated worldview,” (Lifton, 1986) the goal was to exclude people with mental illness and certain physical disabilities from the gene pool in order to produce a stronger race of German people or Volk. Toward the end of the decade, however, the ideology shifting toward greater approval for the elimination of people with mental illness rather than just their exclusion.

EUTHANASIA SELECTION CRITERIA BASED ON SOCIAL FACTORS The Concept of Social Worth In his book about the social organization of dying, Sudnow (1967) used the concept of social worth to explain how physicians and nurses in a public hospital emergency room decide from among patients who arrive as “possible dead on arrivals” which ones will receive resuscitation and efforts to revive them. Using social factors such as the age, social class, and perceived moral character of a patient, physicians made more attempts on behalf of younger patients than older ones, middle or upper class more than lower class patients, and patients perceived as morally “upright” as opposed to drug addicts, alcoholics, and prostitutes who were perceived as wasters of scarce hospital resources. Sudnow’s ethnography did not find that doctors consciously intended to punish certain social groups by withholding life-saving measures, but the social factors used for “triage” indicated which patients had more “social worth” than others. The concept of social worth is a useful model to help us in determining that at least four social factors which were used in addition to physical factors, to select victims of euthanasia: age; perceived moral character of the victim; curability or incurability of the illness; and the ability or inability to work. The accounting methods and amount of detailed record keeping cannot be underestimated here. The patient form required information as to four different patient categories: 1) those with “schizophrenia, epilepsy, senile dementia, therapy-resistant paralysis, feeblemindedness, encephalitis, and Huntington’s Chorea,” and who are “not employable” or capable of nothing other than merely mechanical work; 2) those who had been in the asylum more than five years; 3) those who were ‘criminally insane’ (that is, committed by the courts); and 4) those who were not a German citizen. Once the completed patient forms were filed with the Operation T4 headquarters, a team of 3 “expert” referees would decide on the fate of the mental patient. If the patient was selected for euthanasia, the patient’s home institution would be notified to ready the patient for transfer. Lifton (1986:57)
Throughout the 1930’s, the field of psychiatry tried to improve its public image (which had become heavily stigmatized in the previous decade) by trying to find therapies that would bring about a cure for mental illness. Psychiatrists applied new therapies to asylum patients; for example, somatic therapies, such as insulin shock therapy (Burleigh, 1994:84) or electro-convulsive shock therapy were tried on patients with acute cases of mental illness, such as depression.

**Work And The Inability to Work**

Even before their sterilization, institutionalized mental patients were considered to have relatively little human worth. By being sterilized, they could not produce children who would become workers for the State or potential members of the Nazi party. By being institutionalized, they were regarded as an economic drain on the State or individual family resources. But if they could perform work, the chances of being spared were better than for those mental patients who could not work. Those who could peel vegetables, make cardboard boxes, or perform tasks to maintain the building and grounds, were more valued than those who could not work. But it was not only the ability to work, but the amount and type of work a patient could do was considered, relative to the kind of work was needed in the institution, which “influenced the decision on inclusion in the killing operation” (Friedlander, 1995:77).

The most important criterion in the decision to transport a patient to a killing centre was economic (Friedlander, 1995: 82-83): essentially, it was patients’ ability to work, the amount of work they could do, and the type of work that determined whether they stayed in the institution or were transported to their death. Those who were regarded as incurable and could not work were deemed to be totally worthless. Those with chronic or unproductive cases became society’s throw-aways.
Prisoners at work in the quarry of the Flossenburg Concentration camp.

Concentration camp inmates at forced labour hauling cartloads of earth for the construction of the "Russian camp". (April - May 1942)

Photos from About.com
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the <strong>political expediency</strong> at the time?</td>
<td>What impact did the <strong>political expediency</strong> have on the Holocaust?</td>
</tr>
<tr>
<td>(Expediency means a regard for what is politic or advantageous rather</td>
<td></td>
</tr>
<tr>
<td>that for what is right or just; a sense of self-interest.)</td>
<td></td>
</tr>
<tr>
<td>What were the <strong>social pressures</strong> on the Nazi’s medical profession in</td>
<td>Why were these <strong>social pressures</strong> so strong?</td>
</tr>
<tr>
<td>Germany to defend the medical holocaust?</td>
<td></td>
</tr>
<tr>
<td>What <strong>cultural factors</strong> in Germany maintained the Holocaust?</td>
<td>How did the factors of <strong>common sense</strong>, <strong>racial stereotyping</strong> and</td>
</tr>
<tr>
<td></td>
<td><strong>cultural assumption</strong> affect the individuals involved including</td>
</tr>
<tr>
<td></td>
<td>psychiatrists at the time?</td>
</tr>
<tr>
<td>What do these accounts tell you about the <strong>diagnostic process</strong> being</td>
<td>How is the process of diagnosis today different from what happened</td>
</tr>
<tr>
<td>followed at that time?</td>
<td>then in mental health services?</td>
</tr>
</tbody>
</table>
Handout 4a(1) – example of starting points

<table>
<thead>
<tr>
<th>What was the political expediency at the time?</th>
<th>What impact did the political expediency have on the Holocaust?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intolerance of difference was a way of making the masses feel protected and safe and also supported a view of economic superiority by ensuring only the most productive were allowed to live</td>
<td>Justified murder on the grounds of protecting the national interest and also through dehumanising others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What were the social pressures on the Nazi’s medical profession in Germany to defend the medical holocaust?</th>
<th>Why were these social pressures so strong?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicine was seen as an agent of the state. Compliance with the professional calling was tantamount to complying with the wishes of the state.</td>
<td>Information was provided to the nation in a particular way which led to some commonly held untested beliefs. A social climate existed where the political forces were entitled to act because of the demands of the public but these demands were engineered by the way information was provided.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What cultural factors in Germany maintained the Holocaust?</th>
<th>How did the factors of 'common sense', racial stereotyping and cultural assumption affect the individuals involved including psychiatrists at the time?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deference to power</td>
<td>Science was used to search for and produce evidence to support hypotheses that were morally and empirically flawed</td>
</tr>
<tr>
<td>Pursuit of perfection which translated into an intolerance for difference</td>
<td></td>
</tr>
<tr>
<td>A belief in Germanic superiority</td>
<td></td>
</tr>
<tr>
<td>What do these accounts tell you about the <strong>diagnostic process</strong> being followed at that time?</td>
<td>How is the process of diagnosis today different from what happened then in mental health services?</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Political and social forces created the concept of what was normal and what was pathological. Evidence was then sought in individuals to support a diagnostic process where the criteria were set to categorise particular groups as being pathological – i.e. it was fixed.</td>
<td>The approach to research, randomised Controlled Trials and peer reviewing leads to a different burden of proof and rigour in science. However other factors such as drug company funding, cultural views about what constitutes evidence and beliefs about what constitutes illness means that there are more similarities than might initially be apparent.</td>
</tr>
</tbody>
</table>
Handout 4b – Diagnosis & Social Context model exercise

1851 Dr Samuel Cartwright – Mental health problems of slaves (from ‘My Southern Home’ by William Wells Brown, 1815-1884)
Dr. Samuel A. Cartwright was a prominent Louisiana physician in 1851 and one of the leading authorities at the time on the medical care of ‘Negroes’. Dr. Cartwright claimed to have discovered two mental diseases peculiar to Black people. These were called “dрапетомания” and “дисаестезия аэтиопика”.

The first term came from drapetes, ‘running away from home’, and mania, meaning ‘mad or insane’. Cartwright claimed that this ‘disease’ caused Black slaves to have an uncontrollable urge to run away from their home (the plantation) and their ‘masters’.

Dysaesthesia аэтиопика supposedly affected both mind and body. He described it as “hebetude (dullness of mind)… a disease peculiar to Negroes called by overseers – rascality.” The diagnosable signs included disobedience, answering disrespectfully, refusing to work and deliberate damage to equipment and tools. The ‘treatment’ was to put the person to some kind of hard labour which apparently sent “vitalised blood to the brain to give liberty to the mind” or alternatively being whipped.

1895 Dr. T.O. Powell – ‘Slaves are mentally healthier’

Dr. Cartwright also stated that “The disease is the natural offspring of Negro liberty – the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks”. This theme was later developed and scientifically ‘proved’ in 1895 by Dr. T. Powell, Superintendent of the Georgia Lunatic Asylum. He compared the census records between 1860 and 1890 and showed that insanity among ‘Negroes’ had increased from one in 10,584 to one in 943. Dr. Powell believed the stable, secure and structured lives led by slaves served as protective factors against ‘mental illnesses’. Dr. Powell stated: “Freedom, however, removed all hygienic restraints, and they were no longer obedient to the inexorable laws of health, plunging into all sorts of excesses and vices; leading irregular lives and having apparently little or no control over.

By the middle of the eighteenth century, in London alone, there were 18,000 Black slaves, forming nearly three per cent of an estimated population of 650,000. The influence of slavery and colonisation has left an indelible mark on African-Caribbean people by familiarising them with many aspects of British life and institutions. (The Parekh Report, 2002)

...by 1860 ten of the richest men in America lived not just in the South but in the Natchez district of Mississippi alone. In 1810, the cotton crop had been worth $12,495,000; by 1860, it was valued at $248,757,000. Overall, 26 percent of Southern white families owned slaves.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. What was the <strong>political expediency</strong> at the time?</td>
<td>2. What impact did the <strong>political expediency</strong> have on the issue of slavery?</td>
</tr>
<tr>
<td>(Expediency means a regard for what is politic or advantageous rather than for what is right or just; a sense of self-interest.)</td>
<td></td>
</tr>
<tr>
<td>3. What were the <strong>social pressures</strong> on people in the South to defend slavery?</td>
<td>4. Why were these <strong>social pressures</strong> so strong?</td>
</tr>
<tr>
<td>5. What <strong>cultural</strong> factors in the South maintained slavery?</td>
<td>6. How did the factors of ‘<strong>common sense’, racial stereotyping</strong> and <strong>cultural assumption</strong> affect the individuals involved including psychiatrists at the time?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7. What do these accounts tell you about the <strong>diagnostic process</strong> being followed at that time?</td>
<td>8. How is the process of diagnosis today different from what happened then in mental health services?</td>
</tr>
</tbody>
</table>
Social factors*

• **Political expediency** – slavery. To show that slavery was a ‘natural’ condition for Black people would help to justify its existence as being an inevitable fact of a ‘natural’ process. Slavery at that time was a highly contentious political issue that was fuelling a civil war and there were strong vested interests on both sides of the argument for and against.

• **Social pressures** – Many people were implicated in the practice of slavery and there were strong economic incentives to defend slavery in the Southern States of America. Runaway slaves were extremely uneconomical as it was expensive to track and bring them back to the plantation. Many of the inhuman punishments severely reduced the slaves’ value to owners or, of course, people were sometimes murdered to serve as a lesson for others and exert ‘social control’ through fear.

• **Traditions** – The culture in the American South had been steeped in the slave trade and a great deal of wealth in the local economy in the South had been generated in the past through plantations and the trafficking of slaves. Slavery was felt to be an inherent part of the South’s culture and so any attack on slavery was an attack on the South’s culture.
Individual Factors*

• **Common sense** – It was generally thought that Black people brought to America as slaves were better off than those remaining in their countries of birth as they were being ‘civilised’. White people at that time, including psychiatrists, were convinced that Black people were very different from White people and that they were certainly inferior.

• **Racial stereotyping** – It was felt that Black people were less intelligent and less civilised than White people. It was even suggested that they did not feel pain as much and could stand long days working hard in the sun without damage to their health. Interestingly, similar views were held about people in mental distress in the early ‘asylums’ where inhumane ‘treatments’ were justified on the grounds that people in distress could not feel physical discomfort or pain. It was held that Black people would not experience the same forms of mental distress as White people as their brains were fundamentally different.

• **Cultural assumptions** – It was so strongly believed that slavery was right and ‘natural’ that White people from the South thought that even Black people would see the sense and benefits of it. Black people who escaped were seen as acting irrationally and thus ‘mentally ill’. Towards the end of the Civil War it was even suggested that Black slaves may fight for the South to defend plantation life and culture, paradoxically in return for their ‘freedom’.
Handout 5 - Themes of Equality

**Theme 1 ~ Valuing Cultural Diversity**

Valuing cultural diversity would begin with reinforcing the cultural identity of individual service users and taking the issue of cultural background seriously in practice. The ‘iceberg’ model would suggest that understanding where a person is coming from in terms of their cultural identity involves enabling BME service users to feel comfortable in sharing their cultural beliefs and values with practitioners. It means that the service user and their families and carers should be viewed as the ‘experts’ in their own cultural identities. Hence, BME service user participation is essential for culturally appropriate practice.

On a wider front, services should be made more culturally appropriate for BME individuals and communities. Culturally appropriate services are not just about having the right posters on the wall or having the right kind of food available to service users. The ‘iceberg’ model shows us that the real challenge is to develop mental health services that are inclusive of people’s beliefs and values as well.

**Theme 2 ~ Preventative Approaches**

Preventative approaches require services to ensure its priorities are to provide support and early interventions to everyone who may need mental health services. Under-reaction and over-reaction is not only damaging to people it also results in long-term and costly problems further down the line. It requires services to intervene in a timely fashion when problems are detected rather than wait until a crisis occurs, so a responsive service is crucial for a truly preventative approach. Preventative services must also increase opportunities for people to grow and develop and build resilience and endurance in relation to mental distress.

**Theme 3 ~ Autonomy & Advocacy**

There will be times when people will be unable or unwilling to express their own point of view and interests in services. It would be necessary to provide assistance to people to advocate for themselves at these points. Independent advocacy is required for advocates to be able to truly represent the service user’s viewpoint and interests. The ultimate goal of any advocacy should be to enable and empower service users to speak for themselves and take more control of the important decisions being made in their lives. For BME service users it would be best to have someone advocating that understands the experience of racism and surviving
the psychiatric system. Ideally BME people should have access to a group of BME service users/survivors so that they can generate a sense of solidarity as well as gaining exposure to positive role models leading to greater self-confidence.

**Theme 4 ~ Holistic Approach**

A holistic approach requires services to view service users not just as individuals but as members of families and communities and take into account wider social and community factors in assessing individual needs. Assessments have to be balanced with consideration given to the personal strengths and interests of the person and a wider view of their needs not just a narrow focus on ‘symptoms’ of mental distress or problems in the person’s life.

Many mental health services focus on just the basic needs of people for everyday survival but services need to move beyond this goal to really improve the quality of life for service users. Services must help people to identify a desirable personal future and achieve the kind of lifestyle people would want. There are often discriminatory barriers preventing people from achieving their goals for happiness and fulfilment and services must focus on assisting people to remove these barriers.

**Theme 5 ~ Participation & Information**

Mental health services have to be more proactive around equality issues and reach out to groups who have been poorly served or excluded in the past. The lack of credibility created by a legacy of poor services in the past will be a serious barrier to progress unless service providers work actively to establish credibility with BME communities. One of the most effective strategies for gaining credibility is to enable the genuine participation of BME service users and their communities in the design and improvement of services. A good first step for services is to provide accessible and accurate information to BME people about what is available in the locality. Participation has to be meaningful for the people involved and so having a carefully thought out strategy is essential with resources set aside to implement improvements that are needed. There are now an increasing number of examples of BME service user-led audit and service improvement initiatives to draw examples of good practice in participation.

**Theme 6 ~ Safeguarding Rights**

Mental health services have the potential to infringe people’s rights so there must be safeguards to ensure that people are protected from abuse and exploitation. Compulsory admission to hospital and forced medication are all unique to mental health and so robust safeguards are required. Policy and procedures to promote equality and diversity have to be implemented and monitored to be of any real value. Systems such as monitoring the quality of services are best undertaken in partnership with BME service users, families and carers to guarantee that judgements about service quality are based on criteria that are important for BME
people. Complaints procedures should be fully accessible to BME service users with the necessary supports. Leaders must ensure that they model and promote good practice in their decision-making and ensure that they support BME service user participation. Participation is vital for safeguarding rights as it acts as a check and balance against practitioner power increasing the likelihood of culturally appropriate practice. Finally, practitioners have to start taking individual accountability for promoting race equality in their own practice and within their teams. It includes training such as this where learning gained must be put into practice if we are to ever really change the culture of mental health services.
**DISEMPOWERMENT**

Sleepless nights, enveloping despair - guilt.

Guilt at being me - black, female, poor,

Part of a large family -

Part of an even larger society

Resounding with racism and rejection.

Tablets, psychiatrists, falling more into the abyss

Of white man’s medicine.

Hospital, enforced activity, constant cajoling

To fit their categorization of me,

All the time denying me my pain, my hurt, my confusion.

Reinforcing my “badness” at feeling these things.

Isolating me - alone - with my problems,
Unexpressed anger, increasing guilt,
The silence growing louder.
Largactil, locked doors, ECT, eventually stillness.
Sinking deeper and deeper into the sanctuary of insanity:
Beautiful - silent - still - feelingless - internal death;
Pushing back the screaming agony
Before I infect them with my poison -
The poison of my blackness, my culture, my very being;
All wrong, all contradicting the norms of their society,
All disrupting their ordered world.

And in the end I saw it their way, the guilt was mine.
So I tried - and battled - and pulled my self out of it -
And buried myself deeper, keeping me inside,
Smiling nicely, acting right, colluding with them,
Ensuring their equilibrium was maintained,
So I have the privilege of existing in their world -
Of experiencing their values, their beliefs,
Their prejudice, their power.

What does it matter that I died in the process?

What does it matter? One more black, crazy female,

One more drain on society, what does it matter?

To them nothing -

And ultimately to me it must mean nothing too,

Otherwise even existence becomes impossible

And internal death can only be mirrored in external reality.

by Premila Trivedi in” Survivors’ Poetry - from dark to light” - Survivors’ Press 1992)
I became disempowered by …

- Not being listened to
- an over-emphasis on the fact that my “illness” is a medical phenomena, with little account being taken of social stresses (in particular the impact of personal and institutionalized racism) on my life and an over-emphasis on drug treatment
- an over-emphasis on conforming to European ‘norms’ and values
- the assumption that I could have no responsibility for my ‘illness’ or my response to it
- a disregard for my own coping skills and mechanisms
- being treated as if I had only ever been a psychiatric patient
- the assumption that I will always be just a psychiatric patient

Over time:

- I have become more empowered by …
- being listened to and having my views and opinions taken seriously
- having recognized that social factors (including personal & institutionalized racism) also contribute significantly to my mental health crises
- making me see that drugs are only one response and other things may be of important complementary value
- acknowledging and respecting my own cultural and social norms, and helping me to see myself in those contexts
- helping me understand that I could take some responsibility for my illness, particularly recognising and doing something about signs at an early stage
- an acknowledgement that I do have coping skills that I can use much more to help me self-manage
- the recognition that I have a past and skills and talents that don’t just disappear because I’ve become a psychiatric patient
- the recognition that I have a right to a hopeful and useful future

By Premila Trivedi
A model of personal empowerment

Empowerment is a process that you work on with a person not something that you do to people. The process of empowerment varies from person to person and is influenced by a person's past experiences. It is vital to get the pace of empowerment right and to be sensitive to a person's changing needs in terms of personal support and degree of autonomy. There are times when a person wants someone else to make a decision and there are times when the person wants to make the decision themselves. People who
have been affected by ‘institutionalisation’ may need many years before they can fully take control over all of the decision-making in their lives. However, it is important for any plan of assistance to be aiming at the ultimate goal of people taking control of their everyday lives.

For BME service users, the process of empowerment must be culturally appropriate in terms of the seven dimensions of culture. For example, it may mean that the person’s family will be very much involved in the process of empowerment as their sense of individuality is very much towards the ‘group’ end of the spectrum or decisions are made to ‘accept’ the situation rather than take ‘control’ of what is happening. The model of empowerment outlined here was created through work with BME people with learning disabilities in self-advocacy groups. It needs to be sensitively applied with BME service users as explained above and should never be rigidly applied but used in a flexible way to generate possible strategies for empowerment.

There are eight ‘building blocks’ in this model of empowerment as follows:

1. **Build a positive self image**

   It is impossible to ascertain people’s interests, needs and wishes if they have little sense of who they are or feel bad about themselves. People may require help in re-discovering and re-affirming their identity. Providing positive role models and building solidarity with others who have similar experiences can be very useful in building a person’s sense of cultural identity and self confidence. People in mental distress usually ask fundamental questions of themselves and BME people often fall back on their cultural heritage and spirituality as a source of strength and recovery.

2. **Increase control and responsibility over one’s own life**

   People often become more dependent within mental health services and service providers inadvertently take control of the person’s life in all sorts of unnecessary ways. Practitioners need to actively help people to increase service users’ control over their lives and not use their power coercively to impose narrow and discriminatory approaches to dealing with mental distress. Along with control over one’s life comes responsibility not to put oneself or others in harms way and so issues of risk and safety have to be discussed openly and honestly with service users. BME service users are particularly at risk of being poorly served by services and so these
risks also have to be looked at seriously. People are bound to make mistakes along the way as this is part of human nature but it is important to be supportive and help people to learn from their mistakes and not to respond in a punitive way.

3. Supporting self-advocacy

People should always be supported to express their point of view even if it is in opposition to service providers or families and carers. Points of difference and potential conflict can often form the basis of a plan of action to improve the situation and mediate conflicts in the person’s life. There are always going to be times when people are unable to speak up for themselves and there may be need of independent advocacy. Practitioners can advocate for their service users to some extent but there will be limitations as conflicts of interest arise especially when service users are in dispute with service providers. Independent advocacy is the best option in these situations where advocates can truly represent the voice and views of the service user. BME service users will need advocates who can understand their point of view and their experience of institutional racism and discrimination. There may well be cultural and language skills needed by advocates to be fully effective. Care has to be taken in selecting a suitable advocate for BME service users as simple ‘ethnic matching’ may not work due to differences in gender, class, religion, political reasons or just the skills of the worker concerned.

4. Giving the person information

Knowledge is certainly power. BME service users and carers are often given inadequate information about what is available to them in a locality especially if they are an ‘out-group’ such as refugees or asylum-seekers who are new to the country and do not know the mental health system. Giving people information about medication seems to come up in many surveys of BME service users’ views and also ties in with one of the other ‘building blocks’ regarding people’s rights. People need accurate and up-to-date information to enable them to make well-informed decisions. On the other hand ‘information overload’ may not be very helpful for a person in extreme distress and so working with families, carers and advocates is a useful alternative – practitioners must use their judgement in an empowering way.

5. Enabling participation in service provision

We have already discussed how important it is to fully involve BME service users and their families and carers in the process of service provision if we are to create truly culturally appropriate services. However, there are many barriers to genuine participation in services in the way that practitioners do things such as take referrals, assess people’s needs, plan and review through activities such as ‘ward rounds’ and ‘case conferences’. All of these approaches do not lend themselves to be very accessible to BME service users. Service providers have to be more flexible and enter into a real partnership with BME service users, families and communities if the quality of service is to improve. BME service users and families also have to begin to trust practitioners who are genuinely trying to each out to them and work more collaboratively. This may not always be easy if people have had very bad
experiences of services in the past but it is essential to meet practitioners half way or we will never bridge the gap of credibility and distrust that currently exists for a lot of BME people. Work in the field of BME service user and community participation has shown that once we do overcome the initial hurdle of trust, admittedly a big one in many areas, some excellent work can be done and good progress made in improving service quality (see forthcoming publication by the author ‘Journey to Participation’ from Pavilion Publishing).

6. Helping the person to find creative options

People going through difficult and stressful times often develop ‘tunnel vision’ where they see very few or no alternatives in their situation. Capable practitioners must help people to explore their situation more thoroughly and think creatively about what is possible. However, this is unlikely to happen if the person is feeling very fearful and anxious. The practitioner must ensure that they are exploring the situation with the person and be there with them through the process of exploration. ‘Being there’ is again something that a lot of BME service users have asked of service providers, it is a powerful statement of solidarity for people who are not only feeling alone in a wider hostile society but are also being threatened with rejection within their own hitherto safe family and community. Having someone who is knowledgeable and capable with them during this period can serve to allay some of a person’s fear and enable her or him to think more creatively.

7. Helping people to plan for the future

Much of mental health service provision focuses on survival in the present and very little is done to help people to consider and plan for a desirable personal future. However, we all need our hopes and dreams to keep striving for a better quality of life. If we do not enable people to raise their eyes to the future horizon we do not give people any real motivation to keep struggling to grow and develop as people. This results in a ‘self-fulfilling prophecy’ where people enter a downward spiral of being stereotyped and oppressed, being denied valuable life opportunities as a result, subjected to a restricted existence and a poor environment for growth and development, resulting in increased dependence and deskilling of the person and finally a confirmation of the original oppressive stereotype. The diagram below summarises this process.

8. Safeguarding the person’s rights

BME people have consistently been poorly treated within mental health services despite some pockets of good practice, often in the Black voluntary sector. Concern has been voiced by a range of practitioners about the threat to the fundamental human rights of BME people within mental health services in terms of legal safeguards as well as straightforward health and safety issues and freedom from racial and other forms of abuse. Issues of social control through the Criminal Justice System and forensic services, misdiagnosis, the over-use of drugs, the lack of preventative services, the exclusion of BME families and carers from interventions are all just a few of the difficult and complex problems being faced by capable and committed practitioners.
Some of the previous ‘building blocks’ certainly do provide some safeguards such as the provision of robust independent advocacy and accessible information and these measures are not difficult to bring about. However, at the heart of the problem is a more intractable problem of a need for a cultural transformation in mental health services and this will be a much longer-term goal requiring strategic and ‘whole systems’ thinking.

We have stated that systems change can drive different behaviour from employees and a small start can be made by services looking at and changing some key systems that safeguard people’s rights. Complaints procedures exist in all mental health services now and ensuring that this system is accessible to BME people and their families is a first step to providing real protection of rights. Some areas have introduced advocates and carers advocates to help people to better access the system of complaints and go through the process. Another important system that is more ‘proactive’ than complaints is the evaluation of service quality. BME service user-led audit has been a useful catalyst for change in a locality by providing a clear and focused agenda for action that is based on a BME service user and family perspective (again see ‘Journey to Participation’ by the author). These kinds of system changes will start to shift the organisational culture in the right direction to protect the rights of all vulnerable groups using mental health services. Changes and legislative frameworks and the policies of mental health organisations can further enhance and reinforce the changes already beginning to happen.
The summary of research discussed earlier has highlighted several problematic issues in mental health services for BME service users. The holistic model outlined here directly addresses these experiences of institutional discrimination for BME people. The holistic model used acknowledges the important role of good clinical practice. However, it also recognises that mental health needs have to be understood in their wider social context and not subjected to a narrow medical approach

1. Holistic assessment

Several sources in research studies have suggested that misdiagnosis of BME people in the psychiatric system is a great concern. A holistic model of mental health would not attach undue importance to a person’s medical diagnosis but would view their health needs within a wider socio-economic context and, in relation to BME people, this would include the context of institutional racism in services. People with similar diagnoses will often have very different personal needs and require different forms of assistance to support community living.

2. Challenging stereotypes

BME people often have to deal with powerful stereotypes arising from a legacy of racism that has been handed down to them through a history of slavery and colonialism. Racist stereotypes have infiltrated several areas of professional practice in public services, particularly the theoretical frameworks used by professionals in their work. Practitioners have to be constantly vigilant to guard against the influence of stereotypes in their practice, particularly in areas where racial discrimination has been proven to exist (such as in decisions about ‘dangerousness’ and problems associated with cultural stereotyping and misunderstanding in assessments). A holistic model avoids making assumptions about individual needs based on any categorisation or ascribed characteristics of the individual concerned. Stereotypes in practice are exposed and challenged through a process of critical self-reflection, informed questioning and constructive challenging by peers.

3. Reinforcing cultural heritage

Cultural misunderstanding by practitioners has led to poor assessment and treatment in mental health services. In a holistic model, greater importance is attached to individual cultural heritage and ways are sought to support cultural identity through service provision. Holistic assessment includes the identification of the cultural and spiritual needs of the person and clarifies their desired
lifestyle with a view to maintaining and developing their lifestyle in the future. It is essential to understand the cultural heritage of a service user if a good-quality service is to be provided, one which offers opportunities for personal growth and development, transmits a positive self-identity and increases self-confidence.

4. Culturally appropriate services

Evidence suggests that many BME people do not use mental health services because they find that they are often culturally inappropriate. The provision of culturally appropriate services is central to a holistic model. Remember the ‘iceberg model’? Culturally appropriate here means all levels of culture – not just having the right food and posters on the wall but being inclusive of people’s core beliefs, assumptions and values.

5. Overcoming communication barriers

Language barriers are a major contributory factor to the low take-up of services by BME people from non-English speaking backgrounds. A holistic model improves access to services by ensuring that information and publicity about services is available in different languages and in different formats. People whose first language is not English need access to interpreter and translation services. The ideal option, of course, would be to have an ethnically representative workforce in mental health services where practitioners would have the necessary language skills to work with their BME service users directly.

6. Outreach and preventative work

BME communities may often need better information about services, but they also need education about mental health in general. The stigma attached to ‘mental illness’ is a problem in all communities and more outreach work has to be undertaken by services to all BME communities. Communication strategies and mental health promotion initiatives would help to increase knowledge about mental health as well as breaking down the stigma attached to using mental health services. There is some evidence from transcultural studies that the western medical model of ‘mental illness’ exacerbates stigma (see chapter ‘Psychiatric stigma and racism’ in the book Cultural Diversity, Mental Health and Psychiatry. The struggle against racism by Suman Fernando, 2003). Hence emphasis on a holistic approach to mental health problems, rather than the strict diagnostic approach, should reduce stigma. Better communication, mental health promotion and encouraging discussion of mental health issues could all help in breaking down stigma. Individual mental health practitioners who take a health education approach to their work can make a significant contribution to community education. A holistic model emphasises a preventative approach rather than a crisis-oriented one. The development of a range of community support services would be essential for a preventative approach.
7. Focus on discriminatory barriers

What happens sometimes through institutional racism or the tendency to ‘blame the victim’ is that BME service users or their families are blamed when services do not seem to be helping them. They may then be seen as ‘difficult’ or even ‘aggressive’. To counteract these negative processes, the holistic model focuses on the social processes of discrimination and devaluation that create unfair barriers for people, and reflects this in assessment and planning to meet the needs of individuals.

8. Appropriate intervention

There has been a consistent pattern of ‘over-reaction’ or ‘under-reaction’ to the needs of BME people by mental health services. Over-reaction has been characterised by crisis-oriented responses, which are often punitive or controlling in nature. Under-reaction has led to services ignoring what can be serious problems until these have reached a crisis point. At this stage, services have become involved, but too late to prevent serious harm occurring to BME individuals and their families. A holistic model requires timely and appropriate service responses, which neither discriminate in practice nor lead to inaction arising from a fear of being accused of ‘being racist’. This style of intervention also has to be culturally appropriate for BME service users, and outcomes have to be in line with their personal preferences and concerns.

9. Family/carer support

Lack of support for BME families and carers is part of the wider problem of lack of access to mental health support services for BME communities. A model of good practice requires proper assessment of family/carer needs and the development of a range of flexible and readily available support services for families/carers.

10. Range of therapeutic options

The over-use of drugs and physical treatments with BME service users in the mental health system is well documented. A holistic approach encourages the use of alternative therapies from different cultural traditions of healing. The main aim of good practice should be to increase the treatment options available to BME service users. The increased use of talking therapies with BME users would provide less restrictive treatment programmes and would also challenge the racist stereotypes of BME service users as being unintellectual and non-verbal.

11. Empowerment and advocacy
Statutory authorities have often excluded BME service users from participation initiatives. BME service users usually lack representation when decisions are made about the planning and delivery of mental health services. Good practice requires a process of empowerment for BME service users, to increase self-confidence and foster assertiveness. The development of independent advocacy and self-advocacy schemes is urgently needed, for BME service users to achieve proper representation and to speak up for themselves more effectively. Holistic services would promote advocacy actively and incorporate BME service user participation and advocacy in their procedures.

12. Safeguarding rights

The disproportionate use of compulsory sections of the Mental Health Act and the links between mental health and the criminal justice system suggests that the basic rights of many BME service users are under threat in the mental health system. A holistic model emphasises basic human rights and requires great caution in the use of statutory powers in mental health services. BME service users’ rights are safeguarded through anti-discriminatory procedures, accessible appeals and complaints systems and accurate monitoring of service quality. Safeguards include quality assurance systems which are based on service users’ views with indicators of service outcomes that reflect improvements in the quality of life of BME service users.
Handout 10 - A Holistic assessment and planning process

Holistic Assessment

- Get to know the person and their culture

Practitioners have to build a relationship of trust and establish a dialogue with the person if they hope to identify their real needs. Practitioners should be able to put themselves in the shoes of the service user to appreciate their point of view and this means they must understand the cultural background of the person.
• **Help to clarify the person’s desired lifestyle**

People may need some help in thinking through what kind of lifestyle they would really like to have and what they are aiming to achieve in the future. Most mental health services focus on survival in the present and do not encourage and assist people to plan for the future and strive for their hopes and dreams. The quality of people’s lives will not improve appreciably unless people learn from the past, understand and deal with the present as well as plan for their future.

• **Find out what the person thinks about their mental distress**

Looking at the meaning of mental distress for the person is an important step in providing a culturally appropriate service. The meaning of distress and how it impacts on the person’s quality of life will help the practitioner to assist the person in a sensitive way.

• **Identify the barriers to the person’s desired lifestyle**

By focusing on the barriers to desired lifestyle it is less likely that the service user will be ‘blamed’ for their situation either openly or in a covert way. It is also more likely that BME service users will engage with services that are focused on helping them to achieve what is important for them in terms of quality of life. Focusing on discriminatory barriers gives mental health services a sharper focus and often leads to a more effective use of resources.

**Holistic Planning**

The holistic planning process begins with the formulation responses by services to help meet the holistic needs of people and better achieve their desired lifestyle. It is important to separate out the two stages of the process of assessment and planning to ensure that an accurate picture of a person’s situation and needs is built up before looking at meeting needs. This approach avoids ‘slotting people into existing services’ as described in a ‘service-led’ approach earlier as a ‘Theme of Institutional Discrimination.

• **Generate creative options to address barriers to desired lifestyle**

Focusing on barriers to desired lifestyle ensures that services do not ‘pathologise’ or blame the individual for their situation and this is particularly important in dealing with BME people who are vulnerable to institutional racism. It is more likely that practitioners will be successful in engaging BME people in mental health services if they address their concerns and interests rather than pursuing a service-led agenda. The options generated may not be service options there may also be suitable non-service options. It must be
remembered that it is not possible or even desirable that services meet all the needs of service users as it is much better to strengthen and build the natural social networks of people and enable them to meet their own needs as much as possible. This will avoid long-term dependence on services and enable people to take more control over their own lives. However, it is not a ‘green light’ for services to opt out of providing adequate assistance and support for service users but a plea for services to intervene in a more empowering and focused way.

- **Check cultural appropriateness of options and consider need for risk assessment**

Once possible options for BME service users have been identified, they must be evaluated for their cultural appropriateness. Trying to see the proposed intervention from the BME service user perspective may help to make the package of assistance more sensitive to people’s needs and stop the plan from breaking down at an early stage. The approach taken here is to use the ‘rainbow model’ of culture to assess appropriateness of any interventions. If there are any concerns about risk, an assessment focused on this issue should be undertaken prior to any package of assistance being constructed.

- **Put together a package of assistance**

A final agreement has to be reached with the service user about what needs can and cannot be met by the services and interventions being offered. Service users and their families and carers should be clear about what services are being provided, who by, when and to what standards. Any service provision should be linked to specific objectives within the plan of assistance with criteria for quality so that the plan can be accurately monitored and reviewed by the service user, their family and service providers. Any written agreements should be communicated to service users in an accessible and understandable format.

- **Plan for monitoring and review of assistance package**

The monitoring and review of any plan of assistance must be conducted with the fullest participation of BME service users and their families/carers. Such an approach will provide further safeguards against culturally inappropriate services. This may well include overcoming language and other communication barriers. The power dynamics inherent in any monitoring and review process must be carefully considered and the systems and procedures involved adapted to ensure participation of BME service users.
Case Study 1: Gita & Dilip’s Story

Gita is a 36 year old Indian woman who has been living with her older brother Dilip in a comfortable flat for the past year, there is no-one else living with them. Gita is the youngest of 4 children and the only girl. Gita has three brothers who all live locally and have families of their own apart from Dilip. Gita has been using mental health services since she was in her early twenties. Her father died when Gita was three and her mother died two years ago when Gita herself was in the local psychiatric hospital.

Gita has been given a diagnosis of schizophrenia and is currently on tablets but she used to be on depot injections until a year ago. She was managed on 2-weekly injections of Depixol and oral Procyclidine, but two months ago (at the request of her brother Dilip) her medication was changed to oral Clozapine. She is being supported by the local community mental health team as Gita has a history of going into crisis quite suddenly and going back into hospital. However, she has managed to stay out of hospital for over 18 months with the support of her brother Dilip.

Gita came to live with Dilip over a year ago after she had been living with her other brother Sanjay and his family. Gita says that she really loved living there as she used to get on so well with Sanjay’s young children and she often used to ‘baby-sit’ for them when they were younger. Previously, she had lived for several years with her eldest brother Sanjay, but the arrangement broke down about 18 months ago when Gita fell asleep with a cigarette in her hand and started a fairly serious fire in her bedroom. Distraught and overcome with guilt, Gita took a significant but not life-threatening overdose and was admitted to the local psychiatric ward as an informal patient. Sanjay made it clear it would not be possible for Gita to return to his house when she was discharged because of the threat she might pose to his family. At this stage Dilip (the only unmarried brother and one who had always been an advocate for Gita) volunteered to take Gita, mindful that it was going to be important to ensure that the relationships between Gita and Sanjay’s family (and the rest of the extended family) were repaired and maintained.

Gita now says that she wants to stay with Dilip because – “he is my brother and he really understands me”. She also says that she really loves having her family around her especially the ‘young ones’. Initially, Gita seemed to settle at Dilip’s, quickly taking on the role of ‘looking after’ Dilip (who works in a pressurized job in the city), tidying the flat and cooking the occasional ready meal. Dilip in his turn worked hard to ensure that Gita remained engaged with the wider family and recently the relationship between Gita and Sanjay’s family has started to improve.

She says the good thing about living at Dilip’s is that he’s out all day and she can do what she wants, such as stay in bed all day or go to the park and meet up with the people who congregate there. Dilip does not approve of these people and has tried to
discourage Gita from meeting them. Overall, Gita and Dilip seem to get on well together, although there are times when the relationship becomes strained because of Gita’s dependency on and clingyness towards Dilip, and his frustration at her passive acceptance of her ‘illness’, marked subservience to her psychiatrist and her general lack of drive and motivation. He has also taken control of Gita’s finances as he knows she tends to spend her money erratically on ‘gifts for friends’, and feels she is vulnerable to other’s preying on her.

Gita says that she often goes to the temple late at night or in the early morning because she feels at peace there – “just having people around at the temple who understand your beliefs makes you feel a part of your community”. When upset or anxious she often recites Hindu prayers and has told her CPN that this helps her to accept her fate and recognize she is only a very tiny fragment in a huge universe and whatever happens to her is in the hands of higher forces. So it’s like every so often things go out of balance and I seem to lose myself and my bad spirit takes over. I believe I need to improve my spirit - then my mind and body will get better. But to improve my spirit I must learn to accept my fate and pray. I have to believe in our gods. We are all just a small part of the wider universe.

Gita had abandoned her Hinduism when she first became ill after an elderly aunt had told her that she obviously had bad ‘karma’. However, since moving in with Dilip, Gita has been remembering some of the prayers her mother had taught her as a small child and has also started going to the local Hindu temple where she says she feels safe and “can be with mum again”. Recently Gita has become more involved at the temple and sometimes helps to prepare the daily meal for the priests. She also assists the teacher with the youngest children at the Hindu Sunday school, and has shown herself to be reliable and popular with the children.

On the whole Gita seems to have been managing adequately with the current arrangement of visits every two weeks from her Community Psychiatric Nurse and appointments every two months with her psychiatrist. Dilip has been told to contact the team if there is any cause for concern.

Gita’s Care Manager and Community Psychiatric Nurse have been contacted by Dilip with a request for Gita to have a trial in a local ‘group home’ as he “cannot cope anymore”. The Care Manager and the CPN have agreed to try to get Gita into the group home to ‘increase her independence’. Dilip says that he doesn’t want to force Gita to live somewhere else and he would be happy to carry on living with her but he ‘doesn’t know what will happen next’. She stays at home all day often in bed, goes out late at night without telling him and seems to be getting worse recently. The Care Manager’s notes state that Gita is ‘lacking self-care, aggressive when challenged and very clingy towards Dilip’. Gita has been taking money from Dilip’s wallet according to him and recently fell asleep with a lighted cigarette in her hand. Dilip is worried that she will set the flat on fire and he says “I just don’t know whether I will come home one day to some catastrophe – I just can’t stop worrying about her at work and its affecting my career prospects”. Dilip works as an accountant for a large company and has been very successful up until now. When asked about taking money from Dilip she says – “I needed it for my cigarettes – anyway its not stealing, he is my brother”. Dilip has taken control of Gita’s finances as he says she has been prone to spend money erratically in the past on ‘gifts for friends’. 
Gita is adamant that she doesn’t want to live in the group home even though when they visited it recently she seemed to get on well with the staff some of whom were Indian and she seemed reasonably happy with the other tenants. Dilip had been quite resourceful in finding out about the group home on his own. The group home takes both men and women from a wide catchment area. Gita says that she values her independence with Dilip as no-one tells her what to do and she wants to live with her family. However, Dilip is getting increasingly stressed by Gita’s ‘clingyness, withdrawal and lack of self-care and personal hygiene’. Dilip says – “I can’t even go out on my own I have to take her everywhere – I just don’t seem to have a life of my own – I can’t even meet girlfriends the way things are at present”. Dilip has always encouraged Gita to stay in touch with the rest of the family even at times of some tensions due to the fire incident. Dilip always makes sure that she is included in family get-togethers and special occasions like weddings. Dilip says that he wants Gita to move into the group home but does not want her relationship with him or the rest of the family to be threatened. He feels quite ambivalent about Gita moving out as he would miss her greatly but he can see no alternatives.

Gita had attended a day centre nearby a year ago where there were very few Black service users and there were mainly men at the centre. The staff at the centre reported to the Care Manager that Gita was difficult to motivate to do anything and she seemed bored to them despite their efforts to provide her with activities in the groups they run. Gita reports that she had been racially abused by another service user at the centre and she did not feel safe there with some of the men. She did not go to the centre for very long and preferred to go to the local park where she regularly meets up with her friends and where she likes watching the children play. Gita has recently admitted to Dilip that she sometimes sells her tablets to her friends in the park. Dilip does not like the people she mixes with down at the park as they are seen to drink in public. He has spoken to the Care Manager saying that he cannot afford trouble with the police if Gita is ‘dealing drugs’. Gita says that it helps her with getting more money.

Gita would like to do some work again as she used to help out at Sanjay’s business doing office work but what she really wants to do is to work with children. Gita secretly would like work with children properly, but feels that she will never get the chance because her psychiatrist has told her it would be impossible with her ‘psychiatric record’. She would like to undertake a child-care qualification and do some work in a nursery. Dilip feels that Gita has a very good way with young children and was always trusted with family ‘baby-sitting’ until the ‘fire incident’. Gita also enjoys doing voluntary work at the temple where she also likes to discuss religious issues. He would like to see Gita using her potential much more and is pleased she is at least having some contact with children at the temple. Dilip is also very concerned that Gita tends to go to the temple very late at night or early in the morning, and he is worried about her safety. A group home place is now going to become available in one month’s time.
Case Study 2: Huseyn’s Story

Huseyn, a Turkish man in his early twenties, is a refugee. He had left Turkey when he was about ten when his family fled because of fear of the authorities, near relatives having been imprisoned and tortured. He arrived in UK seven years later. After about two years he left his parental home because of overcrowding to live in a hostel for the homeless. He began to learn English, worked in a restaurant and got himself a rented room. He met a White woman, Sybil, and she moved in with him but she left him a few months later when she got a council flat. Sybil wanted Huseyn to marry her but he did not want to get married and then Sybil asked him not to see her. When he persisted in trying to continue the relationship; she called the police and he was sent to prison for four months on a charge of ‘stalking’. After release, he happened to see Sybil in the street and she invited him to visit her again. But when he did so, Sybil abused him, broke a glass pane in her front door and called the police. He was then held in custody until his transfer to hospital under Section 37 of the Mental Health Act as ‘suffering from paranoid schizophrenia’. The symptoms were identified as ‘paranoid delusions and thought disorder’ on the basis that Huseyn thought that Sybil had been spying on him and interfering with his body.

After one year in hospital, Huseyn appealed against his detention. He told the independent psychiatrist who visited him that he had felt under stress when remanded in prison and was glad to have been taken to hospital. He believed that his enemies in Turkey had paid Sybil to spy on him, interfere with him, try to remove his kidneys and get him sent to prison to be tortured. But all this was now in the past, he wanted to leave hospital in order to get married to someone in Holland and lead a ‘normal life’.

The assessment by the Responsible Medical Officer (RMO) was that Huseyn remained ‘deluded’ and had ‘unrealistic’ plans for the future which were probably based on delusional thinking. Also Huseyn was isolating himself by not participating in ward activities. He was thought unfit for discharge and to still presented a danger to the victim of his ‘index offence’. It was felt that his ‘illness’ required further treatment with medication possibly for an indefinite period.

In the view of the independent psychiatrist (who took a transcultural view), Huseyn had suffered a ‘transitory psychotic state’ as a result of being in prison. His ‘psychosis’ should be understood in terms of his background. The fear of torture with electricity and having kidneys removed was a reality for Huseyn. It was known that kidney removal for sale was practised in parts of Turkey and a real fear among some people there. Huseyn had isolated himself on the ward because he had no interest in the type of Occupational Therapy activities available and his English was not good enough for him to follow what was discussed at group meetings. Since he had relatives in Holland, his plan to go there seemed realistic. At the Tribunal, Huseyn’s mother asked whether X-rays had been done to make sure Huseyn’s kidneys were intact because she believed Sybil was a malicious woman. She divulged the information that the family was arranging a marriage for him with a cousin in Holland. The RMO’s view was accepted by the Tribunal and Huseyn was not discharged.

Story by Dr. Suman Fernando
Case Study 3: Annette’s Story

Annette is a 22 year old African-Caribbean woman, who has a baby son aged nearly one year. Her medical notes indicate that she has been diagnosed as having ‘depression’ and possibly a ‘bipolar illness’, she also has a condition of cerebral palsy. She is able to get about fairly well although she gets tired easily especially since she has developed diabetes soon after the birth of her son, Michael. Annette has not been in a psychiatric hospital for mental distress for over two years now and is determined never to go back into hospital. Annette says that she does not get on with her current psychiatrist who has noted in her records that ‘Annette does not always comply with medication’ and ‘can act aggressively on occasions when challenged’. Annette has said that she has been worried about taking her medication while breast-feeding even though everyone has assured her that the medication she is on would not affect her baby.

Annette became mentally distressed when she was still at school after an intense period of bullying. Her mother still blames the school for not doing enough to protect Annette when the bullying first came to light. At first Annette developed a phobia about going out of her house and at the time of her distress she believed that she could ‘speak in tongues’ with a secret language hidden in her Bible. During this time her family had attempted to get help from mental health services but with no real success. She then started self-harming and eventually she made suicide attempt with an overdose eventually being taken into hospital on an emergency basis. Since that time Annette has had some ups and downs but she has kept relatively well – when she starts to feel unwell she tends to stop eating, neglect her appearance and personal hygiene, and becomes very withdrawn and uncommunicative often staying locked in her room for days reading and chanting to herself.

There has been evidence of abuse of Annette from some of Derek’s (Michael’s father) friends in the past including sexual abuse as well as financial exploitation e.g. eating Annette’s food, using her phone and extracting money from her. There is currently an injunction against Derek preventing contact with Annette. She was strongly advised by her social worker to take out this injunction but Annette secretly would like to re-establish contact with Derek as she feels that he has changed and she misses his company a great deal. Her son Michael is currently doing well and has had no major illnesses or injuries.

Annette had been getting 12 hours of personal assistance in her own Housing Association flat before the baby was born but is now getting only 6 hours. She has 24-hour support for the baby, Michael, since his birth. The child care support staff, from the Children and Family Outreach Team, help out with all aspects of baby care, cooking of food, domestic tasks and shopping, while a separate agency provides support workers for Annette to see to her personal care and provide any other assistance to her. Her son, Michael goes to stay with Annette’s mother on the weekends and Annette can have space for herself at this time. Her mother lives nearby with her two teenage sons, the boys get on well with their young nephew.

Annette’s flat has a constant flow of workers going through it and there have been several staff changes over the past year or so. Annette says that she wants to do things for herself but the support workers do not listen to her and often do things for her and her baby, ignoring her objections. She feels that she has no privacy with her baby and that she is missing out in caring for her child in many ways. She has not been allowed to bathe the baby without staff present as it is felt that the child would be at risk of injury. She says that she needs help but she wants support to do things herself not for others to take over. On several occasions Annette has lost her temper with the Support Workers and sworn at them on one occasion she threw a saucepan at one of the workers in her kitchen. There are now some staff she has refused to speak to.

The constant scrutiny has resulted in a lot of stress for Annette recently according to her mother. The support workers believe that Annette has always had unrealistic expectations of trying to cope on her own and needs more support than she realises.

Annette is terrified that Social Services will take her baby away and is willing to do anything that they say to prevent this happening. She is quite assertive though and well able to speak up for herself but she is beginning to be ‘ground down’ and is becoming more dependent on others. Her confidence seems to have been gradually undermined.

Annette expresses her needs with the baby as requiring help to change his nappy and cook food for him. She feels that she is good at playing with him and talking to him. It is obvious she is a very loving mother in many ways but under a lot of stress. Annette speaks about having a recurrent nightmare where her child is being taken away.

She says that when she goes out with staff people think that the baby belongs to the staff and they do not believe that Michael is her baby. This makes her very angry. Annette’s diabetes has affected her in terms of nausea, tiredness, and high blood pressure. Annette does not know much about her diet and diabetes in general. Annette has been advised by the child care workers that she must take the baby out at least once a day for ‘some fresh air’ but she finds it physically difficult to push the buggy for any distance. She also has difficulty lifting any weight if the surface is at the wrong height for her.

Annette is very interested in developing herself in terms of further education. She is particularly interested in learning more about child care and child development and “working with people”. Annette would be interested in finding part-time work in the future but this depends on the needs of her child. Annette says that she is feeling down at present and fed up with “all these people around her all the time”. She would like to go out more as well. In the past she had enjoyed going to pubs, night-clubs, friends’ houses and a social club for people with ‘mental health problems’. Annette says that she has a lot of friends in the local area.

Annette wants bigger accommodation on the ground floor “with a garden for Michael to play in with a “slide and swings”. Her current flat has steep stairs going down to it. Annette would be interested in any way of owning her own place and not using social services accommodation.

The option of fostering or adoption was suddenly raised by the Children and Family Team at an early stage in Annette’s pregnancy which came as a great shock to Annette and her mother. The Social Care Services would want Annette’s mother to take primary care of the child as this would reduce the cost of support but she works full-time and is not keen on the idea. This option does not seem to have gone away and a decision is currently being taken by the Children and Family Team whether to take Michael into care and use long-term fostering for Michael as the 24 hour package of assistance is proving too expensive to maintain. There has been a recent report from one of the Children and Family support workers that Annette had ‘dropped the baby’ while trying to bathe him on her own.
Case Study 4: Tamuka’s Story

Tamuka is a 26 year old Black African man born in Zimbabwe who currently lives with his mother, who is very ill at present, in a small flat on the 5th floor of a tower block. The flat where Tamuka and his mother lives is not properly heated, it is very damp and poorly furnished. He has been a mental health service user for nearly three years, soon after entering the country to live with his mother who has been resident in this country for ten years. Tamuka had been living with his father in Zimbabwe up until he came to the UK following his father’s death. Tamuka has been compulsorily detained on one occasion two and half years ago when he was working as a minicab driver and got into an altercation with a customer over a fare. Tamuka had threatened to kill the customer and bring ‘evil’ down on his family. The police were called by the customer and Tamuka was eventually taken into hospital on ‘Section 136’ in an ‘agitated state’ according to the officers who attended the call-out. He allegedly attacked a police officer and it is written in the records that he was violent and abusive towards a nurse soon after admission causing some minor injuries. He was in hospital for two weeks before being discharged and he had been diagnosed with ‘schizophrenia’ during his stay. He was prescribed ‘anti-psychotic’ drugs and has always been happy to take his medication without questions even though he had some unpleasant side-effects initially. Tamuka has been keeping quite well and has had only one minor crisis two years ago when he received some intensive support from the local Community Mental Health Team and Home Treatment Team. He is still currently under the local Community Mental Health Team’s caseload but with minimal contact in the past nine months.

Tamuka claims that he has always had ‘special powers’ since he was very young. In Zimbabwe he is considered to be a svikiro – a spirit medium who can talk to ancestral spirits. He often talks to his deceased father (Mukanya) out loud and hears him talking back to him. Tamuka says that his father gives him good advice and cheers him up sometimes when he is feeling very down. He is still very angry with his father though as he took his own life in Zimbabwe after being diagnosed with AIDS following a short illness. His father had carefully planned his suicide and had waited for the time when Tamuka was away from home on a trip to visit relatives. Mukanya then left specific instructions for Tamuka, and made arrangements for him to be kept away from their home – he stayed instead at the relative’s home - from the day Mukanya died. Tamuka now feels his responsibility weigh heavily as head of the family being the eldest son and must now make sure his mother is looked after. His mother had divorced his father some ten years ago and Tamuka feels that she could have tried harder to make the marriage work but he feels a great sense of duty to her and finds it difficult to criticise her now, especially as she is very ill at present. He says – ‘after my father died I felt I had to come here - I didn’t think about all the ‘ins’ and ‘outs’ of the situation - I just knew in my heart that my mum would need me. I get very down sometimes now and think I will just follow my mum when the time comes.’

Tamuka says that he wants help with his mother as she is ‘very ill and dying because she has AIDS’. His mother has been diagnosed as HIV positive and is currently on triple combination therapy which had improved her condition a lot after she first went onto it. She had been in hospital but was not happy to stay there. She was discharged over eight months ago with some domiciliary care put in to give her help with cleaning, shopping and some general assistance. Tamuka is unhappy with the number of hours and the tasks that the Home Care staff provide. He had an argument with one of the Home Care staff and he said to her ‘I know you have rules but what can YOU do for me?’ After his outburst she refused to come back again and now he has someone else that he doesn’t know. He says that now ‘he does all the cooking as no-one else knows the kind of food his mother likes’. He also says that his mother has got much worse in the past few months – there does not seem to have been any recent review of his mother’s needs. He is not sure what to do as he doesn’t understand the system and he doesn’t read English very well.
Tamuka is very proud of being a svikiro and he says – ‘I have respect amongst my people because I’m a ‘ svikiro ’ - everyone respects them, don’t they?’ He is particularly concerned to get back to Zimbabwe in the next two months to perform an important ceremony at his father’s grave which welcomes his spirit back into the family otherwise his father’s spirit will wander unhappily and bring ill-fortune to the whole family. Tamuka’s mother thoroughly disapproves of her son’s beliefs as she is a born-again Christian and this gives him a lot of pain as his spiritual beliefs are very important to him. The topic of spirituality has been a source of arguments between mother and son in the past.

Tamuka had been working as a minicab driver and had many friends in this community. Several of the drivers were from Zimbabwe in the local area and Tamuka used to attend the Africa Centre regularly where he enjoyed their company, in particular his friend ‘Simba’, who he sees rarely now as he has moved to a nearby area – Tamuka says “he taught me a lot about computers and how to survive here”. He was also recognised at the Centre for his ‘special powers’ and he got on well with the ‘sangoma’ (diviner-priest), who advised him about the incomplete rituals left for him to fully inherit his powers and fulfil his potential. Tamuka was a keen footballer and used to play for a local African team in an amateur league. He has not played football for over two years now and has not worked as a driver during that time either – he says “I miss the football but I watch on the telly”. Tamuka used to enjoy having friends visiting his flat but no-one has called for many months now and he suspects that they no longer call because of his mother’s illness. His mother used to be very active in the local church and had many friends there but she is no longer well enough to attend church. Tamuka rarely leaves the flat now - he says ‘I have to look after my mother’.

Since coming to this country Tamuka has felt that he no longer has the respect he deserves as a ‘big man’ in his community. He says that sometimes people insult him and make fun of his accent but he says that he will not take ‘rubbish’ from anyone. He says that he does not understand the racism in this country, “in ‘Zim’ you just trade insults maybe have some ‘boxing’ but then it is forgotten because you know what you are dealing with. But people here smile at you to your face and then do something bad behind your back – its hard to trust these people”. Tamuka says he would like to work in computers as he has finished a course in computers in the past and has learned more about how to fix them. He says “everyone used to come to me to fix their computers and I always knew what to do”. However, he can’t see himself doing anything in the near future as he feels that ‘you just have to accept your fate and you must keep in touch with the spirits around you - You must honour your ancestors or you will invite evil and get bad luck’. He still feels ‘very down’ at times and he often says – ‘I just can’t stop thinking about what happened to my father – it goes over and over in my mind’. The anniversary of his father’s death is approaching and Tamuka says that “if I don’t get back to Zimbabwe soon and perform ‘the ritual at his grave’ something very bad will happen to me”.

What new information did you pick up from the RECAP course?
In what ways will the RECAP course and materials be useful to you?

What are the things that you are going to do or change as a result of being on the RECAP course?
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Handout 13 - An Immigration Timeline

- **250 AD** Rome sends a contingent of legionnaires from the African part of its empire to stand guard on Hadrian's Wall in northern England. These soldiers are probably the first black people seen in the British Isles.

- **1290 AD** After several years of anti-Semitic persecution, Edward I orders the expulsion of all remaining Jews in Britain. At this time, about 5,000 Jews live in Britain, spread among 27 towns and cities throughout England. Even before the expulsion ruling, they are forbidden by the Church to own land, employ Christians or bear arms.

- **1510 AD** The first Roma Gypsies arrive in Britain from southern and Ireland and Eastern Europe (although it is believed that most Roma originate from the Punjab region of south Asia). Many make a living as tinkers, pedlars and horse dealers.

- **1555 AD** The first black African slaves are brought to Britain, heralding the start of a 250-year trade in human beings.

- **1650 AD** Lascars (seamen from south east Asia and India) and sailors from China and West Africa find themselves in demand as Britain’s trading empire and financial muscle increases. This is in spite of the 1660 Navigation Act, which requires 75 per cent of a British ship’s crew to be British. Many eventually settle permanently, laying the foundations for the modern-day Chinese communities in Liverpool and London.

- **1685 AD** The first of over 20,000 Protestant Huguenot refugees take sanctuary in England persecution in their native France, after the government there declares Protestantism illegal. Most settle in London, where they form five percent of the city’s total population at that time, while others settle in Canterbury. They bring with them skills in silk weaving and in the making of clocks and guns. Others were goldsmiths, silversmiths, merchants and artists.

- **1750 AD** During the early years of the Industrial Revolution, thousands of Irish labourers travel to Britain to begin work on the construction of new roads, canals and railways.

- **1845 AD** Ireland’s potato crop is ravaged by blight and the effects of destructive farming methods, causing a severe and widespread famine which eventually causes as many as a million deaths (nearly one in eight of the population). Over the next five years, an estimated 200,000 Irish people will flee to Britain.
• **1881 AD** Russia’s Tsar Alexander II is assassinated, and a young Jewish woman identified as one of the suspects. This prompts widespread persecution of Jews in Europe, and, during the next three decades, nearly a million European Jews will arrive in Britain.

• **1916 AD** Thousands of Caribbean people arrive in Britain’s seaports and major cities to work in munitions factories, armories and the merchant navy. They establish themselves in the seaports and major cities, where their presence leads to race riots in the years immediately following World War I.

• **1917 AD** Small numbers of Russians, escaping the Bolshevik Revolution, establish a tight-knit community in London. Britain signs an agreement with Russia that men born in Russia, now living in Britain but not naturalised, would have either to serve in the British army, or return to Russia and serve in the Russian army.

• **1940 AD** Britain faces an urgent need for fighter pilots as it becomes clear that Hitler would attempt to defeat her with air power. Trained pilots from the Caribbean, South Africa, India and Eastern Europe (especially Poland and Czechoslovakia) join the fighter squadrons and play a major part in repulsing the Luftwaffe. Some squadrons are made up entirely by South Africans or Poles. After the Battle of Britain is won, many of these migrant pilots go on to serve in the bomber squadrons of the Fleet Air Arm.

• **1941 AD** During the war, more than 60,000 Irish men and women work in Britain, manufacturing munitions, equipment and food supplies for the war effort, and helping to fill the gaps left in public services.

• **1948 AD** On 22 June, the SS Empire Windrush, carrying 450 Jamaicans (mostly ex-servicemen) docks at Tilbury, and receives an official welcome from the government. This marks the beginning of a sustained period of migration from the Caribbean to Britain over the next fifteen years. Between 1955 and 1962, a total of over 250,000 people arrive in the country. More than 66,000 make the journey in 1961 alone, which was the final year before Britain’s first immigration law took effect.

• **1972 AD** Britain admits 28,000 Asians expelled from Uganda by its dictator Idi Amin. Many settle in Wembley in Middlesex, and Leicester in the Midlands. Large numbers also arrive from Kenya, due to the government there introducing new laws banning foreigners from working in the country. The government had initially been reluctant to admit the refugees, even though the majority were highly skilled and had British passports. Some fear that they might destabilise race relations in the country, which had been increasingly strained since the mid-1960s.

• **1974 AD** President Archbishop Makarios is briefly deposed in a military coup by Greek Cypriots seeking unification with Greece. Fearing for the rights of the minority Turkish population, Turkey invades northern Cyprus and expels Greek
residents. The island is officially divided and the buffer zone between the two sectors is still patrolled by the UN more than three decades later. An estimated 20,000 Greek Cypriots flee the island and make their way to Britain.

- **1975 AD** The long-running war in Vietnam ends on 30 April when the Saigon government announces its unconditional surrender to North Vietnamese forces. On 3 December 1977, the first boat people, as they become known, flee the now-communist Vietnam. Between 1979 and 1982, 12,500 refugees will arrive in the UK, many with little or no education and unable to write in their own language, let alone English.

- **1981 AD** The Conservative government passes a new Nationality Act which effectively removes the right to British citizenship from significant numbers of people from ‘new Commonwealth’ nations (in other words, those from the Caribbean and the Indian subcontinent) who have previously been classed as British citizens. For example, Hong Kong British passport holders were now no longer entitled to move to, and live in, the UK.

- **1983 AD** For the first time in its history, the UK begins a sustained period where the number of people arriving in the country (immigrants) exceeds the number of those leaving it (emigrants). In this year, the net increase was 17,000 people; between 1983 and 1992 the net inflow would increase to 240,000; and between 1993 and 2002 it would reach just over 1 million. In only one year during the period from 1964 to 1982 was there a net migration into this country.

- **1986 AD** As a result of the tighter immigration controls introduced during the 1980s, the bulk of new immigrants entering Britain are Americans, Australians, New Zealanders and South Africans making use of family-ties entry rules, and South Asian men and women entering the medical professions. Between 1984 and 1986, only 240 applications for asylum were accepted for every one million of the UK’s inhabitants, representing less than 0.1 per cent of the population. By comparison, Sweden takes 5,000 asylum seekers per million of its population, and Denmark and Switzerland more than 4,000 each.

- **1990 AD** The ousting of Somalia’s government in 1991 leads to prolonged civil war and tens of thousands of people fleeing the country. Many more Somalis leave in later years to escape severe famine that follows. The combined effect of these factors will see annual applications from Somalis for asylum in the UK rise from less than 400 in 1988 to 7,000 by 1999.

- **1998 AD** More than 8,000 ethnic Albanians from Kosovo arrive in Britain, many of them young single men in fear of their lives due to the continuing civil war in Yugoslavia. Most are granted temporary asylum, but nearly 600 are allowed to settle permanently.

- **2000 AD** The legacy of wars fought during the 1980s and 1990s in Iraq and Afghanistan bring asylum seekers and refugees to Britain. In Zimbabwe, many white farmers (and British passport holders) are persecuted by Robert Mugabe’s Zanu-PF party and have their land rights confiscated, prompting many to leave the country for good.
2001 AD The 2001 Census shows a 50 per cent increase in the size of the ethnic minority population compared with the figures from 1991. One in nine people are from ethnic minorities (in other words, belonging to an ethnic group other than White British). The largest ethnic minority group in Britain - people of Indian descent - now numbers over a million, or just under 2 per cent of the population. The next largest groups were Pakistani (746,000), Irish (691,000), Black Caribbean (566,000) and Black African (485,000). The total UK population increased by 2.2 million compared to 1991, some 1.14 million of whom were born abroad.

2002 AD UN figures show that 103,000 people (24% of the EU total) have sought asylum in the UK this year. This is the highest figure in the EU; Germany is next on the list with 17%. The most common countries of origin for asylum claimants during this year were Iraq, Zimbabwe, Afghanistan, Somalia and China. The Home Office later estimates that 42 per cent of applications resulted in grants.

2003 AD According to the Home Office, the largest number of asylum applications came from nationals of Somalia (over 10% of applications), Iraq (8%), Zimbabwe (7%), Iran (6%) and Afghanistan (5%).

2004 AD On May 1, nationals of the ten new countries admitted to the EU (including the Czech Republic, Slovakia, Estonia, Hungary, Latvia, Lithuania and Poland) obtain the right to travel freely and live anywhere in the enlarged EU. However, for up to seven years, the established 15 member states may restrict the right to work of people from the eight central and eastern European accession countries. The UK, Ireland and Sweden are the only countries to open their labour markets to workers from these countries straightaway. More people than the government expected - around 130,000 - arrive in Britain as a result, representing the largest wave of immigration since the 1950s and 1960s.

2005 AD Estimates from the Office for National Statistics suggest that nearly a quarter of a million more people entered the UK than left it between June 2004 and June 2005. This net increase of 235,000 was the largest yearly total since the current system of estimates began in 1991. Migration into the UK was around 59,000 more than in the previous mid-year period, a rise of 11 per cent, and migration from the UK fell by 8,000.

2005 AD During the year, a total of 30,500 people seek refuge in the UK, according to figures published by UNHCR, the UN's refugee agency. This represents a 70 per cent drop compared to the record figures in 2002, and is the lowest total since 1993. The figures also reveal that the UK was the 18th most popular destination out of 50 industrialised nations, with 0.5 asylum applications per 1,000 people. This compared with 0.8 in France and 0.2 in the USA. Iranians formed the largest groups of people claiming asylum in the UK (3,990), followed by Somalis (3,295) and Pakistanis (3,030).
• **2006 AD** Home Office figures reveal that around 375,000 people from Eastern Europe have come to work in the UK since 2004 and the number of foreign workers in the UK now stands at 1.5 million, or one in every 25 workers. Six out of every ten of these new migrants is Polish. Many are skilled and will find work in construction, agriculture, catering, retail and healthcare. Most have stayed in the south of England, with 34,000 living and working in London and 27,000 in East Anglia. More than 10,000 head for Scotland, where the Scottish Executive actively encourages immigration from the new EU countries as part of its ‘Fresh Talent’ initiative.

(Adapted from CRE website: [www.cre.gov.uk](http://www.cre.gov.uk))

• **2007 AD** Applications for asylum, excluding dependants, fell by 1% in 2007 to 23,430. The nationalities accounting for the highest numbers of applicants were: Afghan, Iranian, Chinese, Iraqi and Eritrean.

(See source: [http://www.homeoffice.gov.uk/rds/pdfs08/hosb1108.pdf](http://www.homeoffice.gov.uk/rds/pdfs08/hosb1108.pdf))
The RELATE Model

- Recognise the discrimination
- Express your concern
- Listen to the response
- Accurately educate with facts and feelings
- Talk to relevant authorities
- Enable self support

Caroline Hounsell,