❑ ERICA BURMAN, KHATIDJA CHANTLER
& JANET BATSLEER
*Manchester Metropolitan University*

# Service responses to South Asian women who attempt suicide or self-harm: challenges for service commissioning and delivery

*Abstract*
This article draws on an investigation of service responses to women of South Asian background who have attempted suicide or self-harm within northwest England to outline policy challenges for adequate provision to this population. This article highlights, in particular, the challenges for service managers arising from and documented within the study, outlining implications for improving policy, service commissioning and provision. We suggest that these omissions have resulted in the distress of South Asian women going unrecognized in the name of respect for cultural diversity, thereby sanctioning policies and practices that further the oppression of South Asian women. Four main issues emerging from the interviews are discussed: 1) the impact of the contract culture on the form and structure of service provision; 2) limitations of current partnership arrangements with South Asian communities; 3) practical and conceptual problems within models of both consultation and change; and, 4) key practical consequences of the covert ways in which the structure and interpretation of service responses work to treat 'race' as more important than gender. In terms of specific implications, it is suggested that the current policy focus on addressing service inequalities via recruitment of South Asian workers warrants critical re-evaluation, while training and management development should take as central the intersections of 'race', culture, class and gender as systemic issues to be worked with rather than marginal or optional considerations. It is argued that attending to the specific needs and conditions of South Asian women attempting suicide or self-harm by providing integrated culturally and gender-sensitive services highlights good practice for everyone.

**Key words:** gender, mental health, 'race', service partnerships

## Introduction: from the specific to the general

This article develops the implications of a 10-month study[1] investigating service responses to women of South Asian[2] background, who have attempted suicide or self-harmed, to illustrate the challenges faced by managers and policy makers in delivering culturally relevant and gender-appropriate services. We suggest that, notwithstanding – or rather precisely because of – the specific character of this topic, the issues it raises are widely applicable to a range of health, social service and welfare provisions in at least four ways. First, we start from an analysis of the intersections between cultural, racialized, classed and gendered positions (see, for example, Anthias and Yuval-Davis, 1993) in order to understand the conditions giving rise to particular experiences and positions of distress. This brings key policy challenges to the fore (see also Burman et al., 1998) and, although attending to these intersections is broadly accepted within academic debates (Anthias and Yuval-Davis, 1993; Bhavnani and Phoenix, 1994; Brah, 1996; Kincheloe and Steinberg, 1997; Werbner and Modood, 1997), this is not always reflected in service commissioning – provision or practice. So, while this article concerns South Asian women in relation to suicide and self-harm, we would claim that understanding the centrality of those intersections and the broader conditions giving rise to these in accounting for this particular manifestation of distress, and responses to such distress, is relevant to all services and across all sectors of societal practices. It does, however, pose specific challenges for services engaging with the intersecting issues of health, welfare and mental health.

Second, we will discuss how the production and reproduction of forms of institutional racism, sexism and class oppression within services are exacerbated by the limited extent to which – notwithstanding current rhetoric – medical, mental health, welfare and social services, statutory and voluntary services, families and the state really are 'joined up'.

Third, in terms of the relationship between mental health and other more apparently social or 'political' issues, both the rates and numbers of attempted suicide and self-harm in South Asian women dramatically highlight how distress demands a systemic analysis. For, such distress and responses to it arise in relation and response to a range of circumstances, including many that would not typically be

identified as mental health issues. Social and environmental factors, such as housing and an adequate income, are readily seen as vital in the care of distressed people (Davies and Betteridge, 1997; Shepherd et al., 1994; Slade et al., 1995). Yet additional specific factors emerging from the survivors'[3] perspectives documented in our study, such as immigration status and racism, are rarely acknowledged. Furthermore, even where domestic violence or sexual abuse are acknowledged as featuring significantly in women's distress (see Arnold, 1994; Liebling et al., 1997; Pembroke, 1994), their racialized dimensions lack adequate appreciation within policies and practices.

Hence, issues of mental health (and correspondingly its absence, distress) underlie and permeate all others, thereby challenging the current compartmentalization of resources and delivery of services. In particular, as indicated by the *National Service Framework for Mental Health* (NHS, 1999), addressing Standard 7 on preventing suicide continues to exercise policy makers as clearly both a public health and mental health issue. Similarly, sociopolitical factors have been widely recognized as entering into the definition and recognition of what counts as self-harm. The further general policy question posed in specific ways by this study was that of investing in specialist versus generalist services, whether the 'specialism' concerns cultural or gender issues or a focus on suicide and self-harm services.

In terms of general principles around accessibility and appropriateness of services, the picture emerging from this study illustrates the complex ways in which sexism and racism intersect and permeate layers of policy and practice. Our analysis of attempted suicide and self-harm in South Asian women suggests that this arises from multiple processes of functional neglect. By this we mean that neglect was functional (i.e. arose as a product of the ways in which services functioned) rather than an intentional outcome. The design of the study aimed to generate accounts from different parties and highlight their convergences and differences. The analysis juxtaposed the perspectives of survivors of attempted suicide and self-harm with those of practitioners and managers of services. From this it emerges that this neglect happens in part through the very attentiveness to the differences posed by the (gendered and cultural) positions of South Asian women and by their forms of distress (suicide and self-harm). We go on to explore this later in the article.

Further, the study highlighted systemic disconnections between services that gave rise not just to some instances of active exclusion

from services, but also to more insidious processes of being passed over (not noticed, distress going unrecognized, considered a 'family' or 'cultural' matter, and so on) and, beyond that, being passed around. This included the ways that services unintentionally or implicitly excluded women because workers reported feeling that they could not provide appropriate services (either on the grounds of issues of culture or gender, or alternatively in relation to expertise around suicide or self-harm).[4] Hence, a survivor's encounter with the Community Psychiatric Nursing Service was described by her as follows:

> And I went to see her [CPN] and she said to me I can't really do much for you because you come from the Asian community, I'll refer you to somebody that's Asian, [who was not a CPN] that's what she said . . . she said there's not much I can do to help you 'cos of your culture and I think that they should. . . . They should go out there and learn about it and help people because that's what we've done, we've mixed in with the English community very well, I have and I can understand what they're saying and everything and they should do the same thing for Asian people, they should learn more. Sometimes I get the feeling that they don't want to learn, they don't want to know which is very upsetting.

Contrary to assumptions about cultural matching (discussed further later on), this survivor argued that mental health workers should be able to work competently across cultures. Clearly, at a time when community psychiatric nursing is deemed appropriate, it is not very 'caring' to remove from a service user the choice as to their preference of worker or, second, to refer the user to somebody they do not see as equivalently professionally qualified. Hence, 'culture' becomes privileged over the service user's mental health needs. Since the resort to attempted suicide or self-harm can itself be regarded as a symptom of acute distress arising from isolation and exclusion (Liebling et al., 1997), we should view with extreme concern evidence of their further exclusion from services.

Furthermore, juxtaposing such accounts with those of South Asian mental health workers highlighted how some women, while apparently receiving services, were in fact simply being referred from one place to another. Within our study, such accounts of women seeking services fitted with the views of South Asian workers whose cultural expertise was privileged over their mental health/support skills: 'I do have some skills, but I'm not an expert [on issues of suicide and self-

harm], as for example [name of organization], but because I'm seen as a South Asian, there are unfair and high expectations put on me.' There are clear implications here for how the mental health needs of South Asian women could be addressed, as well as the monitoring and evaluation of services. Having now indicated some of the key issues generated by this study, the article will now provide further detail of its context, moving on to focus in particular on the policy challenges and developments it indicates.

## Context of the study

In this section, we situate the local, geographical and precipitating contexts of the study. As well as arising in response to a mobilization of local Asian women's organizations around suicide and self-harm,[5] the broader policy context for the study was the *National Service Framework for Mental Health*'s priority to reduce suicide rates by one-sixth by 2010 (NHS, 1999). While Manchester's reputation for being the 'suicide capital of Britain' is mainly associated with young men,[6] South Asian women are also indicated nationally as having high suicide rates (Merrill, 1990; Merrill and Owens, 1986; Soni Raleigh, 1996; Yazdani, 1998). It should be recalled that available statistics are unreliable, not least because of the many interpersonal as well as cultural factors, including sensitivity to family members, that contribute to an underreporting of verdicts of suicide (Chambers and Harvey, 1989; Kelly and Bunting, 1998; Kleck, 1988). Moreover, ethnicity is not recorded on death certificates presumably because, at the time when such practices were introduced, Britain was assumed to be a homogeneous population. This, of course, flies in the face of the longstanding cultural, intellectual and economic connections between British, Caribbean and South Asian cultures (Brah, 1996; Gilroy, 1993). Among other implications, this renders futile efforts to compare cross-cultural patterns of the prevalence of distress, while increasing globalization has extended to the Indian subcontinent supposedly western expressions of distress such as eating disorders and self-harm (Littlewood, 1995).

In terms of methodological frameworks, as with other studies that concern institutional exclusion, we have to *interpret* the significance of what is *not* known about within available evidence as much as what *is* (Bhavnani, 1991; Burman, 2000; Kidder and Fine, 1997). The

limitations of available patterns of (under)representation within service use therefore need to be analysed in terms of its partialities and privileges, in two ways. First, *absences* within the available empirical accounts can be identified, analysed and conceptualized and, second, from this other evidence can be proactively generated to interpret, if not fill in, the gaps. In contexts where quantitative information is scarce or subject to obvious selection effects, qualitative or interpretive research explores meanings that can only be inferred from statistics. Moreover, by documenting the perspectives of multiple stakeholders, an overall picture can be analysed in order to generate strategies for intervention (Banister et al., 1994; Burman, 1997).

This is particularly useful for health needs and evaluation research, especially where there are questions around patterns of representation or underrepresentation within services. Hence, it is indicative that Kelleher and Hillier's (1996) volume on cultural differences in health is almost exclusively concerned with qualitative analyses. Further, the dynamic of normalized absence/pathologized presence that characterizes academic and policy attention to black[7] and minority ethnic women (Phoenix, 1987) is reflected in patterns of referral of black women to psychological therapies (Aitken, 1996). As Marshall et al. (1998) also note in relation to their analysis of accounts of maternal and postnatal care, it is particularly important both to identify how South Asian women's needs are overlooked within existing mainstream provision (as a normalized absence) and where they are explicitly attended to as a specific concern requiring remediation (i.e. a pathologized presence). Beyond this, it remains to be investigated how adequately this mainstream/specialist analytic framework covers the range of conditions and expressed needs of South Asian women. Within this rationale, the objectives of the study were, in brief, to:

- compile a service map of potential sources of help;[8]
- identify the current level and appropriateness of services being offered to South Asian women who self-harm or are suicidal;
- increase understanding of the specificities of factors contributing to the distress of South Asian women;
- identify examples of good practice;
- identify gaps in service provision to this service user group; and
- make recommendations to improve self-harm/suicide services to South Asian women.

Thus, the study researched accounts of service provision as well as perceptions of South Asian women's mental health needs in relation to suicide and self-harm, and was organized around researching four different sets of perspectives. Analysis was based on audiotaped interviews with eight senior managers (both commissioners and providers of services), 18 discussion groups with service providers (including both statutory and voluntary sector, and mainstream as well as specialist), four community groups and seven South Asian women survivors of attempted suicide and self-harm. The specific picture emerging from the thematic analysis (see, for example, Banister et al., 1994) was contextualized within broader policy and practice debates, with recommendations for action at local and national levels.

While we focus here on challenges posed for policy makers, service commissioners and providers, it is fitting to note two broader issues that are raised when researching around questions of 'race' and gender. First, service provision inevitably engages with broader contexts of racism and sexism that inform – in some cases directly – the trajectories and needs of the service population. Elsewhere we elaborate in more detail (Chantler et al., in press) on how current stringent immigration legislation (around the 'one year rule'[9] and 'no recourse to public funds'[10]) was cited as directly impacting on the precipitating conditions for, and inadequate responses to, South Asian women's attempted suicide and self-harm. Hence this study highlights how individual distress cannot be dissociated from broader regional and national policies and practices, and correspondingly indicates the need for structural and systemic analyses and responses.

Second, in both the conduct and presentation of this research, it has been important not only to recognize the stereotypes that abound (both around Asian women and around what attempted suicide and self-harm might mean), but also the anxiety that pervades any discussion around 'race'. The issues at the core of this study were difficult and challenging for all our research participants, and our emerging recommendations include highlighting how this area touches on a number of key areas of sensitivity and vulnerability around competence and awareness. Sustained, developmental and meaningful training and support are needed to address this. Indeed, our hope is that readers who may be in equivalent positions to those of the senior managers and workers participating in the study will be able to draw on this analysis to inform their own policies and practices.

## Situating manager perspectives

In the rest of the article we focus on four key issues arising in particular from analysis of the interviews with senior managers of services. These are:

1 the impact of the contract culture;
2 representations of partnership and consultation;
3 models of how change occurs as discussed by the managers; and
4 the consequences of privileging racialized or cultural identities over gender in the context of an overdependence on (culturally) specialist (South Asian) mental health services.

The article concludes by identifying some specific recommendations on strategies for taking the issues identified forward to improve practice.

The managers were drawn from both the statutory and voluntary sectors and spanned both health and social services within the region of study. Notwithstanding their considerable diversity, what they shared was holding the organizational authority and responsibility to initiate and sustain policies leading to developments in practice. Below we discuss key themes emerging from their interviews, with indicative quotations offered where appropriate.[11] As an interpretive approach, the accounts offered by these participants are situated in relation to the broader picture emerging within the study and, where appropriate, we highlight their commonalities and differences with survivor and practitioner accounts.

While it might be assumed that senior managers' distance from service users would make their explanations for distress of little relevance, the explanations senior managers put forward to account for South Asian women's distress highlighted a central theme emerging throughout the study in terms of a focus on cultural or racialized issues rather than gender. In this section, we highlight the consequences of this and then move on to identify two strategies for managers to reconfigure key arguments put forward as obstacles to being proactive in providing for South Asian women. In particular, cultural or racialized positions were typically emphasized to the exclusion of gender issues, thus giving rise to a failure both to perceive and practically engage with how issues of gender, culture or 'race' intersect with the commissioning and delivery of services.

### *Privileging 'race' over gender*

Both 'cultural' and structural factors figured in managers' understandings of South Asian women's distress, including acknowledgement of the failure of services to adequately engage with or provide for South Asian women experiencing distress. Familiar explanations concerning culture clash and generational conflict were offered – (as critiqued by Arnett, 1999; Brah, 1996; Marshall and Woollett, 2000) – neither of which was mentioned by the survivors. Moreover, many of the factors cited by survivors within our study (such as domestic violence, abuse, immigration controls, poverty, and so on) failed to appear within the policy makers' accounts. Thus (as Brah, 1996; Mercer, 1986; Yuval-Davis, 1997 have also noted), an emphasis on cultural issues can sanitize or mask other issues.

Managers certainly seemed aware of policy as well as resource limitations within the current organization of services, for generic services were regarded as being exclusionary: 'I don't think we have a carefully thought through plan in terms of South Asian women . . . at a strategic level there hasn't been enough considered planning and discussion around South Asian women and there needs to be.' Thus, a key effect of attending to the 'visibility' of 'race' or cultural issues in their explanations was the tendency to override gender while, alternatively, attending to gender seemed to presume a culturally homogeneous (and therefore putatively white) population. The latter conception clearly feeds into black critiques of second wave feminist analyses as assuming a white, middle-class 'yardstick' or norm (Amos and Parmar, 1984; Carby, 1992), while the former warrants the overlooking or subordination of women's interests to those of family or community (see Sahgal and Yuval-Davis, 1992). Clearly neither position is viable. What is needed instead is for managers to design policy informed by a clear analysis of the structural ways minoritized women's perspectives are likely to be subject to a dual marginalization – both within their communities and in relation to the majority population.

### *'The numbers game': thinking differently about demographics and resources*

It is a common refrain in any policy discussion around resources to cite demographic information about the pressure of numbers in

limiting service developments. The senior manager interviews were no exception. But the small number of South Asian communities within some areas of the study (and we should note there was considerable variation within this) does not reduce their entitlement to services, although currently they are often effectively excluded from these due to a lack of language skills and other culturally appropriate provision. Moreover, as was discussed by some senior managers, the kinds of innovative practices emerging from thinking through and responding to the needs of South Asian women – including such relatively simple measures as single sex provision in hospitals and child care – are likely to benefit a far larger range of groups. Therefore, instead of providing services to a standard model of person that in fact fits no one, a better strategy is to attend to specific expressed needs such as those required by South Asian women. As one manager put it: 'White women can link into the service and systems better and the system understands them better. Services are there to meet the needs of mainstream and if you fall outside that it's hard to have your needs met.'

### *Specialist South Asian mental health services*

Within the area studied, South Asian services had some visibility and profile in mainstream services. Yet, while available specialist South Asian services were highly praised by both managers and workers, they appeared to be accorded a disproportionate number of responsibilities for work in this area and few resources. These responsibilities included community-based mental health services, secondary care services, training, monitoring and evaluation, and membership of the Local Implementation Group. These small voluntary organizations were apparently expected to offer the full range of services to work across the mental health field. Even were such services adequately resourced, the need would still exist for mainstream provision to give women a choice about which services they accessed since, for reasons of anxiety around anonymity,[12] it seemed likely that some users may actually have wanted to avoid a specialist South Asian service. As some managers indeed commented:

> Having specialist services for South Asian women, but also we need to think carefully about the rest of services so you don't [only] create pools of accessibility.

> Specialist services act as a voice but that doesn't mean that's the only contact otherwise you're perpetuating the discrimination and isolation.

### *South Asian community groups and attempted suicide/self-harm*

Clearly community groups are valuable places for support but, notwithstanding the frequency with which they were mentioned by senior managers, they seemed to be being relied upon rather uncritically as both a means of accessing other services and as providing a mental health resource in themselves:

> Can't tell you in detail. One hopes, assumes that workers from the community groups know how to contact mainstream services and develop good links – there are local authority and health authority agreements in place, so presumably they should link into mainstream services. As low intensity community groups they're meant to provide support and be preventative rather than crisis. I think that's good because it's about people having access to help and advice at as early a stage as possible and mainstream services kick in after that.

What was less readily acknowledged was how such specialist groups provide only very general support in contexts of informality and lack of specialist knowledge that may actually offer very distressed or isolated women little, and thereby confirm their isolation. The picture emerging from the survivor interviews and confirmed by previous British-based work (Pembroke, 1994; Spandler, 1996; Yazdani, 1998) is that attempted suicide/self-harm is often a response to oppression based on racialized, gendered and classed experiences including sexual abuse, domestic violence, racial harassment and immigration. Yet these issues are the very ones that 'traditional' community groups may have difficulty working with, as they challenge the very context of their existence and the benevolence of tradition, community and family (see Yuval-Davis, 1997). As this survivor commented:

> that hurts more because your own community, your own colour, your own caste won't help you. They should be helping you, they talk all Islam, but no one . . . these religious people are a disgrace . . . community? It's just a name, a label. How could anyone help abuse, how can we have a [family] meeting and emotionally they can't help you.

Clear implications follow from this for the funding of generic community-based mental health support groups without an appreciation of the structural complexities and exclusions of their functioning, particularly in terms of how these may perpetuate the isolation and failure of provision for the most vulnerable and marginalized within those communities. While such community provision is often perceived as supplementing mainstream provision, it is not structurally constituted to do so. The onus remains on mainstream services to become accessible and sensitive in relation to gender as well as cultural issues, and to address the practical ways in which issues of culture, gender and class intersect. Hence, this point has consequences not only for dedicated mental health services, but also within primary care – for GPs, health visitors and community nurses who refer to and liaise with community groups.

## Impact of the contract culture

As well as highlighting issues that explicitly concerned South Asian women and suicide/self-harm, other general aspects of the contemporary organization of services emerged as impacting in specific ways on access to and delivery of these for South Asian women. Five main issues emerged in relation to the current contract culture.

First, the purchaser/provider split structuring the forms and provision of services impacted on senior managers being able to deliver integrated and comprehensive provision. While providers reported their 'hands being tied' in terms of service developments, with commissioners setting the agenda, correlatively commissioners claimed that they were dependent on providers' interest or expertise. In this context, responsibility for providing services was being passed from providers to commissioners and back again, leading to a vacuum around actual delivery.

Second, this culminated in a fragmented, uncoordinated and ultimately inadequate analysis of 'need' in this area. Given that 'needs analysis' is central to current policy around the resourcing of provision, this point is of particular concern. Such structural exclusions around delivery will remain unless criteria for evidence-based practice are reconceptualized to analyse *what is missing* from the picture about South Asian women's use and representation within services, as well as

what is present (Aitken, 1996; Burman et al., 1998; Sangha et al., 1996).

Third, the general climate of competing for contracts appeared to militate against agencies sharing ideas and resources and learning new ways of working and training. Arenas for discussion, including discussion of joint working that functioned within the 1980s – especially across the voluntary sector – were reported as having disappeared under the pressure of such competition. Claims of 'choice' for users appeared as elusive as ever, alongside further fragmentation of service provision into 'niche markets'. Hence, one key implication emerging from this picture is that specialist provision (whether in relation to a specific population such as South Asian women or a particular area of distress) potentially militates against the recognition and permeation of appropriate provision within more general services. Once again, instead of providing services, this negative cycle of referral is a particularly worrying outcome of this organizational set-up.

Fourth, much emphasis was placed by senior managers of mainstream services on drawing upon the expertise of specialist voluntary sector services, whether specializing in suicide and self-harm or Asian communities. However, within the context of the contract culture, managers from such voluntary sector organizations reported feeling ill-equipped to meet the bureaucratic demands of monitoring and evaluation, with the emphasis on outcomes working to impede development work and innovative practice both with and for service users. Indeed, the traditional strengths of voluntary sector organizations in terms of innovation, outreach work, community mobilization and campaigning were specifically identified as being curtailed by the tight specification of form and timing of interventions within contracts (such as specifications on proportion of time spent in direct client contact). Good practice thus appears to be limited rather than enabled by such contracting processes. One key question posed, therefore, is how development work can be maintained within the current climate, with money tied (in the name of transparency and accountability) to specific projects rather than core funding, and for service provision rather than planning or development.

A final fifth point is particularly relevant in thinking about both access to, and consequences of accessing, forms of psychological service provision. Current classifications of mental health services refer to 'mild to moderate' or 'severe and enduring' problems. Such classifications seem particularly detrimental to people with suicide

and self-harm issues as their difficulties often span both categories. Furthermore, the tying of contracts to diagnostic categories of mental illness promotes a medicalization of issues around attempted suicide/self-harm that itself may pre-emptively limit forms of, and corresponding access to, service provision since attempted suicide/self-harm is seen by many survivors not as a symptom of mental illness, but as a rational response to intolerable circumstances (Spandler, 1996; Yazdani, 1998). Policy responses that address these needs in terms of categories of 'personality disorder' may render relevant help even more inaccessible (Arnold, 1994; Pembroke, 1994; Warner, 2000).

## Partnership

At the time of conducting interviews,[13] mental health services in Manchester were being reorganized to connect social and health service provision via new mental health partnerships. Notions of partnership correspondingly figured heavily within discussions with policy makers, but, notwithstanding the emphasis placed on partnership and consultation between services and South Asian communities, these were acknowledged as difficult to achieve in practice. Two issues in particular emerged: first, an overemphasis on 'cultural' factors to the detriment of others (class, gender, state structural) in framing consultation/partnership arrangements; and, second, an underemphasis on those services that provide gender-sensitive, anti-racist support.

Regarding the first of these points, while many participants talked of the multiple differences between the various South Asian communities in terms of culture, country of migration and religion, few discussed the role of class, economic difficulties (such as unemployment) or gender which are at least as relevant contributory factors leading to distress. The often expressed desire to gain 'cultural' information about black and minority ethnic group habits, while well intentioned, did not seem to be the best way of arriving at sensitive and individually tailored services. In particular, while some participants acknowledged the structural complexities *within* communities and the corresponding need to attend to the structurally marginalized voices within any community (such as women and young people),

consultation that took account of such complexities was on the whole considered too difficult to do.

> It's one of the things that we know, that every segment of the population needs to be heard, we are mindful of the deficiencies. How we go about rectifying this comes back to the issue of how much resource we put into user consultation.

Existing partnership arrangements tended to consist of groups or organizations even when they were also known to be less than representative – 'We've tried to engage with community leaders and get them to tell us what to do' – while the process of such consultations was recognized as less than facilitative:

> We recognize it's quite difficult because there's such a diversity of different cultures, I feel quite worried because we have meetings and people don't find them easy to come along to . . . difficult if you have too big a group, it's difficult for people to participate.

Second, as is well known of the dynamics of formal consultation procedures (see, for example, Gibson, 1987), the outcome of only consulting with community 'leaders' or visible minority ethnic organizations – which, like the power structures within any community, are typically headed by men – only confirms women's marginalization. This was manifest in this study where key organizations working at the intersections of 'race', gender and abuse, namely black women's refuges, did not figure within managers' accounts of their partnership arrangements, nor in any of the worker accounts as providers of mental health support services. This is despite the well-known links between domestic violence, abuse and suicide/self-harm (Arnold, 1994; Liebling et al., 1997; Pembroke, 1994; Warner, 2000). In this context, it is perhaps significant that the one key service that emerged within the study as providing gender-sensitive, culturally appropriate support was the Asian women's refuge.

Any genuine commitment to improving services for South Asian women requires more complex, flexible and therefore nuanced models of consultation and participation. Acknowledgement of how the power relations structuring all communities give rise to the under-representation of the needs of marginalized voices highlights further the need to target resources towards such marginalized groups.

## Models of change

In terms of mechanisms for change, managers acknowledged that the whiteness and maleness of existing arenas of consultation and representation were likely to make it difficult for South Asian women to voice their views and needs. Yet they could offer no suggestions to redress this situation. Insofar as any was put forward, the main strategy for change discussed was in terms of committed individuals 'championing' their passionately adopted cause rather than arising through institutional commitment, ownership of responsibility or responsiveness. Effectively this meant the onus for change was either discretionary or fortuitous. Thus, models of change, as formulated by managers, were reactive rather than proactive. This is also a problem given that the loudest or most powerful voices within any consultation or representational arena, through historical and current structures of disadvantage, are unlikely to be those of South Asian women. Moreover, framed in such ways, opportunities for strategically-led, anti-discriminatory change are being lost. Organizations who have a clear remit and analysis relevant to the factors precipitating attempted suicide and self-harm did not appear to be being included in planning or consultative arenas, and strategy was left to the vagaries of commitment of highly placed individuals. It seems an irony – one structurally indicative of our topic – that, while isolation was a key factor explicitly acknowledged by managers in leading women to attempt suicide or self-harm, there appeared to be little happening at an institutional level to contact or make links with South Asian women. The marginalization of South Asian women who attempt suicide or self-harm is thereby reproduced in the difficulties of motivating for change.

Further, while some partnerships with black and voluntary sector services and user groups were discussed by managers and new partnership arenas mentioned, it was clear that black organizations were not being involved at all levels of planning and evaluation. As previously indicated, both from the senior manager interviews and from the picture of service provision emerging across the range of provider and user perspectives in the study, the same few black and Asian organizations carried major responsibilities in training for and designing and delivering culturally appropriate services. Yet they were offered no decision-making authority. Hence, while the notion of

partnership was rhetorically powerful, it was certainly not being practised as a relationship between equals. Thus, the burden for 'championing change' seemed to rest with the least resourced and most marginal agencies.

Finally, there was a general recognition that the current policy focus on consultation could lead to an avoidance of implementing emerging recommendations for change. This effect of consultation as avoidance breeds both cynicism and 'burn-out'. As one manager put it: 'We ought to know [the issues] by now'; and another warned: 'There is a danger that black communities could be consulted to death'. Instead of continually generating the same information from community consultations, this information needs to inform initiatives that have concrete and tangible outcomes or else the practice of consultation will be justifiably interpreted as avoidance of addressing the structural issues implicated by such processes (see Bingley et al., 2000). We identify some such tangible outcomes in our final section.

## The way forward

The evidence presented in this study establishes the need for suicide and self-harm services for South Asian women. This is in line with other studies at both national and regional levels (Soni Raleigh, 1996; Yazdani, 1998). It indicates how key general features of the current policy climate (e.g. the contract culture) as well as specific resource priorities (such as demographic arguments about 'numbers') and an overattention to cultural rather than gender issues all work to render appropriate provision less available and accessible to South Asian women. In this, the senior manager interviews resembled the perspectives of the worker discussions in terms of their focus on 'cultural' explanations for women's distress – explanations that were notably absent from the survivor accounts generated by the study. Similarly, there was a disparity between the emphasis on social and structural issues, such as domestic violence and immigration status, discussed by the survivors, and their absence within the manager and worker interviews.

As we discuss more fully elsewhere (Batsleer et al., forthcoming), it seemed that every aspect of the 'specialness' of South Asian women concerning issues around suicide and self-harm, far from commanding

extra attention or resources, actually worked to exclude them from getting provision. Thus, insofar as we highlight specific needs or contexts faced by South Asian women, these are not in terms of South Asian communities or marriages being particularly oppressive (which would put the onus of responsibility onto the community and perpetuate a particularly pernicious cultural stereotype). Rather, current immigration legislation strips South Asian women of the legal and personal support available to white British female citizens. As one survivor of attempted suicide, in which domestic violence was put forward as a major contributory factor, put it:

> The one year rule causes a lot of problems. The law has given all the power to the man. They can control women for a year. The law has given the man the power to treat me as he wants, I have no protection under the law, it has given the man the right to use me as he wants. It's all in his hands, I've got no rights.

Furthermore, while managers frequently bemoaned the lack of South Asian (including women) workers, if recruitment of South Asian workers is to work as a strategy for improvement, it is clearly also necessary to put in place policies promoting the generation and retention of black staff. However, it cannot be assumed that all black staff are suited, inclined or even equipped to work with South Asian women attempting suicide or self-harm since whatever training they have had will have been structured according to available disciplinary models of theory and professional practice whose relevance in terms of gender and cultural issues has largely yet to be re-evaluated (see Burman et al., 1998; Dominelli, 1988; Mercer, 1986). Notwithstanding the current policy focus on cultural and gender 'matching' as a strategy to increase access, there are strong indications from both the survivor interviews and the community group discussions that South Asian women often have too many concerns about anonymity to approach for support someone who is identifiably linked with their own community. Hence, it should not be presumed that a South Asian service user would necessarily choose to work with someone from her own background, although she should also be offered that choice. Thus, the strategies of supporting specialist South Asian services and paying particular attention to provision that addresses marginalized groups within those communities have to be *in addition* to ensuring that mainstream provision, as provided by white as well as black staff, is sensitive and appropriate. This would ward off the

current implicit strategy of relying on recruiting black staff, which effectively abdicates broader institutional responsibility for 'race' or gendered equality of access to sensitive and appropriate services (see Lewis, 1996).

In terms of staff and management development, echoing Sivanandan's well-known analysis (1985), there is general dissatisfaction with existing available training in the areas of anti-racism or gender awareness. While it lies beyond the scope of this article to offer any detailed comments on training, implications follow in terms of taking into account the anxieties mobilized around thinking through the intersections of 'race' and gender. Alongside this, there is a need to unsettle the ways discourses of ethnicity focus on minority rather than majority cultures and experiences (Charles, 1992). This strategy offers less personally charged ways for providers to explore their own implications within historically constituted, if currently perpetuated, forms of oppression. We propose that revised models of training should nevertheless engage with appropriate issues of individual as well as institutional responsibility. Rather than being focused on personal qualities or knowledge, training should be more specifically focused on outcomes to help managers address the range and scope of policy, commissioning and provision issues posed by the kinds of complex structural needs expressed by attempted suicide and self-harm in South Asian women.

Moreover, attending to the specific needs and conditions faced by South Asian women highlights the need for systemic analysis to take account of how care, welfare and mental health issues intersect. This specific context – including the links between domestic violence, minoritization and the 'one year rule' – shows how the apparently 'private' area of mental health links up with 'public' issues of state immigration policy. More speculatively, it also indicates the challenges involved in taking action around domestic violence since this breaches the public/private dichotomy in terms of transgressing the ideological boundary between the state and individual/family (Mama, 1989; Maynard, 1993). Furthermore, within a context of minoritization, the privilege accorded cultural over gendered issues threatens either to normalize women's oppression within violent or abusive relationships or to pathologize specific cultures (Bhattacharjee, 1997). Challenging the interconnections between state structural racism, sexism and service provision requires as a starting point an analysis of how these practices intersect, as well as how they give rise to specific

patterns of distress. A significant, if only interim, major mental health intervention should be to resource voluntary sector organizations to work with women 'with no recourse to public funds' who are among the most excluded and vulnerable of all those in need.

## Concluding comments

While this article has identified key ways in which services inadvertently perpetuate exclusionary practices, we end by highlighting some strategies for improvement and reiterating how good practice for everyone can emerge from attending to and providing for this specific group. Our focus on policy makers and senior managers arises from their central role in the design and provision of services. Their authority and responsibility can be used proactively to ensure that the complex issues posed by suicide and self-harm are framed by policies that connect anti-racist and gender-sensitive understandings as well as clinical governance and the clinical management of distress and abuse.

Specific recommendations arising from the study include:

- acknowledging and supporting the role of South Asian and other women's refuges as providers of gender-specific, anti-racist services;
- promoting a women-only collaborating forum for working on issues of suicide and self-harm in South Asian women;
- supporting the development of South Asian women's survivor groups;
- the provision of safe and supported housing for South Asian women in distress;
- the creation of an Immigration Welfare Fund to respond to women with no recourse to public funds; and,
- the development of autonomous black women's counselling and complementary therapy services.

General recommendations from the study address all services at all levels, and we conclude by highlighting four points. First, the study highlights the need for statutory and voluntary sector management to undertake gender-sensitive anti-racist work in relation to suicide and self-harm services for South Asian women. This should include attending to the current lack of consideration of the needs of South Asian women and the privileging of 'race' over gender in commissioning, partnership arrangements and service provision, both of which are indicated as contributory factors to South Asian women's suicide

attempts and self-harm. There is also an urgent need to connect policy making around service commissioning and provision with broader political processes, including making representations at a national level to challenge legislation (for example, immigration law) and policy which disadvantages South Asian women and other black people. The need remains as urgent as ever for non-medicalized services, and for service specifications, evaluation and monitoring processes to contribute to greater inclusion of South Asian women.

A second key area for action involves staff development strategies that help to support mental health practitioners in developing sound gender-sensitive and anti-racist practices, and to work confidently and competently with South Asian women presenting with issues around suicide and self-harm. Such training would usefully include GPs, other primary care professionals and social care staff who may be the frontline staff users encounter (with health visitors acknowledged as having a particularly important role). Our study documents how workers feel ill-equipped on the basis of cultural background as well as expertise on attempted suicide/self-harm. As we have already indicated here, this contrasts with quite mixed responses from survivors, some of whom are more than satisfied with their care from white practitioners, while others experience stereotypical and unhelpful judgements, and express the desire to work with other South Asian women as service providers. Thus, staff development strategies need to be wideranging, working towards enabling all workers – that is, not only black or minority ethnic workers – to feel competent to work in this complex area.

The specific example of attempted suicide and self-harm in South Asian women highlights the interconnectedness of the impacts of racism, sexism and other oppressions, thus challenging 'colour-blind' approaches to provision and dominant hierarchies within 'helping' relationships. Moreover, training needs to be orientated towards more accurate risk assessment, care and treatment, as well as developing skills in working interculturally and in counselling skills. While anti-racist and gender-sensitive training are now mandatory components within all professional qualifying courses, their limitations in terms of being detached from relevant contexts of practice, as well as having a very minor time allocation, are renowned. Precisely because of this, as our third concluding point, we draw attention to the role that non-managerial casework supervision could play for mental health practitioners and link workers. The desire for such supervision emerges

from workers in all sectors, and not only could this ensure safer practice, but it could also provide support to practitioners to address the complexities of issues of both 'race'/gender and attempted suicide/self-harm in a non-threatening environment.

Finally, partnership arrangements could be developed and implemented to recognize omissions within current arrangements. This should include recognizing the consequences of partnership with more 'conservative' South Asian groups, addressing issues of tokenism and power dynamics within partnerships, and also ensuring that mainstream agencies do not abdicate their responsibilities onto South Asian groups.

Thus, the service issues posed by the needs of South Asian women attempting suicide or self-harm involve addressing key challenges that span conceptual and very practical issues. The proposals outlined above include some relatively minor as well as major initiatives which could have quite a significant immediate impact in addressing this key area of inequality of access and provision. Finally, the principle of developing services to address the specific needs and contexts of particular users has much broader applications and benefits.

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## Notes

1. This study was commissioned and funded by Manchester, Salford and Trafford Health Action Zone (HAZ) in July 2000. The principal researcher on the project was Khatidja Chantler who worked in partner-

ship with Erica Burman and Janet Batsleer of the Women's Studies Research Centre at Manchester Metropolitan University. The community perspectives strand of the research was conducted by Col Bashir, seconded from the Central Manchester Primary Care Trust mental health needs assessment/commissioning project.

2. For the purposes of this study, the descriptor 'South Asian' is used to refer to people whose cultural, national or religious heritage originates from the Indian subcontinent. This formulation includes British-born citizens, second and third generation citizens, as well as first generation immigrants.
3. While it is recognized that this term has many other resonances, in this context the term 'survivor' should be understood to mean survivor of attempted suicide or self-harm.
4. We should note that, within the conduct of this study, we deliberately chose to remain open-minded about distinctions between attempted suicide and self-harm in order not to pre-empt the meanings these held for participants, and precisely because of the widespread subscription to formulations distinguishing between self-harm as a way of coping in order to continue living and suicide as a way of ending intolerable living, such as that recently discussed within locally conducted research (Spandler, 1996) and that reflected more generally (Pembroke, 1994; Warner, 2000).
5. A conference jointly organized by two Manchester-based organizations, the Asian Women's Mental Health Coalition and 42nd Street, in March 2000 (funded by the Manchester, Salford and Trafford HAZ) on 'Suicide and Self-Harm in Asian Women' formed the immediate policy context for this study.
6. This is reflected in the Manchester, Salford and Trafford HAZ 2000 poster campaign and interactive counselling provision entitled CALM, the Campaign Against Living Miserably.
7. We use the term 'black' as a political category of identification and organization to denote people subject to racism on the basis of skin colour.
8. This was the original remit of the study, but it was extended to permit evaluation of the scope and accessibility of the services so identified.
9. This is the Home Office rule that women who enter the country to join their spouse are subject to deportation (on the grounds of having pretended a 'bogus' relationship to immigrate) if the marriage breaks up within one year. This is unless extenuating circumstances (such as domestic violence) can be proven, but this in itself is no easy matter (Mama, 1989) and can, in turn, become a source of pressure and oppression for women.

10. Women are subject to the 'one year rule' where, by virtue of not having indefinite leave to remain, they are not allowed any entitlement to claim welfare benefits of any kind. This economic constraint is part of the apparatus that keeps women within oppressive relationships and domestic contexts as even women's refuges have no resources to provide for women in such positions.
11. Unless otherwise indicated, quotations presented here are all from senior managers. No further designation is provided (for example, of sector, organization or position) in order to maintain anonymity, as established within the research contract.
12. In drawing attention to these anxieties, we do not mean to imply that such worries are founded, but rather that they may structure client choices about which services/workers to approach. Clearly, breaches of confidentiality are not compatible with professional standards of practice. The point is that service users may be fearful that workers will be asked for information from other family/community members. The crucial issue, however, is how the small size of communities exacerbates the potential for overlapping networks between South Asian practitioners and service users, so that it can be difficult to maintain the level of anonymity required for service users to feel safe. Hence, one policy recommendation emerging from the worker and survivor interviews is to employ South Asian workers who do not live in the same area as the service user.
13. The study as a whole was conducted between July 2000 and March 2001. However, the senior manager interviews took place between November 2000 and January 2001.

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❑ Erica Burman is professor of psychology and women's studies at Manchester Metropolitan University, where she co-directs the Discourse Unit and currently convenes the Women's Studies Research Centre. Her research engages with critiques of, especially developmental, psychology in relation to questions of theory, method and practice. Her recent books include the edited *Deconstructing Feminist Psychology* (Sage, 1998) and co-edited *Culture, Power and Difference* (Zed/UCT Press, 1998). She is currently working on various projects concerning intersections of gender, culture and models of psychological therapy provision and practice, including attending to the role of representations of childhood and how this enters into the false/recovered memory debates. She is also a group analyst. *Address*: Department of Psychology and Speech Pathology, Manchester Metropolitan University, Hathersage Road, Manchester M13 0JA, UK. email: e.burman@mmu.ac.uk ❑

❑ Khatidja Chantler is an independent researcher who also undertakes consultancy work and is a counsellor and supervisor. She has worked in health and social care settings, in both the statutory and voluntary sectors, for over 20 years. She has also been a tutor on professional training courses in social work and counselling. She is committed to working towards more inclusive and innovative approaches to health and social care, particularly around 'race', culture, gender and class. Recent articles include 'Self-harm and Culture' (*Community Care*, February 2002) and 'The Invisibility of Black Women in Mental Health Services' (*Mental Health Review*, March 2002). ❑

❑ Janet Batsleer is a senior lecturer in the department of applied community studies at Manchester Metropolitan University. She is also active in a young people's mental health project in Manchester, 42nd Street. She has recently edited a special edition of the journal *Youth and Policy* on sexuality and has written on attempted suicide and self-harm with Helen Spandler in her jointly edited (with Beth Humphries) book *Welfare, Exclusion and Political Agency* (Routledge, 2000). ❑