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THE MENTAL HEALTH SUPPORT EXPERIENCES OF BLACK WOMEN, BORN OUTSIDE OF THE UK, IN LEEDS.

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Foreward

Touchstone's vision is to inspire communities and to transform lives. Over our 30 plus years of operating across West Yorkshire this aspiration has led us to focus on the hopes, experiences and outcomes of our most diverse communities as experience shows that these communities are most often the most excluded, marginalised and overlooked.

These two research reports will hopefully go some way to ensuring the rights and entitlements of Roma men and Black women born out of the UK across Leeds are recognised and honoured by service providers in the future. More widely than these two groups, we also hope that the different needs and experiences of Black, Asian & Ethnic Minority (BAME) communities and people with complex needs in particular, are distinguished by services and that considered, culturally sensitive responses are put into place, as a consequence.

In doing so, Touchstone intends that the voices of all will be heard and the visibility of our diverse and rich communities will improve, thus supporting all our neighbourhoods and localities to thrive and the people within them - whatever their needs - to be part of the potential of a new day.

Alison Lowe
CEO Touchstone

Acknowledgements

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Executive summary

Key messages:
1. Mental health problems are often associated with extreme, negative behaviour but there are signs this perception is starting to change.
2. Risk factors for mental health problems include a lack of language skills and cultural differences.
3. Refugees and asylum seekers experience great fear and uncertainty, which negatively affects their mental health. Issues include; traumatic past experiences, fear for (or of) their family and the asylum process creating fear of being deported or detained, uncertainty, disorientation and not feeling valued.
4. Barriers to accessing services include denial, a lack of language skills, fear of authority or that a diagnosis will impact on other areas of their life and perceptions that GPs don't have the time or understanding to help.
5. Voluntary and community organisations (VCOs) provide critical support because they can connect with communities, involve people from the community and establish trusted relationships. They provide activities to treat and prevent mental health problems, practical life support and help accessing services.

What is this research summary about?
This summary presents the key findings from a project that aimed to find out how VCOs can help improve the mental health and wellbeing of Black women born outside of the UK. Factors that can help improve mental health and wellbeing and those that affect it negatively were explored. People were asked what barriers there were to accessing mental health services and what support VCOs can give.

The research was conducted in Leeds for Touchstone by Health Together, the Centre for Health Promotion Research at Leeds Beckett University. Similar research was conducted with Roma men and a summary of this is also available.

Stigma
Stigma towards mental health problems within the community was evident. Mental health problems were often not acknowledged or discussed, associated with extreme behaviour or seen as 'evil'. People feared being labelled or ostracised from the community. Some people felt that times were changing and people with mental health problems were now more accepted. The terminology used by mental health services and how mental health is perceived was unfamiliar to many community members.

> *"I think we have changed, with development, with medication, with the mental health hospitals, you know, even in the community, we know there is somebody who in that house, who is like this, who is…. That used to happen, it's very true, you would run away, you would do whatever, you know that was it, but it has changed".*

Speaking English
A lack of language skills was found to be a key risk factor for mental health problems. This affects a new arrival's ability to connect or interact with others, perform the functions of normal life and engage with services. It is especially hard for people who are not fluent in a language to discuss their emotions or feelings, making it more difficult to interact with people or services that may be able to help.

> *"The main thing is the language barrier if you come to a new country that you can't speak the language that's a big challenge, that's big mental health, because you aren't able to communicate, even if you want something, how could you explain and try to analyse so they can understand, so that's big impact."*

Contrasting cultures
Cultural differences between how people live in Africa and in England were highlighted. The African way of living was described as being more community and neighbourhood based, whilst English culture was seen as more family-focused. This led to some new arrivals feeling isolated and, at times, unsupported.

> *"Many people just lock themselves up in their houses and do whatever they are doing, I think that's a very big issue with coming from where we come from … we grew up respecting and loving everybody, but here it's a little bit difficult, so that isolation is a culture shock"*

Fear and uncertainty

Refugees and asylum seekers experience multiple issues that contribute to severe mental and physical strain. Traumatic past experiences and concerns for (or of) family left behind affect people's mental health. The asylum process itself leads to people being afraid of being deported or detained, living with long periods of uncertainty and not feeling valued as they can't use their skills. People feel very disorientated when dispersed to new cities. Domestic abuse was raised as an issue, with people feeling it stemmed from male orientated cultures, the stress of the asylum seeking process and women not being aware of or afraid to ask for help from, the services that could help them.

> *"It's like this er uncertainty people have, that they are actually, like think that when the letter arrives, their life is going to start, they don't realise this is their life now, so they wait for their life to start, to do something, cos they think when I get my papers, my status I could work, or study or do something else, so they think like they are actually living in just like in a dream and they are going to wake up one day and do it, but these people especially they tend to go like that for years because the process can take for years, but when the time comes and the letter arrives, they don't have the passion anymore to do anything."*

Accessing services

Barriers to utilising mental health services include an unwillingness to acknowledge mental health problems and lacking the language to express their feelings or emotions. Being afraid of authority or the consequences of a diagnosis reaching employers, the Home Office or Social Services was a strong theme. Women were seen as having a tendency to put themselves second. The perception that GPs did not have the time to address mental health issues or always have a helpful attitude also emerged as themes.

Protective factors

Being connected to others in the community, being able to develop trusted relationships and, for many faith and church were all protective factors for improved wellbeing. Others emphasised the importance of being active and, more specifically, volunteering.

> *"We have one church, big room, every Wednesday, the person go there, you eat, drink or talk, the same language, the same problem, sometimes you forget your problem."*

Voluntary and Community Sector (VCS) Support

VCOs offer critical support for many people - including mental health specific activities, preventative sessions and support in accessing statutory services. They also offer practical help, provide a welcome and help orientate people, thus reducing loneliness and alienation. Being well connected to the communities they serve, involving community members (peer led) and providing accessible and approachable services means they can establish trusted relationships.

Recommendations

1. Continue to raise awareness of mental health problems to reduce stigma, using trusted individuals and organisations.
2. Provide support at critical life moments. Peer support is ideally placed to do this.
3. Provide opportunities for new arrivals to learn to speak English, including around emotional issues.
4. Encourage greater interaction between GPs, mental health services and VCOs.
5. Improve awareness among GPs and mental health services of the types of issues this community may face and the barriers to accessing services that they experience.
6. Support appropriate, community led activities that help people to connect and build relationships
7. Implement appropriate funding models which support VCOs' role in improving the mental health problems of this community and others

How we did the research

In 2015 we held three focus groups with 20 Black women born outside of the UK who had some experience (either personally or via their family and friends) of mental health problems. We also interviewed nine people, from seven organisations, who worked or volunteered with Black women born outside of the UK.

Contact / further information

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1   Introduction

1.1   Background to the research

Touchstone, a Voluntary and Community Organisation (VCO) based in Leeds, has a strong history of working with Black, Asian & Minority Ethnic (BAME) communities to improve Mental Health & Wellbeing[1]. Their projects are wide-ranging, including Community Development Services who work with partners and organisations to support BAME communities in Leeds to improve Mental Health, Improving Access to Psychological Therapies (IAPT), Elder's Groups and East Leeds Health For All.

This research arose out of concerns raised by Touchstone relating to BAME people's experiences of mental health services, their relationship with Primary Care and potential stigma within communities. A desire to improve mental health prevention, support and recovery by understanding experiences and attitudes in greater detail was expressed. This research was to build on work previously undertaken by the Community Development team.

As many ethnic groups live in Leeds (140 according to the Leeds Joint Health & Wellbeing Strategy, 2013-15) a focus in terms of which communities to research was needed. Following discussions between Touchstone and Leeds City Council it was agreed to concentrate on two communities who had been born outside of the UK:
- Black women
- Roma men

It was felt that both these groups were likely to have a high level of need and that there was a lack of research into their mental health and wellbeing and in particular their engagement with the VCS.

The research proposal was agreed between Health Together (Leeds Beckett University), Touchstone and Leeds City Council. It was felt that focusing the research on the VCS would be useful for commissioners, practical to achieve within the timings and in keeping with current policy. Indeed, the Leeds Mental Health Framework (2014-17) states that there is a need for a diverse range of Mental Health provision to *"meet the diversity of needs presented"* (p5) and that this should include both Primary Care and the VCS in order to help people by *"building resilience, self-help and peer support opportunities"* (p4).

The research was to be conducted by individuals from Health Together (the practice arm of the Centre for Health Promotion Research at Leeds Beckett) and the Centre for Men's Health. The Community Development Team was to provide support by recruiting VCOs to participate and assisting during discussion groups.

1.2   Aims and objectives

Research aim:
- To explore the potential role of VCOs in improving the mental health and wellbeing of two BAME communities in Leeds.

Objectives:
- Identify and explore protective factors for positive mental health and wellbeing
- Identify and explore the risk factors[2] for mental health problems
- Explore perceptions of barriers and enablers to engaging with health services
- Identify what types of support are currently offered by VCOs to prevent / aid recovery from mental health problems
- Explore the reach and acceptability of this support
- Identify any 'gaps' in services that may help prevent mental health problems / aid recovery
- Identify best practice and provide recommendations for improvements in practice within Leeds

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[1] See TouchstoneSupport.org.uk for more information

[2] These could be social, personal, cultural, economic – as raised / perceived by participants

1.3   Existing research

Whilst it was outside the remit of this project to conduct a full literature review, some of the most relevant evidence in this area is summarised here.

There is a longstanding and well-documented history of racial disparities in mental health services. A range of initiatives have been introduced in the UK to reduce these inequalities and promote racial equality. A notable initiative was the 'Delivering Race Equality' (DRE) programme launched in 2005 (DH, 2005) with the overall aim to improve the mental health care and treatment for Black and Minority Ethnic(BAME) communities in England. This programme achieved some positive outcomes, but there remain concerns that the situation for BAME communities has not been much improved. The latest report of the Care Quality in Commission (2013), for example, shows that inequalities in mental health persist for BAME groups and that there are specific issues for certain BAME groups. Key reported challenges (DH, 2009) include engaging with and understanding the complex and diverse nature of BAME communities; and persistent evidence that social factors affecting mental health include deprivation as well as how services are delivered. A research synthesis for Lankelly Chase Foundation (2014), found that a sense of disengagement often persists between various BAME communities and UK statutory services, and that asset-based and community centred approaches hold the most promise.

The Bradley Commission briefing on BAME mental health (2013) finds that VCOs are key to engaging BAME communities that are disproportionately represented both in mental health care and in the criminal justice system. The Joint Commissioning Panel for Mental Health guidance for commissioners (2014) reported that mental health services need to work better for BAME communities reflecting challenges of changing demography, delivering appropriately tailored care to enhance wellbeing across diverse groups, reducing mortality and morbidity, and tackling inequalities.

Research for the National Institute for Mental Health England (NIMHE) Community Engagement Project (Fountain and Hicks, 2010) emphasised that: fear of mental health services is a persistent deterrent for BAME community members to engage; services' over-reliance on medication is a deterrent; talking therapies were valued but some groups e.g. some Black Africans, some migrants, did not see any value in talking about feelings in isolation from practical life issues. This, compounded with issues of stigma presents challenges for engagement. Communication and language issues also persist in relation to service access, especially for Black African migrants (Ochieng, 2012) and Roma (Craig, 2011). Mental health service providers are not always understanding of, and sensitive to, the intersection of gender and cultural issues when diagnosing and treating BAME patients (Fountain and Hicks, 2010). Racial abuse was reported most by BAME groups and particularly by migrant workers from Eastern Europe, Muslims and asylum seekers. Barriers to recovery included a poor experience of treatment, a lack of support from family and in the community, the stigma of mental illness, an unchanged environment after treatment, and not believing that recovery as possible (Fountain and Hicks, 2010).

Research for the Migration Observatory (Jayaweera, 2014) highlights particularly high rates of depression and anxiety among asylum seekers and refugees compared to other migrants or local nationals. Barriers to access to health services include information, language and transport, and cultural insensitivity of some providers. It is also true that many migrants fall outside existing and particularly statutory health services, especially those many whose situation is precarious in the host society, which adds to the risk that mental health issues arising from past and present trauma and life struggles go unrecognised and untreated (Carta et al., 2005). A significant number of Roma (Craig, 2011) and also Black African migrants (Migrant and Refugees Communities Forum and CVS Consultants, 2002) are or have been seeking asylum. This has often meant they could not work, and social integration is highly problematic, adding to the issues which may have caused them to flee their country of origin, all of which gives rise to a greater risk of serious mental health problems and can contribute to issues of trust with health services (Craig, 2011).

Research concerning BAME communities' experiences of mental health (Robinson and Keating, 2010) has found that engaging with BAME people's understandings of and wishes for their own health and well-being can enable practitioners to support them more effectively. Instead of reinforcing narratives of illness and blocked recovery, this approach helps to put BAME people back in control. Statutory services are not always enabled by their organisational contexts to play a comprehensive trust-building or advocacy role, so well-considered and evidenced use of community resources and services can help BAME people to break the spiral of blocked recovery. On the other hand, BAME mental health service users have expressed a view that

supportive social interaction and taking part in purposeful, relevant and/or enjoyable activities maximises the effectiveness of treatments and supports recovery (Fountain and Hicks, 2010).

Mind's report on commissioning mental health services for vulnerable adult migrants (Fassill and Burnett, 2014) stresses the importance of commissioners and providers understanding people's specific migratory experiences; recommends a co-production approach to commissioning services; highlights migrants' needs for additional support in accessing services; emphasises the importance of designing and delivering services in partnership with migrants; calls for links with peer mentoring programmes to build local capacity; and calls for large providers to sub-contract to small community based providers who should be encouraged to bid in partnership to provide services.

The context for the present project is therefore a growing weight of evidence showing that migrants, refugees and asylum seekers face intersecting challenges to their mental health and wellbeing, related to their daily lives and past and present experiences, some of which are common to different BAME groups in the UK, some of which are shared widely by many migrants, while others are very particular and represent further complexities, including those of gender and community. This research addresses a need to take a community focused and asset-based approach, in order to further understand specific experiences of people from two particularly disadvantaged communities, Black African women who were born outside of the UK and Roma men, and to develop context-rich insights for service development.

1.4   Report structure
The research and reporting was done in two phases. This report includes the data relating to Black women born outside of the UK, the sister report contains the data relating to Roma men.

An overall methodology is included, followed by findings – findings from the key stakeholders and the focus groups are presented together, due to substantial commonality in the themes emerging. The report concludes with some recommendations, offered modestly to build on other evidence, in what needs to be an ongoing, participatory engagement.

1.5   Timings
Individual interviews with representatives from VCOs were conducted between 29th May and 17th June with one exception of an interview taking place on 14th July. The focus groups took place between 1st and 7th July. Transcription and analysis was conducted immediately afterwards.

2 Methodology

2.1 Overall methodological approach

As the research was exploratory in nature, a qualitative approach was utilised. Two types of participant per phase, were to contribute:

- Five people who worked or volunteered at organisations in touch with the communities of interest were to be interviewed.
- Three focus groups, with people from the community of interest who had lived or direct experience of mental health problems, were to be held. These were to be organised via the voluntary groups involved in the interviews.

Ethical considerations

All participants received an information sheet detailing what the research was about and their contribution which was explained to them if they could not read English (appendix 1). This made clear that participation was voluntary and they could withdraw at any time. It explained their contribution was confidential and the recordings of the interviews and focus groups would not be played to anyone outside the research team. Consent was given verbally and recorded. Ethical approval was applied for and attained via the Leeds Beckett University Local Research Ethics Coordinator.

Selection criteria

The selection criteria for the focus groups were carefully considered. It was felt to be important that participants had some experience of mental health problems – either personally or via their family / friends – so that they could add insight to the issues being discussed. However, in order to not cause harm, we briefed the voluntary organisations who were recruiting participants to only include those who were *"able and well enough to contribute"* and, if they had had a mental health problem, they were in recovery. They were asked to exclude anyone especially vulnerable – for example, anyone who had been traumatised by their previous experiences. We made clear that participants would not be asked to discuss their own personal experiences but instead they would be asked to comment about the community as a whole (appendix 2).

All focus group participants received a £10 high street voucher as a thank you for their time and they were reimbursed any travel expenses. A Touchstone Community Development team member attended where possible. Information about available crisis support was developed by Touchstone and given to all focus group participants (appendix 3).

Interview and focus group schedules

The interviews with individuals working or volunteering at VCOs were conducted using a semi-structured schedule (appendix 4). This asked individuals about their organisation, perceptions of mental health problems in the community of interest, use of / barriers to mental health services and the potential role of the VCS.

The focus group schedule (appendix 5) was developed after considering feedback that participants may not be used to discussing mental health and wellbeing and may lack awareness of the language and terminology surrounding this issue. The schedule therefore started gently, asking participants about the issues their community faced and how these made people feel. The term mental health was only used after these initial conversations had taken place. An easy to understand definition was given (based on work done with Mind) with mental health being described as *"feeling well enough in their mind, so they can function at their best"* and a mental health problem being when *"someone feels unwell in their mind and is struggling to cope with every-day or normal life"*. Participants were asked to comment on how their community dealt with the issues facing them, interactions with GPs or Mental Health services and the role of voluntary organisations.

Showing a section of the film developed by Touchstone on the issue of Mental Health & Wellbeing was considered but was ultimately not used. This was because of the time limits for the focus groups plus the fact that most participants seemed able to understand Mental Health when it was described to them – albeit this is discussed in more detail in section 3.

Analysis

All interviews and focus groups were recorded. These were then transcribed and analysed thematically by the research team.

2.2 Interviews and focus groups

Interviews

Touchstone identified many VCOs that were likely to have contact with Black women born outside of the UK. Touchstone and the research team identified six key organisations to participate. All agreed to take part.

We conducted seven stakeholder interviews (see Table 1) with ten people. Six were one to one interviews whilst the one with Skyline included three people. All the individuals were working or volunteering in part at least with black women born outside the UK. Three voluntary organisations worked specifically with asylum seekers and refugees. The other four organisations worked with people from BAME backgrounds, many of whom originated from Africa – these may be asylum seekers or refugees but they could also have migrated for work or study.

Table 1: Interviews with VCOs (Black women born outside of the UK)

Number of participants	Organisation	Interview date
1	Solace	29th May
3	Skyline	1st June
1	Touchstone	1st June
1	RETAS	4th June
1	WAST	16th June
1	Health For All	17th June
1	City of Sanctuary	14th July

Interviews lasted between 20 and 40 minutes. Some of the individuals interviewed had worked for many years with the community of interest being studied, as such capturing all their years of experience in one interview was not possible.

Focus groups

The recruitment of focus groups participants was more challenging and took nearly seven weeks. After discussions with Touchstone, six organisations were contacted in relation to helping recruit women from the target community to take part in a discussion group. Of these six, three agreed to recruit women for a focus group but were unable to do so. Their feedback was that, despite having good, trusted relationships with the women, many were reluctant to talk about mental health. After repeated attempts with more organisations it was possible to recruit three focus groups with a total of 20 participants - see Table 2. Please note that some organisations were not contacted about recruiting for a focus group as it was agreed by Touchstone and Leeds Beckett that the women they were in contact with were likely to be too vulnerable.

Table 1: Focus groups with Black women born outside of the UK

Number of participants	Organisation	Focus group date	Notes
4	City of Sanctuary	1st July	Volunteers – but had also migrated themselves to the UK.
14	Skyline	2nd July	Support group for African women with HIV
2	Yorkshire Fullah	7th July	Support group for women from West Africa

The groups contained a diverse range of participants. The first contained women who had migrated to the UK themselves via the asylum / refugee process. They now worked as volunteers for other women in similar circumstances. They were very eloquent and able to describe other women's experiences as well as their

own. The second group also contained women who had migrated from Africa to the UK – some relatively recently, others up to 20 years previously. Some very actively participated in the discussion whilst others preferred to listen and observe. The last group only contained two people but both gave vivid accounts of their own and other's experiences.

All the groups were conducted in English – for many women this was their second language and at times they struggled to describe their thoughts and feelings fluently. This was particularly true in the second and third groups.

Whilst all the groups contributed greatly to the topic area the research team feel that data saturation was not reached. A wide variety of cultures and experiences falls under the category of Black women born outside of the UK – and to capture all of these in three focus groups is not possible. Common themes did however emerge and these will now be described.

3 Findings

In this section we have summarised the main themes emerging from the stakeholder interviews and focus groups with community members. We have combined their feedback as the themes emerging were broadly the same – any divergences are highlighted. We have used quotations extensively in order to give participants a direct voice and to illustrate the themes discussed.

Initially what participants said about mental health in general and the problems that exist in their community are presented. We then present the overall findings, organised into themes, in relation to the study's objectives, as follows:

- Risk factors relating to mental health
- Barriers to accessing mental health services and any gaps identified
- Factors protective of mental health
- Support available from VCS and the reach and acceptability of this support
- Gaps, examples of best practice and recommendations for improvement

3.1   Mental health & wellbeing and the presence of stigma

Mental health problems in the community appeared common. Focus group participants talked about isolation or loneliness, depression, stress, trauma and feeling suicidal. These problems were especially severe amongst asylum seekers and refugees. One stakeholder said that all the female asylum seekers she worked with had mental health problems.   Others said they saw a lot of post-traumatic stress disorder.

> *"It's not easy, it's very hard, because if you don't speak the language it's very hard. It's my first time in England, is very very very hard for me, I cried for one month … "* ... *"In 2013 the Home Office, she take me the details, I take, I want to kill myself because it's very hard for me."* (FG3)[3]

Gender affected participant's experiences of mental health problems. Focus group participants felt men and women experienced similar amounts of mental health problems, as the causes were similar; *"men, they get stressed … also men can get lonely"* (FG2). However they felt that African men were more likely to bottle their problems up and not talk about them, partly due to pride;

> *"They don't want to be weak or be noticed as weak, but I would say they can suffer from depression more than we do because, or mentally, or whatever it is, or they end up just falling off a bridge. They always bottle it up. … Yeah, and then after some time, then it explodes, and when it explodes, that's when they kill themselves."* (FG2)

Women, it was felt, were both more likely to talk about their problems, and have more opportunities to do so – via, groups orientated around children for example. In addition it was felt that women tended to have a more defined role than men – as they had children and the house to look after. Male refugees and asylum seekers especially, lacked a clear role as they are unable to work. Participants felt this could lead to them become frustrated, potentially behaving in a controlling way towards women (for example, forbidding them to leave the house) and domestic violence.

Stigma towards mental health problems within the community emerged as a theme from the majority of interviews and focus groups. Participants talked about how mental health problems were not acknowledged or openly discussed. One participant, relating how her sister had suffered from postnatal depression, said *"if we explain that to our parents they will say, women have to pick themselves up together and get on with the job."* (FG2)

Having a mental health problem was associated with extreme behaviour and being 'crazy';
> *'..when you tell them that maybe you have a problem, you become enemy because what we know a mental person…is throw stones, he's crazy, he's doing all sorts of funny things, holding in the chains, put in the hospital – that is what we know as mental.'* (P5)

It was associated with being evil or possessed;

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[3] FG = focus group, P = Participant in stakeholder interviews

'…it's been a taboo, it's a no, you're crazy, you're mad, you need a witch doctor' (FG2)

'I think it is because, in our culture, we thought that, if somebody's got a mental health problem, we say he has been witched. … Or demonic possessed.' (FG2)

There was a fear or being labelled by or ostracised from the community;

"They don't want to say it to somebody who is from the same community because they afraid of being stigmatized or ostracised, they say, she is weak, or she is hanging her linen in the public, so they tend not to talk about, their problems, their mental issues, with people who are from the same society" (FG1)

Whilst this was a common theme, it must be noted, that there was some disagreement. Some focus group participants felt that times were changing and people (both in the UK community and in Africa) were becoming more accepting of mental health problems - often from knowing someone who was suffering;

'No, I think we have changed, with development, with medication, with the mental health hospitals, you know, even in the community, we know there is somebody who in that house, who is like this, who is…. That used to happen, it's very true, you would run away, you would do whatever, you know that was it, but it has changed'. (FG2)

One participant strongly denied that people were ostracised because of a mental health problem – feeling instead that the issue was people not having the capacity to deal both with their own and somebody else's problems;

'If you are facing though some difficulty and you realise that other person's facing a similar thing, you try to, tend to try and help, but then yourself as a person has a lot to deal with …being stressed about that other person, being worried about that other person all the time, erm, especially if you think that they're more vulnerable than yourself. I've heard other women talking about different communities that they would push away people with mental, just erm, problems but I don't think it's true with every community. I'm sure there are people who are willing to help.' (FG1)

The stakeholders particularly felt that people in the community did not perceive mental health in the way it was conceptualised by providers of mental health services in the UK. One stakeholder explained that in African culture there is no concept of mental health, only of mental illness:

'The definition you give to mental health in this country is not the same in Africa because in our culture saying that someone is going to, got a mental health issue is like the person is mad already.' (P4)

This is echoed by a focus group participant who found the concept of positive mental health in the UK very different from attitudes in her home country;

'If you are from Zimbabwe, they say, that girl has got mental health, people think you going crazy, it's just something that's not accepted, in an African community. I'll speak for my own world, home country, Zimbabwe, they say, that girl has got mental health issues, they think it's that person who goes outside and pick up papers… you see it's all just, it's true, it's all discriminating, I think, I don't know, they look at you just like you a person who's gone crazy, mental health is something completely different from what you define in England.' (FG2)

Stakeholders felt that the terminology used by UK services, in regards to mental health, often appeared unfamiliar to community members, who may lack the words to describe how they are feeling in their own language.

3.2   Risk factors for mental health problems

All respondents spoke at length about the many factors that put Black women born outside of the UK at risk of mental health problems. Some relate generally to living in a new country and a different culture leading to women feeling isolated, lonely and alienated – these are discussed first. Other risk factors relate specifically

to the refugee or asylum seeking process and the fear, disorientation and trauma associated with this. These are discussed second.

An inability to fluently speak the English **language** emerged as a key risk factor. This affected a new arrival's ability to interact with others, live a normal life (e.g. buy a bus ticket) and engage with services.;

> "They feel unhappy, because, as I said, the main thing is the language barrier if you come to a new country that you can't speak the language that's a big challenge, that's big mental health, because you aren't able to communicate, even if you want something, how could you explain and try to analyse so they can understand, so that's big impact." (FG3)

Some talked about approaching strangers in the street who looked like they came from their home country, in the hope they could speak in their own language and being very downcast to discover they could not.

Being able to discuss feelings in a language they are not fluent in is especially hard. One participant, who had been living in England for 15 years, spoke about this difficulty when she first arrived;

> "I found it hard, to express my emotions in a different language, I've had to go and read books to understand emotional language, to be able to explain that, to a counselor, when I had been referred to a counselor for example, I just found it very very difficult." (FG2)

The very **different culture** in England as opposed to Africa was discussed at length. Participants described how in African countries people lived in a more communal way, with neighbours and even strangers interacting far more *"supporting you or listening to you"* (FG2). People did not hesitate to, for example, assist with their neighbour's children or to move in with someone if they had been bereaved *"unlike back home, you mingle with people even if you are not related to them" (FG2).* The nuclear family based system in the UK was clearly a shock to many participants who felt sad about this way of living, feeling it led to loneliness and isolation;

> "Sometimes it's depressing … that people don't want to go out, they just want to stay in, you know, and then, the other issue that people can face you know, in Africa, people are friendly … you know your neighbor, you can stay outside, play, but for here, you know, you just go inside and close your door, even sometimes your neighbor, you can't see your neighbor, you can't even know. So that's another challenge as well, for us, we're not used to tha.t" (FG3)

> "Many people just lock themselves up in their houses and do whatever they are doing, I think that's a very big issue with coming from where we come from … we grew up respecting and loving everybody, but here it's a little bit difficult, so that isolation is a culture shock." (FG2)

Poverty – and being stuck in either low skilled jobs or in poor housing – was also identified as a risk factor;

> "they are generally you know just fed up, you know, cause they have you know limited budget and you know the money doesn't go round enough…it's more general feelings they have, living on low incomes, and poor housing, things like that.' (P3)

Refugees / asylum seekers suffer from 'layers' of issues that put them under severe mental and physical strain. These include the traumatic circumstances that had led to them seeking asylum and the process of claiming asylum. They were also often concerned about the people they may have left behind. The fact they were unable to work left them feeling dependent and not valued. Throughout these discussions fear emerged as a strong theme - participants talked about being fearful of being deported or detained, fearful of domestic abuse and fear of or for their family back home. In addition, to all this was the uncertainty they lived under, not knowing what the outcome of their claim would be.

> "[lots of people]…go through torture and they seen bad things in their country and been yeah…the system itself, having the asylum process itself…. just increases their mental health because they go through trauma and when they come yeah, without adequate support people facing isolation that can only increase the problem they had before." (P4)

Past experiences clearly still impacted on participants. Women may have experienced a range of ordeals including torture, rape and death of loved ones plus a potentially hazardous journey to get to the UK. A volunteer working with asylum seekers, felt that untangling everything that had happened to them 'takes years' even with the right support.

> *"The issue she got with erm the past (…) so all the time is really really affecting them, even though they feel happy, settled, even though they got everything here, still she feel that kind of scared."* (FG1)

The exact circumstances surrounding individuals own journeys was not discussed however it emerged that participants' families back in their own home country were a source of concern. Some were worried for their families, others were scared of them finding out where they were;

> *"All the time they got a kind of fear, so they worried maybe somebody from their country, they know they are here, they're gonna tell their husband or their families you know, all the time .. so all the time she says, please don't say that, don't tell that, you know…"* (FG1)

> *"if I left my children there, [the woman is thinking] I don't know next time they are eating, I don't know when I will re-join my family."* (P5)

The asylum process causes its own trauma. Participants spoke about being housed in a prison like immigration centre on arrival and, even when they were living in the community, being continually afraid of being detained or deported. One stakeholder described the four 'Ds' of the asylum process to illustrate the strain it puts people under;

> *"Asylum seekers, they are fleeing in fear of their lives, so they've left persecution of some sort, so that will impact on their mental health, and that could be a variety of things. But, then, there's evidence that shows that going through the asylum system here makes it, mental health worse, and there's quite a lot of evidence on that. And I think there's different reasons why, one being because of the living in limbo, because it takes so long for decisions to actually be made, and people can't move on. And then there's, we call them four Ds, of four key things that will, that going through the process impact on people. The first one is dispersal….destitution is the second one, then detention and deportation.' (P10)*

Some stories relayed by stakeholders illustrate how traumatic this time can be;

> '*[one woman] was dawn raided, and the daughter separated from her, all these armed guards taking her, others taking the daughter, for a whole week in detention, not allowed to touch or be near her daughter, who was 18 months. And actually then, taken to the airport, to be deported, and at the airport the solicitor managed to intervene and stop the deportation. And then, then, having kept her in this prison, it's a prison, detention.' (P10)*

The same stakeholder went on to explain that if people have their claim for asylum refused and have no children, they are left destitute. She described how she had helped *"one woman who was up to 38 weeks pregnant, destitute, on our streets, of Leeds".* Another woman she worked with described how "*sometimes I have to sleep with men to get a bed for the night."*

The **uncertainty** people live under, whilst going through the asylum process, were seen as having a very negative impact on their wellbeing. Many wait years before getting a decision re their asylum claim (one example was a woman who waited over 12 years). During this time they are 'living in limbo', unable to work and not knowing what the future holds. One participant talked about how waiting for their status to be confirmed by the Home Office meant women wasted years of their life;

> *"It's like this er uncertainty people have, that they are actually, like think that when the letter arrives, their life is going to start, they don't realise this is their life now, so they wait for their life to start, to do something, cos they think when I get my papers, my status I could work, or study or do something else, so they think like they are actually living in just like in a dream and they are going to wake up one day and do it, but these people especially they tend to go like that for years because the process can take for years, but when the time comes and the letter arrives, they don't have the passion anymore to do anything."* (FG1)

Being unable to use their skills and abilities was often mentioned, leading people to feel 'useless' and not valued. In addition, feeling controlled and regulated by the government emerged – an often used example was not being able to buy their traditional food as they had to shop at defined venues using the vouchers they were given, rather than money.

Being dispersed to a new location or city clearly led to refugees or asylum seekers feeling very **disorientated**. They describe arriving in a strange city with few or no contacts and not knowing where the key services are, or how to access them. This led to many feeling 'stuck at home' and isolated. This was exacerbated if they had no cash in order to use public transport, for example.

> *"Sometimes you're just dispersed into a house, given some contact numbers and you don't have credit on your phone, so those people stay stuck at home."* (FG1)

The role of **male partners** was mentioned both generally and in relation to asylum seekers / refugees. Several respondents talked about how the mental health of women can be negatively affected by the male dominated cultures they come from, where men may not allow their wives to go out without them. Participants in the first focus group discussed the negative impact this had on mental health;

> *"She feel like more controlled, can't do, like things that make her happy, she and her kids, so she's feel like only the way she can enjoy her life, only in her house, she can't go anywhere, so this kinds is make women feel uncomfortable, anxiety, domestic abuse, so even kids get affected and sometime women can like hurt herself you know, by suicide, or do something say, I don't have family, I don't have friends where to go, I don't know anywhere to go, so is make her life shorter and more depressed."* (FG1)

The issue of **domestic abuse** was raised a number of times – both specifically for refuges / asylum seekers and more generally for Black women born outside of the UK. One stakeholder said that in her experience 50% of women asylum seekers were suffering domestic violence. It was felt that the stress male asylum seekers are under could lead to them being violent towards their wives. Exacerbating this situation was that the women either do not know about, or do not have the right to use services that may be able to help them - if for example they are here on their husband's visa or have been refused asylum.

Overall therefore, a multitude of damaging risk factors for mental health problems exist, that vary depending on exact circumstances. Being isolated and a feeling of not belonging affect many, whilst for refugees and asylum seekers fear, disorientation and low self-worth dominate. Stakeholders clearly felt that it would be surprising if women facing these circumstances did not have a mental health problem.

3.3 Barriers to accessing mental health services

A range of barriers to accessing mental health services was identified in both the stakeholder interviews and focus groups. The first category relate to the culture, attitudes and understanding within the community of Black women not born in the UK. The second relate to how services are provided and perceived.

One of the biggest barriers identified was that Black women born outside of the UK either **did not acknowledge they had a problem** or were not used to seeking support or help for it from services;

> *"Sometimes when we get these kind of problems, we are in denial ourselves, and so we don't open up, and we don't attempt to take to, go for help, until the situation gets worse (…) so I think it's not to really up to the doctors or nurses to say, it's up to us."* (FG2)

> *"I guess, people find it kind of weird that you go to someone to talk to, as well, if they're not used to erm, experienced it before."* (FG2)

This denial or refusal to ask for help partly relates to the issue of stigma discussed earlier, as one stakeholder said mental health is "*just not mentioned….people haven't disclosed or spoken about it' (P3)*. Many, even if under great stress, may just see it as 'life' and not something they can do anything about or get help with.

Language or terminology also impacted on women's ability to express themselves (see section 3.2);

"I'm working with [a woman] who for long time we knew that she was going through a mental health crisis but she hadn't identified it herself. But then when she did, I think sometimes the health facility, the GPs are not very helpful sometimes and probably because of language barrier and the culture.' (P2)

Fear of engaging with services also emerged. This may relate broadly to a fear of authority (perhaps based on negative experiences in their home country) or, more often mentioned, a fear that divulging a mental health problem and / or their personal circumstances would reach the Home Office (affecting their status), their employer (affecting their work) or social services (affecting their parental rights).

"They also maybe don't want to put their, they don't want to come in contact with authority because of poor experience around authority." (P2)

"Yeah, because of who you are, your status, you are not a citizen, you are illegal, you are scared to expose yourself, this is they take your details, they will get you and deport you. Yeah that was what kept me away, I was scared, honestly, so that is true." (FG2)

"The mothers with children especially, they are scared that if they tell you they are having problems, and it's affecting their mental, they think you are going to tell the social service to come and take their children." (FG1)

In one focus group whether or not your medical records (of a mental health problem) would be provided to a prospective employer was discussed at length;

"The moment I mention I am a little bit stressed, the GP is putting it in my notes, my employer will know about it, and they won't employ me." (FG2)

Being used to **putting themselves, as women, second**, also emerged - perhaps leading to them not asking for help. As one stakeholder said, as a woman you would be;
"Quite happy to put yourself second 'cause that's probably what you've been doing for a long time.' (P2)

"The kind of culture they are born in that they are not supposed to be on the front line to talk about themselves....they are not allowed to talk in public, they are just for the kitchen." (P5)

A **lack of awareness of their rights to access services** for free emerged. Many will have come from countries where services cost and were limited or non-existent in relation to mental health; *'they might come from culture or countries where they don't have the same rights' (P3).* For destitute women refused asylum these fears are well placed as one stakeholder pointed out they are no longer entitled to free services. This may also be the case for some migrant women here temporarily.

Perceptions of doctors or mental health services were mixed. Some participants related positive experiences of caring doctors and being referred to counseling, but in general there was a perception that they lacked the time to discuss mental health problems and tended to rely on prescriptions;

"The doctors, I think the only thing they do, because they, especially now, in most of the GPs surgeries you only get like 5 minute appointments, and as soon as you go in the doctor is already printing out the anti-depressants. (laughter) And the paracetamol. Because you about to tell him and he already, okay take this, come back in two or three weeks." (FG1)

Being sceptical of their story also emerged. In general, communicating with doctors was felt to be difficult – partly because of the patient not being able or used to expressing their feelings and partly because of doctor's attitudes and their lack of time;

"The way (a woman client) speaks to me is that nobody's listening to her and she can't explain to people; she can't explain to a doctor and the doctor's fobbing her off. There are lots of things going on; she has a lot of issues since she's been in this country and she do need help, but going to a GP

and trying to think the GP's just fobbing her off and she feels that she's not, maybe she's not explaining herself properly.' (P6)

The **cost of prescriptions** was an issue for those on low paid or zero hours contracts;

"Some people will be deterred by the cost, because some people, oh, I can't keep going to the doctors because the prescriptions will be so much and I work for the agency, this week I didn't get any shifts so I don't have the money, so that problem can deter people from going to the doctors." (FG2)

Other barriers to accessing mental health services included; having to wait a long time to get an appointment, lack of transport to get to appointments, the service not being appropriate/friendly and appointments given at times they could not attend because of child-care. Several stakeholders made more general comments about some of the issues underlying these barriers, including cuts to already limited mental health services, a target culture, lack of outreach services and a failure of primary care to engage with the VCS and make and accept referrals.

3.4   Protective factors

This topic was discussed less than others but flowing through the interviews and focus groups was a need for these women to be **connected** to others in the community.

"I know everybody there [at the support group]…and even if I don't come, they say 'what happened'? So you connect. Before I have a family…that is one of the best things…connecting with people.' (P5)

"I live, we lived in (name of North Eastern city), yeah, so we have one church, big room, every Wednesday, the person go there, you eat, drink or talk, the same language, the same problem, sometimes you forget your problem." (FG3)

Faith and church did emerge regularly as a source of comfort for the women – somewhere they felt able to engage with others. Spirituality was clearly very important for some – one woman related how she did not go to church for many years as she struggled with the English way of worshipping. When she went again to an African church she felt an "emotional buzz … *I felt what I was missing over 35 years ago, where I came from"* (FG2)

The women needed to be able to develop **trusted relationships** that meant they felt comfortable talking about their situation;

"Could be a friend, like the befriender (name) we had before. He was a befriender, but most of these befrienders, they become their client's friends, so yeah, it was very much like a process of trust with them and … when they actually feel comfortable enough to open up about this kind of problems, because, before, no." (FG1)

The importance of **being active** was also stressed – though it was recognised that those seeking asylum are not allowed to work and lack the resources to be active;

"Well, we talk a lot about support but the real support..is people should get working, get active, help themselves, help their family – that is the best support you can ever have." (P5)

One participant strongly advocated **volunteering** – which recently became something refugees and asylum seekers can do. She felt being a volunteer helped raise morale and build self-esteem and confidence;

"I think they encourage people to volunteer, it does make a huge difference, because people actually feels useful, they feel empowered and they feel they actually can do something else, even though they not getting paid or anything like that, but they actually feel able to do, to help others and I think that's a very strong tool, to get people out, and even take control of their lives .. because some people when they come, they have no vision of what they want to do in their lives, but one day they start doing volunteer, they just, it's like the doors just opened." (FG1)

Much of the work the voluntary, community and faith sectors are doing is aimed at providing activities and enabling people to connect, in order to promote and protect their mental health, as we describe in the next section.

3.5 Voluntary and Community Sector (VCS) support

The support offered by VCOs is clearly critical for many Black women born outside of the UK. They offer services relating specifically to mental health including; counseling, therapy, stress management, group activities, preventative sessions and support/advocacy to access statutory services. In addition they offer practical help and support, provide a welcome and help orientate people – thus reducing feelings of loneliness and alienation. Their unique position means they are able to build connections, trust and help increase a sense of belonging. Key elements of their role, as identified by participants are:

- Being well connected to the communities they seek to serve, having good relationships with them and being trusted by them
- Involving members of the communities they work with, i.e. a peer led approach
- Providing services that are accessible to those communities – in terms of geography, language and approachability
- Practical support and signposting

Connected to communities

Working with communities on the things that matter to them was seen as important;

> *"…it's important for those organisations to work closely with communities and try to identify the needs and do that with them, not for them. Because you try to say okay this is what I'm offering you, is that really what I need, I'm not sure. But having conversations with me trying to do that with me, that would help you to….and I would understand why you are trying to do it for me…'*(P4)

This approach relies on building relationships of trust with communities, which is not only vital to enable women to use their services but also to access statutory provision:

> *"Because they built the trust with us first and then they know that maybe we're the ones who could then refer them on to, especially mental health, and I do think a lot of them don't have faith in their GPs.'* (P6)

Another interviewee also expressed the view that black migrant women may not trust their GPs, and may feel intimidated trying to access help, partly because of language issues;

> *"The way you present yourself, if you're all {official}, people will feel intimidated and straight away they will just fall away….and you won't be able to offer the support you want to give them...and also the language. When people go to GPs, what do they say? You know asking for help sometimes can be the most difficult and if they don't have a relationship…then if you don't see the same person all the time as well, which is really common in GP surgeries and also in their hospital appointment experience, you know there's no trust there, there's no building of trust.'* (P2)

Because they are not seen as the 'authority', can talk to women in their own language, and work with them over a long period, voluntary sector organisations are able to build the trust necessary for women to open up about their mental health problems.

Peer support

There was an emphasis on involving people from the communities they wished to serve in the delivery of activities – both as volunteers and paid workers. This peer approach was seen as vital to building trust and offering an accessible, appropriate and effective service:

> *"The peers, because we had asylum seekers and refugees helping others, they listened to them, messages get through in ways it doesn't get through when it's white middle class people telling you."* (P10)

"I think peer-led organisations are always powerful you know, so if it was, if it employed women who's gone through the migrant, being migrant and also having a mental health issue, if they had the experience…..it is powerful for people to hear and see that people in organisations are like them.' (P2)

As noted in section 3.4, this approach also benefits those who are volunteering - gaining a sense of self-worth and building their own confidence and connections.

Accessible services

Voluntary sector organisations are often more approachable than statutory services - with people who look like you, understand your culture and speak your language.

Stakeholders stressed the importance of providing a 'safe space' for women with a variety of activities which were not directly related to mental health but which could do a lot to promote it. They emphasised the importance of approaching mental health sensitively and avoiding labels which could be seen as stigmatising. So for example one agency offers sessions on improving self-esteem – which whilst clearly related to mental health are not advertised as such.

One volunteer and asylum seeker emphasised the importance of providing activities that everyone could join in with – and were not always just about talking.

"I think personally that physical activities make these groups a lot more inclusive, because they get you to move and you always have a laugh, and this, I think this is quite a, the impact is a lot better than just sitting." (FG1)

She described how dance classes reduced anxiety and how women's football had led one depressed woman to really engage for the first time;

"She was really angry, but once she started playing, she was just laughing and when I saw her I can't believe she's laughing because everybody knows here and she doesn't talk to anyone, but it was really incredible for me." (FG1)

Practical support

A key positive aspect of the support offered by VCOs was its broad nature and its practicality. They are able to help women with the huge social and economic problems they may have and need to start addressing before they are able to benefit from counseling for example. One woman relayed how a community group had helped her with housing and food;

"The community help more than the doctor, I think (…) because each community he help anywhere, if there is a problem like food, problem the house, problem the, before I came in Leeds, I don't have a GP, I don't have a doctor, nothing, I go to church for this, they help me for doctor, they help me for dentist … they will help you so you know your way around." (FG3)

The welcome provided by some voluntary community organisations helped orientate women and started the process of connecting them to others.

The overall sense from this initial research is that VCOs offer vital services for women who are often in great need of support to build and protect their mental health. Their offering is distinct from statutory services, for the reasons stated above, but they are also able to support women in accessing statutory services where necessary.

The issue of a lack of funding was raised. One example of this was of a befriending service that supported refugees or asylum seekers when they were dispersed into the community which had to close through lack of funding. Whilst it was not a specific 'mental health service' it played a vital role in helping new arrivals negotiate their way in a new country and thus protect their mental health.

4   Improvements and best practice

This section will discuss areas where the mental health support for Black women born outside of the UK could be improved. Topics covered include; raising the awareness of mental health problems in the community, provided targeted support at key life moments, referrals, community activities and improvements to mental health services.

Raising awareness of mental health problems was felt by focus group participants to be crucial. By educating people in the community and normalising talking about mental health problems people would be encouraged to seek help when they may need it;

> *"Education, let's talk about it. Let's talk about it. You know, let it be an open book, so once people get to know that people can normalise and be signposted into different places. (…) Because we are not talking about it, that is why people live in denial."* (FG2)

It was felt that outreach was essential i.e. going into workplaces and churches – wherever people congregate. Such an approach, using *"community leaders, pastors, mothers, fathers, schools"* would, it was felt, lead to the messages spreading across the community. People needed to know how to identify the warning signs – just as they were being educated about those for diabetes or cancer.

> *"I mean our prevention team go and speak to firstly with some community leaders, why doesn't someone, why isn't someone doing that job with those people too around mental health needs of migrant women? Where the migrant women go…so it would be the churches, you know that sort of thing…shops and schools, hairdressers. Migrants will always go to the same shop to buy meat so there are shops there, markets and stalls, why aren't there people trying to advertise these services there?'* (P2)

Community and voluntary organisations were seen as being in an ideal position to spread these messages (for reasons discussed in section 3.5) whilst the onus was on doctors to bring up the topic during appointments.

A parallel was drawn with HIV – a condition that faces similar issues in terms of denial and lack of acknowledgement in the community. By proactively talking and educating people about the condition one community / voluntary group felt it had been successful in helping tackle the silence surrounding it.

Targeted support at critical life moments
Participants thought there was scope to offer support at critical points in the asylum seeker, refugee and migrant journey, which could prevent problems at a later stage;

> *"I mean one woman said to me today when I said to her about it, and she said to me, she had a terrible experience getting to this country and she, and she said when she got to this country, there was no help whatsoever to begin with and she said what she would've liked, to succeed is at the first port of call, that they have access to a GP, a doctor, and that was the first thing she said.'* (P6)

The point was made by one respondent that help with mental health issues is needed before people newly arrived in the country can made any progress with education or employment.

The support offered by befrienders (volunteers who had also been through the refugee / asylum process) was felt to be absolutely critical – and unique in its ability to help connect people and build trust;

> *"We bring (the befriender) to women and asylum seekers and we are helping giving different services for them, go with GP, so we try to match people as my friend says, we try to match people they are speaking the same languages so to stop that barrier of language, or go with them like, show them Leeds."* (FG1)

Any organisation or individual offering such support needed to be trusted by the individual – as often they thought they were *"the Home Office sent to spy"* (FG1). This emphasises the importance of building up a relationship over time and providing the support in an appropriate manner.

Referrals

Participants felt that referrals between GPs / Mental Health Services and voluntary sector organisations needed to increase - with greater integration between the sectors. One stakeholder felt that GPs were slow, or reluctant, to refer to them, despite what they were able to offer in terms of support ;

> *"I don't think I have ever had a referral from a GP…..I've tried in the past to give leaflets to the GP surgeries and you're not allowed.' (P6)*

One example of best practice was a nurse at a voluntary organisation that offered initial assessments to newly arrived people, to check they were okay. She would refer on to mental health services or other organisations if necessary.

Community activities

The need for community based activities, which bring people together plus befriending and advocacy support came across strongly.

Activities, irrespective of the focus, help to connect people and promote the realisation that other people may be facing similar problems – both important protective factors. A range of activities were praised including women getting together to cook and eat, social occasions (such as church) and physical activity groups (section 3.5). Such activities can help women who may be stuck at home to broaden their horizons;

> *"Even the short trips, like to the places, that is out of Leeds, like maybe Yorkshire Dales of wherever, one woman she say, oh my god, I didn't know that even in England there is a place like this, because she said, every time she is in her house and they are going out to, she felt like she is a person again, she can interact and walk without any restrictions… here I see everybody free, walking this direction, walking that direction." (FG2)*

Working with traditional sources of support, like churches, so that they react appropriately to mental health issues was recommended;

> *"It's not just working directly with the women, it's also going to sources of traditional support that these women would access to try and normalise it [mental health problems] in all areas of their lives."(P2)*

One group of volunteers felt that mixed groups should be encouraged – for example, male and female groups and mixed cultures / ethnicities. She felt this would encourage people to realise their similarities and promote the integration that would help people live more harmoniously in the future;

P1 & P2 from FG1

> *"I think, for our integration, if you want to live in a society where is so many different cultures, you have to learn how to integrate with them, how to interact, what they think, things like that, so you feel more comfortable to just out and do stuff with them, and you know how to talk to this, to this different types of people."*

> *"I think it should be broader. I've only been in the UK the last three years but I've noticed that each community is just grouped differently, without having any connections, and it would be nice, yes, we all have our differences, but I think we have lots of similarities…it would be nice if people mixed a little bit, really nice."*

Encouraging volunteering was also felt to be beneficial – see section 3.4.

Improvements to mental health services

Whilst individuals' interactions with mental health services were not discussed as respondents did not necessarily have any experience of these, they felt that GPs could improve how they interact with Black women born outside of the UK when they presented with mental health issues. Providing language support/interpretation was seen as important as was the approach taken – it was felt GPs needed to adopt a friendlier persona and give people the opportunity to talk and open up. Understanding more about the barriers Black women born outside of the UK may face in engaging with services and helping them with terminology, rather than just prescribing medication, also came across as important.

5 Conclusion and recommendations

Although only small this qualitative study has gathered valuable data about how mental health is perceived by Black women who were not born in the UK and how mental illness is stigmatised. Whilst mental health issues are generally not talked about the evidence gathered here is that they are very widespread in this community and closely linked to poverty and the role of women in male dominated communities. The stress of migration, living in a foreign country and the asylum process add considerably to pressures on mental health.

Cultural issues and stigma act as barriers to seeking help for mental health problems but many women also experienced barriers in the way their GPs responded to them when they sought help. VCOs play a vital role in raising awareness, advocating for women and in some cases offering mental health support. Crucially they provide a safe haven for many women where they can connect with people in a similar situation, find friendship and a feeling of community, take part in a variety of activities and in some cases get involved as volunteers themselves.

Recommendations
1. Continue to raise awareness of mental health problems to reduce stigma, using trusted individuals and organisations.
2. Provide support at critical life moments. Peer support is ideally placed to do this.
3. Provide opportunities for new arrivals to learn to speak English, including around emotional issues.
4. Encourage greater interaction between GPs, mental health services and VCOs.
5. Improve awareness among GPs and mental health services of the types of issues this community may face and the barriers to accessing services that they experience.
6. Support appropriate, community led activities that help people to connect and build relationships
7. Implement appropriate funding models which support VCOs' role in improving the mental health problems of this community and others

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7 Appendices

Appendix 1: Participant Information Sheet – reformatted for the report)

Improving the Mental Health and Wellbeing of Black women born outside of the UK

You are being invited to take part in a research study. Before you decide whether you would like to talk to us please take the time to read this information carefully.

Leeds Beckett University have been commissioned to explore how community and voluntary organisations can help improve the Mental Health & Wellbeing of Black women, born outside of the UK, now living in Leeds.

We would like to invite you to take part in an informal group (with about 5 to 8 people) discussion lasting about 1 hour. This will take place at a time and in a place convenient to the group. To thank you for your time you will receive a £10 High Street voucher and refreshments will be provided.

What will we be talking about?

We will be talking about how community / voluntary organisations could help Black women born outside of the UK be prevented from developing a mental health problem and what may help aid their recovery. You will not be asked to discuss your personal experiences of mental health problems.

Please ensure that you feel able and well enough to take part in a group discussion about mental health problems in this particular community.

Do I have to take part?

No – taking part is entirely voluntary. You have the right to stop taking part in the research at any point and you do not have to give a reason why. If you change your mind about taking part afterwards, you can withdraw what you have said up until the point at which we have started to analyse the findings – after that it becomes difficult to separate everything out.

If you do decide to take part we will ask you to consent either verbally or in writing.

What will happen to the information you give us?

With the group's agreement we would like to tape record the discussion so we can remember everything that is said.

We may use some of the things that you say and write them in reports but your personal details will be kept private – your name will not be used at any point.

All recordings, notes and information that you provide will be stored securely. Paper copies will also be stored in a locked filing cabinet at Leeds Beckett University.

We hope that the research will eventually be published in articles and reports and presented at conferences.

Thank you for taking the time to read this information sheet. We look forward to meeting you very soon.

If you have a concern about any aspect of this research you should ask to speak to the researchers who will do their best to answer your questions. If you remain unhappy and wish to speak to someone independent from the study, you can do this through Dr Diane Lowcock, Faculty of Health & Social Sciences (email: d.lowcock@leedsbeckett.ac.uk).

Contact us

If you wish to contact one of the research team, please do not hesitate to get in touch with:

Jenny Woodward
Research Fellow
Centre for Health Promotion Research
Tel: 0113 812 5856
email: j.l.woodward@leedsbeckett.ac.uk

or

Karina Kinsella
Research Assistant
Centre for Health Promotion Research
Tel: 0113 812 7651
email: k.kinsella@leedsbeckett.ac.uk

Appendix 2: Recruitment letter to Voluntary Sector Organisations

Improving the Mental Health and Wellbeing of Black women born outside of the UK

Dear *(name of voluntary / community organisation),*

We understand you work closely with Black women born outside of the UK who now live in Leeds. We are conducting a research project into how the mental health and wellbeing of this particular group could be improved. We want to find out how the community and voluntary sector may be able to help prevent mental health problems and aid recovery from them.

We would be grateful if you would take the time to talk to us about this research and potentially be involved. If you could contact me at k.kinsella@leedsbeckett.ac.uk or by telephoning me on 0113 8127651 by Friday 22nd May I'd be very grateful. More details about the project are provided below.

Who is conducting the research?
The Centre for Health Promotion Research at Leeds Beckett University is conducting this research. Judy White, Jenny Woodward, Dr Mark Robinson and Karina Kinsella will be the key people involved. We all have lots of experience of undertaking health research with community / voluntary organisations and always work hard to ensure any disruption is kept to a minimum and that professional standards are maintained. Touchstone Support and Leeds City Council have asked us to do this research.

Why are we interested in Black women born outside of the UK specifically?
There is evidence to suggest that this group suffer more from mental health problems than average. We want to find out why that might be and what could be done in the community / voluntary sector to help them.

What would taking part involve?
Professionals / Volunteers
We would like to interview some key individuals who work or volunteer at (name of organisation) for about half an hour who have an insight into this topic. The interviews will take place at a time and date convenient to them, either face to face or by telephone. We would explore with them risk and protective factors for positive health and wellbeing, what is currently available for them in the community / voluntary sector in Leeds and what ideally would be.

People with lived or direct experience of mental health problems
We'd also ask you to help us recruit some Black women, born outside of the UK, to take part in a focus group. These would be people who have some lived or direct experience of mental health problems (or their families, friends or carers) but are in recovery.

Please ensure that anyone invited is able and well enough to take part in a group discussion on this topic. They will not be asked to discuss their personal experiences of mental health problems. We will ask them to comment on how community / voluntary organisations could help other Black women be prevented from developing a mental health problem and what may help aid their recovery. They would receive a £10 voucher as a thank you.

This project has been approved by the Leeds Beckett University ethics process. More information on this is attached - please be assured that we'd only progress with the interviews or focus groups if informed consent is given. Findings will be made anonymous. We would work closely with your organisation to ensure the safety and wellbeing of anybody who wish to take part.

Kind regards,
Karina Kinsella
Research Assistant

Appendix 3: Crisis Support Services

List of Mental Health Emergency/Crisis Support Services
Produced by: Samantha Powell – Touchstone Community Development Service
samanthap@touchstonesupport.org.uk 0113 2484 880

Telephone Phone Support

Connect Helpline
What it is:
- Connect is a telephone helpline open 6-10.30pm every night of the year when many other services are closed for people living in Leeds.
- Connect supports people in crisis, as well as providing a preventative service, by supporting people before they reach crisis point.

Who it is for:
- Connect Helpline is here for anyone living in Leeds who needs someone to talk to.
- The service provides emotional support and information for people in distress.
- People can ring who are in crisis, anxious, depressed or lonely.
- Provides emotional support to people who are carers.

What they do:
- Connect Helpline can offer you support and information.
- We can offer you someone who will not judge you but listen with warmth, acceptance and understanding
- Information about other support services and services for carers.
- A confidential service – we won't tell anyone else about your call unless you ask us to – except in exceptional circumstances.
- We're open when many other services are closed.

How to contact:
- **0808 800 1212**
- We're open from 6pm – 10.30pm every day of the year

Samaritans
What it is:
- Available 24 hours a day to provide confidential emotional support for people who are experiencing feelings of distress, despair or suicidal thoughts.

Who it is for:
- Anyone

What they do:
- Talk to us any time you like, in your own way, and off the record – about whatever's getting to you.
- Know a lot about what can help you through tough times. We can help you explore your options, understand your problems better, or just be there to listen.

How to contact:
- 08457 909090

Drop in Support Services

Dial House – see additional sheet for frequently asked questions
What it is:
- Dial House is a place of sanctuary open 6pm–2am Friday, Saturday, Sunday, Monday and Wednesday Evenings.

Who it is for:
- Anyone in crisis

What do they do:
- Visitors can relax in a homely environment in complete confidence.
- Visitor do not need to use their real names if there would prefer not to.
- Dial House is a place of sanctuary, if visitors want to talk they can have an hour of one to one support from the team of Crisis Support Workers who may tell them about other services that are available.
- If they don't want to talk that's ok, Dial House is a place of safety where people in crisis.
- Visitors will be offered something to eat if they wish.
- At Dial House we have a family room, so parents in crisis can bring children with them.

How to contact:
Leeds Survivor Led Crisis Service
Dial House
12 Chapel Street
Halton
Leeds
LS15 7RW
Telephone: 0113 260 9328
Email: info@lslcs.org.uk

If it is your first visit, you can turn up at the door from 6pm.
If you have visited before, you must:
- ring 0113 260 9328, or
- text 07922 249 452,
- from 6pm on the night you want to visit.

We also free transport visitors to and from the house by taxi, to make their journey safe and comfortable.

Dial House @ Touchstone
What it is:
- Dial House @ Touchstone is a partnership between Leeds Survivor Led Crisis Service (LSLCS) and Touchstone. It brings together LSLCS's expertise in providing crisis services and Touchstone's in supporting people from BME groups.

Who it is for:
- Crisis Service for people from Black and Minority Ethnic (BME) groups.

What they do:
- Open 6pm-11pm Tuesday and Thursday

How to contact:
- Call 0113 249 4675, or text 07763 581 853, Tuesdays and Thursdays between 6pm and 11pm

Other Crisis Services

Crisis Assessment Service
What is it:
- The Crisis Assessment Service works out of the Becklin Centre and provides a 24/7 service across the whole of Leeds for adults of all ages.

Who it is for:
- Anyone

What they do:
- The service aims to assess all service users who are in crisis and presenting with significant risks to themselves and/or others and who may require acute mental health care.
- The service gate-keeps all acute admissions to the inpatient wards.

How to contact: 0300 300 1485

Single Point of Access
What it is:
- Service which acts as a gateway to all mental health services

Who it is for:
- Anyone

What they do:
- A service open 24 hours a day whereby you can call and discuss the issue with a member of the team.
- Offer help and advice
- Able to refer to crisis Assessment Service if required

How to contact:
- 0300 300 1485
- Open 24 hours a day

Accident and Emergency (A&E) / 999
What it is:
- An service available for accident and emergency
- Should be used when there is an extreme crisis e.g. Someone who is at immediate risk of suicide; at risk of harming self or others or is in serious crisis needs and needs help/support

Who it is for:
- Anyone

How to contact:
- Visit A&E department or dial 999

Other Services that Support Refugees and Asylum Seekers Mental Health and Emotional Well-being

G.P.
IAPT http://www.touchstonesupport.org.uk/services/improving-access-to-psychological-therapies-iapt-service/
PAFRAS Mental Health Worker http://www.pafras.org.uk/
York Street Health Practice
http://www.leedscommunityhealthcare.nhs.uk/our_services_az/york_street_health_practice/
Solace http://www.solace-uk.org.uk/

Pre-amble
Hi, my name's *(name).* I'm a researcher from Health Together at Leeds Beckett University and we've been asked by Touchstone to do a study of mental health in two communities in Leeds – ROMA Men and Black women born outside of the UK. We are talking to staff and volunteers in organisations working with the two communities as well as members of those communities with experience of mental health problems. We will be writing up the study for Touchstone who will be sharing it with public health commissioners at LCC.

Check:
- *Participants have received an information sheet – that they've read it and understood it and are happy to proceed*
- *Go through the consent form with them*
- *Okay being recorded*

Capture:
- *Name of interviewee and their position in the organisation*

NOTE: the main questions are numbered, the bullets are prompts to be used if needed.

Section A: About the organisation and interviewee's role in it
First I'd like to find out a little bit more about your organisation and your role in it:

A1. *(Keep this brief!)* Could you tell me a little bit about your organisation:
- What are your aims?
- What communities do you work with/ what geographical area do you cover?
- How many people are employed or volunteer with you?
- What activities do you undertake and what groups of people you mainly work with?

A2. What is your role in the organisation?

Section B: *Mental health problems in* Black women born outside of the
I'd like to ask you about mental health problems in the community.

B1. What are your perceptions of mental health problems in Black women born outside of the UK?
- Would you say that there are a not many/usual amount /lot of mental health problems?
- What sort of problems?
- Are there any groups who are particularly affected?
- Would you say mental health problems in the community are greater than across Leeds as a whole?
- Why do you think there are more/less mental health problems in this community?

B2. How do people perceive mental health problems in their community?
- What is their attitude to those who are having mental health problems?
- Are mental health problems openly talked about?

Section C: *Mental health Services*
C1. Do people with mental health problems seek help from mental health services?
- At what point do they seek help?
- Where are they likely to go for help?
- If there is reluctance to seek help – why is that?
- Are mental health services reaching people who need help?

C2. What is your perception about the help people with mental health problems receive if they do seek help?
- How would you describe the support they get?
- Are the services culturally appropriate?
- Do you have any comments on aspects of mental health services which need enhancing? Or improving?
- Are there gaps in service provision?
- Any examples of good practice which need highlighting?
- Is the service your community gets the same as other people get?
- If not, in what way is it worse? Why do you think this is?

<u>Section D:</u> ***Role for the Voluntary and Community Sector in relation to mental health in Black women born outside of the UK.***

I'd like to move on now to talk about the role of the Voluntary and Community Sector in relation to mental health in X community.

D1. Does your organisation play a role in relation to mental health problems in the community?
- Do you have a preventative role with people mental health problems – even if this is not a stated aim of your organisation?
- Do you support people with mental health problems for recovery – even if this is not a stated aim of your organisation?
- Do you think you could have more of a role in prevention and support?

D3. What role do you think Voluntary/Community organisations in general play/could play in relation to mental health?
- Can you give me any examples of VCOs that are helping to prevent mental health problems or support those with problems?
- Overall what do you think should be the role of VCOs in relation to the prevention of mental health problems in the community?
- And what about in relation to support of those with mental health problems to help them recover?
- How does the role VCOs play, or could play, differ from what statutory organisations do? What about partnerships, for example with other VCOs or statutory sector?
- What would you see as the factors that are preventing VCOs taking a greater role? What can be done about this?

<u>Section E:</u> ***General comments***

E1. Do you have any additional comments that you would like to make? Are there one or two priority actions which could make a big difference for mental health in the community you work with?

E2. Any questions?

Many thanks for your help

Appendix 5: Focus Group Schedule

Hi, my name's *(name).* I'm a researcher from Health Together at Leeds Beckett University and we've been asked by Touchstone to do a study of mental health in two communities in Leeds – Black women born outside of the UK and ROMA men. Thank you very much for coming along today to talk with us.

Check:
- *Participants have received an information sheet – that they've read it and understood it and are happy to proceed*
- *They are aware that we will be writing up the study for Touchstone who will be sharing it with public health commissioners at LCC – but we will not quote them directly or write anything which means they can be identified.*
- *Remind them that their participation is voluntary and that if there is anything we ask about that they do not want to talk about, that's fine. Plus if they want a break, or to leave at any point, that is fine to.*
- *They understand that we all need to treat what is said in the room as confidential.*
- *We are not asking them to talk about their personal experience directly – we will be talking generally about mental health in the the community.*
- *Everyone should have opportunity to speak, not just a few; if by any chance conversation strays 'off-track' onto sensitive topic we may pause or steer it back.*
- *Go through the consent form with them*
- *Okay being recorded – if not can take notes.*

Section A: Introductions
First I'd like us to make some introductions so that we know each others names, just first names is fine.

How did you find out about this group / discussion today?

Section B: Issues / challenges in their community
B1: I'd like to ask you about the challenges your community face in their everyday life in Leeds?

B2: How do these issues make people feel?
- Sad / angry / stressed / confused?

B3: Are there any experiences that are particularly difficult for women? / Do you think women experience these issues differently to men?

B4: Do some of these problems or feelings come from experiences people may have had before they migrated?
- Are there problems that they left behind but have not really gone away?

Can we introduce the word mental health at this point? By mental health we mean someone feeling well enough in their mind, so they can function at their best.
A Mental Health Problem would be when someone feels unwell in their mind and is struggling to cope with everyday or normal life.

POTENTIALLY SHOW A FEW MINUTES OF FOOTAGE FROM TOUCHSTONE FILM

Section C: Mental Health and the Community
C1: Are mental health problems talked about in the community?
- What is the attitude to people who have a mental health problem?

C2: If people in your community are feeling very unhappy –feeling so un-well for example that they are not going out – who would they talk to?
- What might other people in the community do to help them cope?

Section D: *Mental health Services*
D1. If a person from the community is struggling to cope / has a mental health problem would they talk to a Dr or Mental Health Services?
- At what point would they look for help?
- If not - what would stop them asking for help?

D2: Could anything be done to help people feel more comfortable talking about how they feel with a Dr or Mental Health Services?

D3. Are you aware what type of support people receive if they get in touch with Mental Health Services?
- Were the services provided in a way that is right for your community? If not, why not.
- What could be improved?
- Are there things that are good which more is needed of?

D4: Is the service your community gets the same as other people get?
- If not, in what way is it worse? *Why do you think this is?*

Section E: *Role for the Voluntary and Community Sector in relation to mental health in the community.*

E1. Does this organisation help improve mental health in your community? If so, how?
Ask for examples, but emphasise that people should not use names.
- Do you think community groups generally (groups that include volunteers and are based in the community) can help improve mental health? If so, in what way? (probe – prevention / supporting those with problems)
- Could they do more?

E2. Is there anything different about community groups giving support to people with mental health problems and the support mental health services give?
- Can you give me any examples of voluntary/community organisations that are helping to prevent mental health problems or support those with problems?
  Please don't use real names
- Are there things preventing organisations like these taking a greater role? If so, what do you think should be done about this?

Section F: *General comments*
F1 Are there one or two things which would make a big difference to mental health in your community?

F2. Do you have anything else to say or any questions to ask?

Many thanks for your help

Ensure all participants receive their high street voucher and expenses. Hand out: support group list plus list of where you can spend your vouchers.