Research paper

Understanding mental health and experience of accessing services among African and African Caribbean Service users and carers in Birmingham, UK

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What is known on this subject
- Black African and black African Caribbean people in the UK experience inequalities in mental health service provision.
- They are disproportionately represented in psychiatric hospitals and report experiences of different pathways to access care, insufficient access to talk therapies, and generally poor mental health service provision.

What this paper adds
- It offers a deeper understanding of the views and experiences of black and minority ethnic (BME) communities, in particular Somali and Congolese service users and carers.
- It highlights the link between the erosion of family and social support systems and mental illness,
- It provides an argument for culturally competent healthcare staff who respect individuals' explanatory beliefs about the nature of illness.
- It emphasises the role of spirituality in mental healthcare and recovery.
- It offers new challenges for redressing health inequalities by confronting social inequalities.

ABSTRACT

This paper examines understanding of mental health and the extent to which statutory and voluntary mental health services in Birmingham are meeting the needs of members of a range of black African and African Caribbean communities. Qualitative data were collected through nine focus groups and four individual in-depth interviews. Using a purposive sampling strategy, 25 service users and 24 carers were recruited. Interviews were recorded, transcribed and analysed using Krueger's framework. The participants understood mental illness as a social problem linked with material and social deprivation, racism, and an inappropriate response to the treatment of mental and physical illness. Lack of respect and understanding in relation to religious and spiritual beliefs was a cross-cutting theme. While appreciating the positive aspects of medication, the participants raised concerns about interaction with recreational drugs, the dosage of prescribed medication, and equity with regard to accessing talking therapies. Engaging users and carers in a care pathway, acknowledging users' health beliefs and the importance of spirituality in healing, the provision of alternative interventions and working closely with voluntary organisations and spiritual leaders are recommended for improving clinical outcomes and patient-centred care.

Keywords: African Caribbean, black African, Congolese, mental health, Somali, spiritual beliefs

Introduction

This paper presents an exploration of the views and experiences of adult black African and African Caribbean people who use mental health services in Birmingham in the UK, and the potential role of spirituality in managing mental health conditions. Numerous reports have identified shortcomings in mental health services that have contributed to the poor quality of care and treatment provided for many black people (Department of Health, 2003; Keating and Robertson, 2004; Lawlor *et al*, 2012). Stereotypical beliefs, lack of understanding among staff about culturally based issues, lack of culturally competent practices, language barriers and institutional racism have all been cited as reasons why black people frequently receive less appropriate interventions, and experience less satisfaction with service provision, than white people (Raleigh *et al*, 2007; Department of Health, 2005; Myrie and Gannon, 2013; Rabiee and Smith, 2013). The geopolitical situation of the last decade, and an influx of refugees and asylum seekers from African countries, have added to the challenge of psychiatric service provision, particularly in relation to understanding the 'social experience in a life course interaction' of migrant communities (Morgan and Fearon, 2007, p. 122). In addition, the unmet mental health needs of African communities have specifically been highlighted (McCartney, 2010; McColl and Johnson, 2006; Mind, 2009).

The relationship between healthcare professionals and service users in mental healthcare requires understanding of and respect for service users' perspectives on health and illness. A patient-centred approach has been argued as the way to improve clinical outcomes, by empowering patients and involving them in healthcare planning and management to ensure that services are culturally appropriate (Bergeson and Dean, 2006). Current government directives and legislation focus on capturing patients' experiences and engagement to improve support or develop tailored and patient-centred services (Department of Health, 2005, 2006; Wanless, 2004). Alongside these developments, the notion of spirituality and its relevance to well-being has generated a lot of interest in recent years, and the debate around the extent to which religion and spirituality should be integrated into routine mental healthcare is continuing (Swinton, 2003; Poole and Higgo, 2010; Durà-Vilà *et al*, 2011). The 'psycho-spiritual' paradigm outlined by Culliford (2010, p. 76) adds a new dimension to this debate and, as highlighted by Culliford, this new paradim does not necessarily 'invalidate but supersedes the prevailing secular scientific paradigm.'

The present paper is part of a larger study (Rabiee and Smith, 2013) commissioned by the UK Department of Health to address concerns raised by a number of local non-governmental organisations (NGOs) and mental health professionals about the quality of care provision for black and minority ethnic (BME) communities in Birmingham. The study aimed to explore the extent to which mental health service provision is moving towards a patient-centred approach as set out by Bergeson and Dean (2006). It focused specifically on experiences of accessing services among black African and African Caribbean service users and carers in relation to a range of factors, including cultural appropriateness, the extent to which the services met service users' needs, the impact of factors such as racism, discrimination, culture and religion, and issues relating to funding in care provision. The findings were expected to provide evidence for the mental health service redesign strategy to improve patient care. However, as the study progressed new challenges emerged in relation to the mental health needs of, and service provision for, refugees and asylum seekers. This allowed us to go beyond the initial aims and to further explore understandings of mental health and illness, and the role of spirituality in mental healthcare and recovery.

Methodology

The study was based on the interpretative paradigm (Giorgi, 2003), focusing on how people attach meanings to social reality that influence their actions. Focus group interviews were chosen as the main method of data collection, to facilitate an understanding of service users' and carers' views and experiences (Krueger and Casey, 2000). In addition, four individual interviews were conducted with participants who were unable to participate in these groups.

A cooperative inquiry approach (Reason, 1999) facilitated working with NGOs as co-researchers, service users and carers from the inception of the study until the dissemination of the findings to the relevant professional groups (Rabiee and Smith, 2013). Prior to the start of the study, the lead researchers provided a two-day qualitative research training programme for NGOs to help to recruit co-researchers with relevant languages in order to capture the views and experiences of those participants who were not able to communicate in English.

A favourable ethical opinion was obtained prior to the start of the study (Rabiee and Smith, 2013). All potential participants received letters inviting them to take part, together with written information in English about the nature of the project. None of the participants who were recruited was suffering from an acute mental health problem at the time of the study.

Study participants

Black African and African Caribbean communities are not homogeneous, but rather they include people from a range of countries with diverse cultural, religious, language and socio-economic backgrounds and political challenges (Ahmad and Bradby, 2007). Consequently, we aimed to recruit service users and carers from a broad range of communities. African Caribbean participants were recruited through contacts made by NGOs and via established groups for carers and users. However, recruitment of African participants was a major challenge. First, there were no groups for carers or service users. Secondly, attempts to recruit participants from a range of African community associations were unsuccessful, the most frequent response being 'There is no mental health problem in our community.' After a considerable investment of time, a decision was made to focus on participants from Congo and Somalia who were supported by NGOs (Rabiee and Smith, 2013). Thirdly, the concept of a 'carer' differed between communities. 'Carers' could be spiritual or community leaders, or young people involved in peer education. Regardless of gender, many African service users had no family or friends to care for them. We used the term 'other' to capture their perspectives. A total of 49 participants were recruited, consisting of 25 service users and 24 carers (see Table 1). All of them were adults (28 women and 21 men). There were similar numbers of African Caribbean ($n = 12$) and African ($n = 13$) service users, but more African Caribbean ($n = 15$) than African ($n = 9$) carers and others participated in the study (see Table 1). More than two-thirds of the African participants were non-British.

Data collection

A topic guide was developed and piloted following an extensive literature review and advice provided by the steering group. Participants were asked about the accessibility and cultural appropriateness of the services they used, the positive and negative aspects of the services, factors that facilitated or prevented meeting their needs, and ways in which the services could be improved.

Nine focus groups were conducted, of which five were undertaken by the second researcher (PS) alone, and four were undertaken by PS with support from three trained co-researchers in Arabic and French. Four semi-structured interviews also took place. The focus groups and interviews lasted a maximum of one hour each. Permission was obtained to digitally record all of the interviews where possible. Some of the participants either refused to be recorded or were unhappy about being recorded, and in these cases detailed notes were made to record the content. All of the recorded interviews were transcribed verbatim.

Data analysis

Data analysis was systematic, sequential, verifiable and continuous (Krueger and Casey, 2000). The aim was to provide a trail of evidence and ensure dependability, consistency and confirmability of the data (Denzin and Lincoln, 2003). Transcripts were analysed using Krueger's framework and Rabiee's guidelines (Krueger and Casey, 2000; Rabiee, 2004) to identify themes and sub-themes. To ensure anonymity, all interviews and focus group data were coded; each focus group was given a number (1, 2, 3, etc.). Each of the participants in each focus group or interview was given a letter. Thus, for example, 1B refers to participant B in focus group 1. The gender of the respondents is indicated as M (male) or F (female), and their ethnicity as AC (African Caribbean) or AF (African). In addition, an indication of the role of each participant was included (service user (SU), carer (C) or other).

Findings

Two main themes emerged from the data: understanding mental illness and contributory factors, and experiences of using mental health services.

Table 1 Characteristics of the participants

Participants	Number of participants	Gender	Ethnicity
Service users	25	14 F 11 M	12 AF 13 AC
Carers	24	14 F 10 M	9 AF 15 AC
Total	49	28 F, 21 M	21 AF, 28 AC

Understanding mental health and illness and contributory factors

The focus group participants were invited to offer accounts of how they came to be using mental health services. These accounts, and other comments, provide insights into the ways in which different stakeholder groups understand mental health and illness. The following sub-themes emerged.

Loss

Loss was a recurrent theme across different focus groups, although the nature of loss ranged from losing a loved one to loss of home, identity or social status among different participants:

> That was when my children were taken off me … and then it's like I didn't know what to do with myself, you know.
>
> (6D, F, AC, SU)

In a different set of interviews, one participant talked about having a breakdown at the age of 20 after both her parents died within a year of each other. She took herself to Accident and Emergency because she was feeling mentally unwell:

> I wasn't mentally well, so I took myself to Accident and Emergency in S Hospital in L and they referred me to a psychiatric unit that they've got there at S Hospital and I was there for about two or three months and I received medication. I wasn't offered any counselling at all even though I was bereaved.
>
> (5A, F, AC, SU)

For the African service users, accounts focused on the circumstances that had led them to come to England:

> I have mental health problems. Because in 1991 I saw my mother and sister killed in front of me, I had their blood on my face.
>
> (9C, M, AF, SU)

In another focus group conducted with women, all of the participants commented that they experienced flashbacks relating to the war in Somalia. Several knew women who had been raped, and had lost friends in the war. One had been shot in the back and had seen 'a dead person' (7A, F, AF, SU).

Often mental illness was constructed as an inevitable response to life events such as bereavement or trauma. Participants sought help to support them in coping with the event, but the nature of the 'support' offered was often a diagnosis of mental illness and entry to the system.

For others, the focus was on depression and stress related to the experience of being a refugee, including leaving their home and family behind and feelings of not belonging, loss of identity, and not being welcome in England:

> If you are lonely you have depress [depression] and stress. When I come here and my family were there and there was fighting there, you feel crying inside, sadness, you remember where you used to be and you can't be with family, you are here. When I was in Somalia, I had a lot of friends, especially on Friday, I go to the beach. … I don't know how to work this country.
>
> (7C, F, AF, SU)

Some also talked about loss of control as a parent, and how bringing up children in this new environment meant having less respect and authority. A further theme that was highlighted was the effect of drugs on mental health: 'The khat makes people mentally ill' (6B, F, AF, C). They felt that it was difficult to stop their children using drugs in the UK:

> Boys come here, use different drugs. In Africa, we respect our mothers, here the kids won't listen to the parent, and the parents know that. In our religion, it is a bad thing to take drugs.
>
> (7B, F, AF, C)

Social stress

A number of participants across all groups also talked about mental illness as being linked to social stress. One participant commented:

> 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?
>
> (5A, F, AC, SU)

The participants talked about mental illness in terms of emotional, social and financial problems. Some also mentioned the impact of inequality and racism:

> In our religion it says you cannot put yourself above anyone, you have to be equal, if someone is felt to be outcast, they are lower than someone else, that gives problem.
>
> (9B, M, AF, other)

Trauma

Other participants talked about a triggering trauma and an inappropriate treatment response. One particularly poignant situation related to one carer's daughter who had experienced racism and abuse, but instead of being given any emotional and psychological support, such as counselling, she was simply put on medication and moved into the mental health system. She has never come out:

> My daughter has been ill from when she was 17 and when she was in the Duke of Edinburgh scheme. They sent her

to Aberdovey on an Outward Bound course. She was the youngest person there and the only black and they made her life hell. When she came back, I didn't recognise her. She said every day they would harass her. ... She lost weight and wouldn't get out of bed. I talked to the doctor ... gave her tablets. I didn't know what they were. He put her in X ... place, I didn't know I was putting her in the system. She never had no counselling at all. To this day, she's still in the system and getting worse.

(3D, F, AC, C)

Diagnoses of mental illness

A few participants talked in terms of a medical model of mental illness (e.g. an imbalance of chemicals in the brain), and believed that medication was needed to restore this. Some were concerned that western medicine does not recognise different causes of mental illness and is therefore not equipped to diagnose or treat certain types of illness that are caused by demonic possession or magic, which require a spiritual cure. The participants' accounts identified various ways of experiencing mental illness, such as madness and paranoia, which were emphasised as being very different from each other. The accounts also distinguished between different causes, such as possession by an entity or *djin*, magic or curses, extreme stress, and despair or *dismoral* when expectations are not fulfilled:

Dismoral, distress, and despair are the same, when people come here with no status and no way out, no solution. Some people come here to seek asylum. When they don't get asylum, this damages them, they are not entitled to a job, a house, university – all this causes problem. This all comes under mental health.

(8E, M, AF, C)

With all these categories, one participant concluded that making a diagnosis requires specific expertise and that the medical profession did not have a sufficient understanding of possession, nor is this included as part of their training:

When you go to hospital and you are a doctor, you can't understand whether I have a djin. ... Somali doctors specialise in the case of magic. Other people ... know about the tradition of magic, [B] knows how to, he did his own traditional medicine so can't ignore these things. In European countries they don't know about djin and evil eye, they don't know they need to recite the Koran.

(8B, M, AF, other)

Spiritual leaders reported that people with mental health problems come to them for help; one mentioned that he had two or three people coming to him every week. He commented that despite not being medically educated, he was collecting information about people's symptoms, and, where appropriate, was referring people to the GP. Another

spiritual leader talked about knowing two people whose mental illness had been helped by the NHS, but was not able to identify the specific services used.

There was general agreement among the African participants that for problems caused by *djin*, magic or curses, the cure is spiritual, not medical:

If a person is paranoid he can be treated with tablets, but if a man is magicked [or cursed] he needs to be treated differently.

(8A, M, AF, other)

There was concern that difficulty with diagnosis and the lack of availability of either appropriate experts from Africa or medically trained doctors with expertise in *djin* were leading to experimentation. Sometimes such experimentation, for example, treating someone with mental illness with spiritual help and someone with *djin* with medication, was successful.

Similar spiritual beliefs were highlighted by some African Caribbean participants. These included the belief that there is a list of names of people who are 'saved', the belief that mental illness is related to witchcraft, beliefs about the links between mental illness and illegal drug use, and beliefs about how 'superpower is watching you and your strengths.'

Networks, support and material deprivation

Concerns were raised about the lack of resources, such as family support, but also family breakdown as a further issue affecting mental health. Material deprivation and unemployment were believed to cause stress, and reliance on benefits meant that men were not fulfilling the traditional role of providing for the family.

The resources that existed before they had come to live in England, such as having family and social support close by, were being eroded and this in turn was reducing their mental resilience. One person summed up the link between the erosion of resources such as family and social support systems and mental illness as follows:

Here ... every few months you see a new mad person walking down the street. The reason why he is mad is family break-up. He's missing the emotional support. If we had an organisation that could help them, we could help. If you're down emotionally, you are mentally down; it's all connected.

(8A, M, AF, other)

Issues relating to integration

The struggle to balance different cultural expectations was perceived to be leaving people with mental health problems in a position of not being able to access help from anywhere. For some people, the need to be

accepted shaped the way that they viewed their experiences. Some of the participants talked about the wider culture in the UK as being 'acceptable' (3A, M, AC, SU), while others highlighted experiences of racism within hospital services: 'They wouldn't be really nasty ... they wouldn't be racist ... I mean you can learn to live with that, ah sure' (3B, M, AC, SU). Some participants also mentioned feelings of not belonging and of not being welcome in England.

Experiences of using mental health services

The participants talked about positive and negative aspects of these services and how they might be improved.

Positive experiences

> I was [at W House] about three years, it helped in my recovery. ... There's psychiatrists based on both sites, both campuses, and they used to help me through what I was going through in life at the time, helped me to get over it ... I appreciate what W and H House have done for me in recovery.

> (1C, M, AC, SU)

African Caribbean carers tended to provide more responses to the questions about positive experiences of mental health services than their African counterparts. At least four of them offered examples of support from mental health services and carers' support from NGOs. Some valued the offer of support even if they were not ready to take it up: 'The doctor did say if I was finding it too hard, they could send someone to sit in with me. They offered. At some later date, I will take him up' (5D, F, AC, C).

Two carers felt that the support provided was exemplary: 'There are lots of positives. ... Going beyond caring, coming to my house' (5B, F, AC, C). The above examples clearly indicate that the mental health services are meeting the needs of a number of users and carers in our study, particularly through third-sector bodies. What was particularly valued about this support was being able to attend NGOs; meeting other people with mental illness helped them to feel less isolated, as did being supported, advised and encouraged, and feeling cared about. One participant emphasised the important role of NGOs in helping them to cope with everyday activities. Working with the third sector appeared to be a way in which services can be improved and person-centred care can be developed and achieved.

MEDICATION

A number of service users emphasised medication as a positive aspect of the support they received in the context of helping them to 'sleep or shut out trauma.' However, carers expressed concerns about the dosage of medication. They believed that the medication provided was too strong. The problems were believed to be exacerbated by taking medication and the recreational drug *khat* at the same time:

> The khat is more important for them than the medication. Sometimes they don't take [their medication because of khat] ... my nephew said if I take the medication I go mad, want to kill somebody, so I don't take it and now I'm normal ... when he took [both] he slept 5 days continually without doing anything.

> (7A, F, AF, C)

Negative experiences

When asked to identify negative experiences, the participants highlighted lack of continuity of care, the attitude of staff, being overlooked, not understood and respected, and lack of equity in accessing resources, particularly in relation to talk therapy. There were also strong views that mental health services do not operate in terms of a social model:

> Seeking to understand people, their personal circumstances, their culture, and their beliefs – not simply dishing out medication.

> (5E, F, AC, C)

Concern was raised about the lack of involvement of carers in care plans by some health professionals. Respecting patient confidentiality, particularly when the patient did not want contact with their family, and was admitted against their will, meant being cut off and not able to provide support for the loved one. Carers also commented negatively on the way that mental health services are perceived to criminalise black people. One participant 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. A further issue highlighted by carers was that support from mental health services often breaks down in a crisis, particularly out of hours, at weekends and during public holidays.

For carers from the African focus groups, there was also a belief that they were being overlooked, with people being left to support themselves, without resources and without understanding. Service users also talked about negative experiences with regard to medication, including the side effects and lack of access to alternatives such as psychotherapy. Not being able to see the same doctor, and concerns about having repeatedly 'to re-live the traumatic experience'

when describing it to a new doctor, were frequently mentioned.

RACISM

A number of service users and carers, particularly from African communities, voiced their concerns about racism. Four women stated that racism was part of their everyday experience, both from service providers and more widely. Two women also commented on GPs saying to them 'Why are all you Somalians in the UK? Why don't you go [home]?' (7C, F, AF, SU).

African Caribbean participants also provided examples of racism in hospital, 'how people are beaten up in hospital by staff and patients', and the degrading behaviour of some community care staff. For example, one participant described how when she was given an injection by a male staff member he pulled her underwear right down to her ankles.

There was also a feeling that 'being black and being female, you know I don't really stand a chance' (6A, F, AC, SU). As a black woman, this participant felt that she had no right of redress because 'even if I do complain, who will I complain to? It's like complaining to the government about the government.'

Discussion and implications for practice

The findings of this study indicate that the participants understand mental health and illness in terms of the impact of the underlying social, cultural, economic and political environment (Barton and Grant, 2006; Stansfield, 1999). Loss in its wider sense was viewed as the main contributory factor. They experienced social stress, trauma and loss combined with limited social support and perceived racism within services, in which the way that people express their grief was 'pathologised.'

Cross-cutting themes highlighted by most of the participants were lack of respect and understanding in relation to religious and spiritual beliefs (Leavey et al, 2007; Poole and Cook, 2011). Data from both our study and those of others (Koening, 2008; Department of Health, 2010) clearly suggest the therapeutic role of religion for people with mental illness, and spiritual leaders as an important source of contact and support for some BME communities. This view is echoed by the assertion of Tokpah (2010) that spirituality dimensions should be addressed and considered as part of holistic patient care and psychiatric nursing care.

Building better relationships with communities as a whole in understanding patients' perspectives, and de-

stigmatising mental health problems, could increase help-seeking behaviour and promote mental health at the individual and community level. *Delivering Race Equality in Mental Health Care* (Department of Health, 2005) aimed to address some of the issues raised in this study. However, its implementation remains debatable (Department of Health, 2010; Rathod et al, 2010; Mind, 2011).

Although a number of participants talked about the positive aspects of medication, concerns were raised about the interaction of recreational drugs and equity with regard to accessing talking therapies (Raleigh et al, 2007; Department of Health, 2005, 2010; Mayers et al, 2007; Rathod et al, 2010). Participants were also concerned about the disproportionate emphasis on the medical model of service provision, and welcomed the option of talking therapy, as they felt that this approach would help them to overcome some of the social issues that were affecting their mental health (Rabiee and Smith, 2013). Controversial experiences of psychotherapy in African American communities have been reported (Thompson et al, 2004; Carpenter-Song et al, 2010; Chae et al, 2011; Chou et al, 2012; Williams, 2013), and further research is therefore required to examine African and African Caribbean experiences of culturally appropriate talking therapies in the UK.

Concerns about the dosage of medication and approaches to prescribing also confirm issues raised previously by transcultural psychiatrists (Andrade, 2005; Chen, 2006). Andrade (2005) has suggested that variations in drug prescribing for different ethnic populations, based on differences in their genetic make-up, metabolic factors or previous exposure, cannot be ruled out.

Material deprivation, loss of support networks (Kawachi and Berkman, 2000; Morgan and Feanon, 2007; Richardson and Ratner, 2005), social relationships and the impact of current social policy for asylum seekers and refugees (McColl and Johnson, 2006; Faculty of Public Health, 2008) in relation to accessing housing, education and food vouchers were factors believed to be eroding participants' mental resilience. The participants also frequently mentioned mental distress as an outcome of demoralisation and despair, an issue highlighted by Friedli (2009) as social injuries.

Refugee participants frequently talked about the racist and discriminatory attitudes of some healthcare professionals who requested their documents prior to providing care, and poor diagnoses, highlighting the inequality of care and training needs of healthcare professionals (Aspinall and Watters, 2010; Mind, 2009).

Depression and stress related to the experience of being a refugee, including the loss of home and family and feelings of not belonging and not being welcome

in England, were frequently described. There were issues about the psychological impact of trying to integrate within the wider culture, and a shared belief that developing internal and external resources in response to extreme stress and trauma can help to maintain mental health. These resources included hope and resilience, cultural identity, support from friends, spiritual beliefs and social inclusion. Mental illness was understood in terms of a social model rather than a medical one. Suggestions made for maintaining emotional wellness echoed the Care Services Improvement Partnership (2007) recommendations for recovery.

The advocacy role played by specific NGOs was highlighted, and was seen as supportive and person-centred and maintaining people's independence. Practical support such as the provision of food, shelter (in inpatient services), rehousing within the community, and social activities provided by NGOs were highly praised.

Negative experiences of mental health services also included feelings of guilt and inadequacy among carers, some of which were exacerbated by the way that mental health services operate, including the process of being sectioned, which is perceived as criminalising black people. No gender differences were observed, but ethnic differences were found in the experience of African and African Caribbean carers. This could be in part related to the shorter length of stay of African participants in the UK, and their citizenship status (Rabiee and Smith 2013).

Several carers and users stated that there was a need for culturally competent healthcare staff who respect individuals' explanatory beliefs about the nature of illness and are prepared to hear their concerns and perspectives (McCabe and Priebe, 2004; Mayers et al, 2007) and engage them in care planning. Durà-Vilà et al (2011) advocate the need for compassion, empathy and 'spiritual competency' in addition to cultural competency for provision of appropriate and individualised patient care in general and psychiatric care in particular. One participant eloquently summed this up as 'being understood, being respected' rather than just 'dishing out medication.' This is essential for patient-centred, good-quality care together with the provision of equitable psychiatric services, particularly with regard to the process of sectioning, provision of talking therapies, and ensuring continuity of care. This approach echoes Labonté's 'health rights-based frame', that is, the human rights aspect of health policy (Labonté, 2008).

Strengths and limitations

Although the participants, particularly those from the African community, cannot be considered to be representative in a generalisable sense, they do represent the groups to which they belong, and shared their experiences. As such, within the theoretical framework that was utilised, generalisability is replaced by transferability (Denzin and Lincoln, 2003) to similar settings and experiences of accessing mental health services among BME groups, and in particular among refugee and asylum-seeker communities.

The recruitment of trained co-researchers strengthened the study design and methodology, as none of the participants were excluded because of language barriers. In addition, the training programme and subsequent recruitment and involvement of the co-researchers from the third sector added value to the research.

Conclusion

The findings of our study, while echoing some previous findings, also add a deeper understanding of the views and experiences of BME communities, in particular some African service users and carers, and they provide new challenges for redressing health inequalities (Friedli, 2009; Kawachi and Berkman, 2000; Melzer et al, 2004; UCL Institute of Health Equity, 2010). Graham (2007) argues that in order to improve health inequalities, the social inequalities of 'people's unequal lives' need to be understood and confronted.

Provision of alternative interventions, engaging users and carers in the decision-making process and working closely with voluntary organisations and spiritual leaders are recommended for improving clinical outcomes and patient-centred care.

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CONFLICTS OF INTEREST

None.

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