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International Journal of Mental Health Promotion

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rijm20

Being understood, being respected: an evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK

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Published online: 15 Aug 2013.

To cite this article: Fatemeh Rabiee & Paula Smith (2013) Being understood, being respected: an evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK, International Journal of Mental Health Promotion, 15:3, 162-177, DOI: 10.1080/14623730.2013.824163

To link to this article: http://dx.doi.org/10.1080/14623730.2013.824163

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International Journal of Mental Health Promotion, 2013
Vol. 15, No. 3, 162–177, http://dx.doi.org/10.1080/14623730.2013.824163

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Being understood, being respected: an evaluation of mental health service provision from service providers and users' perspectives in Birmingham, UK

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(*Received 10 July 2013*)

This paper examines the views and experiences of using and providing mental health services from the perspectives of black African and black African Caribbean mental health service users, their carers, voluntary services and a range of statutory mental health professionals and commissioners in Birmingham, UK. Using a qualitative approach, data were collected through telephone interviews ($n = 15$), individual face-to-face ($n = 20$) and focus group interviews ($n = 12$), and analysed using Krueger's framework and Rabiee's guidelines. Findings showed differences in the experiences of mental health services amongst African Caribbean and their African counterparts, the impact of social inequality on mental health and the needs of asylum seekers and refugees. It highlighted the important role of voluntary organizations in provision of care and support, insufficient provision of psychological therapies and concerns about high dosage of medication. The implications for practice are discussed, particularly the role of health beliefs in help-seeking behaviour and barriers to accessibility of mental health services.

Keywords: mental health; BME community; refugees; culturally competent care

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1. Introduction

Previous studies in the UK have demonstrated that black service users who have mental health problems are more likely than white service users to be diagnosed as schizophrenic (Fearon et al., 2006; Kirkbride et al., 2008), more likely than white service users to be prescribed psychotropic medication (The Sainsbury Centre for Mental Health, 2002) and less likely than white service users to be offered social and psychological help (DoH, 2003).

In addition, compared to their white counterparts, black people with mental health problems are less likely to have their mental health problems detected by general practitioners (GPs) (The Centre for Social Justice, 2011), more likely to be sectioned under the Mental Health Act (Care Quality Commission, 2010) or more likely to be regarded as violent and, thus, in need of detention in secure accommodation (Bhui & Bhugra, 2002a).

Shortcomings in mental health services that have contributed to the poor quality of care and treatment provided for many black people include stereotypical beliefs, lack of cultural understanding and competence in practice, language barriers and institutional racism (McKenzie, 2003; The Sainsbury Centre for Mental Health, 2002).

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This paper reports on a study that aimed to address these issues from the perspective of African and African Caribbean service users, carers, commissioners and providers of statutory and voluntary mental health services in the second largest city in the UK.

The study was carried out by examining current statutory and voluntary mental health service provision for African and African Caribbean communities in relation to a range of factors including service accessibility, cultural appropriateness, the extent to which the services meet service user needs, the impact of factors such as racism, discrimination, culture and religion, and issues relating to funding in care provision.

The research also aimed to explore the views and experiences of service users and carers in relation to these issues, and examined the extent to which the current services are meeting the government directive on Delivering Race Equality (DoH, 2005a). Furthermore, it examined the challenges and opportunities for provision of culturally sensitive patient-centred care.

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2. Methodology

2.1 Study design

A cooperative inquiry approach (Reason, 1999) was taken which involved working with non-governmental organizations (NGOs) as co-researchers, service users and carers from the inception of the study until the dissemination of findings to the relevant professional groups. A steering group comprising representatives from three local NGOs, a carer, two service users, two mental health professionals and two academics was established to oversee the research design, recruitment of participants and development of interview schedules to ensure that terminology was culturally appropriate.

The study was based on the interpretative paradigm (Flick, 2006), which allowed for in-depth exploration of experience and the application of multiple methods. The work was conducted in three stages.

2.1.1 Stage 1

A telephone survey ($n = 15$), using a semi-structured questionnaire, was conducted to map voluntary service provision for black African and African Caribbean communities.

2.1.2 Stage 2

Nine focus groups and four semi-structured individual interviews with 25 service users and 24 carers were conducted. Individual interviews took place with those informants who were unable to attend the agreed focus group schedule. Most interviews took place in English but four interviews were in other languages and were carried out with the help of three co-researchers who were drawn from the relevant communities. Co-researchers attended two days of basic qualitative research training organized by the authors prior to the start of study.

2.1.3 Stage 3

A total of 16 individual interviews were carried out with a range of mental health professionals representing statutory service providers: strategic and service managers, psychologists, social workers, consultant psychiatrists and mental health nurses. These included people working in primary care liaison teams, home treatment, rehabilitation and recovery, assertive outreach, psychology services, inpatient units, community psychiatric nurses (CPNs), an independent sector provider and commissioners. In addition, after the

first stage of data analysis, three focus groups were conducted with key providers and commissioners ($n = 15$) to expand and check interpretation of the data and to assess the feasibilities and constraints relating to the implementation of emerging recommendations.

2.2 Piloting

2.2.1 Stage 1

After piloting the questionnaire, a decision was made to record the telephone interviews for transparency and ease of analysis. The voluntary organizations surveyed varied considerably. It quickly became clear that simply ticking relevant boxes was not enough; participants frequently digressed to explain their service in more detail. Consequently, data were analysed and interpreted qualitatively, although some quantitative analysis was possible in terms of the frequency, range and types of services provided, route of referral and source of funding. This paper presents only the findings of the qualitative data from stage 1.

2.2.2 Stages 2 and 3

Topic guides were developed for various stakeholders following an extensive literature review and advice provided by the steering group. The topic guides were piloted and modified accordingly for use in the focus groups and individual interviews.

2.3 Recruitment process

All voluntary organizations that provided services for black African and African Caribbean communities within Birmingham city were approached and recruited for this study ($n = 15$).

A purposive sampling strategy consistent with this methodology and the aim of the study was utilized to recruit service users and carers. African Caribbean participants were recruited through contacts made by the NGO and via established carers and users groups. Recruiting African participants was a big challenge; attempts were made to recruit participants from Nigeria, Algeria, Sudan, Sierra Leone, Cameroon, Congo and Somalia. After a considerable investment of time, a decision was made to focus on areas where it was possible to set up focus groups with participants from Congo and Somalia. Participants from these two groups were recruited from established community groups.

As most of the black African and African Caribbean service users reside in the east and western part of the city, a range of mental health professionals providing services to these parts of the city were approached; those agreed were recruited for this study.

2.4 Data collection and analysis

The second author carried out all interviews, but four of the focus group interviews were undertaken with support from three different co-researchers to capture the views and experiences of those participants who were not able to communicate in English.

The maximum amount of time for each individual and focus group interview was around one hour. Permission was obtained to digitally record all interviews and focus groups, where possible. Three participants refused, or were unhappy about being recorded, and therefore detailed notes were made to record the content. All recorded interviews and focus groups were transcribed verbatim. Transcripts were analysed using Krueger's

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framework and Rabiee's guidelines (Krueger & Casey, 2000; Rabiee, 2004) to identify themes and sub-themes; data were interpreted considering the actual words used and their meaning, the context within which the comments are made, the frequency and extensiveness of comments, the intensity of comments, internal consistency, specificity of responses and the emergent picture with implications for larger trends or concepts that emerge from an accumulation of evidence which cut across the various discussions.

Analysis was systematic, sequential, verifiable and continuous (Krueger & Casey, 2000); this provided a trail of evidence and increased the extent of dependability, consistency and conformability of data, important issues for assessing the quality of qualitative data (Denzin & Lincoln, 2005).

Each interview was analysed separately, findings from different stakeholders were then triangulated (Denzin & Lincoln, 2005) and five main themes emerged from the data. Illustrative quotes are provided to aid transparency of categorization and theme representation.

2.5 Ethical considerations

Ethical approval was sought from both a local NHS Research Ethics Committee and the appropriate committee within the university. The ethical principles of respect for autonomy, honesty, beneficence, non-maleficence, and justice and research governance framework (DoH, 2005b) informed the conduct of the study. All potential participants were given letters of invitation to take part and written information about the nature of the project. A signed consent form was obtained from each participant prior to the interview.

None of the service users recruited was suffering from an acute mental health problem at the time of the study. To ensure anonymity, all interviews, organizations and focus group data were coded. In phase 1, each organization was given a number and an indication of the main target group was provided, such as African (AF), African Caribbean (AC) and *not targeted*. In phase 2, each focus group was given a number (e.g. 1, 2, 3). Each participant in each focus group or interview set was given a letter. Thus, 1B refers to participant B in focus group 1. The gender of respondents is indicated as M (male) or F (female); their ethnicity is also indicated, except for professionals as this would have made some respondents identifiable. In addition, an indication of the role of each respondent was included, for example service user, carer or other (informal carer).

3. Results

A total of 97 respondents agreed to take part (Table 1). Participants included 15 voluntary organizations, 25 service users, 24 carers, 16 statutory health professionals, 2 commissioners and 15 key members of the statutory service providers. Similar numbers of female ($n = 49$) and male ($n = 48$), a higher proportion of African Caribbean than African (51 vs. 29) and a small number of white British ($n = 10$) and Asians ($n = 7$) as service providers were also involved in this research.

Findings from various stakeholders are presented under the following five main themes emerged from data:

(1) the range of mental health services utilized;
(2) the role of voluntary organizations in providing and improving mental health services;
(3) the role of service users and carers in improving mental health services;

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Table 1. Characteristics of participants and methods of data collection.

Participants' group	Method of data collection	Number of participants	Gender		Ethnicity			
			F	M	W	AF	AC	AS
NGOs	Telephone interview; structured closed- and open-ended questionnaire	15	6	9	2	5	8	
Service users	Focus group interviews	25	14	11		12	13	
Carers	Focus group interviews	24	14	10		9	15	
Statutory service providers	Individual interviews	16	7	9	4	1	8	3
Commissioners	Individual interviews	2	2		2			
Key informants from mental health trust	Focus group interviews	15	6	9	2	2	7	4
Total		97	49	48	10	29	51	7

(4) the accessibility and responsiveness of services;
(5) providing culturally sensitive mental health services for black people.

3.1 The range of mental health services utilized

Mental health services were defined as any services and support that people accessed either for themselves or to support the person they cared for. There were clear differences in accessing and using services between Africans and African Caribbeans. African Caribbean service users and carers accessed and used both voluntary and statutory services such as hospital care, community-based early intervention, day care services and assertive outreach. In contrast, Africans tended to rely on support from family, friends, faith-based sources of help and GPs. When asked about specific examples of mental health services such as CPNs, community mental health teams and hospitals, several focus group participants mentioned '*these organisations you talk about are not publicly known*' (other 9A, M, AF).

3.2 The roles of voluntary organizations in provision of mental health services

Service users and carers were highly appreciative of the help provided by voluntary organizations. Support groups for users and carers, advocacy, training opportunities including life skills and advice about benefits were particularly valued. Signposting for financial or legal advice, accompanying people to visits to the doctor or nurse and referral to a GP, CPN or other source of help were also appreciated.

Some participants talked about being mistrustful of voluntary organizations at first. They worried about being labelled '*as a person who can't cope, a person who has problems that can't deal with this, that and the other*' (service user 1A, F, AC) even though '*in reality that was my situation*'. The supportive attitude of staff who visited people at home and helped them to deal with practical matters such as letters led to a change of opinion: '*He talks to me … gives me confidence and so on*' (service user 3C, F, AC), '*That's true he makes you feel worthy*' (service user 3A, M, AC).

The staff in voluntary organizations did not regard their services as focusing primarily on mental health issues. This was particularly the case in organizations serving African migrants. These tended to reflect specific countries of origin and their main purpose was to provide advice and support for a wide range of issues that included residency status, housing, welfare and employment because 'people have complicated lives …, their concentration is bad … The main issue many people are struggling with is housing problems and also dealing with community language problems, not serious mental illness' (voluntary organization 15, F, AF).

Stigma related to mental illness was highlighted by a number of informants and examples were offered of people trying to hide mental illness or explain it in more favourable terms, such as about people becoming mad through studying too hard. A spiritual leader mentioned people approaching him about mental illness in secret. Others talked about the reasons for stigma being to do with a lack of status or shame connected with mental illness, fear of being permanently labelled as mentally ill and about the impact of mental illness on marriage prospects. Staff at voluntary organizations and spiritual leaders talked about the type of support and education they provide to de-stigmatize mental ill health. Funding these services was a constant problem that engendered considerable insecurity. Lack of collaboration between the voluntary and statutory sectors added to the difficulties:

> '*We don't call our services mental health, but contribute a lot to the wellbeing of our client groups through advocacy, counselling, education, community building, helping them to*

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develop life skills, find job etc. There should be a better links with mental health services and our organisation. People trust us & know we can help them overcome their anxiety and emotional problem which could lead to mental health'. (Voluntary organization 8, M, AC)

Statutory service providers recognized the contribution of voluntary organizations in picking up unmet needs. Voluntary organizations were regarded as having trusted status amongst the communities they served. There was less stigma associated with accessing these services compared to those for mental health. In spite of this, there were barriers to successful joint working: insufficient up-to-date information about voluntary services and concerns about their financial security, a sense of being in competition with each other, exacerbated by Government policy and managers, perceptions that voluntary services were under-skilled, often not governed by the codes of conduct and protocols which informed professional practice. There was also a high turnover in voluntary services working with African and African Caribbean communities and an over-reliance on volunteers that impacted on sustainability.

3.3 The roles of services users and carers in improving mental health services

Carers were regarded as important in shaping service provision and there was recognition that carers could be a powerful group:

'we need their views … As a group, if they come together, they can influence and say we need more beds etc. with carers, we can't ignore them anymore, with the NSF and Carers Assessments, their views are coming more to the fore, but whether they can influence the Mental Health Trust as a body, they can and do. One guy went to the press'. (Social worker 2, F)

Service users and a number of staff agreed that there are some good models for service user involvement in the Mental Health Trust: participating in monthly staff team meetings, involving service users in recruitment, providing informal opportunities for staff and service users to engage with each other through drop-in sessions, socializing and eating together. Concerns, however, were raised that existing forums for service users (e.g. user voice and patient and public involvement forums) were predominantly white and did not adequately engage black people.

Carers raised concerns about not being sufficiently involved in care plans and the need for balance in preserving confidentiality. Sometimes, respecting patient's confidentiality cut off the family members who provided support. This was particularly the case when individuals were detained against their will which could lead to feelings of guilt and helplessness in carers. Carers also complained of instances where members of statutory services had not recognized the onset of acute mentally ill health, even though it was obvious to them:

'*… they don't understand X because I am there every day I can see. So I am going there to explain because sometimes X don't talk and I know what she is suffering, but they said they don't find anything wrong about her*'. (Carer 8B, F, AF)

However, carers were sometimes perceived as difficult to work with. Views ranged from a feeling that '*it is very difficult to satisfy carers', I think* (consultant psychiatrist 1, M) to a perception that families could be suspicious and hostile or even abusive towards staff:

'*When families come here they can be quite hostile, e.g. always the focus is about the percentage of young black males that end up in hospital. That can be intimidating and it's about having the confidence to address this, say it is an anomaly, you need to talk to us, not shout at us … We have had some abusive phone calls from families but it's really about speaking to people before a complaint arises. It can be difficult sometimes with families …*' (Mental health nurse 2, F)

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Some of these difficulties also related to conflict between carers and the people they cared for which could place staff in a difficult position. The importance of recognizing the barriers faced by carers was also highlighted. The very nature of their role meant that opportunities for respite were limited, so, when they did occur, carers might choose to meet other needs such as sleep and social support, rather than attending carers' groups.

3.4 The accessibility and responsiveness of services

Some African Caribbean service users and carers were positive about the accessibility and responsiveness of the services they received: '*... I appreciate what hospital and various mental health services have done for me in recovery*' (service user 1C, M, AC), '*There are lots of positives ... Going beyond caring, coming to my house*' (carer 5B, F, AC). In contrast, most African participants were neither aware of the services nor satisfied.

Lack of continuity of care and equity in accessing resources particularly in relation to talk therapy, however, were highlighted. Carers also commented negatively on the way that mental health services are perceived to criminalize black people. One offered an example of how the police had tried to handcuff her daughter; another talked about a neighbour who had been dragged out of the bath with no clothes on.

For service users and carers, mental health was seen as a social issue that was not always understood by professionals:

> '*Mental illness is a social problem, I don't think it's necessarily an individual problem, it's a social problem. I mean there's lots of things that can make people go off their head; if they haven't got proper accommodation, if their house is leaking or if their partner's gone off or if there's a bereavement or divorce; all those issues can make people just flip, you know what I mean?*' (Service user 7A, F, AC)

Service provision was based on medication rather than on counselling and psychological support:

> '*Sometimes you get a number of ... urgent problems ... in that kind of situation I need someone to talk to more than anything else. You can take tablets but the tablets kind of just dampen you down so that you can't deal with any of the things that are causing the problems in the first place*'. (Service user 1A, F, AC)

Concerns about usefulness of medications and experimental approaches to medication were also raised: '*...none of the medication is helping, surely they could try other therapies but they're always saying: it's the cost, the cost*' (carer 3C, F, AF).

This view was shared by some health professionals:

> '*Very frequently we think in terms of diagnosis and symptoms and having interventions that would deal with and focus on symptoms but a lot of times if you ask service users what they want they are talking about totally different things.... A lot of times the way that people understand why they feel uncomfortable or why they feel unwell is quite different to how professionals understand it*'. (Psychiatrist 2, M)

Although a few service users viewed medication as helpful in helping them 'to stay calm', the high doses of medication, side effects and interactions between prescribed and recreational drugs, including *khat*,[1] evoked additional concerns which were shared by professionals. They were aware that patients' experiences of feeling unwell could be quite different to the ways in which staff conceptualized what was happening. The combined use of prescribed and recreational drugs was a big problem that often resulted in higher doses in an attempt to manage symptoms:

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'*We see a lot of patients with psychosis in our area and, as you are aware, in this area several people are misusing illicit substances. Either they are having a misunderstanding that cannabis is good for health or they are self-medicating; one or the other. We need to use high doses because of their drug habit; that is my general way of working in this area*'. (Consultant psychiatrist 1, M)

Within African communities, differences exited between the experiences of asylum seekers and refugees and those with UK citizenship. This related to a range of issues: lack of information about the available services, the severity of mental health problems not being recognized by GPs, hence no referral to secondary care, and the constraints within UK law, since their immigration status as refugees or failed asylum seekers meant either GPs were unable to help or the service users were not able to utilize appropriate statutory services.

Inconsistencies of approach around the provision of care for asylum seekers were also highlighted by professionals. Asylum seekers, who have lost their appeal, legally had no access to mental health services: '*... lack of provision of alternative therapy especially for those exhibiting signs of post-traumatic stress disorder, such as flashbacks*' (voluntary organization 9, M).

Access to talking therapies was also problematic if service users did not speak English:

'*The barrier for providing talk therapy is working through interpreters, and not having sufficient resources*'. (Psychologist 2, F)

In addition, perceived racism amongst some GPs was a barrier reported by asylum seekers. Responses by GPs were perceived to be inappropriate particularly in relation to symptoms of mental distress following trauma. Lack of continuity of care and the negative attitudes of staff also gave cause for concern to a wide range of service users and carers. Participants talked about the experience of reliving the trauma leading to mental health when visiting different doctors and professional groups.

Carers also raised concerns about crisis management and how lack of out-of-hours support lead to problems for service users and their families: '*couldn't find any CPN or care coordinator, GP didn't recognise how unwell Z was ... in the end the only option was calling police and then the unpleasant experience of sectioning X*' (carer 5C, F, AC).

3.5 Improving the services

The following sub-themes emerged under the theme for improving mental health services for black and minority ethnic groups.

3.5.1 Provision of culturally sensitive services

Service users needed to feel comfortable with the people looking after them, to have the confidence that they understand their circumstances. At the heart of this confidence was '*being understood, being respected*' (service user 6A, F, AC).

In two focus groups, participants talked directly or indirectly about their spiritual beliefs (including *obeah*, *juju*, spirits, magic and curses). One person commented that these beliefs were neither understood nor respected by mental health services staff, who would think that a person who talked about spirits was mad.

Some service providers mentioned that a balance needs to be maintained between respecting and challenging cultural beliefs and practices: '*They need to understand the scientific view of mental health. We also need their views – the spiritual, mystical thing – and we need to meet in the middle*' (social worker 2, F).

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3.5.2 Culturally competent professionals

Opinion was divided on the need for black male and female psychiatrists and therapists. At least four focus group participants talked about the importance of having psychiatrists and therapists who are African or African Caribbean, women and people from more diverse backgrounds:

> *'I'm not racist or anything, as regarding white or Asian, but I think at the end of the day I think that black doctors have been under- unrepresented in the mental health system. Asian women sometimes get a bit of support especially if they've got an Asian doctor, an Asian psychiatrist. They get more help to cope and then their family would be counselled as well, the whole family. But black people, you know, it's either hospital or prison*'. (Service user 6A, F, AC)

Service providers agreed to some extent with this view, but argued that what people really needed was good healthcare and good services. Poor services, lack of staff, lack of respect for service users and failure to listen to them and treat them as individuals meant that service users did not receive appropriate care. What mattered was trying to communicate and understand transparently what a person was saying rather than language, colour or culture. Where culture was important was in the avoidance of stereotyping and ensuring that staff were equipped to work with black service users and carers.

3.5.3 Attitudes towards mental health

Changing the negative attitudes of black communities towards mental health was perceived to be essential:

> '*We need to change the black community's attitudes towards mental health, so that they're not so afraid of it, so we're not running from it and that we're not getting ourselves confused with the propaganda around misdiagnosis and around our level of mental stability. Actually, we have to acknowledge that we are suffering and it is a lot about being here, it happens here, it happens in America, doesn't happen in the Caribbean, doesn't happen in Africa. We need to know that some of our experiences here, but also some of our lifestyle things are not conducive to good mental health. So we need to go back to some of our original concepts of support systems. We've given up on church, we've given up on extended family, all that kind of thing, which held us … So mental health promotion is about looking at redeveloping strategies, building strategies around mental health rather than mental illness, so we don't go down there in the first place*'. (Independent sector 1, F)

4. Discussion

The findings are discussed under the following five overarching themes.

4.1 Pathways to care

Many of our findings about access to services reflect the experiences of black people reported in previous studies (Aspinall & Watters, 2010; McColl & Johnson, 2006; Mind, 2009). Lack of information about how systems work or what is available and when and inappropriate responses by front-line professionals such as GPs mean that black people often pursue quite torturous paths to obtain the help they need or give up altogether. Collaboration between the statutory and voluntary service sectors including traditional healers could do much to raise the profile of and to strengthen pathways into care (Bhui & Bhugra, 2002a; DoH, 2005a) and prevent access to care via the police and criminal justice systems.

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In addition, the findings highlighted that within African communities differences existed between asylum seekers and refugees and those with UK citizenship. African users and carers from both Somali and Congo were less aware of the range of services offered by either the statutory or voluntary organizations and were instead accessing support more from the faith-based community and spiritual leaders.

Furthermore, service users reportedly mentioned bypassing the traditional GP filters and access psychiatric services and forensic services via accident and emergency departments, the police and criminal justice systems. The ways in which black people are brought into the service, e.g. the involvement of the police and the lack of proper communication about this at the point of section and the use of force and the criminalization of black people, were all themes arising from the research.

Linked to the whole discussion about pathways to care is the issue of crisis management. It is not simply the first contact with services that can be problematic; there were several examples arising from the research of how the breakdown of out-of-hours support could also lead to problems for service users and their families.

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4.2 Health beliefs and help-seeking behaviours

Service users, carers and providers do not share the same explanatory models of mental ill health (Bhui & Bhugra, 2002b; Coyle & Lochner, 2011; Sewell, 2011). Consequently, their understanding of events, subsequent help-seeking behaviours and prescribed interventions may be quite at odds. This is particularly evident when mental ill health is attributed to demonic possession or magic, which requires a spiritual cure rather than western medication (Helman, 2007; Parkes, 2011; Pelechova, Wiscarson, & Tracy, 2012). Lack of respect for and understanding of such beliefs could be problematic in accessing statutory mental health services particularly with regard to the negative attitude of some staff. The current shifts from supply-oriented care to demand-oriented care, also called patient-centred care (Hart, 2010), require developing sensitivity to the users' needs. Taking this approach could increase mutual trust and respect between the providers and service users. It may improve early help-seeking behaviour and reduce late presentation or access through coercive means and via involvement of the police.

4.3 The role of family and network support in early detection and help-seeking behaviour

A comparison of data on forced admissions to mental health hospitals in our study showed that black Africans and African Caribbeans were more likely to experience these than other ethnic groups including South Asians. One possible explanation is that South Asians are more likely to have family members who can seek help for those who cannot do so for themselves (Singh & Burns, 2006). Many of the African service users in our study did not have family members or carers and were fully aware that lack of social support was eroding their resilience and mental health.

Nevertheless, the complexity of help-seeking behaviour needs to be acknowledged. Prior experiences of racism, high-profile media reporting of the experiences of black people together with the over-representation of black people in the psychiatric system have made people wary of seeking help and/or wanting to get out of the system as soon as possible.

Where concerned family members or friends are present, their help-seeking behaviour may be influenced by the stigma that particular communities attach to mental ill health.

Howerton et al. (2007), in their study of understanding help-seeking behaviour amongst male offenders, argue that fear of a diagnosis of mental illness and fear of the reactions of others played a large part in decisions about whether or not to seek help.

Findings from this study showed that stigma remains a major issue particularly amongst members of certain migrant groups. Separation from traditional ways of coping and lack of understanding of services in the host community compound the difficulties. Our findings indicate a great potential and need to work towards de-stigmatizing mental ill health, enabling individuals to overcome their fears and also creating trust and cooperation between patient, family, friends and doctor. This type of development could also empower patients/users of mental health services to help themselves and take control in their path of safe management and recovery.

4.4 Prescribed and recreational medication

Data from this study showed that, for some people, prescribed medication could be helpful but carers, in particular, complained about insufficient attention to side effects and high dosages. These are not new complaints (Andrade, 2005; Callan & Littlewood, 1998; Chen, 2006; Rack, 1982). It is well known that inter-racial differences exist in the way the body responds to both prescribed and recreational substances and in the way that these substances act on the body (Chen, 2006). The ethnicity of the individual service user has to be considered in prescribing certain medication (Andrade, 2005).

Alongside this is the use of recreational substances including '*khat*', how they act on the body, how the body responds and the interaction with prescribed medication. Within the literature, studies also confirm not only that cannabis increases the risk of psychosis, but also cannabis use in people with mental health problems could worsen the symptoms, interfere with medication and increase the chance of relapse (Care Service Improvement Partnership, 2006; Degenhardt, 2003; Smit, Bolier, & Cuijpers, 2004). Carers complained that service providers paid insufficient attention to these factors with, unsurprisingly, disastrous results.

More open discussion between service users, carers and service providers about these issues is needed to enable people to achieve a better quality of life. There is also a need for better health education particularly to adolescents through health promotion activities via schools, other community and family settings. People will probably not stop using recreational substances but they could achieve a better understanding of the risks and thus make more informed choices when discussing medication with their mental health service providers.

Linking to 'experimental approaches to medication', one of the provider informants commented that although it was very important to involve mental health service users in decision-making about medication, one also needs to question whether prescribing practices are different in other branches of medicine. If the practice is not different, there seems to be less concern expressed in research, and particularly in media, in relation to this issue. She argued '*suffering from mental health is very distressing both for the service users and the carers; at times mental health professionals seem to be the easy target for shifting the blame*' (service manager 1, F).

A question also worth asking is why, unlike psychiatric practice, frequent changes in the type and dosage of medication at early stages of treatment or management for other health conditions such as diabetes and blood pressure are not perceived as problematic by patients and their family. It is plausible that a better relationship, clear lines of communication and more trust exist between the patient/family and the practitioners

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of other branches of medicine, or as the above informant argued the nature and severity of mental health illness makes coping difficult for both service users and carers, hence a quick solution is expected.

4.5 Socio-environmental risk factors and mental health

Os, Krabbendam, Myin-Germeys, and Delespaul (2005) suggest that minority status is a risk factor for increased rates of mental illness which may, in part, be attributed to exposure to discrimination (Chakraborty & McKenzie, 2002). Other factors may include social disadvantages arising from poor housing, lack of employment, poverty and social exclusion (Mallett et al., 2006; Castle, Duberstein, Meldrum, Conner, & Conwell, 2004; Commission for Healthcare Audit and Inspection, 2005; Graham, 2007; Marmot Review, 2010; McLean, Campbell, & Cornish, 2003). Linked with this, Singh and Burns (2006) suggest that, regardless of ethnicity, there is an increased rate of mental illness amongst migrant communities all over the world and that '*any potential solutions must go beyond the health sector and involve statutory as well as voluntary and community agencies. The problem does not reside exclusively in psychiatry and hence the solutions cannot emerge from psychiatric services alone*' (p. 650). Sustained, chronic exposure to multiple sources of stress and adversity appears to be an important contributory factor (Turner & Lloyd, 2004). Our findings highlighted additional issues including the experience of trauma and other losses including family breakdown particularly amongst refugees and asylum seekers.

4.6 Barriers to accessibility of services and provision of service user centred care

In spite of strong evidence that psychological therapies work for members of black communities (Roberts, 2006, p. 2), findings from this study indicate that they are unlikely to be offered to service users from these groups. There are clearly barriers that require attention. Access to talking therapies because of a lack of proficiency in English was an issue for service users, carers and service providers alike. The limited availability of interpreters was identified particularly by people from Congo and Somalia. However, even when interpreters were available, some service providers seemed reluctant to use them. Some service providers argued that developing psychological resources would open up floodgates of demand, and targeting those resources to African and African Caribbean people would lead to accusations of favouritism. Such accusations might well follow the introduction of targeted services which were perceived to reinforce the idea that meeting the needs of people from black communities was a specialist role. There was a shared view amongst stakeholders that the way forward is through mainstream service redesign, links and partnerships with the independent/voluntary sector to act as a bridge between community and statutory services.

Other barriers reported included perceived racism amongst some GPs, no referral to secondary care due to the severity of mental health problems not being recognized at primary care and lack of out-of-hours support.

As advocated by Bergeson and Dean (2006), participants in our study also generally agreed that culturally competent health professionals who are able to listen and respect service users' and carers' concerns and health beliefs, and involve them in care planning, could improve communications, create an environment of trust and provide patient-centred care.

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5. Conclusion and implications for the practice

Based on the findings of this study, a number of actions are required to improve the experience and accessibility of mental health services for black African and African Caribbean people in Birmingham as well as other parts of UK. First is the need to ensure that service users and carers are actively involved in the planning and delivery of individualized care within the context of a service that places service users' interest at its core (DoH, 2012). Second is the need for commitment to sustain an effective inter-agency cooperation between voluntary organizations and statutory services. Allied to this is the need to promote awareness amongst black African and African Caribbean communities of how to access help and the importance of doing so at an early stage. Third is the need to expand professional education that promotes an understanding of the diverse cultures and traditions of black African and African Caribbean peoples. There should be an emphasis on the practical application in the assessment of service users in the planning, delivery and evaluation of care. Finally, there is a need to tackle the negative ideas about mental ill health and treatment that prevail amongst certain migrant groups.

For newly arrived communities, there should be a bridge between statutory services and communities. Community Development Workers as advocated in Delivering Race Equality (DoH, 2005a) can act as this bridge. Our findings and recommendations are relevant and transferable to other mental health settings in UK.

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Acknowledgements

Our deepest gratitude to all participants of this project for giving us an open account of accessing mental health services in Birmingham, and to the members of the Steering Group and project administrator for their valuable contributions at different stages of this research. Special thanks to Kate Thomson for her constructive feedback and Paula McGee for her input throughout this research project, proofreading and editing this paper.

Note

1. Recreational drug used in African community, particularly Somalia.

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