

# **COMMUNITY ENGAGEMENT PROJECT: The NIMHE Mental Health Programme**

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING  
ON

Why Black and Muslim women in Liverpool do not access Mental Health  
Services and also to find what services are available and how accessible  
information was to obtain

By

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Funded by NIMHE and managed & supported by the Centre for Ethnicity and  
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## **THE RESEARCHERS**

Six women from the local community volunteered their services for twelve months as volunteer researchers for the Community Engagement Research Programme. They all had relevant experience and skills of either volunteering or working in their community with people from diverse backgrounds and cultures and brought with them not only this experience but also the enthusiasm and commitment to move this project forward for the time they were involved.

One of the six volunteer researchers is a service user whilst another is a carer and the other members of the team benefited from their vast experience gaining knowledge and expertise of community mental health provision for service users. Not all the researchers wished to be mentioned by name and their anonymity is respected in this report. The following provides the reader with a personal profile of four of the researchers who wished to share their personal profile.

### **Nagla Abdulla**

My name is Nagla Abdalla, I am a single Muslim woman doing my PhD degree in Liverpool university and also work part time as a social worker and interpreter for Liverpool City Council. I have been living in Liverpool 8 for the last 5 years and I enjoy working and helping out my local community. The nature of my job allows me to have a better view on my community and identify their needs and the barriers they face. The reason I took part in this research project is to help out my community as possible as I consider my self experience in research as I received a comprehensive training in community based research from John Moores University Liverpool 2002. I also undertook lots of research with the local organisations in different issues in the Liverpool area. My Biomedical background makes it easier for me to improve my understanding in mental health, besides I speak a language spoken by the local community (Arabic) which allows me to communicate with a large number of local people.

### **Hasana Ahmed**

My qualifications include a BA and a Certificate of Education. My current job is as a bilingual teaching assistant and interpreter in Arabic language. I am a member of the Arabic and Muslim women group and a volunteer researcher.

### **Ugo Eme**

My name is Ugo Eme. I am 37 years old, a single mother, born in England. My parents were from Nigeria and Britain and my father had British citizenship. The reason I joined the research project was that I have been diagnosed with a mental health problem and have been sectioned, but also detained in custody due to my mental health and feeling isolated. I wanted to be able to help find out information how to improve services for the BME community and for the future generation. I have worked in the Royal Hospital as a Nurse Assistant. I have also done a lot of voluntary work in my community where I was brought up.

### **Nimo Jama**

My Name is Nimo Jama. I am 25 years old single woman from Somalia. I have been living in Liverpool for the last 10 years. The reason I joined this research project is that I have got a brother who has got long term mental health problems and I been looking after him as a carer, so I consider I have lots of experience around mental health issues. Besides, I would like to help my community as I worked as a childrens' carer and I also worked as an interpreter for the Womens Hospital within the Somali community. This research project helped me a lot and now I have got a job as an assistant carer in Mosely Hill Residential House in Liverpool.

## **ACKNOWLEDGEMENTS**

The volunteer researchers would like to acknowledge and thank the University of Central Lancashire, National Institute for Mental Health in England (NIMHE) and Big Life Services for the opportunity to take part in this research project. Also, we would like to thank the steering group and following organisations who enabled us to speak to the women who participated in our research programme.

- Al-Ghazali Centre
- Alrahama Mosque
- Beaconsfield Somali Women's Group
- Black Sisters
- Granby Community Centre
- International Learning Centre
- Job Education and Training Centre
- Kuumba Imani Millennium Centre
- Social Inclusion Team, Central Liverpool Primary Care Trust
- Muslim Women's Day Centre
- Refugee Action
- St Bernard's Asylum Seekers and Refugees Women's Group
- Toxteth Educational Trust

They would also like to give their sincere thanks to all the women who gave their time to complete the questionnaires. Their feedback gave the researchers a clearer insight as to why Black and Muslim women do not access mental health services in Liverpool.

## **CONTENTS**

The Researchers .....	3
Acknowledgements .....	4
Contents .....	5
Executive Summary .....	6
Introduction .....	10
Liverpool Community Background Information .....	15
Background Information.....	17
Aims And Objectives Of Project .....	18
Methods .....	19
Results .....	21
Discussion .....	37
Conclusion .....	42
Recommendations .....	43
Appendix: The Questionnaire .....	46

## EXECUTIVE SUMMARY

### Background

As one of the first main seaports into Britain, Liverpool is world renowned as a city of diverse cultures and communities. Some of the most established Black, Chinese, Irish and Muslim communities in Europe have been founded in Liverpool. Despite this Liverpool has some of the most disadvantaged communities in the UK. Unemployment is higher than regional and national averages and the general health of the population is poorer.

The focus of the research was to find out why Black and Muslim women in Liverpool do not access mental health services and also to find what services are available and how accessible information was to obtain.

The research was commissioned by NIMHE, supported by The Centre for Ethnicity and Health's Model of Community Engagement and completed by volunteers for Big Life Services.

A local steering group was set up to support and guide the project and to help take the recommendations forward at a local level. Six researchers were recruited from the local community to complete the research and take part in a package of training delivered by The Centre for Ethnicity and Health at University of Central Lancashire.

The researchers developed a semi-structured questionnaire to gather both quantitative and qualitative data during one-to-one interviews with 80 Black and Muslim women. The participants were reached through contact with agencies in touch with this target group. The quantitative data was analysed using tally charts in MS Excel software, and qualitative data was coded and used as direct quotes.

### Key Findings

This section presents the findings from the research project using data from a total of 80 completed questionnaires with Black and Muslim women living in Liverpool.

The sample of women had a spread of ages, but only for those over 18 and under 50; a range of ethnic backgrounds, though a majority had a black heritage; over half the women were Muslim, with a further third Christian; and most of the participants were not born in the UK. These are significant findings for the report in terms of the women's economic situation, cultural understanding of services in the UK, language barriers, and in the provision of services that are sensitive to these faiths.

Perhaps the most significant finding relates to almost half of the women had experienced problems with their emotional well-being. These were more likely to be classed as anxiety, depression, sleeplessness and stress brought on by financial pressures, social & cultural isolation. Moreover, almost a third of the women respondents had, at some point, attended or been referred to more specialist mental health services. This finding further reinforces the conclusion that a significant proportion of black and Muslim women in the area experience difficulties with their mental and emotional health.

Another significant finding is that just 58% of the women experiencing problems had ever visited their GP. The key reasons why these women didn't use their GP were:

**Underestimation of the problem.** Some women just didn't think they had a significant problem. Also, some women perceived their GP as dealing with medical problems, whilst they viewed their emotional health in non-medical terms.

**Lack of confidence.** Some women did not feel able to discuss their mental health problems with a GP. Some mentioned their GP was unapproachable.

**Reluctance to use services.** The researchers found that many women were reluctant to discuss their mental health with them. Some did not want to let others know they had a problem. This reveals the deep stigmas attached to mental health. While others did not want to relive their deeply hurtful experiences.

**Preferred to seek own solutions.** Some women preferred to use other methods, such as complementary therapies or belief in their own faith.

Of those women who had visited their GP, only half had been given any options, and most had been given medication & very few received counselling or other talking treatments. Despite this, counselling was by far the most requested service that the women respondents said they would like to access if they experienced emotional stress.

Considering that a significant number of the women had a limited familiarity with the health system in the UK very few women were made aware of other services in their area. The researchers often had to point out more appropriate places where the women could go.

Some of the women who had experienced emotional health problems, help had been identified, but they had decided not to attend. The findings from this study point to a lack of trust in the UK health system. The responses also point to changes in the way services are delivered, so that they are culturally sensitive, gender specific, easily accessible and used by others from their own cultures.

Most of the women gave suggestions about how information about services could be improved. The three top suggestions were:

- Better information in GP surgeries and in other mainstream health services.
- Better general publicity, such as posting flyers, using community centres, Mosques, pharmacists & schools, and advertising in the press & radio. The most popular media suggestion was better use of the Internet.
- That information should be translated into community languages.

The women participants also gave their own suggestions for improving mental health service provision for Black and minority ethnic women. The main suggestions were:

- Better information and publicity
- Better services specifically for women and BME groups
- Better alternatives to medical services
- Access to employment
- Information & interaction in own language
- More mental health services

### **Summary of key findings**

This research project has revealed some key findings about the emotional health of and use of mental health services by Black and Muslim women in Liverpool. The key findings are that:

- A significant proportion of the women have experienced mental health problems. This incidence appears to be about double that experienced by the general population.
- Most of the women did not gain the kind of treatment they needed.

- About half decided not to use the services available. This seems to be due to lack of confidence among the women and the lack of awareness among services in who to appeal directly to these women to break down barriers of trust and culture. A small number decided to deal with their problems in their own way.
- For those that did use services, these services were not sufficiently appropriate to meet their needs due to their cultural inappropriateness, language barriers, and gender differences.
- Black and Muslim women wish to see mental health services that are more sensitive to their culture and gender, that are advertised better, that involve others from their culture or belief and are conducted in a language most suited to them.

However, the data and the analysis have their limitations, such as missing data, some of the questions had very small number of responses, and the interpretation in meaning caused by language differences could affect responses. Perhaps the most serious limitation is the lack of information about the nature and use of existing relevant services in the local area. Had these services been involved in this project the conclusion may have been different. The report here is based solely on the responses from the individuals interviewed.

### **Recommendations**

The results of this research project suggest the following recommendations.

1. All mental health services should review the information they issue to Black & Muslim women in light of these findings.
2. Staff working in the health service, in particular GPs, should ensure that Black & Muslim women are clear and confident about the services they are being referred to.
3. The PCT, Mersey Care NHS Trust and Liverpool City Council should improve the information they provide to Black & Muslim so they are aware of the help they are entitled to.
4. The PCT should ensure that all women have the option of seeing a female worker.
5. Building on existing good practice, the PCT's information services need to work pro-actively to improve the content and nature of information in community languages by involving people from local communities.
6. Building on the good work in the Social Inclusion Team, the PCT and other health services should continue to pro-actively recruit workers that reflect the diversity of the local communities in which they work
7. The PCT should consider creating a female BME post as part of the forthcoming Community Development Worker to promote the training and capacity building work identified in this report.
8. The PCT should work with the existing local providers, such as Mary Seacole House and MAAN Somali Mental Health project to improve access to primary care self-help and drop-in services, where the women can meet up in groups, discuss their problems, and socialise.
9. For those with more serious depression and anxiety, the PCT should review talking treatments available to ensure that services are accessible and culturally sensitive to their needs.

10. To ensure these recommendations are taken forward, this report recommends that a high level group, for example at the Local Strategic Partnership, Liverpool First, adopts the agenda for change to improve access to primary care and mental health services for Black and Muslim women in Liverpool.

## **INTRODUCTION**

### **The Centre for Ethnicity and Health's Model of Community Engagement**

This section describes the model used by the University of Central Lancashire's Centre for Ethnicity and Health.

#### **Background**

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this section is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers,

and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority and Aimhigher.

### **The Key Ingredients**

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community<sup>1</sup> (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day

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<sup>1</sup> The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

<b>A Host Community Organisation</b>	With Good Links To The Target Community	To Provide Basic Infra-structure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
<b>A Task</b>	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
<b>Support</b>	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important*, if not more important, than the report that they produce at the end of the day. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the first time that these individuals have undertaken a research project*.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers<sup>2</sup>. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project<sup>3</sup>. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with

<sup>2</sup> This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

<sup>3</sup> Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

**The Community Engagement Team**

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

<b>National Programme Directors</b>			
<b>Northern Team</b>	<b>Midlands Team</b>	<b>Southern Team</b>	<b>Senior Programme Advisors</b>
<b>Senior Support Worker</b>	<b>Senior Support Worker</b>	<b>Senior Support Worker</b>	
<b>Support Workers</b> X 3	<b>Support Workers</b> X 3	<b>Support Workers</b> X 6	<b>Drug Interventions Programme</b>
			<b>Regeneration</b>
			<b>Mental Health</b>
<b>Teaching And Learning Team</b>			
<b>Administration Team</b>			
<b>Communications Officer</b>			

**Programme Outcomes**

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

### **The focus of this particular report**

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes.

#### ***National Institute for Mental Health in England Community Engagement Programme:***

***Big Life Services*** were one of 11 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme in 2005. The objectives of the programme were to deliver improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- *building capacity in the non-statutory sector*
- *encouraging the engagement of Black and minority ethnic communities in the commissioning process*
- *ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector*
- *involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services*
- *ensuring greater community participation in, and ownership of, mental health services*
- *allowing local populations to influence the way services are planned and delivered*
- *contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.*

The focus of the research was to find out why Black and Muslim women in Liverpool do not access Mental Health Services and also to find what services are available and how accessible information was to obtain.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

## LIVERPOOL COMMUNITY BACKGROUND INFORMATION

As one of the first main seaports into Britain, Liverpool is world renowned as a city of diverse cultures and communities. Some of the most established Black, Chinese, Irish and Muslim communities in Europe have been founded in Liverpool.

The table below shows the breakdown of ethnic groups in Liverpool<sup>4</sup>. Although this shows a slightly higher than national average percentage of people with a mixed heritage, this also shows below average proportion for other BME groups. Compared to the North West, Liverpool has a lower proportion of Asian people and a higher proportion of black people.

Ethnic group	Liverpool	North West	England & Wales
White	94.3	94.4	91.3
Mixed	1.8	0.9	1.3
Asian	1.1	3.4	4.4
Black	1.2	0.6	2.2
Chinese or Other	0.4	0.2	0.4

The data for Liverpool shows a population whose health is below the national average. The following table<sup>5</sup> shows that life expectancy at birth (years), for 2001-2003, was lower than the North West and national averages.

	Liverpool	North West	England and Wales
Life Expectancy at Birth, Males	72.7	74.8	76.1
Life Expectancy at Birth, Females	77.7	79.5	80

The 2001 Census<sup>6</sup> asked people to describe their health over the preceding 12 months as 'good', 'fairly good' or 'not good'. People were also asked if they had any limiting long-term illness, health problem or disability that restricted their daily activities or the work they could do. The results in the table below show that Liverpool has a greater percentage of people who say their health is 'not good', and people with limiting long-term illness. Almost half of all households have one or more people with limiting long-term illness. This shows that Liverpool experiences higher than regional and national average health problems.

	Liverpool	North West	England and Wales
General health: Good	64.5	66.9	68.6
General health: Fairly good	21.7	22.2	22.2
General health: Not good	13.8	11.0	9.2
People with a limiting long-term illness	24.6	20.7	18.2
People of working age with a limiting long-term illness	20.8	16.4	13.6
Households with one or more person with a limiting long-term illness	44.4	38.4	34.1

<sup>4</sup> Census 2001, Office for National Statistics (ONS)

<sup>5</sup> Life expectancy at birth, 2001-2003, Office for National Statistics (ONS)

<sup>6</sup> Census 2001, Office for National Statistics (ONS)

Other indicators of health are welfare benefits. The Disability Living Allowance is paid to people who are disabled and need help with personal care and/or getting around. In August 2004, 41,405 people in Liverpool received this benefit<sup>7</sup>. This represented 9 per cent of the total population, with the equivalent rate for England and Wales as a whole being 5 per cent. Also in August 2004, 43,775 people in Liverpool between the ages of 16 and 64 claimed Incapacity Benefit or Severe Disability Allowance because they had been assessed as incapable of work due to sickness or disability<sup>8</sup>. This was 15 per cent of people aged 16-64 in Liverpool, compared with the national figure of 7 per cent.

The reasons behind this poor health in Liverpool is largely due to the higher than average levels of deprivation. In the government's Indices of Deprivation 2004, Liverpool was ranked as the most deprived authority out of 354 local authorities in England.

The levels of deprivation in Liverpool are partly explained by the lower than average levels of economic activity. Of the people in Liverpool who were of working age (i.e. those aged 16 to 64 for men or 16 to 59 for women) the employment rate was 59 per cent during the Summer of 2004 (June to August), and 64% during the same months in 1999, compared with an average for Great Britain of 75 per cent during both years. This shows that the proportion of the population in work has actually fallen over then last five years.

The 2001 census found that the unemployment rate in Liverpool was 6%, compared to 3.6% in the North West and 3.4% nationally. This is almost double the national level of unemployment.

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<sup>7</sup> Disability Living Allowance Claimants, 2004, Department for Work and Pensions (DWP)

<sup>8</sup> Incapacity Benefit and Severe Disability Allowance Claimants, 2004, Department for Work and Pensions (DWP)

## BACKGROUND INFORMATION

**Big Life Services** is one of the two registered charities within the Big Life group of social businesses and charities. The Big Life group gives people who have had a raw deal in life the chance to change their lives. It does this by offering first class treatment to people who've always received third class services, giving them the tools they need to make their lives better. It offers health and well-being services, counselling and employment opportunities. The Big Life group works throughout the north of England, from bases in Manchester, Leeds and Liverpool. **Big Life Services** provides the following services:

- The Kath Locke Centre – a community health and resource centre in Moss Side, housing a range of agencies, including the locality community mental health team.
- The Zion Centre – a purpose built community health and resource centre in Hulme housing a range of agencies, including mental health services.
- Therapeutic Services – a range complementary therapies including counselling, massage, homeopathy, reiki & mental health arts project.
- Summergrove – a 24-hour supported residential unit for families after parents have completed drug & alcohol detox.
- Self-help services – a wide range of self-help and support groups for people with mental health needs, using a model of best practice.

The other registered charity within the group is The Big Issue In The North Trust, which provides an integrated package of training and support to homeless people.

The Big Life group was formed in April 2002 from the merger of The Big Issue in the North and Diverse Resources (previous name of **Big Life Services**). **Big Life Services** works closely with Big Life Company, a holding company, which includes the following social businesses:

- The Big Issue in the North Ltd – a weekly magazine sold by homeless people to help themselves by earning a legitimate income;
- Northern Solutions – a building management and maintenance company which provides employment for socially excluded groups;
- Aisha Childcaring– a day nursery, crèche, play scheme and after school club;
- Big Life Employment - an employment agency that helps unemployed people from excluded groups back into employment and training, including people with mental health problems.

All The Big Life group businesses help to create wealth and opportunities for people who are overlooked by mainstream employers and work very closely with the services within the group. The Big Life Company also manage the following successful partnerships between the voluntary and statutory sectors:

- Surestart Longsight – helping ensure that children get the best start in life, offering opportunities to children and support for their families.
- Bloom – a healthy living network reaching excluded people in Moss Side, Whalley Range, Hulme and Old Trafford to improve their quality of life.

## AIMS AND OBJECTIVES OF PROJECT

The aim of the research was to find out why Black and Muslim women in Liverpool do not access Mental Health Services and also to find what services are available and how accessible information was to obtain.

The objectives to achieve this aim included:

- Establish a steering group of local agencies
- Recruit, train & support research volunteers from the local community
- Develop suitable research methods
- Complete data collection in the local area
- Volunteer researchers to complete package of training by UCLan's Centre for Ethnicity and Health
- Analyse the quantitative & qualitative data
- Produce a report to inform policy makers, commissioners and service providers
- Disseminate the report through a launch event

The aims of this project directly supports two of the three key 'building blocks' of Delivering Race Equality<sup>9</sup> in terms of **community engagement**, through the recruitment of local women from BME communities, and in terms of **better information**, by gathering more details knowledge about the barriers of mental health services for Black and Muslim women in Liverpool.

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<sup>9</sup> Delivering race equality in mental health care, an Action Plan for reform inside and outside services; and the Government's response to the independent inquiry into the death of David Bennett, Department of Health, January 2005.

## **METHODS**

This section outlines the steps taken by the group to prepare this report, including setting up a steering group, recruiting the Community Researchers, selecting the methods and collecting the data.

### **Establishment of a steering group**

A local steering group was set up to support and guide the project and to help take the recommendations forward at a local level. Membership of the steering group comprised of representatives from:

- Mersey Care NHS Trust Community Mental Health Team
- Jet South Central
- HASCAS
- Central Liverpool PCT
- Mental Health Consortium
- Regional Race Equality Lead for Northwest representing National Institute for Mental Health in England (NIMHE) and Care Services Improvement Partnership (CSIP)

The steering group met to discuss the progress of the project.

### **Recruitment of Community Researchers**

Six researchers were recruited from the local community. Firstly, the Volunteer Community Research Co-ordinator was recruited at the end of March 2005. The Co-ordinator had lived and worked in the local community all of their life and had worked (both paid and as a volunteer) for local organisations for the past 20+ years. Five Community Researchers were then recruited from the local community in late March/early April. However, all five community researchers withdrew due to work responsibilities and other commitments.

A second recruitment process then took place during mid April and organisations based in the local community were approached. The managers of those organisations e.g. Family Service Unit, Social Inclusion, Jet South Central agreed to refer people who had shown an interest in voluntary work. Two of the researchers were referred by Jet South Central, whilst the third was referred by the Family Service Unit. All five researchers were from the local community, with three being bilingual and from the Muslim community, and all had been involved in other research projects. The researchers attended an interview, had an induction, and met on a regular basis. The researchers were further supported by workshops around research methods and mental health policies and practices by the University of Central Lancashire, together with the support workers visits to the project every two weeks.

### **Choosing the methods**

The researchers decided to use a semi-structured questionnaire (see the Appendix) as the research tool to gather both quantitative and qualitative data during one-to-one interviews. The researchers decided to use this method because of the diverse backgrounds of the targeted groups. It was felt that this method was more appropriate for accessing the community members.

The researchers gathered information about questions to use in the questionnaire through desk research, using the local library and internet, to consider previous

research studies. The researchers piloted the questionnaire to test its suitability before collecting data from the sample. The pilot questionnaires were not used in the analysis.

The sampling method used was the cluster sample method. This was because the research was focused in one geographical area i.e. Liverpool. To achieve the aim of the research the sample was also purposive to target adult Muslim and Black women. A target sample size of 100 was chosen to enable a good cross-section of this community. A work plan was submitted to UCLAn's ethics committee for approval before fieldwork commenced.

### **Collecting the data**

The sample was reached through contact with agencies in touch with the target group. The researchers contacted local organisations within the community to see whether they wanted to take part in the research. A launch was arranged to promote the NIMHE Community Engagement Research Project, which was attended by potential steering group members and local community groups within the area. In addition to this the researchers produced a flyer to raise the profile of the project and assist in gaining access to the sample. Despite these efforts several agencies were very reluctant to allow access to the participants and were weary of the project.

A total of 80 women completed the questionnaire during face-to-face interviews. The Community Researchers conducted interviews in pairs for safety reasons. This was not felt to have an impact on the responses given. Each respondent was given details about the research and was asked to give their written consent on a standard form, agreed by UCLan, which was read out to them before the interview commenced.

### **Analysing the data**

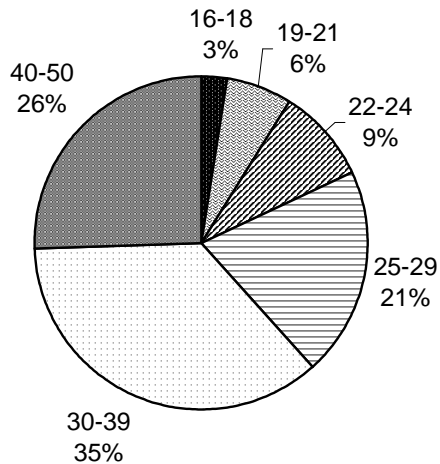
The quantitative data was analysed by using tally charts and summary sheets using MS Excel software. Qualitative data was analysed by coding themes and selecting direct quotes recorded by hand at interview to illustrate the data. Feedback from the researchers was also used to further illustrate key points, for example by giving some simple case studies.

## RESULTS

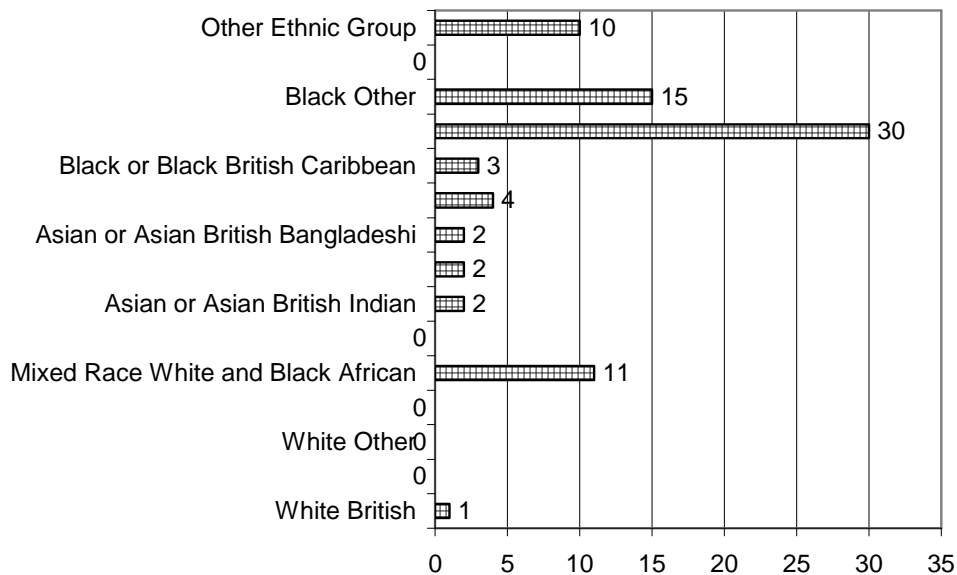
This section presents the findings from the research project. A total of 80 people completed the questionnaire. The data is presented in graphs for each of the questions with numeric data. For some of the questions there are less than 80 answers, so the number of respondents answering each question is given indicated by 'N='. In addition, examples of comments are given in quotes to illustrate answers to the open-ended questions. The findings are presented for each of the questions on the questionnaire in the order they were asked.

### 1. How old are you? (N=78)

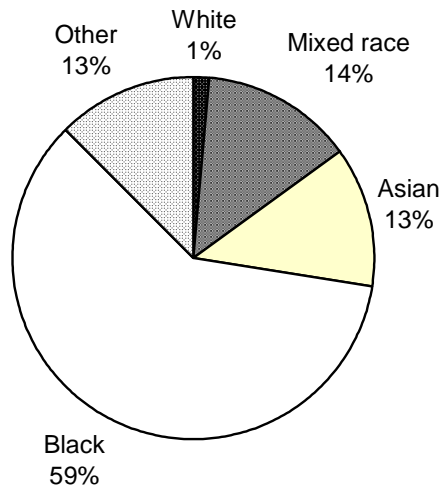
The graph below shows the breakdown of respondents by age group.



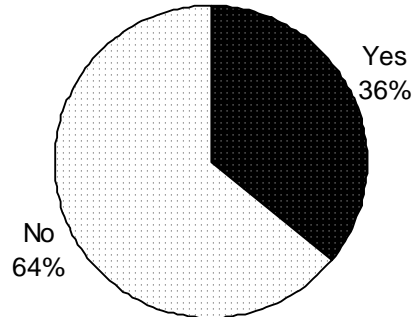
### 2. What is your Ethnicity (N=80)



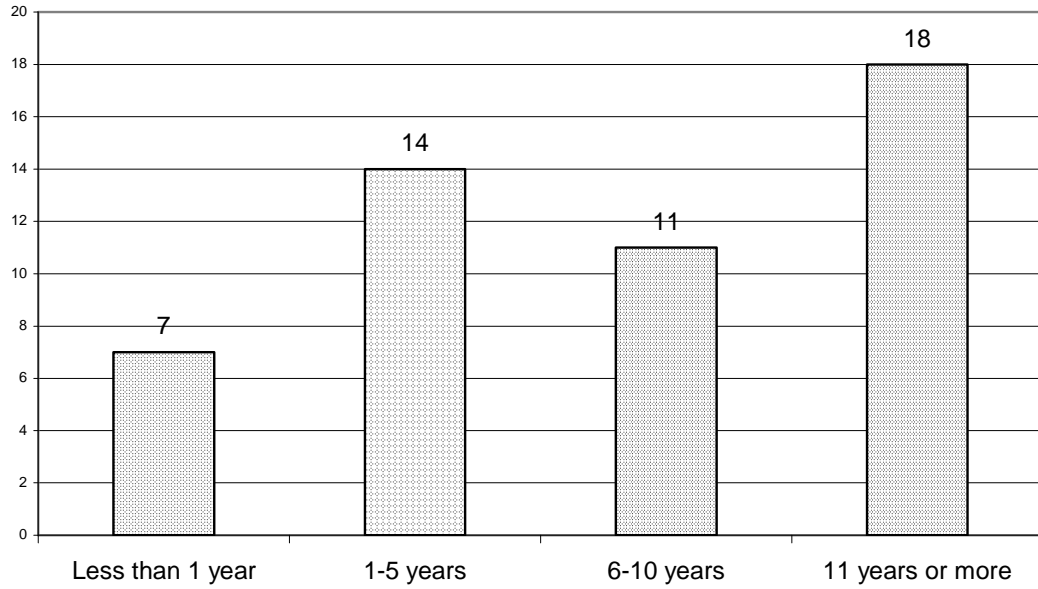
The pie chart below shows the data presented in broader ethnic groups.



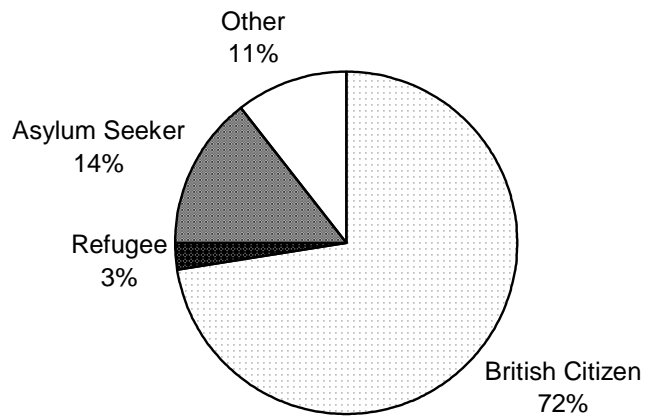
**3. Were you born in the UK? (N=78)**



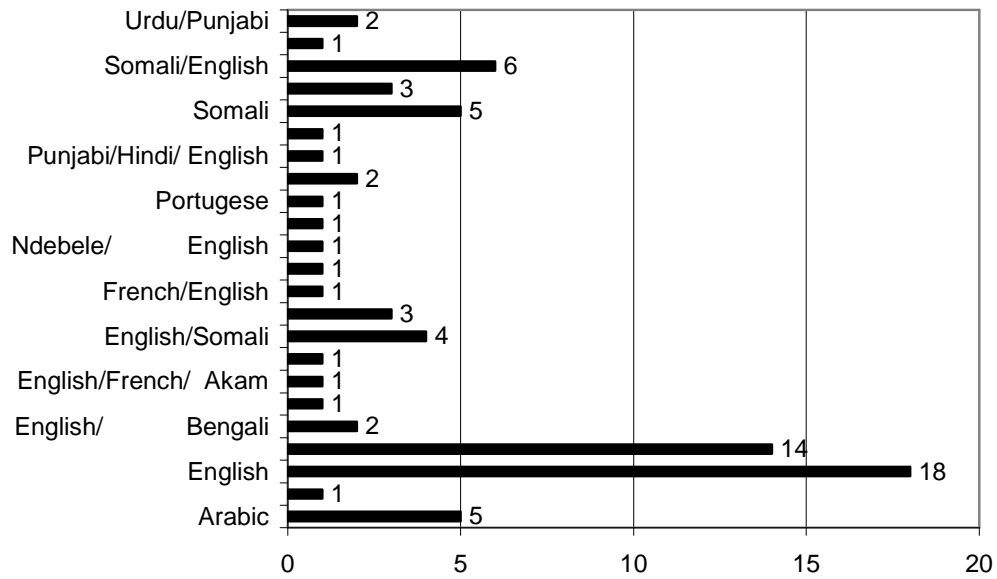
For the 50 people not born in the UK the graph below shows the length of time respondents have been resident.



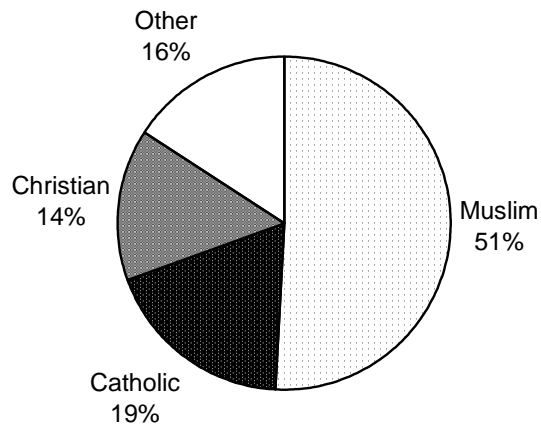
**4. Citizenship (N=76)**



**5. What languages are you fluent in? (N=76)**



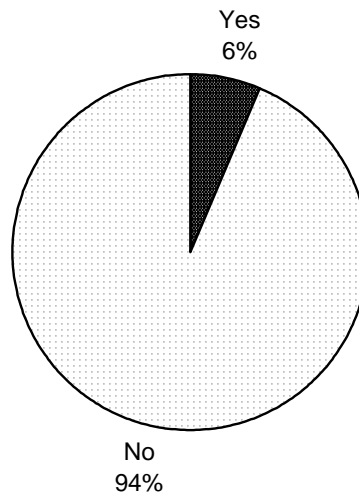
**6. What is your religion? (N=69)**



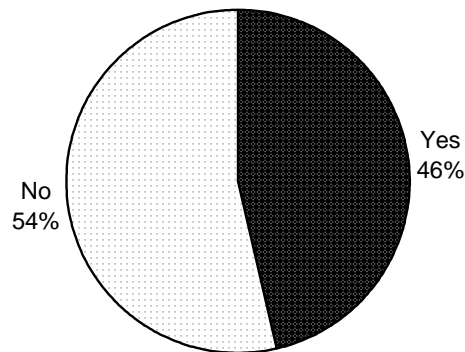
**7. Sexuality (N=77)**

76 (99%) of respondents said they were heterosexual and 1 person said they were bisexual.

**8. Do you consider yourself disabled? (N=80)**



**9. Have you ever experienced Depression, Anxiety, Fears, Stress, problems with eating or sleeping or any other problems which effect your emotional well being? (N=80)**



**10. Would you please give a brief description?**

For the 37 respondents who answered 'Yes' to question 9, 21 (57%) said they had suffered severely with stress, 13 (35%) with depression, and 7 (19%) with sleeping problems. Many people listed more than one problem. The quotes below give some examples of how people had experienced problems with their emotional well-being.

*Stress brought on by financial problems and mounting debt. This caused weight loss, being unable to sleep properly.*

*I feared not being accepted and was depressed because I didn't know who to talk to.*

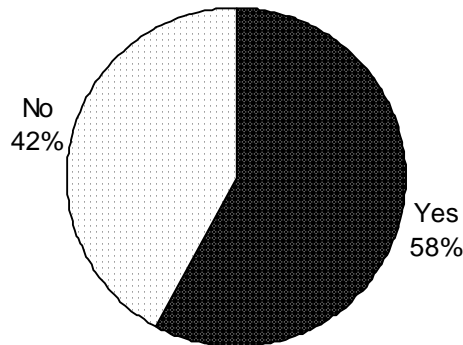
*Its difficult for me to sleep there. where I am because I am not yet used to the place. I've a stress when somebody speaks to me about Home Office resolution and about the fact that my age is disputed.*

*I'm sometimes stress when I have to explain what happened to me in Africa.*

*I suffered domestic violence, got stressed-up when my daughter was being forced to the female circumcision and my homeless situation.*

*Lost job without explanation, end up with huge bank loan what caused mental depression which effect eating and sleeping.*

**11. Have you ever visited your GP about these experiences? (N=38)**



For the 16 people who answered 'No', the following gives some of the reasons why they had not approached a GP.

*Didn't think it was that serious*

*Didn't feel comfortable talking to GP about my problems*

*Because I didn't have the confidence*

*Just don't bother - rather use complimentary therapies*

*Did not know could speak to Doctor*

*In my country there are no hospitals where you can go with these problems unless it is really serious. In Africa we have traditional beliefs.*

*Because I'm waiting for an appointment*

*I don't want to explain every time what happened*

*Didn't like to let him know I am having problems*

*My GP is not approachable*

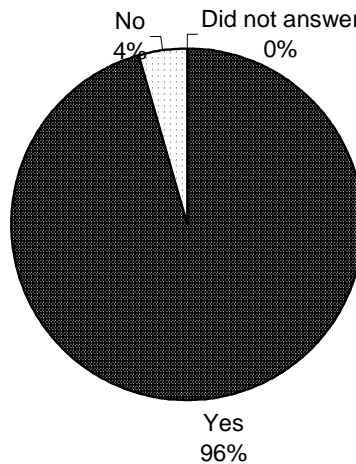
*I did not believe it was serious enough or that my problem was medical*

*I wasn't sure how to go about getting help. I was embarrassed to say anything. I felt like a burden on my family*

*Didn't think GP could do anything about situation*

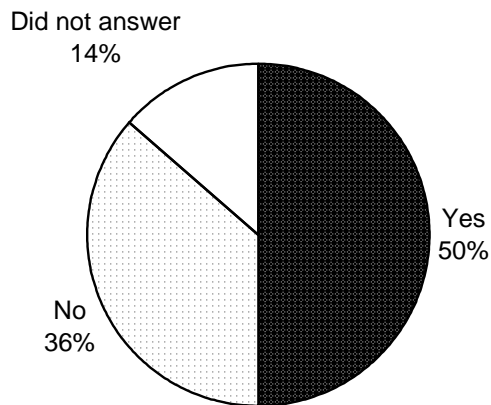
*Because I trust in God I don't need to stress, depression. I am safe in His hands, He takes care or cares*

**12. If yes to question 11, were you given any treatments? (N=23)**



For those 22 people who had received treatment from their GP 14 (64%) were given medication, 2 were referred for counselling and 1 person was sectioned. The remainder did not state any treatment.

**14. Were you happy with the treatment? (N=22)**



**15. If yes, could you say why?**

The quotes below give examples of reasons for those who were happy with their treatment.

*It helped to look after my children*

*Given advice on other treatments available and able to talk to Doctor about problems*

*I was at a low point, made me feel ok*

*It helped me sleep*

*I am still not sleeping well*

*To be able to speak to someone*

*They helped me to sleep when I was stressed, but I really don't like taking too many drugs*

*I feel better at the beginning but later I felt that I couldn't concentrate.  
If I missed a dose I feel dizzy*

**16. If not, why not?**

The quotes below give examples of reasons for those who were not happy with their treatment.

*Woke up in Broadoak, Xmas Day 1996*

*Addictive drugs and controversy about "Wonder Drug" at that time*

*Did not want medication or counselling*

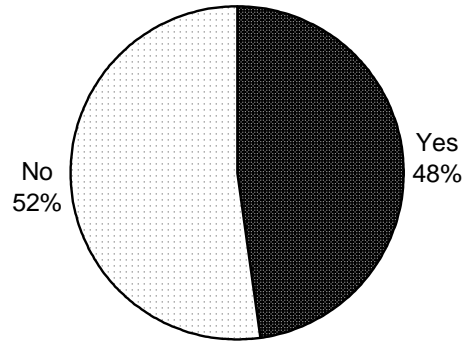
*Because I've not seen my GP*

*I would expect my GP to refer me to specialist clinic or Doctor*

*I am still not sleeping well*

*Did not help - still poor sleep and eating*

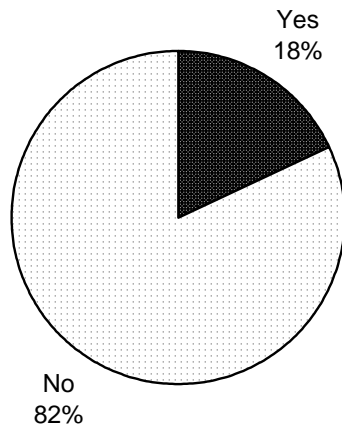
**17. Did your GP offer you a choice of treatments? (N=23)**



**18. If you answered yes to the previous question, what other choices of treatment were you offered?**

9 respondents answered this question, 6 were offered counselling, one a psychiatrist, one 'Tablets, if I wanted them' and another 'Eat more fruit, try and relax'.

**19. Did your GP make you aware of the other services in your area? (N=22)**



**20. If yes, which services?**

Of the 4 people who answered 'yes' to question 19, 3 people gave answers to this question, 2 mentioned counselling and the third a 'service user organisation'.

**21. Did you approach the services? (N=4)**

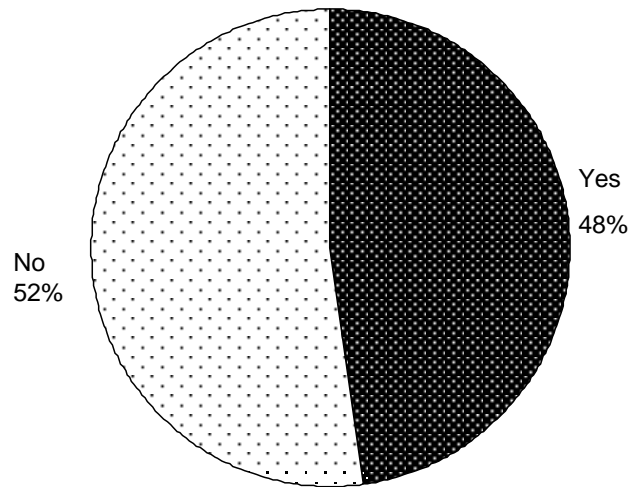
Of the 4 people who answered 'yes' to question 19, 2 people said they did and 2 people said they did not.

**22. If not, why not?**

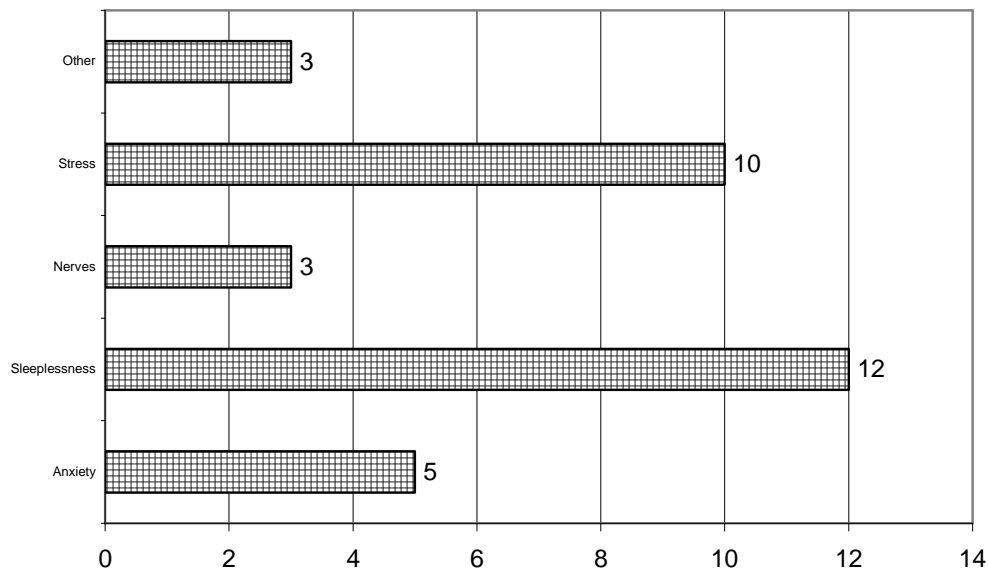
5 people made responses in this section, all said they did not know about the service.

**23. Were you happy with the service provided? (N=4)**

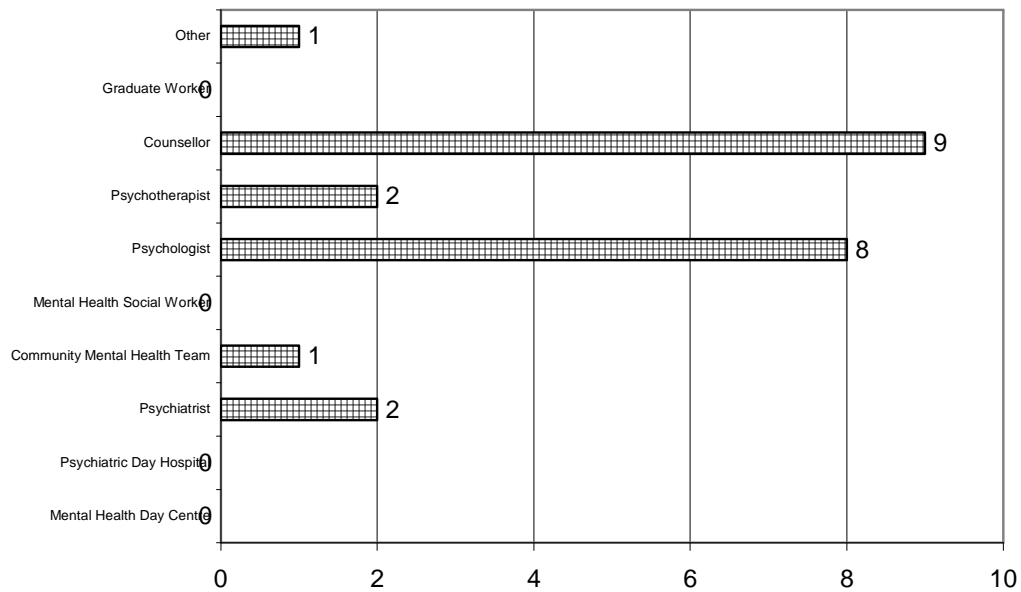
This question was only answered by the 4 people who answered 'yes' to question 19.



**24. Have you ever been prescribed medication for: Anxiety, Sleeplessness, Nerves, Stress, or Other? (N=33)**



**25. Have you ever attended or been referred to: (N=23)**



**26. If you have been referred to any of the above services, which did you find most useful and why?**

Of the 23 people referred to services, this question was answered by 9 people, who gave the following responses.

*Service User Organisation*

*Counsellor*

*Stopped going after three visits I did not feel it was doing me any good*

*A Psychologist because they will know more about my condition and will refer me to useful services that they consider*

*Social Worker - she was a nice woman and kind*

*Counsellor - It was helpful to talk it out*

*Counsellor - Did not attend*

*Somebody to talk to*

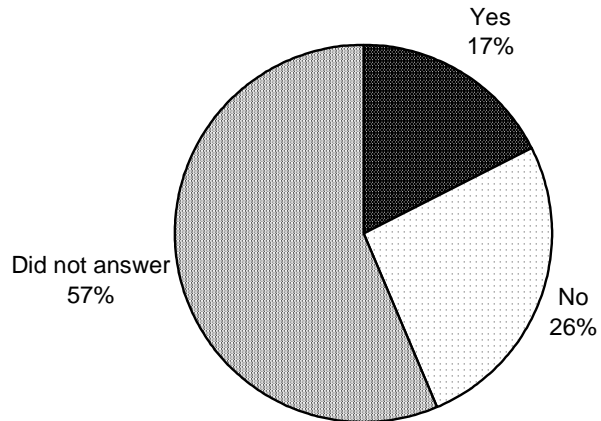
*I haven't been*

**27. Who were your referred by?**

Of the 23 people referred to services 7 people answered this question, with 4 people referred by their GP, one by a social worker, one by 'fellow patients' and another by a friend.

**28. Were you given a Treatment Plan? (N=23)**

This question was answered by just 10 of the 23 people referred to services.



**29. If yes, which one?**

The two responses to this question are given below.

*See GP monthly*

*Socialising with women. Go out*

**30. Did you follow this? (N=4)**

All 4 (100%) of respondents answering this question said they had followed the plan.

**31. If no, why not?**

Two people answered this question with the following responses.

*Because I have not heard about services*

*Made up own Treatment Plan*

**32. Did the Treatment Plan make a difference to your life? (N=4)**

Of the four responses two (50%) said it had and 2 (50%) said no.

**33. If yes, why would you say this?**

The 2 responses to this question are given below.

*Self-governed*

*Feel better, less stress.*

**34. If no, can you explain why you feel this way?**

The 3 responses to this question are given below.

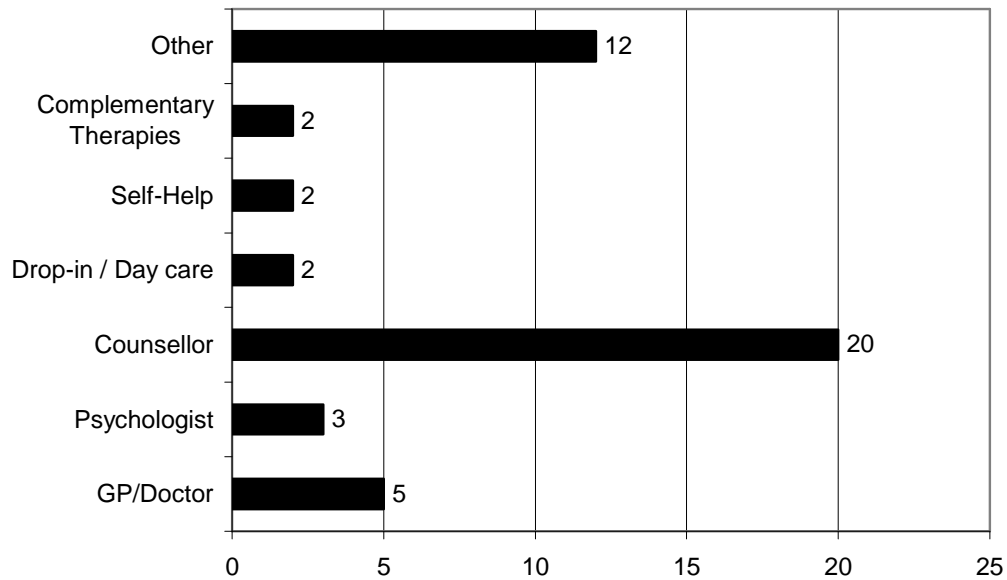
*Medication not working*

*Because the symptoms are still with me*

*No treatment plan*

**35. What type of services would you like to access if you are experiencing emotional stress?**

46 people answered this question; their responses were coded into the following categories shown in the graph below.



Of the 12 people who stated 'Other' services the quotes below give some examples.

*I prefer to speak to my parents and friends to solve the problem, if not going to the doctor*

*Help and support from NHS*

*Stress management service would be good, having someone to talk to during times of stress*

*I would like to access more literature in Arabic. I would like to attend sessions conducted by Arab speakers and attended by fellow Arabs*

*Special person to come to the house to help me with the problems*

*Any support especially for BME women who are stuck at home.*

*Some women are all day cooking, cleaning and looking after children for postnatal depression or antenatal depression*

*Group Therapy*

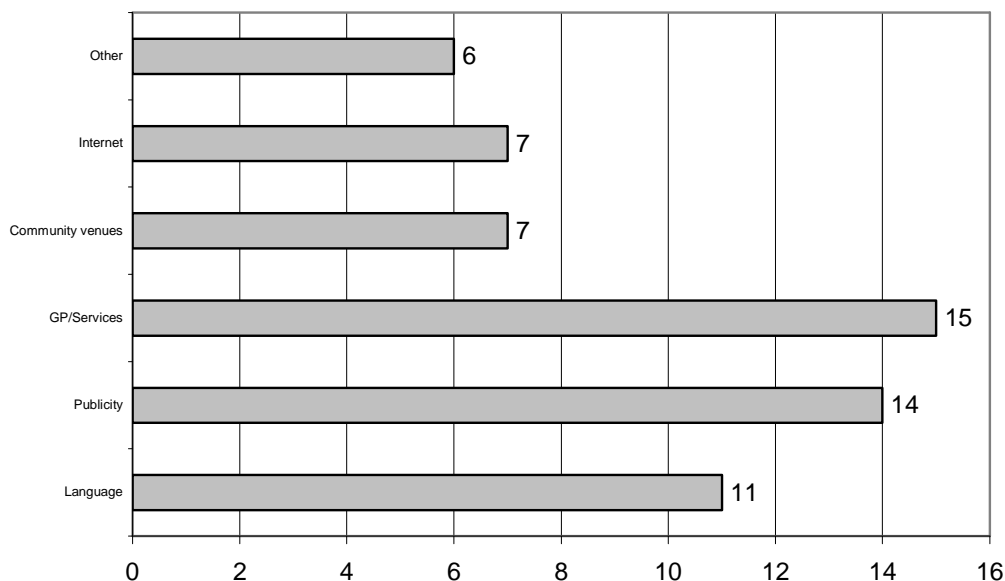
*When I am unhappy or sad I always call my friend*

*Family services in my community and female worker*

*Mental Health Services and GP*

**36. How could access to information about services be improved?**

60 people answered this question, with the responses coded into the categories shown in the graph below.



Some examples of the responses to the question are given below.

*Have different information translated into different languages for people who can't read English*

*Through leaflets, Internet, Surveys, Conferences, Questionnaire, Face-to-face meetings, Tenants Association meetings, through community centre, local Health Centre, exchange information through organisations*

*As an asylum seeker I feel we need to be treated as human beings and told what services are available*

*Language, Distribution - Some people don't know. Local access - a natural therapy centre. Funded practitioners. Natural therapy courses*

*Doctors Surgeries should have more information available to refugees*

*To employ more Black and Minority Ethnic women*

*Leaflets at your doorsteps. Local Press (newspapers). Ads in the GP and Dentists or any place we use or going to e.g. Supermarkets*

*Leaflets would be good, scattered around the community e.g. at the GP or maybe even the Mosque*

*By friends - through the internet - by newspapers - on the TV*

**37. Can you think of THREE THINGS you think could be done to improve mental health service provision for Black and minority ethnic women? Please try to be as specific as possible. Give as much detail as you can about the changes you would like to see.**

There were 47 replies to this question. The 6 broad themes are given below, together with quotes to illustrate these.

#### **Better information and publicity**

*I think mental health service could need more publicity and advertisement for people who need this type of help*

*More information should be made easily available to these women. Because of the lack of information available, very often women from these cultures are shunned simply because of lack of understanding, they do not utilize the services available*

### **Better services specifically for women and BME groups**

*Better Services for Ethnic women. Early support i.e. women suffering from postnatal depression*

*Family Support Service that is run by women who understand what I am going through and not risk what I say my children are going away*

*Muslim Women to have their own mental health day centre as this is part of their beliefs as I think this would help them to feel more comfortable*

### **Better alternatives to medical services**

*From experience I do not really encourage the idea of care home system as they only provide medication assistance which I do believe has bad side effects*

*Natural therapies because I think it works on the clients there and then and is immediate and chemical free and saves NHS lots of money*

*Being made aware of counselling service available for women*

*Counselling*

### **Access to Employment**

*Allow asylum seekers/refugees to work. If you work you don't have time to think about problems*

### **Information & interaction in own language**

*I just want to find nurses or doctors who speak other languages or accept English to the hospital*

*I'll be better if in all surgery we can meet GP, or nurses speak all languages*

*It would be better if they were seen by someone like themselves e.g. ethnic group or background*

*If there is any facility from unknown source maybe I could try but at that time I didn't like to visit my GP as he is from the same community now I am feeling alright because started new job which is much better job than the previous one, no problems now.*

*Mental worker from the ethnic groups who can understand the cultures and backgrounds*

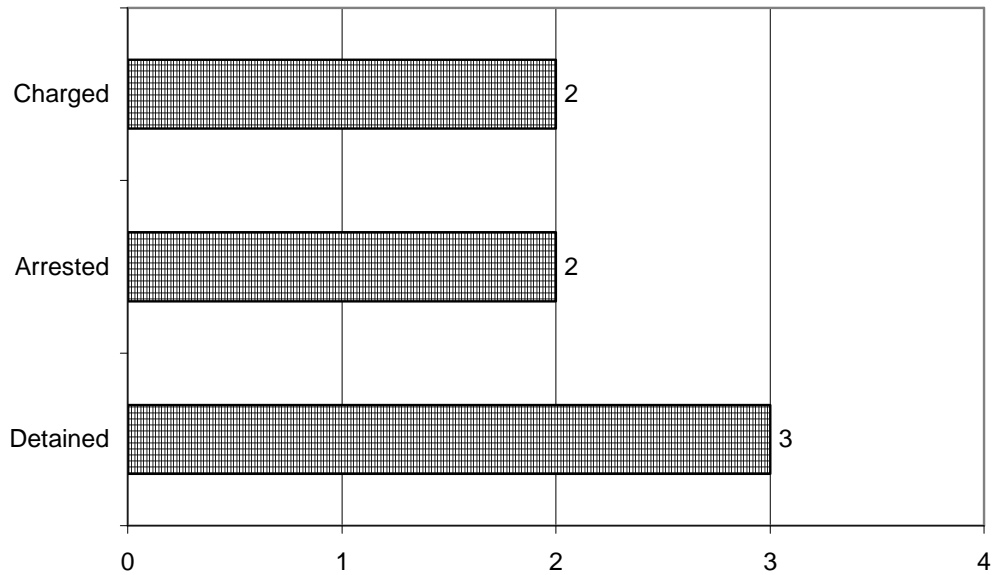
### **More mental health services**

*More mental health services in L8 area.*

*See more clinics*

*More Mental Health Day Care Centres*

**38. Have you ever experienced emotional problems that have led to you being: Detained, Arrested, or Charged? (N=7)**



**39. If you've ticked any of the boxes in question 38, please explain?**

The 2 responses to this question are given below.

*Neighbour dispute which my housing at that time did not resolve, ending in myself being attacked by neighbour but I was arrested because I defended myself and my children. I moved out on my accord for peace of mind and safety for myself and children.*

*Family Disputes*

## DISCUSSION

This report explored why Black and Muslim women in Liverpool do not access Mental Health Services and also to find what services are available and how accessible information was to obtain. To achieve this a total of 80 women were contacted during this study and completed a questionnaire.

The sample of women was not representative of the age of the local population, as the majority of women (74%) were 39 and under, and no women were over 50. This excludes a significant number of older women. However, the data provides valuable information, as the spread of ages for those under 50 was good with roughly a third of the sample falling into 3 age groups under 29, 30-39 and 40-50.

The data shows a range of ethnic backgrounds, with a majority (59%) of women with black heritage. Most of the women were not born in the UK (64%). This is a significant finding for the report in terms of the women's economic situation and cultural understanding of services in the UK and language barriers. However, the majority of the sample (73%), including those who were born in the UK, had lived in the UK for over 5 years. This suggests that most of the women had had the opportunity to settle in the UK. This is further reinforced by the 72% who were British Citizens and the 71% who had given English as a language they were fluent in. Yet, this does leave a quarter of the sample who were non-citizens with, who are not fluent in English, less than 5 years resident in the UK, and with limited experience of the British economic, legal & cultural systems.

Over half the women were Muslim, with a further third Christian. This shows a slightly higher religious commitment than the general population of Liverpool, with over 85% of women stating a religion compared to 82%<sup>10</sup>. This is a significant consideration in the provision of services that are sensitive to these faiths, for example in the gender of practitioners and the opening hours of services in relation to religious holidays.

It is unclear whether the responses to the question on sexuality were reflective as many of the women expressed concern or doubt over this question. This may point to a need to confidential information and support available, particularly to women from cultures who are not open about sexual orientation.

A small percentage of women (6%) classed themselves as disabled, this is lower than average for the general population, with 21% of Liverpool residents of working age saying they have a life-limiting long-term illness, though a similar to the 9% of people in Liverpool who claim Disability Living Allowance.

Perhaps the most significant finding relates to almost half of the women had experienced problems with their emotional well-being. These were more likely to be classed as anxiety, depression, sleeplessness & stress brought on by financial pressures, social & cultural isolation. This is twice the incidence of such problems as in the general population, where approximately 1 in 4 experience mental health problems<sup>11</sup>. The data also shows that 41% of the women had, at some time, been prescribed medication for a mental or emotional health problems. The two main conditions medication had been prescribed for were sleeplessness and stress, which accounted for 36% and 30% respectively of those women who had been prescribed medication. This finding correlates well with the women's own judgement of their emotional health. Clearly this shows the personal pressures these women were under, particularly considering many were socially excluded by nature of language & cultural barriers.

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<sup>10</sup> Census 2001, Office for National Statistics (ONS)

<sup>11</sup> Mental Health Foundation

Moreover, the researchers felt that there was a level of under reporting of emotional problems, as the women were often reluctant to acknowledge mental health issues considering their cultural and faith backgrounds. Of those that did, the researchers also found that poor quality accommodation and financial problems were significant factor in causing poor mental health. This was particularly the case for refugee and asylum seekers, illustrated by the upsetting examples given by the researchers:

*One woman was living with her five children in one room somewhere in Everton. This is a racist area and unsuitable for them.*

*Another woman was living with her husband and three children in one room in a 4<sup>th</sup> floor and barely left the flat as she could not take her 3 young children with her down the stairs whilst her husband was out.*

*One woman had just £35 per week and had to sign-on every day, costing her over £5 a week in travel alone. We put her in touch with support so that she could save money by signing on once a week.*

Another significant finding is that just 58% of the women experiencing problems had ever visited their GP. This is less than the proportion of the general population who seek assistance from their GP. This is a key finding that supports the thesis that black and Muslim women are reluctant to access mental health services. The key reasons why these women didn't use their GP were:

**Underestimation of the problem.** Some women just didn't think they had a significant problem. Also, some women perceived their GP as dealing with medical problems, whilst they viewed their emotional health in non-medical terms.

**Lack of confidence.** Some women did not feel able to discuss their mental health problems with a GP. Some mentioned their GP was unapproachable.

**Reluctance to use services.** The researchers found that many women were reluctant to discuss their mental health with them. Some did not want to let others know they had a problem. This reveals the deep stigmas attached to mental health. While others did not want to relive their deeply hurtful experiences.

**Preferred to seek own solutions.** Some women preferred to use other methods, such as complementary therapies or belief in their own faith.

Of those 22 women who had visited their GP almost all (96%) had been given treatment. However, the majority had received medication and only 2 referred for counselling. This appears very low considering the nature of the emotional problems the women had said they experienced.

Just 50% were happy with these treatments. These treatments, mainly medication, appeared to meet the immediate needs of the women, such as helping to get some sleep and able to look after children. However, many women were unhappy with the treatment they received.

Just under half the women who had seen a GP were given a choice of options. It is here that there are some contradictions in the research data, as 6 women (25% of those who saw a GP) were offered counselling, yet only 2 women had received counselling. This suggested that counselling was given as an option, though not actively taken up by some women. It is not clear from the data why the women who were referred to counselling did not take this up.

Considering that a significant number of the women had a limited familiarity with the health system in the UK very few women (18%) were made aware of other services in their area. Those that were made aware of services were told about counselling and mental health service user organisation. The number of responses in this area were so few (4) that limited conclusions can be made from the data. The data shows

that only half the women approached the services suggested and that they were happy with them. Those that did not approach services did so because they did know about them.

The researchers also picked up problems with inappropriate referrals, such as:

*One woman had been sent to a college course on the Wirral. Why? When there was a college close to her home. We gave her the information and she went there instead. They just go along with things because they were afraid to rock the boat.*

*Another woman was a trained nurse, who could read & write in English, and wanted to return to nursing by attending an Access Course. She had been sent on 3 pre-access courses, then told to complete GCSEs. We got her an application form and she enrolled on the Access Course she wanted.*

*We often had to point out more appropriate place where the women could go. Many did not know English classes were available for them locally.*

29% of the women respondents had, at some point, attended or been referred to more specialist mental health services. This finding further reinforces the conclusion that a significant proportion of black and Muslim women in the area experience difficulties with their mental and emotional health. Of those who had attended or been referred to other services 39% had seen a counsellor and 34% a psychologist. This further supports the conclusion that the emotional difficulties faced by these women were most likely to be the 'common mental disorders' of anxiety and depression related. However, the data also suggests a smaller number who had experienced more serious mental health problems: two had been referred to a psychiatrist, one had been sectioned and seven had either been charged, arrested or detained due to their mental health problems.

When asked why the women found these services useful a key finding appeared to be 'someone to talk to'. However, some responses pointed to a key finding from this study: that for some of the women who had experienced emotional health problems, help had been identified, but they had decided not to attend. Understanding why is an important area to explore further. The findings from this study point to a lack of trust in the UK health system. Of those who had been referred to services most (57% of those who answered this question) had been referred by a GP. Considering the difficulties the women had described above about using GP services one suggestion is that the women lack faith or trust in the service to deal with their problem. Further research is required to learn more about this area.

For those 23 women who had been referred to mental health services only 10 responded to the question about having a treatment plan. The researchers found this was due to the participants understanding of this term and their limited familiarity with the health system. This is the main reason for poor response rates here. However, for those 10 that did answer this question only 40% had been given a treatment plan. The data collected about details regarding the treatment plan is very limited as so few women responded and few conclusions can be drawn from this, other than a limited understanding between the respondents and the researchers about this area.

46 suggestions were made about the services the women respondents said they would like to access if they experienced emotional stress. By far the most requested service was a counsellor (43%). This is clearly a significant finding and one which appears in the recommendation. However, as a note of caution, there are some contradictions in these findings, as some of the women had been referred to a counsellor and not taken up the service. There are two possible reasons for this.

Firstly, it is possible that the nature of the question pre-empts the answer: i.e. Does stress suggest counsellor? Would the answers have been different if other phrases were used, such as mental health problems or depression? The second, and perhaps more plausible reason is that it is as important *how* a service is provided as much as what the service *is*. The following direct quotes from the women highlight the special nature of some of the services required.

*Counsellor with Islamic ethos or with an understanding of the Islamic culture*

*Family services in my community and female worker*

*Counsellor, without waiting list or queues.*

*I would like to access more literature in Arabic. I would like to attend sessions conducted by Arab speakers and attended by fellow Arabs*

These responses point to changes in the way services are delivered, so that they are culturally sensitive, gender specific, easily accessible and used by others from their own cultures.

In addition to pointing a way towards changes in existing services, the answers to this question revealed some new areas for development, in particular self-help support groups.

Most of the women (66%) gave suggestions about how information about services could be improved. The three top suggestions were:

- 25% suggest better information in GP surgeries and in other mainstream health services. Information is often available in these locations, so this points to a review of information provided to ensure it works, as the findings here suggest that existing service information is not effective for Black and Muslim women.
- 23% suggest better general publicity. This finding suggests that services need to be more creative in where they locate information. Leaflet racks in GP surgeries or hospital waiting rooms may not be sufficient. The women respondents suggested: posting flyers, using community centres, Mosques, pharmacists & schools, and advertising in the press & radio. The most popular media suggestion was better use of the Internet.
- 18% suggested that information should be translated into community languages. This is an unsurprising finding considering the nature of the research sample, with just 23% having English as their first language. The researchers also pointed out that although there was limited information to help Muslim women, there was no help at all for the African women they interviewed, many of whom were refugee and asylum seekers and had French as their first language.

The women respondents also gave their own suggestions for improving mental health service provision for Black and minority ethnic women. The main suggestions were:

- Better information and publicity
- Better services specifically for women and BME groups
- Better alternatives to medical services
- Access to Employment
- Information & interaction in own language

- More mental health services

The researchers also found that many women needed better support in day to day living. The researchers came across a group of African women refugee and asylum seekers who came to a group once a week to sort through used clothing. They received help from the Home Office regarding their legal status, but nothing else. They needed help with housing, their finances, education, social life and everyday living skills.

The data and the analysis have their limitations. For example, many of the questions asked had missing data, some of the questions had very small number of responses, and the interpretation in meaning caused by language differences could affect responses. The researchers found that the poor response rates were a reflection of the participants understanding of the terms used by health services. This is itself an interesting finding about barriers to health services. In addition to this, the analysis was limited to interpretation of each question in turn. No relationships between the data have been explored.

Perhaps the most serious limitation in this project is the lack of information about the nature and use of existing relevant services in the local area. This includes Advocacy Project, Mary Seacole House, Windsor House, MAAN Somali mental health advocacy project, Sahir House HIV counselling services, Merseycare primary care counselling, and Big Life Services own volunteer counselling service. Had these services been involved in this project the conclusion may have been different. The report here is based solely on the responses from the individuals interviewed. Further work is required to determine the impact and effectiveness of these relevant services that are available to the participants of this research project. This was beyond the scope of this project, which focussed on the individual's perspective.

The project itself presented many challenges and difficulties. The research team were relatively isolated: both from the steering group, which did not meet as often as planned and had limited involvement from statutory services; and from the host organisation, who were managing the project remotely from Manchester with one staff member working just 7 hours per week supporting the project and co-ordinating the volunteer counselling service. Although the team were supported by a number of agencies: UCLan, NIMHE and Big Life Services; this did not seem sufficient. The role and responsibilities of the volunteer research co-ordinator were too great at times. Future projects of this nature need to include more resources to manage and administrate the complex work and the high levels of support required. The number of agencies involved also contributed to communication problems. An example of this was the misunderstanding regarding part of the evaluation by the University of Central London. The researchers decided to exclude the needs assessment questions as they felt strongly that this was not appropriate to their research project, but didn't appreciate that this was part of the overall process. This is a sad loss for the project as this research could have contributed to this work of national significance. In future, a project of this nature will operate more smoothly with more intensive support from a single contact point. Also, there were some significant delays to the project, for example the first team of 5 researchers left and a second round of recruitment and the health problems of the research co-ordinator delayed analysis and production of the final report.

Nevertheless, despite these problems, this research report stands as testimony to the commitment, drive and passion of the volunteers research team, and the strength and dedication of the volunteer co-ordinator, without whom, this report would not have happened. The successes of this research can already be seen in the women researchers who have completed training in research methods, participated in a

research project, increased their understanding of issues affecting their local community, and gained valuable work experience.

## **CONCLUSION**

This research project has revealed some key findings about the emotional health of and use of mental health services by Black and Muslim women in Liverpool. The key findings are that:

- A significant proportion of the participants had experienced mental health problems. This incidence appears to be about double that experienced by the general population.
- Most of the women did not gain the kind of treatment they needed.
- About half decided not to use the services available. This seems to be due to lack of confidence among the women and the lack of awareness among services in who to appeal directly to these women to break down barriers of trust and culture. A small number decided to deal with their problems in their own way.
- For those that did use services, these services were not sufficiently appropriate to meet their needs due to their cultural inappropriateness, language barriers, and gender differences.
- The participants wished to see mental health services that are more sensitive to their culture and gender, that are advertised better, that involve others from their culture or belief and are conducting in a language most suited to them.

These findings point to recommendations in the next section.

## RECOMMENDATIONS

The results of this research project suggest the following recommendations. These recommendations are based on the key research findings, are linked to national policy and are targeted at local decision makers. This research has highlighted some gaps that these recommendations seek to address. These gaps have been identified previously, from both local & national perspectives, and this report serves to reinforce the need to ensure equitable access to mental health services for Black and Muslim women in Liverpool. The following section describes how this can be done.

**Recommendation 1. All mental health services should review the information they issue to Black and Muslim women in light of these findings.** This will include Liverpool Primary Care Trust (PCT), GPs, Mersey Care NHS Trust's mental health services and voluntary sector organisations. The participants did not know about the services and how to access these services due to poor local advertising. The volunteer researchers found there was nothing mentioned about mental health services and day care in the local newspaper or not enough promotion. Services need to ensure they involve the women from Black and Muslim communities in reviewing and developing new information and ways of reaching those in need. This is in line with the vision set-out in *Delivering Race Equality*, which states:

*a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services.*

**Recommendation 2. Staff working in health services, in particular GPs, should ensure that Black & Muslim women are clear and confident about the services they are being referred to,** e.g. what they are for, where they are, what they can expect. This will ensure that they gain equal access to health services, as set-out in *National Standards, Local Action*<sup>12</sup>. The PCT have already committed to promoting better access to services through the Social Inclusion Team. This service offers much needed help through a team of bi-lingual health workers from several communities. However, the PCT should also issue guidance to GPs to improve the referral process. Ideally, the PCT should commission an organisation to conduct training on this area using trainers from the local communities involved or use the PCT Social Inclusion Team to further promote their work. Training and development of staff is one of the 10 actions identified by Sir Nigel Crisp, the chief executive of the NHS to implement the race equality action plan.

**Recommendation 3. The PCT, Mersey Care NHS Trust and Liverpool City Council should improve the information they provide to Black & Muslim so they are aware of the help they are entitled to.** In particular the PCT should work with the local GPs to ensure that women know they are able to talk to their GP about their emotional well-being as well as medical conditions. GPs will also need guidance on where they can refer people to. As in the above recommendation, the involvement of local women would significantly improve the effectiveness this measure. This action is in line with the actions set-out in *Delivering Race Equality*.

**Recommendation 4. The PCT should ensure that all women have the option of seeing a female health worker.** In particular, this study found that Muslim women prefer to be seen by a female worker as they do not like to talk openly about their problems and concerns to a man. The PCT should set this as a target for all services.

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<sup>12</sup> National Standards, Local Action: Health and Social Care Standards and Planning Framework, Department of Health, July 2004

This is in line with the government's health and social care White Paper, *Our Health, Our Care, Our Say*<sup>13</sup>

**Recommendation 5. The PCT and local authority information services need to work pro-actively with partner agencies to improve information in community languages.** The PCT have made a good contribution to this with the Language Line, run by Novas Arlington Interpreting Services, which can translate information on request. Nevertheless, the majority of the women in this study, with English as their second language, found it difficult to access the information about where, when and how to access the local services available to them: simply, they did not know where to go or who to speak to. This exercise is best completed with people from the local community and this may mean more than translation, but rather a review of how information is interpreted. This may form a role for the forthcoming Community Development Workers. The 10-point plan from Sir Nigel Crisp includes the need for better communication to:

*Encourage fresh approaches to communications to engage people from ethnic minorities more effectively in improving outcomes.*

**Recommendation 6. The PCT and other health services should pro-actively recruit workers that reflect the diversity of the local communities in which they work.** The PCT should set targets within the NHS to achieve a more balance workforce. Sir Nigel Crisp's 10-point plan also includes the need to improve training, development and career opportunities for all staff in race equality issues, with the need to:

*Develop more entry points for people from ethnic minorities to join the NHS and take up training. Improve access for BME staff to the full range of development programmes, support networks and professional training. Encourage appropriately qualified leaders from ethnic minorities in health and other sectors to consider and apply for executive positions*

Some good work has already commenced in this area by the PCT's Social Inclusion Team, who employs 16 health link workers speaking over 20 languages. This good example should be promoted among all health services, so that workers are trained to understand the local community's cultural and religious needs. Ideally, the PCT should commission an organisation to conduct training on this area using trainers from the local communities involved. This could build upon the cultural training for mental health staff for Mersey Care Mental Health Trust delivered by Mary Seacole House, extending this to cover primary care staff.

**Recommendation 7. To promote the training and capacity building work identified above a worker should be recruited to work with the local communities, to improve the information available, drive through the training identified above and to help address the emotional needs of the Black and Muslim women revealed by this study.** To do so, the PCT should consider creating a female BME post as part of the Community Development Worker team. However, the report *Inside Outside*<sup>14</sup>, which signalled reform of mental health care for BME communities, points to the better use of the independent sector to improve access to services. This should be considered when taking this action forward in identifying an appropriate lead agency.

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<sup>13</sup> Our health, our care, our say: a new direction for community services, Department for Health, January 2006.

<sup>14</sup> Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England, National Institute for Mental Health in England, March 2003.

**Recommendation 8.** The PCT should work with the existing local providers, such as Mary Seacole House and MAAN Somali Mental Health project to improve access to primary care self-help and drop-in services where the women can meet up in groups, discuss their problems, and socialise. Most of the mental health problems emerged from this research came from the stresses due to work or family commitments and isolation, as the women from the BME communities had no places to go for socialising. This study suggests that this may reduce the number of women using GP services.

**Recommendation 9.** For those with more serious depression and anxiety access to talking treatments, that are culturally sensitive to their needs, is required. This should include access to counselling, group therapy and CBT. This supports the vision set out in *Delivering Race Equality*, which included:

*a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.*

The PCT has already taken steps to address this through an existing GP based counselling team and funding for some running costs and accommodation for Big Life Service's volunteer service. This report has revealed that these services do not appear to be accessed by the Black & Muslim women who participated in this research. This report recommends PCT should review their own counselling service to ensure this is culturally sensitive and work with other providers, including Big Life Services, to promote better access to a range of appropriate talking treatments. This work should be done in partnership with the PCT, NIMHE, Big Life Services, local GPs and people from the local community.

**Recommendation 10.** To ensure these recommendations are taken forward this report recommends that a high level group, for example at the Local Strategic Partnership, Liverpool First, adopts the agenda for change to improve access to primary care and mental health services for Black and Muslim women in Liverpool. The recommendations require the support from a range of agencies, including the PCT, Mersey Care NHS Trust, Home Office, Job Centre Plus, employment and training providers and the voluntary sector, to ensure that joined-up solutions are found and information is shared.

## APPENDIX: THE QUESTIONNAIRE

**BLACK AND MUSLIM WOMEN'S USE OF  
MENTAL HEALTH SERVICES IN LIVERPOOL**

*ARE THE MENTAL HEALTH SERVICES IN  
LIVERPOOL BEING ACCESSED BY BLACK  
AND MUSLIM WOMEN?*

***THIS QUESTIONNAIRE IS FOR WOMEN ONLY***

This Community Engagement Research Programme is being carried out on behalf of NIMHE,  
UCLAN and BIG LIFE SERVICES

**WE WOULD BE GRATEFUL IF YOU COULD ANSWER ALL OUR  
QUESTIONS**

**ALL ANSWERS WILL BE CONFIDENTIAL AND ONLY USED FOR  
RESEARCH PURPOSES**

**YOUR NAME WILL NOT BE ENTERED ON THE FORM**

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**Please tick as appropriate**

1. How old are you?

15 or under

16 – 18

19 – 21

22 – 24

25 – 29

30 – 39

40 – 50

2. What is your Ethnicity

White British

Irish

Other

Mixed Race White and Black Caribbean

White and Black African

White and Asian

Other (please state) \_\_\_\_\_

Asian or Asian British Indian

Pakistani

Bangladeshi

Other (please state) \_\_\_\_\_

Black or Black British Caribbean

African

Other (please state) \_\_\_\_\_

Chinese

Other Ethnic Group (please state) \_\_\_\_\_

3. Were you born in the UK? Yes  No

If no, how long have you lived here

Less than 1 year

1 – 5 years

6 – 10 year

11 years or more

4. Citizenship

Are you a British Citizen

Refugee

Asylum Seeker

Other (please state) \_\_\_\_\_

5. What languages are you fluent in?

6. What is your religion? (please state)

7. Sexuality

Lesbian or Gay woman

Heterosexual or straight

Bisexual

Transgendered or transsexual

8. Do you consider yourself disabled? Yes  No

If yes, please state \_\_\_\_\_

9. Have you ever experienced Depression, Anxiety, Fears, Stress, problems with eating or sleeping or any other problems which effect your emotional well being? Yes  No

10. If yes, would you please give a brief description.

11. Have you ever visited your GP about these experiences?

Yes

No

11A. If no, why not? (if you have answered this question then please go to question 35)

12. If yes, were you given any treatments?

Yes

No

12. What treatment were you given?

14. Were you happy with the treatment      Yes       No

15. If yes, could you say why?

16. If no, why not

17. Did your GP offer you a choice of treatments?

Yes

No

18. If you answered yes to the previous question, what other choices of treatment were you offered?

19. Did your GP make you aware of the other services in your area?

Yes

No

20. If yes, which services?

21. Did you approach the services?

Yes

No

22. If not, why not?

23. Were you happy with the service provided?

Yes

No

24. Have you ever been prescribed medication for:

Anxiety?

Sleeplessness?

Nerves?

Stress?

Other? Please state \_\_\_\_\_

25. Have you ever attended or been referred to:

A Mental Health Day Care Centre

A Psychiatric Day Hospital

A Psychiatrist

A Community Mental Nurse (CMHN)

Community Mental Health Team

A Mental Health Social Worker

A Psychologist

A Psychotherapist

A Counsellor

A Graduate Worker

Other, please state? \_\_\_\_\_

26. If you have been referred to any of the above services, which did you find most useful and why?

27. Who were your referred by?

28. Were you given a Treatment Plan?

Yes  No

29. If yes, which one?

30. Did you follow this?

Yes  No

31. If no, why not?

32. Did the Treatment Plan make a difference to your life?

Yes  No

33. If yes, why would you say this?

34. If no, can you explain why you feel this way?

35. What type of services would you like to access if you are experiencing emotional stress?

36. How could access to information about services be improved?

37. Can you think of **THREE THINGS** you think could be done to improve mental health service provision for Black and minority ethnic women? Please try to be as specific as possible. Give as much detail as you can about the changes you would like to see.

38. Have you ever experienced emotional problems that have led to you being

Detained

Arrested

Charged

39. If you've ticked any of the boxes in question 38, please explain?

***THANK YOU FOR TAKING THE TIME AND TROUBLE TO  
ANSWER THIS QUESTIONNAIRE***

***WE HOPE THE SERVICES OFFERED WILL BE IMPROVED AS  
THE RESULTS OF THIS RESEARCH***