



African and Caribbean Mental Health Commission

Improving the mental health of the population.
Towards a strategy on mental health for the
European Union

A response from the Green Paper

March 2006

Introduction

The African and Caribbean Mental Health Commission (ACMHC) is a commission of the Mayor of London, Ken Livingstone which was set up in 2002. It is an independent London-wide strategic forum that works to address inequalities in mental health policy and practice in relation to African Caribbean Communities.

ACMHC promote coherence in mental health service planning, provision and delivery.

ACMHC welcomes the European Commission's (EC) Green Paper as a much needed opportunity to considerably improve the mental health and well being of African Caribbean communities within the United Kingdom (UK) and across the European Union (EU).

This Green Paper could potentially be a much needed step forward in improving the mental well being of African Caribbean communities and African refugees and asylum seekers across the EU. We would like to take this opportunity to formally note the European Commission's framework strategy for tackling discrimination set out in a policy communication in June 2005. This highlighted the need for special attention to the particular forms of discrimination and exclusion faced by ethnic minorities.¹ The enlargement of the EU in 2004 increased the Union's ethnic diversity, while violence in France's inner city suburbs in late 2005 highlighted the problem of discrimination and the racism faced by migrant communities in older Member States. The UK experience reveals that it is in the field of forensic psychiatry that racial injustices and cultural oppression are felt most acutely by Black and Asian service users.²

¹ Experts to advise Commission on social situation of ethnic minorities (2006) Equal Rights In Practice

² S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism

Background

Disadvantage and discrimination characterise the experience of Black communities in London. People from Black and minority ethnic (BME) groups suffer poorer health, have reduced life expectancy and have greater problems with access to health care than the majority White population.³

Inequality in mental health services between Black people and the majority White population has been the subject of ongoing debate and study for decades. It is well documented that people from BME communities and African Caribbeans in particular fare worse under the British mental health system.

There is a history of misunderstanding and discrimination when it comes to the use of compulsory powers against African Caribbeans. Black people mistrust and often fear services, and staff are often wary of the Black community, fearing criticism and not knowing how to respond.⁴

The British Government is currently reviewing the 1983 Mental Health Act amid contention with key stakeholders over its handling of the Race Equality Impact Assessment which, in ACMHC's view, has effectively excluded service users, carers and professionals and black health groups from effectively engaging with this process.⁵

A recent social exclusion report on mental health acknowledged that Black people have higher levels of dissatisfaction with statutory (mental health) services and are twice as likely to disagree with their diagnosis.⁶

³ Greater London Authority (2004), Health in London GLA

⁴ F. Keating, E. Francis (2002) Breaking the Circles of Fear, Sainsbury Centre for Mental Health

⁵ How the health department messed up a mental health consultation (2006) Black Information Link. www.blink.org.uk <http://www.blink.org.uk/pdescription.asp?key=11678&grp=5&cat=293>

⁶ Mental Health and Social Exclusion: Social Exclusion Unit Report, Office of the Deputy Prime Minister, (2004)

There is an ever increasing body of evidence that confirms that mental health services, especially the practice of psychiatry within the UK, has been problematic for Black people.

Academics and professionals in this field purport that psychiatric power and race working together in combination, in collusion, is a deadly mixture⁷ (see annex 1). This was tragically highlighted by the death of David Bennett an African Caribbean inpatient in a mental health unit in Norwich, England. Bennett was racially abused on the night of his death by a fellow patient after a dispute over access to the phone on the ward.

He was subsequently forcibly restrained by five nurses for almost half an hour. They only released him after they realised he had stopped breathing. No attempt was made to resuscitate him. A subsequent Public Inquiry into his treatment and care and circumstances surrounding his death concluded that mental health services within the UK are institutionally racist.⁸ Findings in this report typify the African Caribbean experience of mental health services.

Mental Health services within the UK: The African Caribbean Mental Health Experience

The David Bennett Inquiry report made the crisis in BME (Black and Minority Ethnic) mental health a national issue and has brought to light the discrimination in mental health services that has led to black people being excessively diagnosed as 'schizophrenic', over – represented among people who are 'sectioned' (involuntary commitment to hospital) and apprehended in excessive numbers by the police as 'mentally ill'⁹, despite having similar rates of mental ill health as other ethnic groups.¹⁰

Culturally appropriate and acceptable behaviour has also been wrongly construed as symptoms of abnormality or aggression. The recourse to advocacy, tribunals and appropriate care packages has been slow to positively impact this group.¹¹

⁷ S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism

⁸ Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) Independent Inquiry into the death of David Bennett

⁹ S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism

¹⁰ National Centre for Social Research EMPIRIC Report - April 2002

¹¹ Songhai, written evidence to the Governments Joint Scrutiny Committee, (2004) EV 1060

In response to the crisis in BME (Black and Minority Ethnic) mental health the British Government published a report entitled, *Delivering Race Equality: A Framework for Action* (DRE) which detailed a five year programme of work to address racism within mental health care provision as it relates to the care of African Caribbean and other minority patients.

A national census of inpatient psychiatric services has been undertaken as part of the DRE Programme. The findings published in a report entitled *Count Me In* has been undertaken as part of the DRE programme. The Census findings¹² (Annex 2) exposed unprecedented levels of racism within the British mental health services¹³.

Legal factors are also a major determinant in the provision of mental health care for refugees and asylum seekers.

A report funded by the European Refugee Fund looked at political and legal factors which shape the provision of health, welfare and legal advice for asylum seekers and refugees in Rome, Berlin and London.

It revealed that poor physical and mental health amongst migrants and refugees is linked with legislation and policies which increasingly deny asylum seekers the opportunity to work and receive welfare support.

The resulting destitution and poverty is an aggravating factor for individual emotional and mental well-being.¹⁴

Responses to specific questions raised in the Green Paper

1 How relevant is the mental health of the population for the EU's strategic policy objectives?

The Green paper lays out in section 2 the centrality of mental health for citizens and societies. ACMHC concurs with this view of the importance of mental health and the 'costs' of mental ill health. We agree that the burden of mental ill health in the EU and in the UK in particular, has implications for the GDP.

¹² Count Me In Census (2005) Health Care Commission

¹³ M. MacAttram (2005) Census reveals unprecedented levels of racism within the NHS, <http://www.blink.org.uk/pdescription.asp?key=10240&grp=5>

¹⁴ Europe Land of Asylum: reception and social inclusion of asylum seekers and refugees in three European capital cities (Rome 2004) – report of an Observatory carried out as a partnership between Berlin Senate, Comune di Rome, and the Greater London Authority, funded by the European Refugee Fund of the European Commission

Public health is the art and science of preventing disease, prolonging life, and promoting health through organised efforts of society. ACHMC sees one of the chief responsibilities of public health medicine as fostering policies that promote health. Countering racism should be considered a public health issue¹⁵.

ACHMC believes that asylum seekers awaiting determination of a claim should be provided with adequate means to support themselves and maintain health and must not be forced into destitution by policies that refuse them material support and accommodation¹⁶.

The UK spend on mental health is the second highest in the EU. ACMHC views this as an avoidable burden which also falls to individuals, families and carers. There are also other intangible costs to society that ACMHC has found are felt most keenly by African Caribbean and refugee communities.

In forensic psychiatry racial injustices and cultural oppression are acutely felt by Black service users¹⁷ and it is in this field that costs of patient care are highest.¹⁸ The Black Voluntary Community Sector (BVCS) has bridged a gap in providing culturally appropriate mental health care services to ethnic minorities. Organisations within this sector meet the needs of African Caribbean patients that are not currently being met by the statutory sector especially in prevention and aftercare, which is of economic benefit to the statutory services.¹⁹

ACMHC agrees that there is scope for exchange and cooperation within and between member States which may help to reduce mental health inequalities and disparities. There is a need to focus on the factors such as discrimination and institutional racism and the work of the BVCS in addressing this.

¹⁵ K. McKenzie (2005) Mental Health Inequalities in Europe – Migrant Mental Health: Governing for Health Summit. Mental Health and Social Exclusion in Minority Groups. Department of Health

¹⁶ Europe Land of Asylum: reception and social inclusion of asylum seekers and refugees in three European capital cities (Rome 2004) – report of an Observatory carried out as a partnership between Berlin Senate, Comune di Rome, and the Greater London Authority, funded by the European Refugee Fund of the European Commission

¹⁷ S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism

¹⁸ Curtis, L. and Netten, A. University of Kent (2004) Unit Costs of Health and Social Care, PSSRU (Personal Social Services Research Unit). <http://www.pssru.ac.uk/pdf/uc2004/uc2004.pdf>

¹⁹ K. Chouhan, M. MacAttram, Towards a Blueprint for Action: Building Capacity in the Black and Minority Ethnic Voluntary and Community Sector Providing

2. Would the development of a comprehensive EU-strategy on mental health add value to the existing and envisaged actions and do the proposals in the section 'An EU strategy on mental health' propose adequate priorities?'

ACMHC agrees that the EU strategy would add value as indicated in the Green Paper

ACMHC would like to see:

- Effective strategies to tackle mental health inequalities developed and strengthened.
- Studies investigating the effect of racism on the mental health of Black people living in Europe and the development of preventative strategies across EU member states.
- Development of a more robust evidence base for the improvement of long term care of African Caribbean's using Structural Funds and Framework Programme research funding.
- Opportunities for developing larger routine datasets across member states, which ACHMC would regard as invaluable to regular research and monitoring of the African Caribbean experience of mental health services throughout Europe.
- More systematic means of developing dialogue between research, policy and practice across countries on the African Caribbean experience of mental health services.

ACMHC agrees that the WHO's strategy for the European Region along with evidence available from member states should be used to develop a strategy.

Four aspects in the Green Paper are suggested for an EU strategy:

1	Promote mental health for all
2	Address mental ill health through preventative action
3	Improve the quality of life of people with mental ill health or disability through social inclusion and the protection of their rights and dignity
4	Develop a mental health information and research system for the EU

ACMCH agrees with these as a strategic focus, but suggests that addressing the discrimination and inequality in the care of African Caribbean people and refugees and asylum seekers with mental health problems, particularly those detained in secure psychiatric settings, should be explicitly included in the strategy.

EU legislation and policies increasingly deny asylum seekers the opportunity to work and receive welfare support. ACMCH believes they should be brought in line with international treaty rights as poor physical and mental health amongst migrants and refugees is linked with such legislations and policies.

ACMHC would like to see the introduction of ethnic monitoring of mental health services across all EU states as a tool for monitoring and addressing ethnic health inequalities. ACMHC are aware that ethnicity monitoring is illegal in many EU states except in policyping but believes that this is essential to enable the measurement of the outcomes of any new strategies that come out of this Green Paper

Count Me In Census - an example of good practice

http://www.healthcarecommission.org.uk/contentdisplay.cfm?cit_id=1988&wi

ACMHC would like to see work to improve the failings in hospital care of people from BME communities, including those from refugee and asylum seeking communities. As part of this we feel the excessive use of the diagnosis of 'schizophrenia'; and the over representation of these client groups among people who are 'sectioned' through the criminal justice system, should be explicitly addressed in the strategy.

Opportunities for dialogue across countries on the provision of culturally appropriate care for African Caribbean people and other minority groups would also prove valuable.

ACMCH would like the strategy to support actions to address the need for culturally appropriate care including psychotherapy and counselling as an alternative to traditional psychiatry for African Caribbean patients.

There is also a need to strengthen national and European networks between non-government organisations, Black Voluntary Organisations providing mental health services and Public Health Associations and ensure they are effectively linked with key stakeholders and government to contribute to the engagement of African Caribbean communities as key stakeholders.

3. Are there initiatives proposed in Sections 6 and 7 ('seeking solutions' and 'EU consultation process') appropriate to support the coordination between Member States, to promote the integration of mental health into the health and non health policies and stakeholder action, and to better liaise research and policy on mental health aspects?

ACMCH agrees that the promotion of mental health and preventative action is a high priority and that action in various settings within the community as well as schools and the workplace are vital. However research to develop a deeper understanding of possible links between racism and health is a prerequisite for the initiatives to decrease impact at a community and individual level.²⁰

Considering racism as a causative is an important step in developing the research agenda and response from health services. It moves the discussion away from recruitment and access and towards prevention and the impact of societal structures on rates of illness. The investigation of specific risk factors for illness in ethnic minority groups may be vital if it is to develop equity in efficacy of treatment.²¹

Larger scale studies across the EU member states of the mental health of African Caribbean people and other migrant populations would be welcomed as a means of developing a more robust evidence base for these underdeveloped areas of knowledge. Opportunities for developing larger routine datasets across member

²⁰ K. McKenzie (2003) Racism and Health: Antiracism is an important health issue, British Medical Journal

²¹ K. McKenzie (2003) Racism and Health: Antiracism is an important health issue, British Medical Journal

states would be invaluable to regular research and monitoring of African Caribbean mental health.

Within the areas of strategy there should be the opportunity to examine policy as well as psychiatric and therapeutic practice across member states and other countries, where appropriate, to develop initiatives soundly based on good practice.

Are there any specific suggestions for EU initiatives on promotion of mental health, reduction of depression and suicidal behaviour?

There are vast cultural differences in the way depression is seen and experienced in different ethnic groups and there are a variety of approaches from across the world. Medicalising depression, particularly in relation to people from African and Caribbean Communities, excludes taking a wider view. ACMHC believes that ensuring appropriate treatment to diverse communities requires active awareness and promotion of culturally relevant care and treatment.

In most of Europe many African Caribbean people are in a disadvantaged situation because of racism and social exclusion. These issues need to be addressed. ACMHC suggests that depression should not simply be viewed as an illness. To medicalise depression overlooks a multitude of factors such as a communities' social and economic status.

Many African Caribbean people in Europe are in difficult situations, facing disadvantage and uncertain legal status with limited rights as citizens. These issues cannot be dealt with solely in a medical context, but require addressing in a social and economic context, which promotes social equity.

ACMHC supports the transcultural view of psychiatry which considers that suicide and depression are not just illnesses. Within non-western cultures these issues are viewed within a religious and spiritual context. Given that the European Union is a multi cultural community, ACMHC believes that multicultural aspects of care and treatment must be taken into account in working with diverse communities.

Are there any specific suggestions for EU initiatives on promoting social inclusion and reducing stigma?

Stigma marks out an individual as being different and evokes some form of sanction.²²

Labour figures show that only 20% of those who have a mental disability are in work.²³ The added dimension of racial discrimination compounds this situation for African Caribbean people who experience mental distress and is borne out in the latest Labour Force Survey which shows that unemployment rates for Black people are three times higher than their white counterparts.

These are significant contributory factors to the social exclusion of large numbers of this group from many areas of British society.

Psychiatrists themselves share the stigma of mental illness with their patients to such an extent that professionals working in this field have advised that an examination of attitudes towards mental illness should be included in medical training.²⁴

In 2000 the Royal College of Psychiatrists embarked on an anti stigma campaign calling it 'Changing Minds: Every Family in the Land' aimed at counteracting psychiatric stigma. However some psychiatric service users objected to the campaign because, by emphasising biological pathology as causing psychological problems and medical treatment curing them, the campaign promotes stigma. The argument here is that stigma is an inevitable result of promoting biological psychiatry.²⁵

ACMHC support the view that stigma is closely tied to the medical model of illness discussed within transcultural psychiatry. Findings from their research indicates there is a higher level of stigma where there is a greater significance of the western model of mental illness. The rise of madness as an illness goes together with the use of psychiatry as a profession.²⁶

²² Reducing the Stigma of Mental Illness (2006) BMJ Publishing Group Ltd.
<http://www.studentbmj.com/issues/03/04/careers/104.php>

²³ Labour Force Survey (2001)

²⁴ Royal College of Psychiatrists, Royal College of Physicians, British Medical Association.
Stigmatisation within the medical profession. Council report CR91. London. (2001)

²⁵ S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism

²⁶ S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against

This stigma against people with mental illness is seen as the largest single obstacle to improving their quality of life.²⁷

Three processes are envisaged in the Green Paper

(7.1) Creating a Dialog with Member States on Mental Health

ACMHC supports the proposal to create a dialog between member states, with the objective of identifying strategies and the elements of an action plan on mental health. The action plan should take into account the cultural needs of African Caribbean communities, refugees and asylum seekers.

The two international documents proposed as a basis for dialog (the WHO Mental Health Action Plan for Europe and the Mental Health Promotion and Mental Disability prevention: a Policy for Europe Action Plan could be augmented by strategies from individual member states and consideration of best practice within the UK²⁸ and elsewhere (e.g., Jamaica and India²⁹).

(7.2) Launching an EU-Platform on Mental Health

There is a need to strengthen networks between non-government organisations and Public Health organisations and BVCS organisations. ACMHC views this platform as a potentially valuable contribution to the dialog and welcomes the inclusion of representatives from African Caribbean communities across Europe. One of the key elements for consideration should be the role faith and community organisations play in the care and reduction of stigma associated with mental illness for African Caribbean communities.

(7.3) Developing an interface between policy and research on mental health.

The interface between policy and research is welcomed. ACMHC recommends that priorities for research for African Caribbean communities across Europe are identified. Exploration of effective ways to disseminate research findings and evidence on best

²⁷ Sartorius N. Stigma: what can psychiatrists do about it? Lancet 1998; 352: 1058-9

²⁸ MacAttram.M. (July/August 2005) Inspired By Life, Mental Health Today Magazine, Pavillion Publishing

²⁹ K.Mckenzie, V. Patel, R. Araya, Learning from low income countries: mental health (13 November 2004) British Medical Journal

practice, research knowledge and policy making should be part of the remit of this group.

African & Caribbean Mental Health Commission
30 May 2006

Annex 1

Deaths of ethnic minority patients in psychiatric custody

Number	Year of death	Name of patient	Age	Circumstance surrounding death
1.	4/9/03	Tema Kombe (aka Emmanuel Silva/ Gladwell Moseki Keenao	32	Tema, a Ugandan asylum seeker was found hanged in the toilet of a psychiatric ward at Heatherwood hospital, Ascot. In January 2004, an inquest returned a verdict of misadventure after hearing that he had made three previous attempts on his life.
2.	21/6/03	Ertal Hussein	32	Ertal was found collapsed at Bethlem Royal hospital, south London he was taken to Princes Royal University hospital where he was pronounced dead on arrival. Since 1990, Ertal had been sectioned several times. A police investigation is ongoing and the hospital has launched an internal inquiry.
3.	3/01	Eugene Edigin	19	Eugene attended the psychiatric unit at the Whittington hospital, north London and was detained the day before his death under the Mental Health Act because of 'erratic behaviour'. The following day he was found unconscious in his bed. The inquest in February 2003 recorded an open verdict. His family were critical of staff who, they allege, failed to monitor his diabetes.
4.	11/96	Vernon Cowan	32	Veron died in Blackberry Hill hospital, Bristol from a blood clot on her lungs. She was admitted to the psychiatric secure unit at Blackberry Hill in October 1996 and died three weeks later. Her mother claims that she was fit and healthy before entering the unit but her physical condition began to deteriorate after she began taking the drugs prescribed by the hospital. At the inquest in April 1997 the coroner directed the jury to record a verdict of death by natural causes. However, the family wanted the inquest adjourned so that they could get independent medical advice, after MIND had submitted a critical report to the coroner about the care Veron received. However, the coroner preferred the evidence from those people connected with the trust which ran the hospital. A verdict of death by natural causes was recorded.
5.	1/96	Newton White	33	Newton a mental patient in the Denis Hill Unit of the Maudesely hospital, south

				London died after being found drowned and scalded in a bath in the hospital. Newton was left unattended for over 90 minutes despite being on a 15-minute observation regime, as he had been assessed as 'at risk' days before his death. The post mortem found no evidence of a heart attack, stroke or head injury. Newton had no history of heart problems, epilepsy or high blood pressure. The inquest in March 1997 recorded an open verdict.
6.	5/6/95	Dajin George	26	Dajin, a schizophrenic, died after falling from the fifteenth floor of a block of flats in Leyton, east London. He was a patient at Hackney hospital and should have been escorted throughout all outside visits. (He was also considered a suicide risk after making two previous attempts on his life.) He fell from a friends balcony without his escort being with him. Inquest verdict not known.
7.	10/8/94	Jonathan Weekes		Jonathan died in Chase Farm hospital, north London after being sent there by social workers who claimed his depression was becoming worse. On the night prior to his death, nursing staff were unable to calm Jonathan so a doctor was called - but did not attend. The inquest recorded a verdict of 'death by natural causes', (pneumonia). However, it was later revealed that Jonathan was receiving eight different drugs, this information was not available to the inquest.
8.	30/1/94	Rupert Marshall	29	Rupert died in Horton psychiatric hospital, Epsom after being restrained and injected with an anti-psychotic drug. Inquest verdict not known.
9.	23/6/92	Jerome Scott	27	Jerome collapsed and died on his way to hospital in a police van. He was suffering from depression and his mother called his GP, who could not help him. The emergency social work team called the police and two psychiatrists, who decided to administer an intravenous injection. Jerome was held down by police and then injected with two different anti-psychotic drugs - haloperidol and diazepam - put into a police van and died minutes later on the way to hospital. The inquest recorded a verdict of therapeutic misadventure.
10.	6/92	Munir Yusef Mojothi	26	Munir was a psychiatric patient at Bootham Park psychiatric hospital, he was given an injection of droperidol and then transferred to Clifton hospital, where he was given another injection of the same drug to calm him down. As this did not work, an intravenous dose of the drug was given by a doctor. This injection had the desired

				effect, but within 15 minutes he had stopped breathing. The inquest found that Munir had died from droperidol intoxication and 'furring of the arteries' and recorded a lack of care verdict.
11.	8/1/92	Mark Fletcher	21	Mark was detained by police and then sectioned under the Mental Health Act and transferred to All Saints Psychiatric hospital, Birmingham. At the hospital he collapsed after being restrained and given an injection into his spine. The inquest, which should have been, but was not, before a jury found that he had died from a cardiac arrest.
12.	28/8/91	Orville Blackwood	31	Orville was found dead in a secure unit of Broadmoor top security hospital after being given a tranquilliser injection. He had been detained under Section 37 of the Mental Health Act 1983 after suffering from paranoid delusions. The inquest in October 1991 recorded a verdict of accidental death. Orville's mother appealed to the High Court for a judicial review of the inquest verdict. The inquest verdict was quashed and a new inquest held in April 1993 which again recorded a verdict of accidental death.

Source: <http://www.irr.org.uk/2004/february/ak000013.html>

Other deaths in psychiatric custody

The Institute of Race Relations, which has been monitoring deaths in suspicious circumstances involving Black and Minority Ethnic people in psychiatric custody since 1970, has on its files 18 cases which give cause for concern. We list below twelve that have taken place since the death of Orville Blackwood in 1991.*

* Deaths in psychiatric custody from 1970-1991 are included in the report, [Deadly Silence: Black deaths in custody](#) (1991), available from the Institute of Race Relations.

The Institute of Race Relations is precluded from expressing a corporate view: any opinions expressed are therefore those of the authors.

Annex 2

African Caribbean experience of Mental Health Services

<ul style="list-style-type: none">• 10% of mental health inpatients
<ul style="list-style-type: none">• 3% of the general population, according to the 2001 census
<ul style="list-style-type: none">• 50% more likely to be placed in seclusion.
<ul style="list-style-type: none">• 29% more likely to be subject to control and restraint
<ul style="list-style-type: none">• 44% more likely to be sectioned under the 1983 Mental Health Act
<ul style="list-style-type: none">• (50%) check figure more likely to be referred through the criminal justice system
<ul style="list-style-type: none">• 14% more likely to be turned away than white people when they ask for help from MH services.
<ul style="list-style-type: none">• Referral the psychiatric services by the Police is almost double for Black Caribbean and Black African
<ul style="list-style-type: none">• Referral through the courts is almost double in the Black African and Caribbean's

Source: Commission for Healthcare Audit and Inspection (2005)
Count Me In, Results of a national census of inpatients in mental health hospitals and facilities in England and Wales

Annex 3

Ethnic issues in mental health services

Black and ethnic minorities are more often:

1. diagnosed as schizophrenic
2. compulsorily detained under the Mental Health Act
3. admitted as 'offender patients'
4. held by police under Section 136 of the Mental Health Act
5. transferred to locked wards from open wards
6. not referred for psychotherapy
7. given high doses of medication
8. sent to psychiatrists by courts
9. have unmet needs

Source : S. Fernando (2003) Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism

Annex 4: Cost of outpatient and inpatient psychiatric care

Daily costs of inpatient care	Pound Stirling	Euros
NHS psychiatric intensive care	435	638
NHS assessment centre	235	345
Acute NHS hospital	172	252
Social Services day care	36	53
Black and minority ethnic voluntary day care	28	41
Black led assertive outreach service	25	37

Source: Curtis, L. and Netten, A. University of Kent (2004) Unit Costs of Health and Social Care, PSSRU (Personal Social Services Research Unit). <http://www.pssru.ac.uk/pdf/uc2004/uc2004.pdf>

This paper represents the views of its author on the subject. These views have not been adopted or in any way approved by the Commission and should not be relied upon as a statement of the Commission's or Health & Consumer Protection DG's views. The European Commission does not guarantee the accuracy of the data included in this paper, nor does it accept responsibility for any use made thereof.