

A Rainbow Nation?

Black Women Speak Out

By

Karan Essien

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This report was written by Karan Essien.

The full report can be obtained from the Mental Health Foundation Website, www.mentalhealth.org.uk. Or by e-mailing K.A.Essien4@Bradford.ac.uk. A summary report of this research can be obtained from the Mental Health Foundation by telephoning 020 7802 0300 or by writing to The Mental Health Foundation, 83 Victoria Street, London SW1H 0HW.

A Good Woman Feeling Bad

The blues may be the life you've led
Or midnight hours in
An empty bed. But persecuting
Blues I've known
Could stalk
Like tigers, break like bone,

Pend like rope in
A gallows tree,
Make me curse
My pedigree,

Bitterness thick on
A rankling tongue,
A psalm of love that's left unsung,

Rivers heading north
But ending south,
Funeral music
In a going-home mouth.

All riddles are blues,
And all blues are sad,
And I'm only mentioning
Some blues I've had.

(Maya Angelou, *And Still I Rise* 1986:60-61)

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Introduction

This exploratory study investigates the experiences of women who identify themselves as being of Black African or African Caribbean descent. They live in Bradford where they represent a minority within a larger minority ethnic population. According to the 2001 census, the largest minority ethnic population is the Asian community which is 18.8 per cent of the total Bradford population and the Black and Black British representation is 0.9 per cent of the total population (Area Profile Frames, 2003). The minority ethnic population stands at over 55 per cent in the inner city area of Bradford, with the majority being from Pakistani or Bangladeshi origins and a small minority being Black African or Caribbean residents (statistics.gov.uk, 2003). Research indicates that minority ethnic populations in general have poorer health than the majority white population but they are less likely to access health services (Smaje and LeGrand, 1997). It is no surprise then that it is difficult to detect how many people from the minority ethnic communities are in mental distress.

As part of the government's recent policy initiatives the National Service Framework for Mental Health, the National Health Service Plan and the Social Exclusion Unit attempt to redress the inequalities in health care for minority ethnic service users who include women in mental distress from Black African and African Caribbean communities. Despite these recent initiatives the government has not provided resources or funding.

Previous research shows that the mental health concerns of Black African and African Caribbean women has generally been an under-researched area (Christie et al., 1996). Many issues about the mental health needs of Black service users concentrates on the needs of Black men; additionally women are not a homogenous group but mental health issues affecting women tend to focus on white females (with the exception of more recent research exploring the needs of women of South Asian origin).

Eurocentric psychiatry generally has stereotypical views about the mental health needs of Black women (and men) (Wilson, 2001). Many service users are given the diagnosis of Schizophrenia but there is evidence to suggest that this may be due either to misdiagnosis or to many Black service users' fear of the mental health system which meant that they became known to mental health services late on in the development of their mental distress (Keating et al, 2002).

User-led research challenges conventional research, it is research *by* and *for* service users. It looks at life from a different perspective because it includes service user's views on how their mental distress impacts on their everyday life. Service users views are important because 'clinical effectiveness, when restricted to the narrow definition of 'symptom relief', may fail to take into account relevant aspects of people's lives,' (Thomas and Faulkner, 2002). I believe that these women are the 'experts' on their own mental health. They can tell us much about their invisibility as Black women; as Black women in mental distress and their absence in psychological literature, and how these conditions impinge on their freedom as citizens and the consequences this has for Black women in general, professionals and other service users.

As a feminist, I felt that women's views should be recognized as being important in society and that by taking part in discussions on the nature of their mental distress

this would empower them and enable others to benefit from their experiences. My interests lie with women's needs and how these needs are often overlooked due to the way society expects women to cope with whatever is passed their way. Mental distress, particularly depression can occur when people are over burdened with responsibilities such as caring for families, studying and sometimes due to adverse childhood experiences and other life events such as bereavement. Women sometimes find that they have no time to care for themselves and that's when their problems occur. In particular, I wanted to find out about the effects mental distress has on Black women who are potentially a marginalised sector of the community. I am interested in mental health issues due to personal experience but found that there was little or no reference to Black women. They were invisible in mental health services, particularly in Bradford.

When I heard about the Strategies for Living Project at the Mental Health Foundation I sent a proposal stating my intent to report the strategies that Black women use in the community that stems particularly from a feminist ethos of listening to and empowering women. I was overjoyed that I had been chosen to do this user-led research project.

Definition of mental distress

Mental distress is the preferred term I use throughout this report to identify all women with personal experience of psychological distress and is interchangeable with 'mental health problems' or by individual women's own self definition of mental ill health.

Aims

This study aims to identify the needs of Black women who are or have been in mental distress. It also aims

- To enable these women to 'speak their minds' about their mental distress, to tell individuals, families and communities without feeling shame for naming their distress.
- For mental health input to be ongoing and supportive to Black women and not just be available when women reach crisis point.
- For Black-led organisations to be recognized and supported.
- To help establish a women's group specifically for Black African and African Caribbean women.
- To collate these findings into an accessible report.

I hope to raise awareness to ensure that Black women service users, within this inner city Bradford community, who are in need of support, are included in local mental health policies and practices.

Methodology

Recruiting participants

I sent out over 100 flyers about my project to statutory and voluntary organisations. I was aware that there were more women in Bradford with mental health issues due to my own experience of accessing mental health services. I decided to target two Black-led organisations that indirectly came across Black women in mental distress. There was a low uptake for this study, some reasons given for non-participation were that some women did not identify themselves as being Black and others felt it was an infringement on their privacy. Altogether, I had five confirmed replies and although there was scope to interview more women from a specific Black-led domestic violence project, no one came forward. Therefore as a mental health service user I decided to include myself in the interviewing process.

My aims were to interview women and give them the chance to articulate the impact of mental distress on their lives and for them to gain recognition in their own right as citizens of the local community and as Black women with mental health needs. Issues covered included the following: what they thought about mental health services they received and whether they found these to be supportive; what approaches and attitudes they found helpful in mental health workers and what personal resources and strategies they employed during periods of mental distress.

Ethical considerations

The women who expressed an interest in the research were sent a summarised account of the Strategies for Living project and a statement of intent about my user-led research project. Included in this literature was information regarding confidentiality and the payment that women would receive in lieu of the valuable time they would be giving up and the information about their experiences. It was also pointed out to them that they could discontinue with the interviews whenever they wanted. I valued what women had to say about their experiences of mental distress and stated from the onset that my reasons for wanting to find out about other Black women's experiences of coping with mental distress in the community were due to my own experiences of mental ill health.

User-led research

User-led research is about people participating and sharing their experiences of using and surviving, in this case, mental health services, of using their own coping strategies and being involved in all stages of the research process from its inception to its end. This entails deciding on the content of the issues raised in the interviews, carrying out the research with the women on their own terms, analysing and writing up the results and sharing the findings with the local community and beyond. The whole ethos of this user-led approach meant that the power differentials between researcher and the researched were acknowledged; I understood that as the researcher I had ultimate power but this power was shared by enabling the interviewees to have the final say in how their research is portrayed to the wider community. This would mean firstly disseminating the results to the Black community, to create an awareness locally of mental health issues affecting Black women and then to inform other groups in the community.

Semi-structured interviews

Five semi-structured interviews were conducted over a period of five months from July to October 2002. Semi-structured interviews minimize the distance between the researcher and those being researched thus enabling the researcher to interact with the women being interviewed and gain more understanding of their lived situations. Rapport and trust were built up at the beginning of the interview and also prior to it through contact such as telephone calls and letters. The women were provided with refreshments and the interviews began with demographic questions such as age and ethnicity. I had a topic guide that enabled me to duplicate the interview process for each individual interview although there was scope for the women to express their individual circumstances and experiences; the issues shared in the interview situation could not be achieved by using questionnaires because respondents would have had restricted categories to choose from.

This qualitative approach used a flexible design whereby the first two interviews influenced the second set of interviews; I began to realise that after the first two interviews the women were talking about issues relating to racism and violence that I had not considered so it became necessary that when I conducted the next wave of interviews that I include questions about how racism impacted on their mental distress.

Transcribing interviews

The interviews were transcribed and continually read through; notes were made about emerging themes that formed part of this grounded theory approach to data analysis. My intention when analysing the transcripts was to quote the women as much as possible in order for it to be a user-led endeavour. The volunteers were given a draft of their transcript and were asked to comment, to either agree, disagree or to make changes to the transcript such as having the power to exclude some parts of it but this was never taken up. All the women agreed the transcripts were a valid write-up of their interview.

Limitations

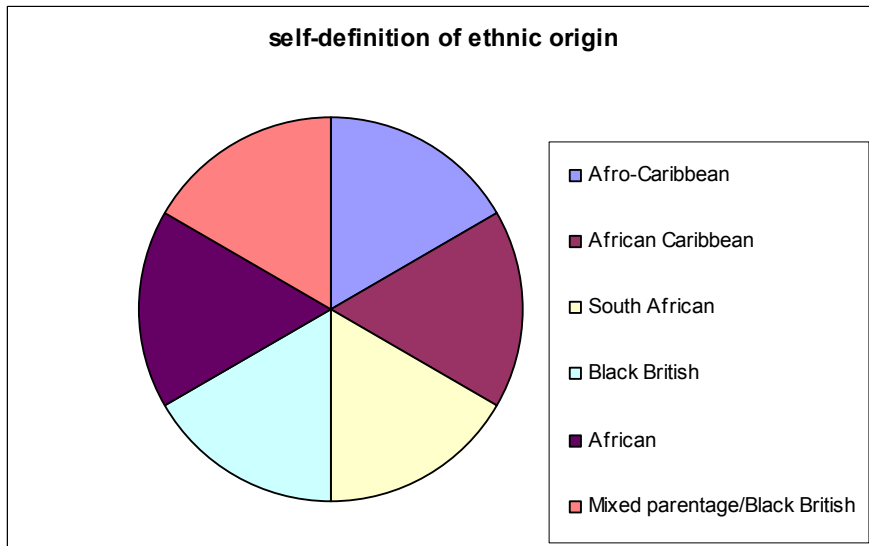
There are limitations to these interviews. Owing to such a small sample of volunteers the results cannot be generalised and are only applicable to the women who participated in this study. However, these findings are valid comments about issues raised regarding mental health services in this local area.

The Volunteers

The women interviewed came from an inner city area of West Yorkshire. Two women were lifelong residents of Bradford whereas three had moved there to go to the university to study and had continued to reside in the Bradford after completion of their degrees whilst one African woman had married and immigrated to England with her English born husband who was local to this area. They were interviewed either in the local Mind centre or in their own homes. This was an important decision on behalf of the women as some had childcare responsibilities. For one woman work commitments meant it was easier for her to be interviewed at her place of work. I felt it was important to let the women describe themselves because there are so many misconceptions about Black women; who are grouped together as if they did not have diversity within their cultures.

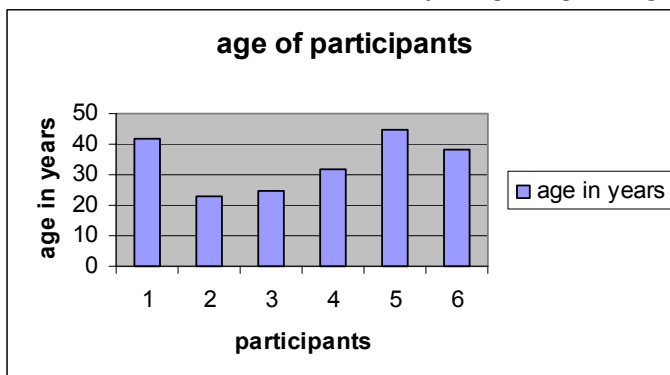
Ethnic origin

The six women came from diverse cultural backgrounds. Four women were born in Britain whilst the other two were born in Africa. They described their ethnic origin as follows:



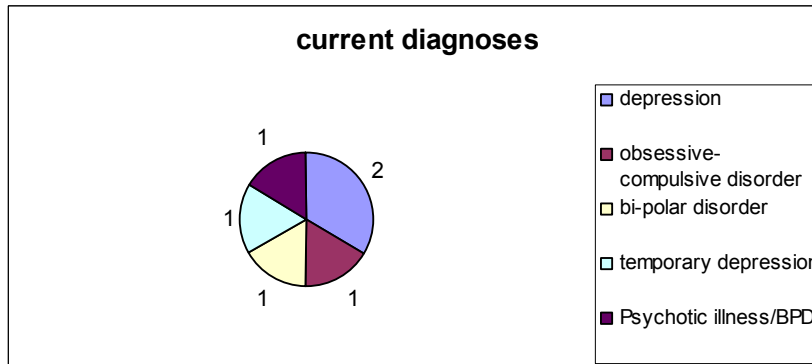
Age

The women were located in the younger age range of the population, for example:



Diagnosis

A range of psychiatric diagnoses initially included Schizophrenia but were subsequently diagnosed as: Obsessive Compulsive Disorder, Borderline Personality Disorder, Psychotic episodes, Bi-Polar Disorder and Depression.

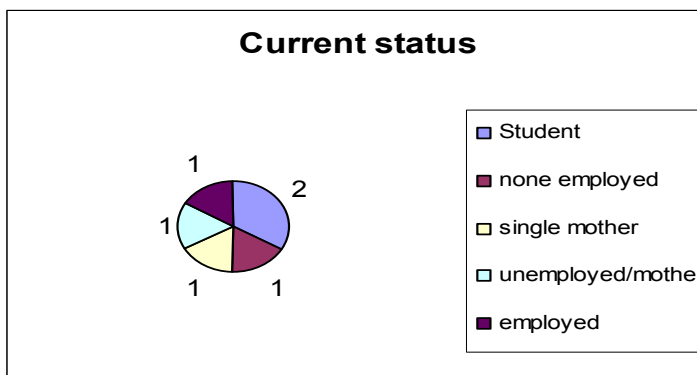


Living circumstances

Four women lived with their families or partners, one woman lived alone and one woman lived in supported accommodation.

Employment status

Although most women had attained qualifications from 'A' levels to degree level and beyond there was only one woman who was employed. This woman was director of a Black-led voluntary sector organisation.



Ability

Despite having a range of mental distress and diagnoses most women described themselves as able-bodied whilst two women described themselves as being disabled; one due to mental health difficulties while the other was for physical health reasons.

Literature Review

The participants of this study were Black women who identified themselves as being of Black African or African Caribbean descent who live in Bradford. This choice of research participant was because there were mental health resources available for minority ethnic women in Bradford, used mainly by Asian women. The following is a brief review of why research with Black women is important.

Racism and discrimination generally has an impact on the mental health of individuals and communities because it reduces self-esteem and undermines one's confidence and self-image (Fernando, 1991). Research that is overwhelmingly conducted with men and generalised to include women is gender-blind, therefore women in general are relatively marginalised compared to men. However, Black women are multiply disadvantaged compared to white women because gender research is conducted with white women and generalised to include all women therefore this type of research tends to be 'race-blind' (Reid-Galloway, 1998). Most research on Black people's mental health tends to focus on Black men who are portrayed as 'big, Black and dangerous' and have a diagnosis of Schizophrenia or other psychotic illnesses (Wilson, 2001). However, this definition is generalised to include Black women who are portrayed as being aggressive and difficult (Reid-Galloway, 1998) which means that Black women who have mental health problems are stereotyped without having their views or needs addressed.

Research indicates that there is a strong correlation between people with poor health problems and social deprivation (Sashidharan, 2003). These vary considerably depending on the ethnic mix of local communities. A study conducted by The Peacemakers Project (2001) found that common ailments amongst African, Caribbean and Black British people included Diabetes, Hypertension, Arthritis, Sickle Cell Anaemia and Asthma. Mental health problems and distress were not addressed but there are also cultural variations on the presentation of mental distress. Disadvantaged people, like Black women in mental distress, are considered more likely to develop mental disorders particularly those people who live in inner cities compared to people who live in rural areas (Thorncroft, 1991).

As a consequence Black women from Bradford are more likely to be socially excluded due to socio-economic stressors such as low incomes, poor housing and general inner Bradford deprivation that make it difficult to become included as active citizens in society (Sayce, 2000). Williams (1999) suggested that 'behaviours defined as symptoms and disorders are best understood as creative responses to difficult personal and social histories, rooted in a person's experience of oppression' and that this is named 'mental illness'. Generally these psycho-social factors are not addressed with individuals or Black communities by health and social care professionals or policy makers. The mental health needs of Black African and African Caribbean women in Bradford have been overlooked; they are a minority within a larger minority ethnic population. Services and support should be made available to these women to enable them to become mentally healthy and function effectively in the community. The attention given to Black women's mental health issues builds on a low baseline in Bradford.

Recent government intervention and policy initiatives

The Mental Health National Service Framework makes it a requirement that standards for reform of mental health services should be implemented within local communities. These standards should meet and include the needs of Black and minority ethnic communities. Standard one aims to promote mental health initiatives in Black communities. These intend to 'evaluate examples of good practice and assess the appropriateness, impact and effectiveness of these initiatives within this sector of the community' (Tidyman, 2003). Improvements in the health of these communities would be an indication that these initiatives have been effective.

Standard Two states that any service user approaching primary health care team should have their needs identified and met and be offered effective treatments. Most people's first contact with a primary care team is with their GP but many GPs are generally considered less likely to recognise mental health problems in minority ethnic populations (Keating et al., 2002). Standard Three states that people with a mental health problem should have access to mental health services. However, it has been shown that Black people are more likely to be offered coercive treatment, hospitalisation and/or medication and were less likely to have access to therapeutic services such as counselling and psychotherapy (Keating et al., 2002). Other standards include the provision of effective services for people with severe mental illness; supporting carers in the community and decreasing the suicide rate although the Inside Outside report indicates that there are no national figures about suicide risk amongst Black African and African Caribbean women in England (Sashidharan, 2003).

DON'T

Don't
Look me in the eye
As if you know me.

Don't
Greet me as friend
When I hate you.

Don't
Tell me what to do
As if you own me.

Don't
Judge me by my history
That's still a mystery.

Don't
Tell others, things
You know about me.

Don't gossip
Don't break confidence
Don't conjure me up.

Don't
Preconceive a history
That's not me.

Don't
Do it
Don't
Think it
Don't

I'm ME!

The Findings

During the interviews the women raised a range of issues that were important to them. These were due to the impact of racism and oppression, of violence and abuse, of the stigma of having a mental health diagnosis, and through everyday life experiences as Black women in British society.

Multiple-diagnosis

Some women had been given multiple-diagnoses. This was often from the notion that when Black women (or Black people generally) are first in contact with mental health services they are perceived as being in an increased stage of mental distress (Keating et al. 2002). Secondary and further diagnoses included bi-polar disorder, obsessive-compulsive disorder, borderline personality disorder and depression.

“I’ve been diagnosed on a whole host of things. They tried to pin schizophrenia on me.”

“It was depression the first time then it was suicide.”

“I was told I was psychotic and then that I had personality disorder.”

“Because I hear voices they put that down as schizophrenia.”

Medication

Four of the women were on medication. One woman was prescribed medication at the age of 17 after three years of contact with Child and Adolescent Mental Health Services. Two women did not know why they were prescribed medication:

“...They told me that (medication) for depression. Still today I don’t understand what it is.”

“Well, if you don’t get the injection you feel like you are gonna go back sick so the injection is like a tonic, it builds you up, lets you fall from going back sick into hospital. Yeah, it’s kept me out.... When I see my doctor next month I’m going to ask him why I am getting the injection because he never told me.”

Medication was felt to have numerous effects on the women:

“Like most of the time I was like a zombie...always sleeping all the time.”

“I’ve had electric treatment to bring me backthat were tough but I got through it.”

“Even now, sometimes, I can’t eat.”

“I’m on anti-depressants and an anti-psychotic drug...so basically I’m stagnant. You know. I mean, there’s nowt I can do for myself.”

Racism

The impact of racism can have detrimental effects on women’s health. Discrimination takes place on an individual and an institutional level and may impact on the types of

support and services one receives. Racism contributes to mental distress and can lead to feelings of isolation, fear, intimidation, low self-esteem and anger. It might be because of all these feelings that it is said that depression is anger turned inwards (Holland, 1995). Most women who were interviewed believed that racism is endemic in British society. They are resigned to the fact that it is an everyday occurrence in their lives.

“In this country [UK] still find it anywhere you go. In South Africa, yeah, it has improved. You know, it is a new generation, they call it a new rainbow nation.”

“Racial discrimination! A lot! A lot!”

“I have been the victim of their nastiness [neighbours]. My children have been the victim of their [neighbours] nastiness through racism.”

“It affects me every day, does being Black.”

Many of the women experienced racial abuse from neighbours, some staff in mental health services, women’s hostels and also from other service users. One woman had been in a relationship whereby her white British husband made racist remarks about Black people on television and in general but assured his wife that she was different. This did nothing to allay her fears of alienation and isolation.

Some of the women cited that they had experienced racism where they live:

“When we first moved here...we had racial discrimination.”

“Had a brick through my window... Eggs... It was a nightmare.”

Two women talked about having to move house because of racism:

“Thought I best move; at least in Bradford... I feel I belong there, you know there’s loads of people’s like me...colour of my skin and everything.”

“We’re gonna have to move house but [children] don’t fully understand.”

Racial harassment was not the only form of discrimination these women endured. Consistent with other minority and majority ethnic populations, violence and abuse was prevalent in the lives of some of the women interviewed either directly or indirectly.

Violence and abuse

Domestic violence and child abuse was also felt to be an issue within Black communities for some women. One woman talked of physical and sexual abuse in childhood by her siblings and not being able to talk about it.

“They (brothers) used to beat me up. They used to give me human faeces on sandwiches to eat [and] they made me drink my piss.”

One woman stated that a male worker in hospital had ‘banged [her] head on the floor’ when she was seeking the support of another worker on the ward.

Another woman was dragged backwards down the stairs and put in a seclusion room where she was held down by five members of staff and sedated.

The one woman who had a high status occupation, actually stated that there was an element of sexism from Black men in the community:

“When they say things it has impact...No matter how small it is, it does affect you...that why should a woman like myself be in this position? (director of a Black-led organisation).”

Impact of mental distress on everyday life

- **Awareness of mental health issues in other people**

Understanding and awareness of mental health issues in other people has been increased due to their own mental distress. As well as their own problems most women knew of relatives, friends and other service users or had worked with people in mental distress:

“I think in one way or another, err, all of us suffer from mental health. For instance if you have a bereavement in the family you may have temporary, err, you know, mental health, you know or depression.”

“I see a lot more (people in mental distress) going through it without seeking any help or support.”

- **Stigma**

There is the issue of stigma attached to mental health labels, of talking about mental distress, being fearful of what can be offered and having negative experiences of mental health services that are not conducive to the women’s future mental health needs therefore they kept their problems hidden.

Although some women acknowledged and accepted their mental distress they were still affected by the stigma attached to being in hospital or having a psychiatric diagnosis, they see this as a sign of losing their self respect in their communities:

“It’s like a disease...it will always be with you.”

“At home, [South Africa] hospitals like this for mad people; I mean, really mad, they’ve absolutely lost it. And at the time, I didn’t even want my family, I didn’t even wish for my family to find out that I’d been in a place like that.”

“...Probably because of stigma: I know that within the community, that is, people always run away from saying they have this...mental, they don’t want to accept it that it is actually happening to them because it is seen as something to be ashamed of.”

One woman expressed mixed feelings of shame and isolation, and that being in hospital had caused her marriage to break down:

“It almost feels like...you’re not normal, you’re not like the others. You feel like an outsider, yeah.”

One woman felt that neighbours interfered in her life and called the police out unnecessarily to her when there were neighbourly disputes; she was often escorted to the hospital by the police. Her neighbours knew about her psychiatric history:

“Oh, I know what’s wrong with her. Where are your tablets? And she was force feeding me my tablets in front of the police.”

One woman stated that she thought it would be embarrassing to say she had been in a psychiatric hospital because it would affect her chances of gaining employment:

“If I’m going for an interview I wouldn’t tell them that I was in the hospital. I’d just say that I’d been to college and I wouldn’t mention anything because one doctor, one nurse, told me if you mention (the psychiatric hospital) they don’t want to know because it means that you have got medical problems and you might pass it on to the others.”

One woman felt exposed and that her mental health problem was ‘visible’:

“you feel that they can see you’ve been in a mad house....when I’m feeling low, I don’t like being out there in the public eye.....I feel like its written on my face.”

- **Lack of information**

Some women felt that they did not know what their diagnosis meant or how it would affect their lives because they hadn’t been given much information about their mental distress:

“They said that I’m manic depressive. I don’t fully understand what it all means. I’ve got a leaflet what they said I’ve got to look into and read and all I know is it’s your mood going up and your mood going down.”

“I only found out that I had Borderline Personality disorder when the psychiatrist wrote it down on my DLA form. I had no idea what it meant, at the time.”

Community Support

There seemed to be a lack of local support in the community for Black women. Some women felt isolated and felt they had nowhere to go to get support:

“The referral system in Bradford is very, very appalling, it’s flawed because they don’t give the sufferers the opportunity to choose where they want to go...and that actually add to the problem of people keeping silent.”

“No security, no support from no-one around here.”

“... Nobody comes to visit us, nobody. They say that we are too far away.”

“I’ve got a CPN but I’ve never seen her. The last time I saw her was when, in the, you know, like they do the ward rounds.” (Six months ago)

“They (local mental health organisation) need us when they want to say we have Black people... but when it comes to supporting us, they’re not there for us. They don’t want to do it; they just want it to be one-way traffic.”

- **Relationships**

Relationships with others, particularly friends, family and mental health workers were felt to be an important source of support. The effects on lost relationships were thought to be especially isolating. Two women had lost friendships due to being in hospital. This is due to the impact of mental distress on everyday life. One woman felt she was forced to stay in a women's hostel because she had nowhere else to go. This service was therefore available but was not what she wanted; it didn't meet her cultural needs so she felt alienated in the hostel. She had children but no other relatives in this country except for her violent ex-husband:

"If there is somebody, mm, in a situation like I was in, I wouldn't advise them to go to the refuge. Unless they don't have anybody else in this country...otherwise, if I had family, I would have gone to my family. I wouldn't have gone to the refuge or put up with that... but where else do you go, you've got no choice."

One woman felt that she had lost friends due to having a mental health diagnosis:

"My best friend at university sent me a letter to say that she could no longer see me because I had been in a psychiatric hospital. She said it was difficult because she was now 'one of them' meaning that she was a psychiatric social worker."

- **Women's hostels**

Women's hostels were noted for not taking into account women's diverse cultural needs. In the hostel for women with severe mental health problems, one resident felt that the staff did not appear to have any training in mental health issues. This was problematic because they appeared not to have any mental health or cultural awareness of the women who resided in the hostel. What the women needed was access to information about the different types of mental distress that they experienced and to be guided to services or support groups that may be of benefit to them. This hostel was staffed only by white workers despite there being Black and Asian residents. The current supported accommodation project that one woman resided in also had no Black or Asian staff, despite Black and Asian resident occupancy.

One woman fled to a women's refuge because of domestic violence but felt that the refuge did not cater for Black African women's cultural needs. This was a refuge for Black and Asian women fleeing violence. This woman felt there was a two-tier system within the refuge that was predominately Asian occupied and this Black woman felt she was being treated unequally once living there. She was segregated from the Asian residents and told by staff to stay in her own unit with her children:

"...In the refuge I found there was just me, myself and my children in my own unit [bedroom] and I couldn't even cook in the kitchen any more because they were taking over the kitchen... It was no life."

Again she felt isolated and felt that the staff did not take into account or understand her specific cultural needs.

A main problem with mental health provision within communities, for example women's hostels, is that they are often located in dangerous areas due to NIMBY-ism. This intensifies the isolation women already feel in Bradford; one woman felt unable to leave her supported accommodation in the evenings and weekends due to being targeted for abuse by locals, the hostel was not staffed 24 hours. Although

aftercare' outreach work was apparently on offer at one hostel, in reality it did not exist, there was no further support in the process of integration into the community.

Care and treatment

The most common form of care and treatment experienced by the women was being hospitalized and/or being prescribed medication. At least two women in the study had been sectioned under the Mental Health Act (1983), one person on more than one occasion.

One woman had experienced ECT but had lost count of the number of times she had been given it:

"I've had electric treatment to bring me back. How many times have I had that, several times"

One woman was able to access the Home Treatment Service as a means of preventing hospital admission and two women interviewed were able to access talking therapies; one was within a voluntary sector counselling organisation and the other within an NHS psychotherapy facility. These women felt they had benefited from these services:

"I have been in psychotherapy for two years now and I find that I am getting somewhere with my life. There is a light at the end of the tunnel."

"I think because they [counselling] are free... and they're easily accessible and there's lots of information about them."

- **Lack of care and treatment**

However, some of the women felt that there was a lack of care and choice of treatments available to them. Some thought that there was a lack of information about mental distress and that services were generally inaccessible to Black women.

"Some of our people go to the hospital and will come out a worse person. They (staff) are not friendly when talking to sufferers."

One distressed woman turned up at the local Accident and Emergency department specifically to speak to the duty CPN and was told to:

"Go home...you know where we are if you need us."

Other women felt that there was often no support in the transition from hospital to home.

"I think, you know, that when you leave the hospital they shouldn't just leave you out there to cope by yourself...because they have you locked in there. They don't even take you out for a day or something. You get locked indoors and then when you leave you're left to face the world by yourselves."

"I don't understand why they treat people in isolation because isolating them actually made the matter worse. People are supposed to be surrounded by friends, relatives and you isolate them...that cause low self-esteem."

- **Bereavements**

Three women had difficulties in expressing their grief of their immediate and extended families that had died in other countries. There is no bereavement counselling specifically for African and African Caribbean women in this situation. One woman was waiting for her leave to stay in this country so could not leave the country as she would not have been able to re-enter; therefore she was unable to attend her father's funeral. Despite the women using various methods to 'cope' with their losses they were too often alone with their grief which are described further in the section on coping strategies.

"I ain't got nobody... from when my mum died...and when my dad died that were the worst... it knocked me, it really did. I stopped eating."

"I traced my dad when he was dying of cancer, I was too upset to attend the funeral but his ashes were taken to Nigeria so I felt there was nowhere to grieve for him."

"My dad died when he went over to Jamaica."

Mental health workers

Most of the women had been in contact with mental health services and they had clear ideas about what they thought workers could offer. This included basic things such as listening to the women. Thus, listening skills were an important factor and could be from a variety of people including support workers, community psychiatric nurses, GP's, psychotherapists, counsellors and student nurses.

The women described some of their good and bad experiences with mental health workers who had worked with them. The following are examples of their individual experiences with professionals.

Important skills in workers included:

"...To listen to me and not to answer...label me or force me to do something I don't want to do."

"All I needed was like...a psychiatrist, you know someone to talk to."

"[Support worker] was really interested in me and helped build my confidence, she never knocked it down."

"You know, just a bit more caring and supportive with the caring."

"My psychotherapist really understands me and listens to what I have to say. I've begun to trust her, something I haven't been able to do in the past."

Another woman stated that her support worker had helped her sort out her debts:

"When I just came out of hospital he (Advocacy worker) took me to DSS and he stood as my support worker and when he came up to the hospital he was always so bubbly and nice and when I wasn't feeling good he came and spoke for me and they wrote it all down 'n what I wanted."

Three women had positive experiences with their GP's who were often their first contact regarding their mental distress, through whom they were able to gain access to mental health services such as being referred to more specialized services such as the Home Treatment Service or talking therapies.

"My [GP] was very understanding because half the things that happened to me he understood more than my mum and dad and brother and sister, yeah."

"My GP is female and I think that is important, I feel she understands me and supports my choices on how I live my life."

"Yeah, doctors are most helpful 'cause they listen to what your parents say more than the nurses."

Some unhelpful skills in workers were:

Although some women had positive experiences with professionals there was agreement that individual workers were sometimes thought to act in ways detrimental to the women's expectations of their assigned roles. Furthermore there seemed to be a lack of support available to them due to staff shortages, or to transient unskilled staff.

"It's just that when you need somebody to speak to, nobody's there for you. And I don't think it helps that they lock you in, you know [psychiatric hospital]...it just makes you more...how can I put it...you get more irritated, it's like you're being punished for your illness, you know, it's like being in prison."

"Well, I had a social worker and he was absolutely rubbish. Everybody said that when you have a social worker in this hospital, they are rubbish. They don't get to the point. They don't tell you what's going on. That's what we all found out."

"I let this woman into my house every week and I don't even know her title."

"She'll sit down there drinking, drinking, drinking...and asking me silly questions. I've said to her mm I want to do a lot more...you see, they do your head in more than anything." (Talking about her community support worker)

"They're not asking me what I want to do. They're just doing what they want to do."

"...You find that the staff as well they don't write down, they don't ask you how you are feeling, or...when you're feeling down, they're not there, it's either they're busy..."

One woman felt that her consultant psychiatrist exerted so much influence over her life that she felt unable to try for another child without first asking for his permission. She felt unnecessarily questioned by him:

"Like he's God..."

Even when in hospital some women were aware of the effects of the NHS budget cutbacks over the years:

“Mm...we used to have lessons in the hospital but now there are no lessons, it's all changed because the government has cut down... We used to do cooking and go on day trips... the government has stopped all those funds, now we can't afford it.”

“I think if they could put more staff [nurses on the wards]...maybe to be different...they could have more time for the patients.”

“If I'm not wrong, they must need more staff because with such an amount of ill people's you can't expect them to see you only because there is other patients' as well.”

Black-led organisations

Also during this research I consulted two Black-led projects for Black African and African Caribbean communities; they did not specifically address mental health issues but encountered women in mental distress; they were dealing with domestic violence and trying to provide for Black women in distress:

“We provide for Black women experiencing domestic violence...and you know that mental problem affect women when they experience domestic violence.”

“We can take the issue of mental health up if we have the resources to employ somebody to provide outreach work and advocacy for people with mental health problems... those people who have been funded for mental health, they don't actually serve our needs.”

There had been a support group for Black service users but it had disbanded due to a lack of interest and had then been opened up to all service users but this was not in operation when I did this study. There was recently a possibility of a short-term creative therapy group for Black women organized by social services but this too experienced a low uptake and did not go ahead.

Cultural specific activities

Nationally there are some support projects and organisations that have empowered Black women but most of the women in this study advocated the need for culturally aware mental health support for Black women in Bradford, they were not interested in the bigger picture as it did not seem to affect them or help them in any way. The women felt that culturally sensitive services were established for other minority ethnic groups in Bradford, but felt that they were excluded and therefore encountered difficulties:

“In Bradford we realise that African community has no centre...we have nowhere to go so we have, have to do something for ourselves without any support because in Bradford they do not recognize the African community on its own and unless you recognize a community you won't be able to help them and support them...because whatever anybody want to do for you, now they need to understand your history, they need to understand where you are came from, they need to be able, it is the, then they would be able to have a package of programme for you.”

“There's no clubs, we only have got (youth centre) and that's the only thing for Blacks in Bradford there is nothing else.”

Practical issues highlighted that could go some way to improving the life of Black women in hospital and in the community included:

- Translators for people from the African continent;
- Having their dietary needs met, such as “having chicken and rice”;
- The Voice newspaper (this did appear sometimes)
- “Someone to come and plait their hair, wash their hair, yeah, you know, even comb their hair for them make them look halfway decent inside that establishment [hospital]...it’s them that know bout white people but what about Black skin and hair.”
- Financial support for Black-led organisations to enable them to deal with Black women’s mental health issues and offer outreach support.

In the community setting some women had specific support needs for on-going issues such as domestic violence. As already stated two women had negative experiences of their contact with women’s hostels in Bradford that did not take account of their diverse cultural needs.

Coping strategies

The women used a variety of self-healing strategies. Some they thought could be used by other women, while one woman reflected that as we are all individuals we must find our own ways of coping that are most comfortable for ourselves. For example, what might be useful for one individual may not be helpful for another, one woman felt that listening to music made her feel depressed whereas another found this a useful coping strategy.

It is necessary also to highlight some positive influences in women’s lives because these women may have specific problems affecting their lives but they also show considerable strength despite often, negative circumstances.

Three women had inner personal strengths and coping mechanisms that enabled them to overcome their grief and loss, often for parents who had passed away in Africa or the Caribbean. Two women felt that their depression was caused by the loss of their extended families in other countries.

One young woman felt her mental health problems had lessened a lot, coming up here (to study in Bradford)’.

While another woman felt that coming off her medication improved her mental health:

‘I was ill but I recovered...Get my bad days and my good days...’

The woman identified the following techniques for coping at times of mental distress.

Many of the women described the importance of having positive relationships in their lives.

- Having a supportive partner, support from family and friends
- Having telephone contact with friends
- “Talk, talk, just talking to people does help a lot.”
- “Being around people. I don’t even have to, you know, like know them or know their names, just in their company.”
- “The only thing that’s keeping me going now is my children.”

Some of the women had found ways of expressing themselves creatively:

- Writing poetry
- Pottery
- Singing and dancing
- Listening to music

Some of the women found being occupied through work or study helpful:

- “I enjoy studying and I go out on day trips.”
- Studying for a Ph.D.
- Caribbean cookery course

Other strategies cited by the women were personal coping strategies that enabled them to feel better about themselves or their situation:

- “Go sit down and lie on the couch and I’m holding myself because that’s the only form of comfort I’ve got.”
- “I make sure that I keep myself busy [cleaning house].”
- Coming off medication
- Taking medication
- Smoking draw
- Going for a walk
- Writing problems down
- Window shopping
- One woman described self harming as her coping strategy

Alternative Therapies

One woman used shiatsu massage as a helpful healing strategy.

Spirituality

Another woman talked about the importance of her religious beliefs:

“Well, it’s the almighty, in it, really, mm, he’s the one that I cry to and he’s the one that answers my prayers and they need answering...It’s my faith, yeah. If I haven’t got faith I’ve got nothing.”

Doing it for ourselves

As well as finding individual coping strategies the women in this study agreed that there should be something specifically for Black African and African Caribbean women in Bradford, like a support group.

“We are part of the community and I’m a citizen of this county so we deserve a better service, as other people are going through, so we want the same service, a quality service, a service that is culturally aware, that is very sensitive, a friendly environment...You want something that is very relevant to your culture, relevant to your experience.”

A social meeting place appears to be what most women in the study feel should be available in Bradford, somewhere to share ideas and gain mutual support from each other. One woman said just playing Badminton or meeting for a coffee with similar minded women who had mental health distress in common would improve her social network and increase her mental health, knowing that she was not alone with her problems.

“There should be something for Black women who want...sort of appropriate services...for their culture.”

“They do not want to help Black-led organisations to be able to help their own people.”

“Imagine when you are running an organisation; you have no fund to pay your salary, your work or to do anything at all. The NHS didn’t give her any money. PCT no money, nothing at all, they just want to use her to be using us, they say: Do you have a Black person there? They say yes.”

Two of the women commented on the importance of being more empowered:

“Because they love doing things for us rather than doing things for ourselves and that is the problem, you know.”

“They don’t help you to stand up as an individual. They always want you to depend on someone else.”

One woman advocated separate services for Black people with mental health problems:

“Because we look across the district there is nobody working on the aetiology of Black African or Black Caribbean. I want to see a Black African-led organisation taking the issues of health, mental health up...and provide mental health support that is culturally aware, that is Black women friendly environment...we want an end for some people doing it for us.”

Overall, the majority of women felt that they would benefit from a support group, somewhere to talk about issues that would enable them to have more control over their lives. Therefore, they believed that a self-help group for Black African and African Caribbean women would be a start. When asked if there was anything in Bradford that they would change, one woman said:

“Listen to what Black women have to say if they’ve got a problem and something is wrong with them, they should take more notice, and jot down what’s wrong with them, what’s wrong with their medication and the injections to improve themselves better.”

“The issue of culture, they do not understand the African culture. They don’t understand whether African women, err, or African Caribbean women, they do not understand their needs, they don’t understand where they are coming from. They have, they have a foreign package and they think it will be okay.”

“I definitely want to change the way Black women has been treated in relation to mental health...the way we have been treated is totally different from the way other people, other races, has been treated. They treated ourselves as if our life is not important.”

Another woman spoke about the diverse needs of food for the African Caribbean community in hospital.

“I asked for one meal, they made me one meal, but it was more like Asian type.”

“You know, when I came out here I start seasoning up my own food; it tastes too hot because they give you all that bland food and you know all these boiled potatoes and things, you know English food. They should have more Black people going into the establishment (psychiatric hospital) and doing something for the Black people... I’ve told them before that I’d work in their kitchens. I said I’d do anything just so the Black men and the Black women could get what they need.”

I invited the women to talk about their plans for the future. Many had quite positive aspirations. All the women maintained that they had high expectations for their future happiness and mental well being; all citing further study, creativity classes and resources and employment as ways out of their poverty, unemployment and ill health.

“Ooh, my plans for the future. I want to educate myself, you know, go to college, and do what I want to do, have my goal. ‘Cause nobody’s going to come and hand it over towards your hand unless you go out and look for it.”

“When I come off my injection I’m gonna get a job in a shop.”

“I plan to get a job, and mm...save some money and move, err...somewhere a bit bigger really.”

Discussion

As this study suggests, Black women's voices need to be given the opportunity to be heard. These women state that culturally aware services that are user-friendly and personal support would go some way towards eradicating the fear and hopelessness that they encounter when in contact with mental health services, and the stigma and shame that they feel from their own communities and wider society. Such services need to be planned and implemented with Black women involved, being a Black woman should not have to mean being second-best. As citizens of Bradford they should expect to have fair services and support to enable them to live like 'free' people.

Some women were able to engage with services via their GPs and other agencies. However, in most cases, the women have been assimilated into mainstream services without any awareness or recognition of their cultural needs. Research indicates that Black people believe that racism and its effects act as a major cause of their mental health problems (Sashidharan, 2001). Stereotypes often influence the diagnosis and treatment that Black people receive. Black people are frequently misdiagnosed and or given multiple diagnoses (Wilson, 1997).

Black people generally are often at the receiving end of the more punitive forms of medication and treatment due to the fact that many are diagnosed with higher incidences of psychotic type symptoms although some research states that psychosis is no more prevalent in Black communities than the white communities but it is the Black population who are more likely to be sectioned and be given medication as the treatment of choice (Sassoon and Lindow, 1995). The women in this study gave their own examples of their experiences of receiving multiple diagnoses, and often not being informed about what these labels may mean. Coincidentally, another study shows that many Black African and African Caribbean communities are reported to have a low incidence of illnesses like depression and anxiety but an increased prevalence of psychotic related disorders such as schizophrenia (Keating et al, 2002). The result of which indicates that they are more likely to feel the effects of compulsion.

Misconceptions of Black women include: being 'big and strong'; working long hours for minimal wages (Lewis, 2001) and not complaining about their problems outside their communities. These misconceptions can mean that Black African and African Caribbean women are not seen as needing external support from statutory and voluntary agencies. The reality is that some women are actually isolated and may find it difficult to ask for support; many may not like medical model terminology for their distress or being medically sedated with drug treatments and therefore do not seek help.

Some women are obviously struggling in the community. They need to be encouraged and supported to be active citizens so that they may be able to participate in society and influence decisions about their lives; such as tackling issues pertinent to Black women and their support needs within the community. Women in general are often pressurised to take on the caring role. They are still predominantly in 'caring' environments either in paid employment (working for less than the average male in a similar job) or working in the home; if not with children or spouse then sometimes caring for relatives who may have health problems (Arber and Ginn, 1991). This impacts on their health and can often be causal in mental distress; having to juggle multiple roles is stressful and should be acknowledged. Having to take care of themselves is often of low priority; for three women in this

study their children came first. This highlights the importance of carers' needs within Black communities are as important as for any other ethnic group and these should also be acknowledged and addressed. Tackling racism and sexism would be one of the most effective ways of improving Black women's mental health. This is the responsibility of the whole of society and should be endorsed.

Ultimately, the medical profession needs to acknowledge and accept that institutional racism exists; they should ensure that professionals are trained to be more culturally aware. This entails offering equal access to treatments to all sectors of the community and advertising culturally specific services. There needs to be increased awareness of the needs of the different Black communities at all levels throughout society, these include: educational establishments, health centres, local community centres and also within the stratified and diverse health and social welfare institutions that can have a real impact on meeting women's needs.

We need to put pressure on, and encourage, the government to target the socio-economic problems of those most vulnerable in society who are socially excluded due to adverse circumstances such as poverty, unemployment and discrimination. Research shows that when unemployment rates are high there are more people prone to developing mental distress. The women in this study were all highly educated and qualified and yet all but one of the women were unable to find employment.

Mental health promotion is the new 'buzz' word for looking further than the current provision of services. The organisation Mentality advocate active participation with the emphasis on intervention of mental distress work being done in consultation with the local Black community, which entails recruiting staff from within local Black communities, who have similar ethnic backgrounds and are therefore representative of Black communities. This may be an effective way to promote Black-led organisations to cater for their communities. Alternatively, some may see this as a reason for under-funding Black-led services and not connecting them to mainstream services where all needs should be catered for.

The City Primary Care Trust has introduced some initiatives such as the Sharing Voices Initiative in Bradford. The intention is to influence and sustain grassroots groups that are already in existence in Bradford but have not until recently included any input into the needs of Black African and Caribbean women. The Primary Care Trust has now employed a person to oversee the specific needs of Black African and African Caribbean women in Bradford in mental distress. Other recent initiatives are encouraging women's groups to be established but there doesn't appear to be an influx of funding to sustain these initiatives in the long term. The aim is to establish these new groups; eventually making them self-financing and are to be initiated by service users and local community members. Whilst these initiatives have good intentions it remains to be seen whether such groups can sustain themselves in the longer term. One pertinent issue stated earlier is that projects have been in existence but it has been the Asian population who have been the first to benefit from them and it is only a recent development that Black African and African Caribbean women have also been identified as having specific needs. The local mental health resources need to be more evenly distributed in a sensitive, inclusive and an accessible way to communicate with the diversity amongst the women in Bradford who have mental health needs.

Conclusion

In conclusion, the women involved in this research wanted to share their experiences and have their opinions heard. They offered ideas about practical ways in which services could be improved and the kinds of support that they would benefit from. The research also shows the women as whole people, not reduced to their symptoms. The women are mothers, students, friends, partners; they take part in creative activities, they cook, shop, dance and sing. It is vital that people are acknowledged in a more holistic way. There have been some examples of good practice locally from the primary care trust but these should be extended to all Black women in the community, there is also a lack of communication about what is available to these women. Local resources should be appropriate and accessible to women's needs and not just based on assumptions about their ethnicity.

Other societal factors need to be addressed such as socio-economic stressors, which is one of the main causes of psychological stress in Black women: otherwise mental ill health within this population will persist. There should be culturally aware support services for women not necessarily related to mental health issues but providing a holistic approach to meeting their needs locally by encouraging relationships with others and providing meaningful services and resources in the community that would ultimately be beneficial to all members of society. Financial support for Black-led organisations would enable them to deal with Black women's mental health issues and offer outreach support in the community.

Recommendations

- Black women do not want piecemeal services. The Primary Care Trust should show that they are serious about supporting them by encouraging and financing Black-led organisations, in particular providing a support group for Black women.
- Black women should have access to alternatives to hospital admission at time of crisis; like the Home Treatment service which should be more widely available. They should also be more choice between drug treatment and other therapies, such as counselling.
- There needs to be more pro-active communication between the Black communities and service providers, to get the Black women involved and engage them in pro-active, independent discussions about issues affecting them, such as how to eradicate the ineffective community resources and promote more effective services and resources, some of which may be beneficial holistically.
- Services need to be more 'needs led' than 'service led'. The 'one size fits all' solution no longer holds in Bradford, recognition of the diversity between women as well as their commonalities would enable groups to meet up occasionally and exchange ideas, we can learn from each other, maybe creating a safe space for a forum.
- Evidence that these practices are being instigated would be a step forward on the ladder of change. For example, to cater for Black women's dietary needs during the time spent in hospital and be aware of their physical health needs.
- There needs to be more promotion of the services available to all members of the community in health centres and schools, and social gathering places which may be the local hairdressers or other places where Black women congregate.
- Women should have the choice to have female workers whenever possible, if this is what they prefer.
- More research needs to be undertaken to investigate the reasons why there are low uptakes of services that are on offer. Some of the questions this research may want to explore are:
 - Do you feel afraid of contact with mental health services?
 - Are the ways in which services are advertised a problem?
 - What other ways should services be advertised, for example in black literature and art?

In addition, research conducted with a larger sample size may be able to extract more views from Black women about their perceptions and their own constructions of their mental distress.

THIS WORLD

This world of our enemies
These lands of our dreams
Making peace for our children
Is easier than it seems;

Hatred based on divisions
Race, culture, creed and colour
What child in distress
Would not call you mother?

See them play happily
No sabotaged inheritance
Let the children choose their friends
Not based on our vehemence.

One day, I prophesize world peace
One day, we will greet our neighbours as equals
One day sisters
This will be the way.

How long must we wait?
Now is the time to begin
Learn that we can live together
In peace before it is too late.

There are no winners in this war
Only losers left behind
When we reclaim our lands
Share our history and time
Hands of the world reach out to mine.
Time to begin
Learn that we can live together
In peace, before it's too late.

Bibliography

- Angelou, M. (1986) *And still I rise*. London: Virago Press Limited.
- Arber, S. and Ginn, J. (1991) *Gender and later life*. London: Sage.
- Bhui, K. and Sashidharan, S.P. (2003) Should there be Separate Psychiatric Services for Ethnic Minority Groups? *British Journal of Psychiatry* 182: 10-12.
- Bradford Statistics from Census. A:\AreaProfileFrames_files\area_Profile.htm
- Chrisite, Y., Burrows, F. and Huka, G. (1996) *African women in the diaspora* in Perkins, R. et al. (1996) (Eds.) *Women in Context: Good practice in mental health for women*, London: Good practices in mental health.
- Dutt, R. and Ferns, P. (1997) *Letting through Light: A training pack on Black people and mental health*. London: Race Equality Unit.
- Essien, K.A. (1993) Unpublished poetry.
- Faulkner, A. and Thomas, P. (2002) User-led research and evidence-based medicine. *British Journal of Psychiatry*, 180:1-3.
- Fernando, S. (1991) *Mental Health, Race and Culture*. Basingstoke and London: Macmillan/Mind.
- Holland, S. (1995) *Interaction in women's mental health and neighbourhood development* in Fernando, S. (Ed.) (1995) *Mental health in a multi-ethnic society: a multi-disciplinary handbook*. London: Routledge
- Keating, F., Robertson, D., McCulloch, A. and Francis, E. (2002) *Breaking the Circles of Fear: A review of the relationship between mental health services and the African and Caribbean communities* London: The Sainsbury Centre for Mental Health.
- Lewis, G. (2001) *Black women's employment and the British economy* in Bhavnani, K.K. (Ed.) (2001) *Feminism and race*. Oxford: Oxford University Press.
- Mama, A. (1995) *Beyond the masks: race, gender and subjectivity*. London: Routledge.
- NHS Mental Health Task Force (1994) *Black Mental Health- A dialogue for change*: London: Department of Health.
- Newnes, C., Holmes, G. and Dunn, C. (Eds.) (1999) *This is Madness: a critical look at psychiatry and the future of mental health services*. Hertfordshire: PCCS Books.
- Patel, K. (2003) Getting Engaged. London: *Mental Health Today: April 2003*.
- Patel, N. (1999) *Getting the Evidence: Guidelines for ethical mental health research involving issues of 'race', ethnicity and culture*. London: Mind Publications.

- Reid-Galloway, C. (1998) *African Caribbean community in Britain*. London: Mind Factsheet.
- Robson, C. (2nd Ed.) (2002) *Real World Research: a resource for social scientists and practitioner researchers*. London: Blackwell Publishers Limited
- Sashidharan, S. P. (2001) Institutional racism in British psychiatry. *Psychiatric Bulletin*, 25: 244-247.
- Sashidharan, S. P. (2003) *Inside Outside: improving mental health services for Black and minority ethnic communities in England*. The National Institute for Mental Health in England, Leeds: Department of Health.
- Sassoon, M. and Lindow, V. (1995) *Consulting and empowering Black mental health system users* in Fernando, S. (1995) *Mental health in a multi-ethnic society*. London: Routledge.
- Sayce, L. (2000) *From psychiatric patient to citizen: overcoming discrimination and social exclusion*. Hampshire: Palgrave.
- Smaje, C. and LeGrand, J. (1997) Ethnicity, equity and the use of health services in the British National Health Service. *Social Science and Medicine* 45:485-496.
- The Peacemakers (2001) *Common ailments amongst African, Caribbean and Black Britons: what should we do in the new millennium?*
- Thornicroft, G., (1991) Social deprivation and rates of treated mental disorder. *British Journal of Psychiatry*. 158: 475-484.
- Tidyman, M. (2003) *Mental health promotion with Black and minority ethnic groups*. <http://www.mentality.org.uk/services/promotion/ethnic.htm>
- Williams, J. (1999) *Social inequalities and mental health* in Newnes, C., Holmes, G. and Dunn, C. (Eds.) (1999) *This is madness: a critical look at psychiatry and the future of mental health services*. Herefordshire: PCCS Books.
- Wilson, M. (1997) African-Caribbean and African people's experiences of the UK mental health services. *Mental Health Care* 1(3):88-90.
- Wilson, M. (2001) Black Women and Mental Health: working towards inclusive mental health services: *Feminist Review* No. 68.

Could you help me out?

Hello! My name is Karan Essien and I have mental health problems. I am doing a research project with women who identify themselves as being of black African or African Caribbean descent in Bradford who are in a similar situation to me.

The Mental Health Foundation is running a lottery-funded project called ‘Strategies for Living’, which aims to document and disseminate people’s ways of coping with mental health distress. I have been funded by the ‘Strategies for Living’, Phase II user-led research project to conduct this study on a voluntary basis.

This project is about the resources available locally for black women with mental health problems, to find out whether alternative support is available to encourage these resources and also to gain an understanding of their experiences of services.

The aims of my project are:

- To identify the needs of black women with mental health problems.
- To promote coping strategies that enable these women to ‘speak their minds’ about their mental health problems and make valuable contributions to this research project, because of their unique personal experiences of coping with mental distress in the community.
- For mental health input to be ongoing and supportive to black women and not just be available when women reach crisis point.
- To ensure that black women Bradford, who are in need of support, are included in local mental health policies and practices.
- For women’s voices to extend to wider society and to encourage women from other minority ethnic groups to approach and benefit from similar support strategies. I would like to see if local resources are appropriate and accessible to their needs and not based on assumptions about these ethnic groups.

If you are interested in taking part in this project, please leave your name and contact details. Ways of taking part will be in a one-to-one interview and an optional group session. All interviewees/participants will be paid £10 per interview because I value what you have to say about your experiences. You are under no obligation to take part, and during the process you are free to discontinue being part of this research project.

The closing date is Friday 22 November 2002.

If you would like to contact me please write or phone:

The ‘Tradeforce Building’, Cornwall Place, Bradford, BD8 7JT. Telephone: 01274 822333. Alternatively you can e-mail me: K.A.Essien2@bradford.ac.uk,

Black Women's Mental Health Project in Bradford

Introduction

The Mental Health Foundation is the leading UK charity for doing research with people who have mental health problems and also for people with learning disabilities. Their work includes pioneering research, community projects and an information service. Their aim is to raise awareness and influence policy makers and professionals who work directly with people with mental health problems, by ensuring that their publications are accessible to a wide variety of people such as those who access mental health services in the community.

The Black Women's Mental Health Research Project is funded by the Community Fund and supported by the Mental Health Foundation, as part of the Mental Health Foundation's 'Strategies for Living' Programme. They train and support people who have experience of mental health problems to carry out their own research with people who have similar experiences, to help promote ways of managing and promoting mental health. The Strategies for Living team supports fifteen research projects in England, Northern Ireland, Scotland and Wales, including this project about the mental health resources of black women in Bradford.

The aims of my project are: to identify the needs of black women in Bradford; to promote coping strategies that enable these women to 'speak out' about what they want from services because they are the experts about their own mental distress; for women to receive ongoing support and not just when they are at crisis point; to ensure that black women are included in local mental health policies and practices; and also that local resources are appropriate and accessible to the needs of black women and not just based on assumptions about these ethnic groups.

My research questions are:

1. What mental health services do black women receive, and do they feel these are supportive?
2. What are the approaches and attitudes that black women find helpful in mental health workers?
3. What other resources and personal coping strategies have black women used in times of mental distress?

Research methods

I am carrying out interviews with black women in Bradford to find out what helps them to stay in the community as opposed to being in hospital, what strategies you have used that have helped you and may be of benefit to other women in Bradford.

I will also be conducting a focus group which means that if you are willing to participate, at a later date, there will be a group discussion with women who all have experience of mental distress/ mental health problems. In this group women can share experiences of accessing mental health services in Bradford and also how they have used their own ways of coping in the community. By community I mean living in Bradford, in the place you call home, whether that is supported accommodation or otherwise.

Agreeing to participate in the research

Firstly, I would like your agreement to take part in the interview. Secondly, there may be the opportunity to participate in a focus group. All participants will be given plenty of notice about the interviews and I hope this information sheet will also be useful. However, you are free to choose at any stage, whether or not to participate in the individual interview or the focus group. You are free to drop out of either at any time as it is your right to do so.

Consent forms

Those of you who have expressed an interest in being interviewed will be asked to sign a consent form. This will state what the project is about and how your interview will be used. It is also for your protection as a research participant.

Confidentiality and anonymity

The information you talk about will be confidential and anonymous. This means that your name and address will not be used in any reports of the research, and will not be given to anybody except me (Karan Essien). Sarah Wright who is the Research, Training and Support Worker for the England researchers, such as me (Karan Essien) may want access to the taped interviews but not access to your names or addresses.

Taping the interview

I intend to tape the interviews because it will be easier for me to remember what has been said in the interview, and partly due to my hearing impairments, and also to write up (transcribe) what has been said. I will give you a copy of the transcribed data so you can check that you are in agreement with what has been written. The data will then be analyzed by me and the results will be written up.

Expected Outcomes

I hope that the report will be used by service providers, such as mental health workers, to find better ways of working with black women and taking into account their cultural needs. I also hope it can be used by other black women as information about what service users in Bradford have found useful and supportive. This could be in the statutory sector or the voluntary sector such as a local support group or even a church that you feel enables you and supports you in the community.

Looking after yourself

I would like to encourage you to use your support networks so that you can look after yourself after the interview, in case it raises some issues for you that are upsetting. I will be giving you an information pack on support services for women with mental health problems in Bradford. I hope you find these useful and that the resources available are supportive. One local resource is Guide - Line which is a mental health information and support line open seven days a week, it is a confidential phone line. They can be contacted on Bradford 01274 594594.

If you want to talk to me about your interview, or want to know more about the project, you can contact me (Karan Essien) on **01274 822333**. Please leave a message if I am not in and I will phone you back.

Appendix Three – Interview Topic Guide

Topic Guide

- Demographic questions:
 - Age;
 - ethnic origin;
 - How long have you lived in Bradford?
 - Have you always lived in the UK?
 - What is your current status?
 - Accommodation status?
 - Religion
 - Able-bodied or disabled?
- Could you tell me a little bit about yourself?
- Could you tell me about your experience of mental health problems/distress?
- What mental health services have you received in Bradford?
- What have you found helpful about these services?
- What have you found unhelpful about these services?
- Have you ever been offered a medical diagnosis?
- What does it mean to you to have a mental health diagnosis?
- Could you tell me how your mental health problem has affected your everyday life?
- Has your understanding of mental distress / mental health problems changed?
- Do you have any mental health professionals involved in your care?
- What do you think are important skills and characteristics in mental health workers?
- Have your experiences of being black affected your mental health problem?
- Have you ever experienced racial discrimination?
- Have your experiences of racism had an impact on your mental health?

- **How has it affected your everyday life?**
- **Tell me some more about a time when you healed yourself? (rather than gone to a mental health professional or GP)**
- **Could you tell me about some strategies that you have used to help you to cope?**
- **In your experience, do you think other women could use your support strategies?**
- **As a black woman, with experience of mental health problems in Bradford, are there any issues which you feel are not addressed?**
- **Are there things, looking back at your experiences of mental health problems in Bradford, that you would want to change?**
- **Are there any facilities that you would like to see become available for Black women in Bradford?**
- **What are your plans for the future?**