



Shifa

Surrey and Borders Partnership



NHS Foundation Trust

COMMUNITY ENGAGEMENT PROJECT:

The National Institute for Mental Health in England Mental Health programme

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING ON 'Why people over the age of 50 from Pakistani, Bengali, Indian, Nepalese and Chinese communities who are living in the North and West Surrey areas do not access mental health services provided by the NHS Trust in North West Surrey and part of North East Hampshire

BY

SHIFA

(Community group in Woking, Surrey)

Conducted by:

Ghazala Waheed, Siu Wan Thomas, Mariam Altaf

Rohit Gurung, Ishrat Ahmad

March 2008

Funded by

The National Institute for Mental Health in England

Managed and supported by

The Centre for Ethnicity and Health, University of Central Lancashire



Care Services Improvement Partnership **CSIP**

PROFILES OF THE SHIFA RESEARCHERS

The following were involved in the development and delivery of this research project:

Ghazala Waheed – the lead researcher for Shifa as well as the coordinator of this project. She is the funder of Shifa, a support group for Asian women with mild mental health problems and emotional health issues. She has been working in the community for the last eight years initially as the Chairperson for WAWA (Working Asian Women Association) and later on worked in the CMHT (community mental health team) as an ethnic link worker for the Asian clients. She also worked as a project coordinator for Explore Club which was an after school club for ethnic minority children and families.

Siu Wan Thomas – a researcher for Shifa, covering Chinese community in Woking. She is a Chinese language teacher and a professional interpreter and translator. She has been an active volunteer for over ten years and has gained vast experiences working with local Chinese community. She was a former Chairperson of the Chinese Association of Woking and the headteacher of the Woking Chinese School. She was also a former nurse and a midwife. Her experiences have led her to her present involvement. She recently completed Postgraduate Certificate in Management & Leadership of Voluntary Organisation.

Mariam Altaf – 28 years old. She has been working as a link worker for Shifa since 2004, providing outreach support to women in Woking. She will be using her position in the community to conduct research with the Pakistani Community in Woking. Previous research experience includes research conducted while doing degree in Early Childhood studies which looks at psychological perspectives of child development. This provided her with an educated insight while she worked in various infant schools. As part of her role in this project, she has been involved in developing the questionnaire with the team, interviewing respondents as well as providing administrative support.

Rohit Kumar Gurung – 44 years old, a Shifa researcher for the mental health research of Nepalese people of 50 plus. He is the current Chairman of Greater Rushmoor Nepalese Community. His work focuses on social harmony of the Nepalese and others in the Rushmoor Borough Council and part of Surrey and Berkshire areas. His objectives include engaging a social cohesion society through cultural, educational and social activities and, integration with the locals by conducting and participating in sports, social and volunteer activities. Rohit has a Law and Science degree from Tribhuvan University, Nepal. He was the President for the society of Medical Sales Representative of Nepal for 5 years.

Ishrat Jahan Ahmed – a researcher for the Bengali and Indian community. She has been a support worker for women information centre, LIAISE (Local Information, Advice and Support Exchange) since 1997. Within this role she supports women and coordinates all the activities including counselling, ESOL and mental health related workshops. She is also the school liaison officer and bilingual staff for Surrey County Council's ELMA (Ethnic and Language Minority

Achievement) team providing mother tongue assessment and support to Bengali, Pakistani, Indian, Sri Lankan and Middle Eastern families for the last five years.

TABLE OF CONTENTS

PROFILES OF THE SHIFA RESEARCHERS.....	2
Table of contents	3-4
List of tables and figures	5-6
LIST OF ABBREVIATIONS	7
.....	8
ACKNOWLEDGEMENTS.....	
EXECUTIVE SUMMARY.....	9-12
1. INTRODUCTION.....	13-22
1.1. Background of the national project.....	
1.1.1. The Centre for Ethnicity and Health’s Model of community engagement.....	
1.1.2. The key ingredients of the model.....	
1.1.3. The community engagement team.....	
1.1.4. Programme outcomes.....	
1.1.5. The focus of this report.....	
1.2. Background information of project areas and host organisation....	
1.2.1. Population and issues.....	
1.2.2. Profile of BME in the areas and information on mental health services.....	
1.2.3. Background of Shifa.....	
1.3. Aims and objectives of the study.....	
1.3.1. Reasons of this research.....	
1.3.2. The aims and objectives.....	
2. METHOD.....	23-25
2.1. Methods.....	
2.2. Reflection.....	
3. RESULTS.....	26-50
SECTION 1 – CORE DATA.....	
SECTION 2 – KNOWLEDGE AND AWARENESS OF MENTAL HEALTH.....	
SECTION 3 – LACK OF ACCESS OF LOCAL SERVICES.....	
SECTION 4 – GENERAL QUESTIONS.....	
4. DISCUSSION.....	51-65
4.1. Core data.....	
4.2. Knowledge and awareness of mental health.....	
4.3. Lack of access of local mental health services.....	
4.4. General issues/views.....	
5. REFLECTIONS	66-68

LIST OF TABLES AND FIGURES

1. Table I		The National Census of 2001 population of ethnic groups in the North West Surrey and North East Hampshire area.....	16
2. Table II		The percentage of population shown in Woking (the North West Surrey) in 2006.....	16
3. RESULTS			
Figure 1.1	q1.1	Age last birthday.....	26
Table 1.1	q1.2	Gender.....	
Figure 1.2	q1.3	Ethnicity.....	27
Table 1.2	q1.4	Were you born in the UK?	27
Table 1.3	q1.4	How long have you lived in UK	28
Figure 1.3	q1.4	How long have you lived in UK	28
Table 1.4	q1.5	Are you a:	29
Table 1.5	q1.6	What is your first language? Spoken.....	29
Table 1.6	q1.6	What is your first language? Written.....	30
Table 1.7	q1.7	Which languages are you fluent in? Spoken.....	30
Table 1.8	q1.7	What Languages are you fluent in? Written.....	31
Figure 1.4	q1.8	Religion.....	31
Figure 1.9	q1.9	Sexuality.....	32
Table 1.9	q1.10	Do you have a disability.....	32
Table 2.1	q2.1	Understand by Mental Health – Positive perceptions.....	33
Table 2.2	q2.1	Understand by Mental Health – Negative perceptions.....	33
Figure 2.1	q2.2	Community understanding of mental health is.....	34
Table 2.3	q2.3	Range.....	35
Table 2.4	q2.4	Social Issues.....	35
Table 2.5	q2.5	Mental health issues.....	35
Table 2.6	q2.5a	How long.....	36
Table 2.7	q2.6	Did you seek help?	36
Figure 2.2	q2.6	Seek further help.....	36
Table 2.8	q2.7	List of local Mental Health services.....	37
Figure 2.3	q2.8	Did you have problem in accessing the services.....	38
Table 2.9	q2.9	If yes, what was the problem?	39
Table 2.10	q2.9a	What action did you take?	39
Table 3.1	q3.1	Factors for accessing Mental Health.....	39
Table 3.2	q3.2	Accessing problems on Mental Health services for you & close ones.....	40
Table 3.3	q3.3	How can the local mental health services be improved to meet your individual needs?	41
Table 3.4	q3.4	Awareness of services for carers within Mental Health.....	42
Table 3.5	q3.5	Preference Order (Chinese Community).....	43
Table 3.6	q3.5	Preference Order (Indian Community).....	43
Table 3.7	q3.5	Preference Order (Pakistani Community).....	43

Table 3.8	q3.5	Preference Order (Bengali Community).....	43
Table 3.9	q3.5	Preference Order (Nepali Community).....	45
Table 4.1	q4.1	How could your community play a role in developing services?	45
Figure 4.1	q4.2	Does your community need mental health services	45
Table 4.2	q4.3	Mental Health Services and location.....	46
Figure 4.2	q4.4	Consider alternative therapies.....	46
Table 4.3	q4.4a	Which alternative therapy?	46
Figure 4.3	q4.5	Experience of Mental Health in community.....	46

LIST OF ABBREVIATIONS

BME	Black and Minority Ethnic
CEP	Community Engagement Programme
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CSIP	Care Services Improvement Partnership
DATs	Drug Action Teams
DH	Department of Health
ELMA	Ethnic and Language Minority Achievement
ESOL	English for speakers of other languages
LIAISE	Local Information, Advice and Support Exchange
MH	Mental health
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
PCT	Primary Care Trust
REL	Racial Equality Lead
SABPT	Surrey and Borders Partnership NHS Foundation Trust
UCLan	University of Central Lancashire
WAWA	Woking Asian Women Association

ACKNOWLEDGEMENTS

The Shifa research team would like to acknowledge the Ethnicity and Health, University of Central Lancashire for providing training, support and guidance to this project, The National Institute for Mental Health in England (NIMHE) for providing funding, Surrey and Borders Partnership NHS Foundation Trust for commissioning the work to Shifa and promoting the work locally.

We are particularly grateful to Anthony Kollie, the Uclan support worker for his consistent support, flexible approach and supervision to our team. Our sincere thanks also go to Pam Howard and Manjit Bola, the UCLan lecturers for providing valuable and productive workshops which proved beneficial in carrying out our research.

We are grateful to members of the project steering group who provided us with support, advice, resources and feedback on written drafts . They include:

Poppy Jaman, the Race Equality Lead (South East);

Alex Martin, Interim Diversity Manager of Surrey and Borders Partnership NHS Foundation Trust;

Raj Chettri, Older Persons Mental Health Service Day Hospital Manager/ Diversity & Equality Champion Adviser of Surrey and Borders Partnership NHS Foundation Trust

Paul Field, Director of Services, Corner House mental Health Services

Anthony Kollie Centre for Ethnicity and Health, UCLan

We would like to thank Jabeen Qureshi, Health Link worker from Primary Care Trust, Woking for helping us to engage with Pakistani community, through her work experience and knowledge of the community.

We are thankful to Beng Poh, Amanda Lee, Emma Haleem and Susan Hawken for allowing the research to take place at the Chinese Community Project and Woking Chinese School.

Last but not the least, we would like to thank all the research participants from the Chinese Association of Woking, Pakistani, Indian, Bangladeshi and Nepalese communities for giving their precious time and views to make this study possible.

EXECUTIVE SUMMARY

Shifa was commissioned by Surrey and Borders Partnership NHS Foundation Trust (SABP) in 2007 to undertake this research project which focuses on 'Why people over the age of 50 from Pakistani, Bengali, Indian, Nepalese and Chinese communities who are living in the North and West Surrey areas do not access mental health services provided by the NHS Trust in North West Surrey and part of North East Hampshire'.

This research project is part of the Community Engagement Programme funded by National Institute for Mental Health in England (NIMHE) and supported by the Centre for Ethnicity and Health, University of Central Lancashire. The research is linked to the 'Delivering Race Equality (DRE) which is a national action plan set by Department of Health (2005) aiming to achieve equality and tackle discrimination in mental health services in England for all people of Black and minority ethnic (BME) status including those of Irish or Mediterranean origin and east European migrants.

To conduct this research Shifa recruited five researchers, one from each target community and a lead researcher was appointed from the team. All five researchers came with wealth of working experiences in the community as well as with older people. Researchers attended community engagement training workshops which were delivered by The Teaching and Learning Team of UCLan. The training consisted of two mental health workshops and five research workshops. In addition UCLan assigned to the team Anthony Kollie as Support Worker to provide regular support and advice and also help the group to implement the research project according to UCLAN CEP programme. Additional support was provided by the steering group and individual members of the Team.

Aims and objectives

- To investigate the causes of the low intake of the mental health services by 50 plus BME population in stated areas.
- To ascertain the understanding, awareness and attitudes of the older BME people about the mental health in designated areas.
- To find out the extent of the mental health issues experienced by people in this community.
- To address the level of provision of the services in the area as well as to find out the issues around access of these services by this age group.

Methods

The researchers developed a semi –structured questionnaire research tool and used a snowball sampling technique to target respondents who were both service users and non service users. Respondents provided quantitative and qualitative information.

Results and discussion

A total of 85 respondents from five communities were consulted analysed. 28% from the Pakistani community, 26% from Chinese, 18% from Nepalese, 16% from Bengali and 12% from the Indian community. The gender balance was 59% male with highest from the Nepalese community and 41% female with highest from the Chinese community. 98% were born outside of the UK but most of them have lived in the UK for more than 11 years. Majority were Muslims. More than 90% said English was their second language.

More than 90% of respondents said their communities knew little or nothing about mental health issues. 45% of those respondents were from the Nepalese community.

All respondents however said that mental health was quite common in their communities.

98% said that they have experienced some form of mental illness of which 74% had experienced stress for more than 6 months. 28% had experienced depression while 54% experienced isolation and loneliness.

More than 60% did not seek help due to barriers including:

55% said language barriers of which 40% said they did get help with translators.

More than half had issues around stigma and shame while others had issues around confidentiality on the part of staff.

“Everything is hidden under the carpet. It is about family shame and honour. If it is a girl she will not be able to get married, if it’s a boy then what about his future”. (Female respondent)

“Mental health problem makes a person very vulnerable. There is guilt and shame involved as if some how it is the person’s fault that he has an illness which cannot be seen as physical illness. All in mind because he/she cannot care/look after the family. Cannot be a good role model for children. Hide the fact so that it does not affect the children’s chance of getting married or being pointed out by the community as ‘odd one out’. (Male respondent)

49% said due to inappropriate or culturally sensitive service.

More than 50% were not aware of local mental health service.

“The most help I received when I was desperate for help for my depression was through Shifa. I used to talk to other ladies in the group which helped and I felt better”. (Pakistani respondent)

92% of respondents said that they take up alternative treatment like talking therapies or other alternative?

Recommendations

The recommendations based on these issues are:

Awareness and education

There is a need for awareness about mental health education across all communities. The awareness is mainly required to eliminate the stigma and taboo associated with mental health in these communities. The understanding of the mental health in these communities is very constricted, according to the results of the research; people make a link to mental health only when someone is severely affected by a mental health problem for example schizophrenia. They associate more readily with depression, anxiety, stress and panic attacks but they hardly relate this to mental health.

- The education and awareness is required for both service users and staff from the statutory or voluntary organisations. In order to deliver these programmes of education more presentations, workshops, seminars and talks etc is required on the local level where access is easier for the community.
- Literature in community languages as well as information and awareness in different formats for example DVDs is also required for increased understanding and information about the mental health.
- There is a need for an educated professional from each community to act as an interpreter as well as an advocate who understands mental health services and issues and interpret the information between the community and the statutory organisation.

Outreach BME staff

A need for outreach workers and staff from BME background is also expressed by respondents on numerous occasions in the research.

- More BME workers in the community are required so that they can help the community in accessing the services available in the mental health organisation. Moreover these workers could also help people to gain access from generic to the mental health sector.
- BME workers with community language skills and interpreting skills are also needed in the community to help people with translating.

Social groups

Isolation and loneliness was mentioned by many respondents as one of the causes of depression and other mental health issues.

- More support groups are required to organise social gatherings, outings, befriending service, cultural events and entertaining activities for the community. These groups could provide a place for socialising as well as help in reducing stigma and taboo linked with mental health. They eventually could benefit the community in preventing the onset of the mental health problems in people's lives.

Transport

Affordable community transport is also highlighted as a need for many people in the community.

- Community buses are required with better and local routes are necessary to improve mobility in the community. Older people mainly require transport to places like GP, hospital, town, community centres and visiting family and friends in the area.

Alternative therapies

- Trained family counsellors who are also aware of the community issues and know the community language, are needed in the community.
- Trained consultants who could provide therapy in yoga, thai chi, acupuncture, seeking advice from religious leaders and homeopathy is required in the community.

1. INTRODUCTION

The introduction includes some background information about the national project, some background information about Shifa and the aims and objectives of the study.

1.1 Background of the national project

1.1.1. The Centre for Ethnicity and Health's Model of community engagement

We often hear the following words or phrases:

- Community consultation
- Community representation
- Community involvement/participation
- Community empowerment
- Community development
- Community engagement

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and Minority Ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their

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

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

- Substance misuse
- Criminal justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher education
- Asylum seekers and refugees

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

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

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, and the National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard and Aim higher.

1.1.2. The key ingredients of the model

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community¹, such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below).

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

It is important that the host community organisation is able to co-ordinate the work and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

The second key ingredient is the research task that the community undertakes. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers². A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project³.

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

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

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

1.1.3. The community engagement team

The community engagement team comprises of senior support workers, support workers, teaching and learning staff, administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker		Senior Support Worker	
Support Workers	Support Workers	Support Workers	Drug Interventions Programme
			Citizen Shaped Policing
Teaching And Learning Team			
Administration Team			
Communications Officer			

1.1.4. Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and ‘hard to reach’ communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.
- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.

- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

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

1.1.5. The focus of this report

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

National Institute for Mental Health in England Community Engagement Programme:

SHIFA Group was one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007. The objectives of the programme were to deliver improve equality of access, experience and outcomes for Black and Minority Ethnic mental health service users by: Chinese, Pakistani, Indian, Bangladeshi and Nepalese.

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

The focus of our work was: ***'Why people over the age of 50 from Pakistani, Bengali, Indian, Nepalese and Chinese communities who are living in the North and West Surrey areas do not access mental health services provided by the NHS Trust in North West Surrey and part of North East Hampshire'***.

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

1.2. Background information of project areas and host organisation

1.2.1. Population and issues

Surrey and Border Partnership NHS Foundation Trust has a large catchment area of BME population of diverse religions and cultural needs. The predominant BME concentration of the population is in North West Surrey (Woking) and North East Hampshire (Rushmoor) areas. The source of our research participants – Chinese, Pakistani, Indian, Bangladeshi and Nepalese are based in these two regions. However, there is no specific research data for Nepalese population recorded anywhere as this is a relatively new community group

According to the information of Woking Borough Council and Hampshire County Council, the National Census of 2001 for the ethnic groups of Indian, Pakistani, Bangladeshi and Chinese are recorded as follows:

Table I – The National Census of 2001 population of ethnic groups in the North West Surrey and North East Hampshire area

Ethnic Groups	Woking (North West Surrey)	Rushmoor (North East Hampshire area)
Population	89,840	90,987
Indian	961	664
Pakistani	3517	418
Bangladeshi	289	100
Chinese	424	591
Nepalese	No record	No record

The age and ethnic group population in 2006:

There is no recorded census data in Rushmoor (North East Hampshire area) in 2006. Moreover, the population of Woking (North West Surrey) in mid 2006 was 90,700 as displayed by the Woking Borough Council, of which:

Table II – the percentage of population shown in Woking (the North West Surrey) in 2006

Aged between 15 and 69	66.1%
Aged 65 and over	14.7%
For Black and Minority Ethnic population:	
Mixed background	1.3%
Asian or Asian British	5.8%
Black or Black British	0.5%

Chinese	0.5%
Other Ethnic groups	0.6%

Our research participants of Chinese, Pakistani, Indian and Bangladeshi fall into the above groups.

1.2.2. Profile of BME in the areas and information on mental health services

Chinese community

During 1960s and 70s, there was a large influx of immigrants from Hong Kong to UK, the majority of them were farmers whose lands were purchased by the Government to develop 'satellite towns'. They came to UK to find employment and without other skills, most engaged in the catering trade. In mid 1990s, there was another influx of Chinese from mainland China who mainly came to study in UK colleges and universities or worked as researchers.

Most of the Chinese live in the major UK cities and towns, the rest are spread all over Britain. In Surrey, pockets of Chinese reside in Woking, Guildford, Farnborough, Farnham, Frimley, Camberley, West Byfleet, Cobham, Chobham, Weybridge, Epsom, Egham, Addlestone, Chertsey, New Haw and Walton-on-Thames. Nevertheless, Woking has the most concentrated population of Chinese. Chinese living in these areas are largely originated from Mainland China, Hong Kong, Malaysia, Singapore and Taiwan. Many of them are engaged in catering, Chinese shops and related businesses with long and unsocial working hours. There is an increasing number entering into professions such as: accounting, nursing, medicine, pharmaceutical and IT fields. Woking has become the cultural, educational and social heart for the Chinese, as there is a Chinese community organisation as well as a Chinese school providing Chinese language, culture, arts, tradition and social integration services. The Chinese community celebrates the Chinese New Year and All Nations Party with the British public each year.

There is no existing provision of community health services from the Chinese organization or any outreach community services from the public health sectors, which includes the mental health and counselling services. Yet, the actual needs of Chinese families might have been underestimated because of their language and cultural barriers on seeking help from public services provider. This is a particular difficulty for older Chinese and the newly arrivals who are isolated and without family network, as well as lacking the English language skills, insufficient knowledge and confidences to access statutory support services. Chinese people are under-represented in the available data on mental health.

Pakistani Community

Woking has the largest Asian community in Surrey, predominately consisting of Pakistani Muslims. Additionally, Woking has the oldest mosque in the UK - Shah Jahan Mosque which was commissioned by Dr Gottlieb Wilhelm Leitner and built in 1889. This was a first ever purposed built mosque in Britain. The purpose was to provide a place of worship for Muslim students at the nearby Oriental Institute and, subsequently it has become the central focus for regular prayers, religious and community events for the Pakistani Muslim community in Woking and surrounding areas.

The Mela Festival is the most popular annual community event with its central theme of 'diverse communities get together to share their positive work'. Mela is held in the ground of Shah Jahan Mosque, participated by many voluntary and statutory organisations, i.e. Police, careers, fire service, Woking Borough Council, Surrey County Council, trading standard agency, many local health and voluntary organisations etc. The event is open to public. The Mosque provides free food for every visitor who comes to the Mela. It has become the main attraction to many communities in Surrey.

The influx of the Pakistani community started in England in 1950s & 60s due to the labour shortage in England. Initially, only men came to work in factories without their families. In late 1960s & early 1970, families started to join them. They came from strong religious and cultural background and took pride in it. Many are isolated as they left their extended families behind. They also encountered language barriers.

In Woking, many Pakistanis have now set up their private businesses, such as: Taxi, local grocery shops and stores. Within the Pakistani community, there is also not much awareness about the mental health issues. Mental health is a very sensitive subject to them and people don't want to talk about it however it does not mean that they don't need the support of mental health services.

Indian Community

During 1970s, a large number of Indians came from Kenya and Uganda. Most of them were professionals, i.e. doctors, accountants and business people. Most of our research respondents came from these two regions with some from the Sikh and Hindu communities. Many of them speak Gujarati; they are academic, high achievers and qualified professionals. There are few Indians in our community engagement programme who work in [lower](#) skilled/paid jobs such as factories or catering.

The current influx of Indians to Woking comes from Southern India. They are highly skilled with IT background. They take pride in their heritage. They believe in yoga and spirituality for their mental health well being. Many of their diets are plant based, especially the Gujarati Jain who are strictly vegetarians. They believe in ahimsa (non violent to any forms of life) and karma 'as you sow, so shall you reap'– if one becomes ill, it is because one might have committed sins in one's past life.

Bengali Community

The influx of Bengali community started in 1965 to 70s, most of them were from the Sylhet district. They worked mainly in the catering business. In the beginning they lived in London, but in mid 1970s, some of them moved out of London to live in Surrey due to the demand for the Indian takeaway. They settled in Woking, Camberley, Guildford, Farnham, Aldershot, Ascott, Sunningdale, Egham, Esher, Epsom and Staines.

Up until now, there have been no Bengali community groups or mosque for the Bengali to get together socially though the older Bengali community feels more settled now and rooted because of the children born in this country. They celebrate their religious and cultural events where they would have big community get together. Only recently they have a community centre in Aldershot and Camberley where they meet regularly as a group. There is a small group of Bengali who meet in school in Woking. Many suffer from stress due to their families left behind. They have language, social and cultural barriers. There is

not much awareness of the mental health and disability issues amongst the Bengali community.

Nepalese Community

The Nepalese community started settling in England in 2003 though there is no known research data recorded anywhere. These were mainly the Gurkha army of Nepalese families who have served the British army for the minimum of 22 years up until 1997. They were given settlement visas in October 2004 in recognition of their services to Britain.

There is a significant Nepalese population in Greater Rushmoor and this is where our mental health community research was based. The area has some 1400 Nepalese and 200 families of Gurkhas Army serving. This accounts for more than 2000 Nepalese living in the area. The Greater Rushmoor Nepalese Community is a charity registered community organization which began in 2004. The objectives of the community are to ensure social harmony of Nepalese and others in the Rushmoor Borough Council and the vicinity area which includes part of Surrey and Berkshire; to engage a social cohesion programme amongst the community through cultural, educational and social activities and; to integrate the Nepalese community with the locals by conducting and participating in Sports, social and voluntary activities.

As far as Mental Health concerns, there is a lack of awareness within the Nepalese community. Hopefully, the mental health research of Nepalese people of ages 50 plus will give us an insight into learning about what their knowledge and understanding is. Will there be any repercussions on mental health and facilities provided by NHS? If the mental health services are culturally, traditionally and socially appropriate for them?

1.2.3. Background of Shifa

Shifa is an independent voluntary organisation with a community based support group for Asian women in Woking. The group was established in April 2003 specifically for Asian women with emotional health problems. It aims to provide a safe and secure setting where members can socialise without feeling stigmatised or isolated. Group members are encouraged to develop life-long learning skills which may help them to increase their self-confidence and self-esteem. Shifa also focuses on the complex cultural and spiritual needs of its Asian women members, an area where help was not available in the past.

Shifa has been successful in bidding for the European funding through the global Grants three times to serve the disadvantaged. The funds were used to provide various leisure and learning activities for Asian women who have the mental health issues. The activities aim to empower the women.

The activities include the following:

Report writing

- ESOL class (English as a second language)
- 10 weeks sewing course
- Computer literacy course
- Women's health course
- Effective communication course
- Cooking class
- Trips to seaside and Hampton Court palace
- Shopping trips to Southall and Birmingham

- Celebration of cultural events – Eid and Diwali
- Yoga
- Presentation talk on domestic violence through women's aid

Shifa used the funds to provide in house crèche and transport services for the ladies who attend these activities. By offering the above courses, social, leisure activities and outings, Shifa works towards preventing the development of acute mental health issues in amongst the Asian women community.

1.3. Aims and objectives of the study

1.3.1. Reasons for this research:

Despite the cultural enrichment to Surrey and of the NHS Trust catchment area, the take up of mainstream mental health services by the older Asian and other BME clients does appear to be low for many complex reason, primarily because statistics about Asian users of the NHS Trust services are more difficult to determine owing to an under recording of ethnicity. Visits to the Older People in-patient services and examination of caseloads in older people community teams show an almost absence of user of older people mental health services from the BME backgrounds.

1.3.2. The aims and objectives:

- Low intake of the mental health services provided by the statutory organisation.
- Low engagement of services especially Asian women in the health service
- To develop and identify the causes of the low intake of the mental health services by older BME communities
- To consult the Asian communities in Woking and North East Hampshire area about Mental health needs.
- To gather the views, perceptions and information about older people with mental health problems from local Asian communities.
- To examine how mental health services are accessed by older people from Asian communities with Mental Health problems.
- To explore levels of mental health problems among the Asian communities in the stated areas.
- To identify attitudes towards mental illness within the Asian community.
- To identify the support needs of older people from Asian communities with mental health problems.
- To ensure that Asian communities gain a better understanding of the mental health issues for their communities.
- To highlight the extent of older people with mental illness within the older Asian communities.
- To determine current community needs in relation to service and support for the older Asian person living in the stated areas.
- To explore current service provision for these communities.

2. METHODS

2.1. Methods used

Recruitment of researchers

Shifa produced an advert for the recruitment of BME researchers. A formal memorandum was circulated to local voluntary agencies in all local communities in Surrey. As a result several applicants were interviewed and five were selected and recruited as researchers. Each one represented one of the five target communities. Siu Wan Thomas was recruited from the Chinese Community, Ghazala Waheed (lead researcher) and Mariam Altaf were recruited from the Pakistani community, Rohit Gurung was from the Nepalese community and Ishrat Ahmad was from the Bengali community. All researchers had varied experiences of working in the community with older people and some in the mental health field.

All of our researchers attended community engagement training programme which was delivered by the teaching and learning team of UCLan. The training consisted of two mental health workshops and five research workshops, which started in May 2007. UCLan assigned Anthony Kollie as Support Worker for the team to provide regular support, advice and help the group implementing the research project according to UCLAN CEP programme.

Researchers – roles and responsibilities

The role of the research team was to organise the research project using the CEP approach. Key tasks included:

- set up a steering group
- access local communities and promote the research project in target communities
- design and develop the research tools, i.e. questionnaire (*Appendix 1*), information sheet (*Appendix 2*), consent form (*Appendix 3*), Publicity flyers in English and Chinese (*Appendix 4*) and Ethical Proforma (*Appendix 5*),
- pilot test the questionnaires
- network with local organisations
- organise interviews and venues
- explain the research objectives and information to respondents, as well as get them to sign the consent forms
- recruit respondents
- interview respondents
- take notes, translate information to respondents as required
- collate data
- analyse data
- write final report

How you selected your sample

We used snowball sampling to target our respondents. This technique was useful as the research is limited to participants aged over 50 and this method helped to identify a few respondents who fit the criteria and they in turn nominated others. Our respondents included service users as well as non-service users. Semi Structured questionnaire was used to carry out one to one interviews with individual respondents.

Ethical consideration

Ethics protect the safety, dignity and well being of research participants as well as the researcher. The ethical Proforma outlines all the steps taken to carry out the research. This is to ensure that no one is endangered as a result of the project and that the research conducted is of good quality. The Ethical Proforma (see *Appendix 5*) prepared was a code of conduct which addressed all issues to ensure that the research carried out was ethical. It outlines how, when and where the research will be conducted, as well as, how the research team will be supported and supervised.

To guarantee that the participants were fully aware of the nature of the research an information sheet was provided to them (see *Appendix 2*). At this point they were given an opportunity to ask any questions about the project they might like. Once they understood the nature of the study and were willing to participate then their consent was gained (see *Appendix 3*) and they were ensured that all the information will be treated highly confidentially. All their names would be kept anonymous. To maintain confidentiality all the collected data are stored in locked cupboards at the Shifa group centre. We also considered the effect of the study on the participant. To ensure the wellbeing of the participants they had the choice to terminate the interview at any point they liked, if it upsets them. Finally, to assure the health and safety of the researchers they worked in pairs.

To sum up, the following points were paramount in our ethical consideration:

- confidentiality
- anonymity
- explanation
- health and safety for researchers and respondents
- research tools - information sheet, consent form and Ethical Proforma
- ethical approval by the relevant body

The role of steering groups

The steering group has been the back-bone of this research project. Members were recruited with the help of Surrey and Borders Partnership NHS Foundation Trust and the group encouraged Shifa to become a lead community partner. They were involved from the start by producing a funding application which was considered by UCLan with a successful outcome. They provided vital information regarding the BME population in the considered areas as well as providing necessary links to the target communities, and information to organize the background work in order to conduct the research. The steering group continued to support the Shifa researchers in the allocation of budgets, provided consultation, management and monitoring of the progress of the project work throughout.

Surrey and Borders Partnership NHS Foundation Trust (SABP)

SABP provides Mental Health and Learning Disability services across Surrey. The Trust provided information, management and support to the community research for mental health project. SABP commissioned Shifa for this project because of its uniqueness on specialising in the mental health issues of the BME women in communities in Surrey.

How we accessed our communities

We accessed the views of the participating communities through semi-structured interviews by using a well designed questionnaire (see *Appendix 1*), which consisted of quantitative and qualitative data. All the researchers are active members or volunteers of their communities and thus have a good relationship with their community members. They used their position to access the communities via their community centres and recommendation by other relevant community groups by means of '*snow-ball sampling*' method. During interviews, the views of the participating communities were recorded on tape and notes were taken in response to the set questions which were asked in a semi-structured interview.

Findings by analysing questionnaires through semi-structured interview

Our particular research questionnaire comprises of both open-ended and closed questions. The quantitative data utilized several question types – open, list, category, quantity, ranking, scale and grid; the data is presented in tabular form, charts and graphs. The numbers and percentages for each question are recorded and correlations established.

We collected our qualitative data through using *open-ended questions*; we created a summary sheet for all questions. Answers were summarised, categories were created for different emerging themes. The data was then placed under these themes. The rate of the frequently emerging themes was counted up to present the data in a tabular form as a number and the percentage was calculated too. In analysing the data, we highlighted the relevant points, quoted comments of the respondents in a manner which does not lead to their identification in any way, thus maintaining their anonymity.

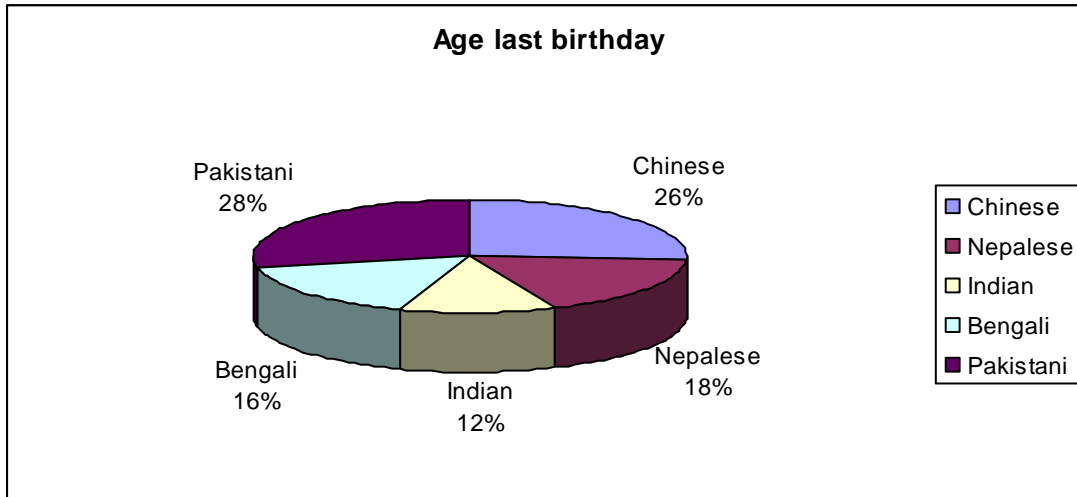
3. RESULTS

SECTION 1 – CORE DATA

1.1 Age last birthday: N=85 unless stated otherwise

All of our respondents were over the age of 50 years; the chart below shows the percentage of each participating community.

Figure 1.1



1.2 Gender:N=85

Table 1.1

Gender	Number / %					
	C	I	P	B	N	T%
1. Male	4	5	8	5	13	41
2. Female	18	5	16	9	2	59
3. Transgender or transsexual	0	0	0	0	0	0

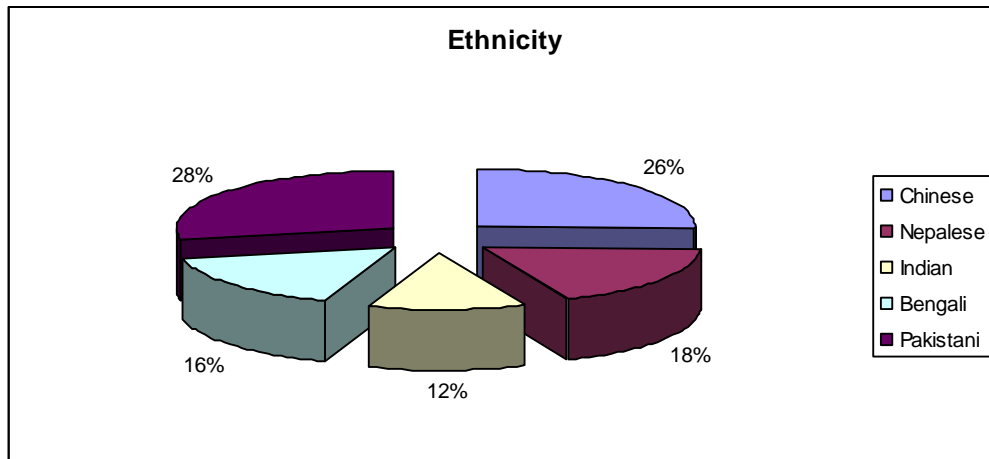
C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

Percentage of male respondents: 41%

Percentage of female respondents: 59%

1.3 Ethnicity:

Figure 1.2



1.4 Were you born in the UK:

Table 1.2

	Number / %					
	C	I	P	B	N	T/%
1. Yes	0	0	0	2	0	2
2. No	22	10	24	12	15	98

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

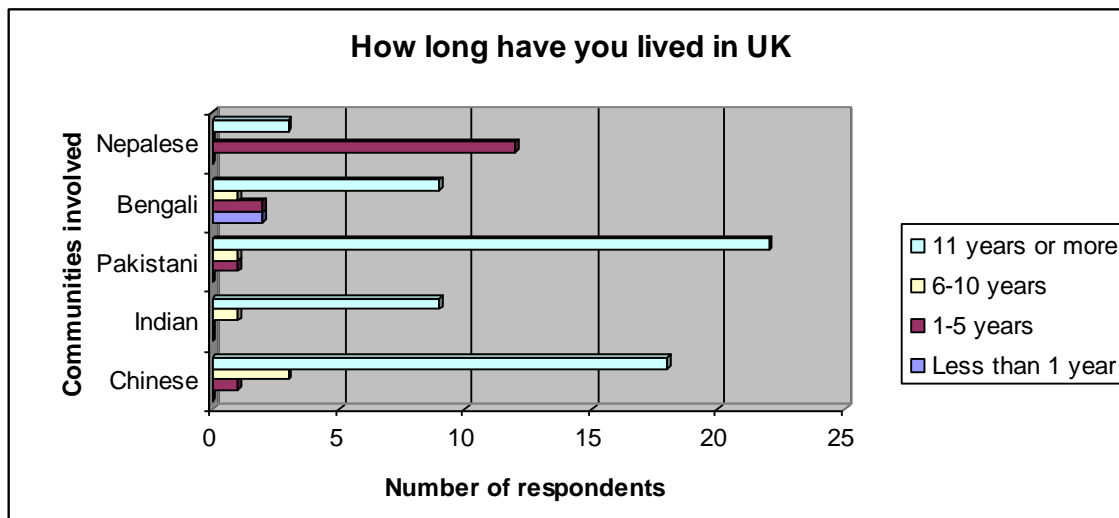
All the respondents from Chinese, Indian, Pakistani and Nepali community were born outside of UK where as 14% of Bengali respondents were born in UK.

Table 1.3

How long have you lived in UK	Number / %					
	C	I	P	B	N	T/%
1. Less than 1 year	0	0	0	1	0	1
2. 1-5 years	1	0	1	2	12	19
3. 6-10 years	3	1	1	1	0	7
4. 11 years or more	18	9	22	8	3	71

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

Figure 1.3



82% of the Chinese respondents have lived in UK for more than 11 years, 14% have lived here for 6-10 years while 4% have been living here for 1-5 years.

90% of the Indian respondents have lived in UK for more than 11 years while 10% have been living here for 6-10 years.

92% of the respondents from Pakistani community have lived in the UK for more than 11 years, 4% have lived here for 6-10 years and 4% have been living here for 1-5 years only.

58% of the Bengali community respondents have lived here for more than 11 years, 7% have lived in the UK for 6-10 years, 14% have lived in UK for 1-5 years while 7% have been living in UK for less than 1 year, while 14% were born in the UK.

20% of the Nepalese respondents have been residing in UK for more than 11 years while 80% of them have been in UK for 1-5 years.

1.5 Are you a:

Table 1.4

	Number / %					
	C	I	P	B	N	T/%
1. British Citizen	16	9	21	7	1	64
2. Refugee	0	0	0	0	0	0
3. Asylum seeker	0	0	0	0	1	1
4. Do not wish to answer	0	0	1	0	0	1
5. Other						
Chinese citizen	1	0	0	0	0	1
American citizen	1	0	0	0	0	1
Australian citizen	1	0	0	0	0	1
Bangladeshi citizen	0	0	0	3	0	5
Indefinite leave to remain in UK	2	1	2	2	13	24

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

1.6 What is your first language? Spoken

Table1.5

What is your <u>first</u> language? Spoken	Number / %					
	C	I	P	B	N	T/%
Nepali	0	0	0	0	14	16
Hindi	0	3	0	0	0	3
Gurung	0	0	0	0	8	9
English	0	4	3	2	0	10
Bengali	0	0	0	14	0	16
Urdu	0	2	9	0	0	13
Punjabi	0	2	16	0	0	21
Gujrati	0	2	0	0	0	2
Persian	0	0	0	0	0	0
Pushto	0	0	2	0	0	2
Cantonese	13	0	0	0	0	15
Mandarin	4	0	0	0	0	5
Hokkien & Cantonese	1	0	0	0	0	1
Waitau & Cantonese	1	0	0	0	0	1
Thai language	1	0	0	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

Table1.6

What is your <u>first</u> language? Written	Number / %					
	C	I	P	B	N	T/%
Nepali	0	0	0	0	13	15
Hindi	0	2	0	0	0	2
Gurung	0	0	0	0	1	1
English	5	3	3	2	0	15
Bengali	0	0	0	13	0	15
Urdu	0	2	8	0	0	12
Punjabi	0	1	2	0	0	4
Persian	0	0	0	0	0	0
Pushto	0	0	2	0	0	2
Gujrati	0	2	0	0	0	2
Chinese	16	0	0	0	0	19
Thai	1	0	0	0	0	1
Not Stated	0	0	0	0	0	0

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

1.7 Which languages are you fluent in? Spoken

Table1.7

What languages are you fluent in? spoken	Number / %					
	C	I	P	B	N	T/%
Nepali	0	0	0	0	14	17
Hindi	0	3	0	5	1	11
Gurung	0	0	0	0	5	6
English	15	10	6	9	1	48
Bengali	0	0	1	13	0	17
Urdu	0	1	11	2	0	17
Punjabi	0	2	18	0	0	24
German	0	0	0	0	1	1
Gujrati	0	3	0	0	0	4
French	0	1	0	0	0	1
Persian	0	1	0	0	0	1
Pushto	0	0	2	0	0	2
Tamil	0	3	2	0	0	6
Sinhala	0	0	2	0	0	2
Sindhi	0	0	1	0	0	1
Cantonese	14	0	0	0	0	17
Mandarin	9	0	0	0	0	11
Shanghaiese	1	0	0	0	0	1
Thai	1	0	0	0	0	1
Waitau	1	0	0	0	0	1
Hokkien	1	0	0	0	0	1
Hakka	1	0	0	0	0	1

Not Stated	0	0	0	0	0	0
------------	---	---	---	---	---	---

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

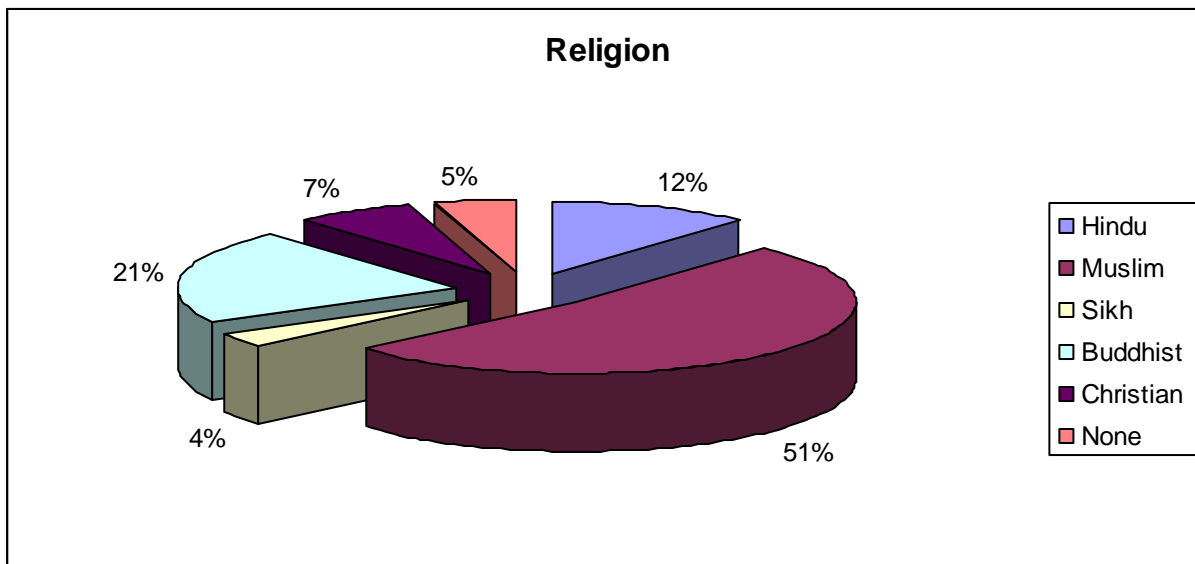
Table 1.8

What Languages are you fluent in? Written	Number / %					
	C	I	P	B	N	T/%
Nepali	0	0	0	0	12	14
Hindi	0	2	0	0	1	4
Gurung	0	0	0	0	0	0
English	16	10	6	8	1	48
Bengali	0	0	0	13	0	15
Urdu	0	1	7	1	0	11
Punjabi	0	1	3	0	0	5
Sinhala	0	0	1	0	0	1
Gujrati	0	2	0	0	0	2
French	0	0	0	0	0	0
Persian	0	0	0	0	0	0
Pushto	0	0	2	0	0	2
Chinese	15	0	0	0	0	18
Not Stated	0	0	0	0	0	0

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

1.8 What is your religion:

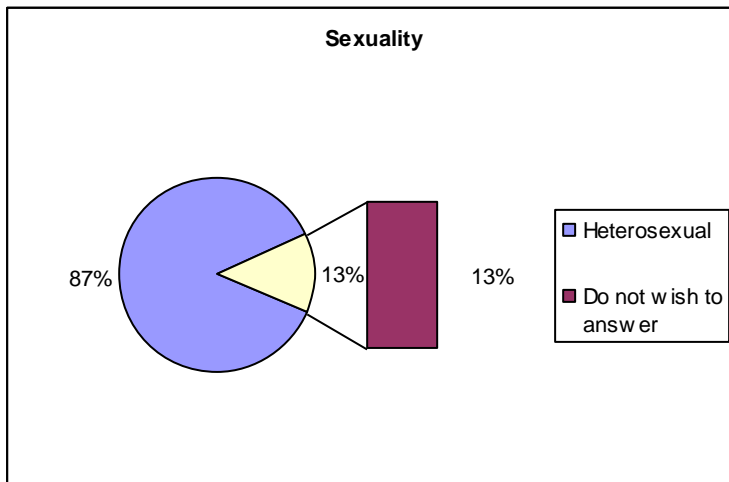
Figure 1.4



C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

1.9 Sexuality:

Figure 1.9



1.10 Do you have a disability:

Table1.9

	Number / %					
	C	I	P	B	N	T/%
1. Yes	2 (physical)	0	1(physical)	0	5(physical)	9
2. No	20	10	22	14	10	90
Do no wish to answer	0	0	1	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

90% of the respondents claimed no disability and 9% had some form of physical disability e.g. sight and back problem, whereas, only 1% of the respondents chose not to answer.

SECTION 2 – KNOWLEDGE AND AWARENESS OF MENTAL HEALTH

Table 2.1

Understand by Mental Health – Positive perceptions	Number %					
	C	I	P	B	N	T/%
1. None	0	2	6	0	0	9
2. State of mentality	2	1	1	0	6	12
3. Mentally and physically healthy, everything is balanced	7	0	3	2	3	18
4. The ability to function and cope normally	1	1	2	0	2	7
5. You don't do bad things and not interfere with others	1	0	0	1	0	2
6. The state of psychological, emotional & mental condition	3	1	0	0	1	6
7. To associate what is right or wrong	1	0	0	0	2	4
8. Able to interact	1	0	1	0	1	4
9. Able to think for themselves	1	0	3	0	5	11
10. Is aware and has knowledge of what mental problem is	1				1	2
11. Being happy	0	1	3	0	3	8
12. Having no stress	0	1	3	1	2	8
13. Not forgetting	0	0	0	0	1	1
14. Not being on any medication	0	0	0	1	0	1
15. Well adjusted	0	0	0	1	0	1
16. Mental fitness	0	0	0	1	0	1
18. Blessing	0	0	1	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

Table 2.2

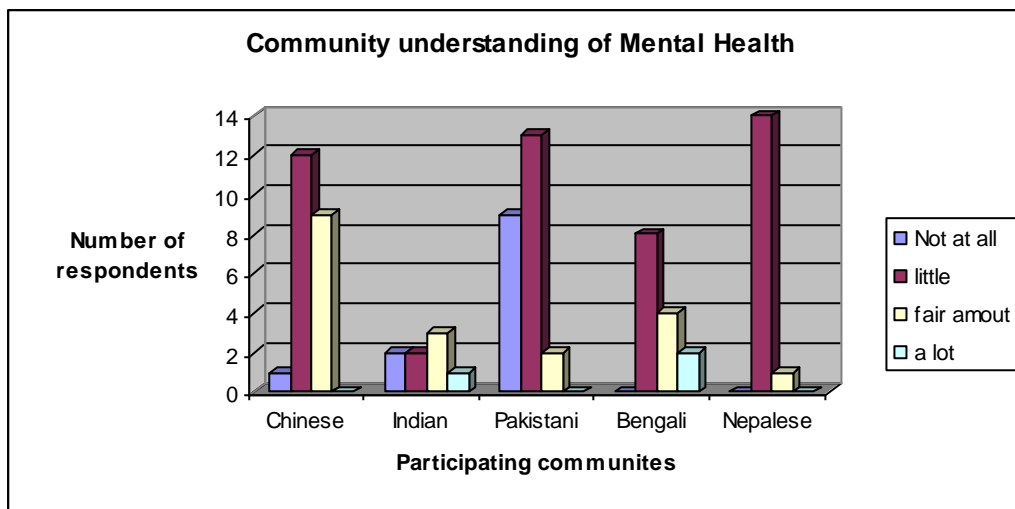
Understand by Mental Health – Negative perceptions	Number / %					
	C	I	P	B	N	T/%
1. Mental illness	1	1	4	1	0	8
2. You are born with it	1	0	0	0	0	1
3. Unhappy or depression or suffering	4	1	3	0	2	12
4. Mental and physical unbalance	3	0	1	1	1	7
5. A mad person	2	0	2	3	0	8
6. Drug or alcohol related	2	0	0	0	0	2
7. Appears normal but actually dangerous	1	0	0	0	0	1
8. Abnormal in their thinking, mind & emotion,	2	0	2	1	0	6
9. Problems related to stress & isolation	2	0	2	1	0	6

10. Problems related to family or environmental circumstances	2	1	1	2	0	7
11. Occurred after illness but can be cured	1	0	1	0	0	2
12. Is aware and has knowledge of what mental problem is	1	0	0	0	1	2
13. Mind stops working as a result of a shock	0	0	0	2	0	2
14. People who don't understand	0	0	1	1	0	2
15. A variety of MH problems not just mad	0	0	0	1	0	1
16. Effects on the brain	0	0	3	2	0	6
17. Dissatisfied, disheartened/ Thankless to god	0	1	1	0	0	2
18. Weakness/shame	0	0	1	0	0	1
19. Curse/ Black magic	0	0	1	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

2.2 How well do you think your community know of and understand mental health issues?

Figure 2.1



2.3 In your opinion, how common are mental health issues in your community?

Table 2.3

Range	Number / %					
	C	I	P	B	N	T/%
1. Not at all	6	2	0	0	0	9
2. Average	8	0	4	1	6	22
3. Quite common	8	7	19	12	9	65
4. Fair amount	0	0	0	0	0	0
5. Extremely common	0	1	1	1	0	4

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

Majority of the respondents felt that mental health issues were 'Quite common' in their community.

2.4 Have you experienced any of the following social issues?

Table 2.4

Social Issues	Number / %					
	C	I	P	B	N	T/%
None	0	6	2	1	0	11
1. Stigma	7	3	8	3	9	35
2. Shame	3	2	8	7	10	35
3. Guilt	4	2	7	7	3	27
4. Cultural shock/migration	5	3	7	6	6	32
5. Language barrier	12	0	16	9	5	49
6. Isolation	10	4	15	11	6	54
7. Witch craft/superstition/curse	0	0	3	0	0	4
8. Resentment	1	1	6	8	7	27
9. Immigration Issues	6	2	4	9	7	33
10. Domestic Violence	1	0	4	10	0	18
11. Other	3	1	0	5	2	13

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

High percentage of the respondents had suffered from isolation and faced language barrier.

2.5 Have you ever experienced any of the following mental health issues?

Table 2.5

Mental health Issues	Number / %					
	C	I	P	B	N	T/%
1. None	0	1	1	2	6	12
1. Stress	17	8	20	12	6	74
2. Dementia	0	0	0	1	1	2
3. Anorexia	0	0	0	0	1	1
4. Anxiety	15	7	12	0	5	46
5. Panic attacks	2	3	3	9	1	21
6. Schizophrenia	1	3	1	6	0	13

7. Depression	7	0	10	1	6	28
8. Phobia	2	0	4	5	0	13
9. Nervous Breakdown	3	2	1	6	3	18
10. Other	0	0	0	0	0	0

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

2.5a How long have you experience it for?

Table 2.6

How long	Number / %					
	C	I	P	B	N	T/%
1. None	0	2	1	5	6	17
2. Less than 3 months	3	3	6	3	1	19
3. 0-3 months	3	0	2	1	1	8
4. 3-6 months	1	1	1	0	1	5
5. More than 6 months	11	4	14	5	6	47

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

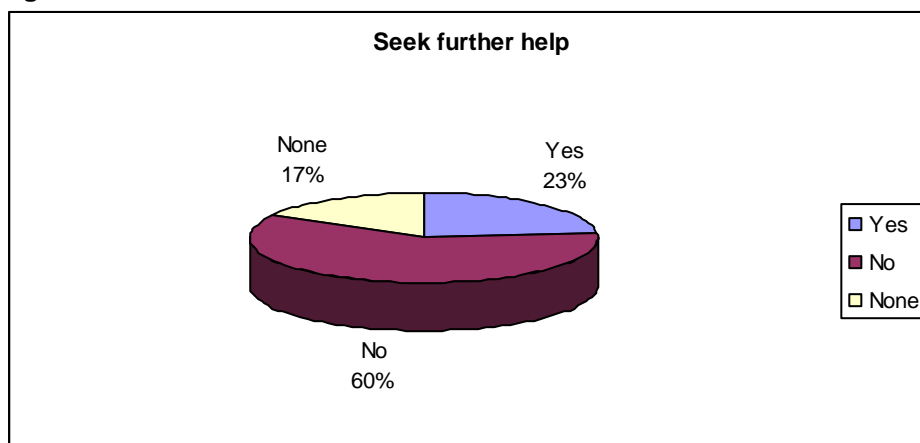
2.6 Did you seek help?

Table 2.7

	Number / %					
	C	I	P	B	N	T/%
1. None	4	1	1	2	6	17
2. Yes	3	5	6	4	2	23
3. No	15	4	17	8	7	60

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

Figure 2.2



Despite a high percentage of respondents who suffered from mental health problems for more than 6 months only 23% seek help.

2.7 below is a list of services, please tick if you have never heard of, heard of or used these services.

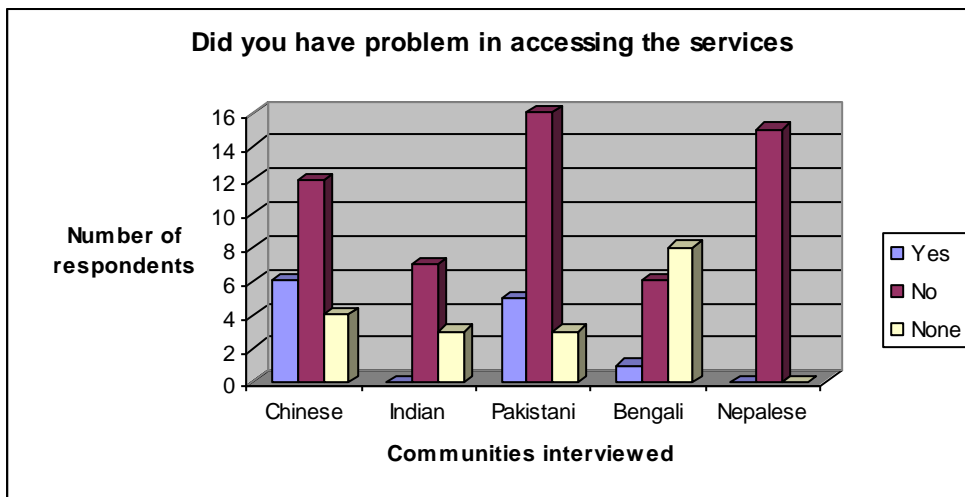
Table 2.8

List of local Mental Health services		Never Heard of	Heard of	Used	If used how did you find this service:
1	Abraham Cowley Unit	49	26	6	very poor / poor / satisfactory (6) / excellent
2	Age Concern	41	40	4	very poor / poor / satisfactory (2) / excellent(2)
3	Alzheimer's Society	58	27		very poor / poor / satisfactory / excellent
4	Bridgewell House-Community Mental Health Team	61	12	8	very poor / poor(1) / satisfactory (7) / excellent
5	Carers Support Woking	47	32	6	very poor / poor / satisfactory (5) / excellent(1)
6	Cedar House ward & Day Hospital	72	13		very poor / poor / satisfactory / excellent
7	Depression Support Group Woking	74	11		very poor / poor / satisfactory / excellent
8	Just Advocacy (Community Partners)	84	1		very poor / poor / satisfactory / excellent
9	Keyring - Living Support Networks	80	5		very poor / poor / satisfactory / excellent
10	Khidmat Group	67	12	6	very poor / poor / satisfactory (4) / excellent(2)
11	LIAISE	51	23	10	very poor / poor / satisfactory / excellent(10)
12	Multiple Sclerosis Society - Woking Runnymede Wey bridge	70	15		very poor / poor / satisfactory / excellent
13	Older Person's Mental Health Unit- Farnham Road Hospital	63	11	1	very poor / poor / satisfactory(1) / excellent
14	One to One (North West Surrey)	82	3		very poor / poor / satisfactory / excellent
15	Onslow Crescent Day Hospital –	82	3		very poor / poor / satisfactory / excellent

	Covering North East Hampshire				
16	Open Door Counselling Service	83	2		very poor / poor / satisfactory / excellent
17	Relate – West Surrey	71	13	1	very poor / poor / satisfactory / excellent(1)
18	Saneline	82	3		very poor / poor / satisfactory / excellent
19	SHIFA	56	21	8	very poor / poor / satisfactory(4) / excellent(4)
20	WIDE (Woking Information for Disability Enquiries)	74	11		very poor / poor / satisfactory / excellent
21	Walton and Weybridge advocacy group-WWAG	81	4		very poor / poor / satisfactory / excellent
22	Woking Accord	82	3		very poor / poor / satisfactory / excellent
23	Citizens Advice Bureau	15	26	44	very poor / poor (3) / satisfactory (24) / excellent(17)
24	Woking Counselling Service	67	13	5	very poor / poor(1) / satisfactory (3) / excellent(1)
25	Woking Mencap Society	68	17		very poor / poor / satisfactory / excellent
26	Woking MIND	79	6		very poor / poor / satisfactory / excellent

2.8 If you have used any of the mentioned services, was there any problem in accessing them?

Figure 2.3



2.9 If yes, what was the problem?

Table 2.9

If yes, what was the problem?	Number / %					
	C	I	P	B	N	T/%
1. None	17	10	20	13	15	88
2. Cannot help my problem	3	0	0	0	0	4
3. Phoned helpline but no answer	1	0	0	0	0	1
4. My doctor did not refer me to any professional	1	0	0	0	0	1
5. Broke the confidentiality	1	0	0	0	0	1
6. Language	0	0	3	0	0	4
7. Transport	0	0	3	0	0	4
8. Long waiting list	0	0	0	1	0	1
9. Counselling culturally not appropriate	0	0	0	1	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

2.9a what action did you take?

Table 2.10

What action did you take?	Number / %					
	C	I	P	B	N	T/%
1. None	15	10	21	13	15	87
2. Community support	1	0	0	0	0	1
3. Approached other services	3	0	1	0	0	5
4. Friends and family help	1	0	3	0	0	5
5. Counsellor	1	0	0	0	0	1
6. God helped me	1	0	0	0	0	1
7. Complained and ceased the service uptake	0	0	0	1	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

SECTION 3 – LACK OF ACCESS OF LOCAL SERVICES

3.1 How do any of the following factors below affect you in receiving mental health services in your area?

Table 3.1

Factors for accessing Mental Health	Number / %					
	C	I	P	B	N	T/%
1. None	0	7	2	1	0	12
2. Cultural, shameful, not good to let others know, or MH is negative, it means crazy, services are mixed sex	4	2	17	6	13	49
3. Religious	0	1	6	7	12	31

4. Spiritual	1	1	3	5	13	27
5. Language barrier	3	2	19	10	13	55
6. Translation /interpretation service	0	1	15	7	11	40
7. Transportation	0	1	14	7	3	29
8. Other						
I) Physical needs	1	0	0	0	0	1
II) Emotional factors (hope to recover through self adjustment)	1	0	0	0	0	1
III) Money issue	1	0	0	0	0	1
IV) Friends and family may reject	1	0	0	0	0	1
V) No help available/services after patient is discharged into community	0	1	0	0	0	1
VI) Important to have frontline staff from BME communities for better understanding of problem and diagnosis	0	0	1	0	0	1
VII) Illiteracy: people don't know how to access the services; unable to read unable to access.	0	0	1	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

3.2 If you or someone close to you needed to get support for a mental health problem what would stop you from accessing Mental Health services? Please state

Table 3.2

Accessing problems on Mental Health services for you & close ones	Number / %					
	C	I	P	B	N	T/%
1. None	6	1	3	3	3	19
2. Language barriers	6	5	6	3	12	38
3. The service are not meeting needs	3	1	3	0	0	8
4. The difficulty is the starting process of finding/accessing the MH services	1	1	10	0	0	14
5. Services are not offered discreetly	0	2	1	0	0	4
6. Cultural factors – shameful, not good to let others know	2	0	9	5	0	19
7. Self-denial, Stigma /Attitude	3	2	5	6	0	19
8. Self help/ self adjustment	1	0	0	0	0	1
9. Support from friends and families would be sufficient.	1	1	0	0	0	2
10. Do not trust any counsellors or psychologist	2	0	0	0	0	2
11. The person involved may refuse to access the mental health services	3	0	3	0	0	7
12. Confidentiality	2	0	3	0	0	6
13. External stress/pressure	1	0	0	0	0	1
14. Unable to express the problems in	1	0	0	0	0	1

words						
15. Education issue – people who are well educated take notice of their mental health but those less educated might not do the same	1	0	0	0	0	1
16. Availability of qualified counsellors with understanding of ethnic and cultural backgrounds	1	0	2	0	1	5
17. Being a female – N	0	0	0	0	1	1
18. Lack of transport	0	0	1	1	0	2
19. Lack of time from family and friends	0	0	0	1	0	1
20. Fear of taking drugs with long-term side effects	0	0	0	1	0	1
21. Being labelled on paper thus unable to get a job	0	0	1	1	0	2
22. The person may be so ill that doesn't know what to do	0	0	0	1	0	1
23. Superstition/possessed	0	1	0	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

3.3 How can the local mental health services be improved to meet your individual needs?

Table 3.3

How can the local mental health services be improved to meet your individual needs?	Number / %					
	C	I	P	B	N	T/%
1. None	7	5	10	3	1	31
2. Provide interpreting services	5	0	1	3	4	15
3. Counselling is not helpful	1	3	0	0	0	5
4. Public teaching / information and awareness about MH	5	0	1	1	1	9
5. Keeping confidentiality	1	1	1	2	0	6
6. Flexibility in providing the mental health services	1	0	3	1	0	6
7. Organised referrals and proper follow ups for mental health problems	1	0	0	0	0	1
8. Access to psychiatrist & psychologist	2	0	2	0	1	6
9. Referrals to counsellors and alternative therapies	1	0	3	0	3	6
10. More cultural awareness training for service providers from various statutory /non-statutory organisations.	6	0	0	1	0	8
11. Publicity leaflets or small booklets in English and other languages	1	0	0	1	0	2
12. Recruitment of people from different ethnic background to the MH service	1	1	4	1	1	9

13. "The doctor should not change medicine so readily"	1	0	0	0	0	1
14. CMHT should have more outreach workers	0	0	1	0	1	2
15. Agency involved should be more active	0	0	0	2	1	4
16. Services should be placed locally	0	3	3	4	3	15
17. Provide culturally traditional help	0	1	2	0	1	5
18. Help should be provided through a community group	0	1	2	0	1	5
19. Transport provision	0	0	0	1	0	1
20. Home tutoring to teach English	0	0	0	1	0	1
21. Encouragement to ask for help	0	0	0	2	0	2
22. Social clubs and activities should be provided to stop the development of MH issues	0	0	2	0	0	2
23. GPs should help to keep physically fit by giving correct medication	0	0	1	0	0	1
24. Should provide educational services to stimulate brain	0	0	1	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

3.4 Are you aware of any services for carers within Mental Health?

Table 3.4

Awareness of services for carers within Mental Health	Number / %					
	C	I	P	B	N	T/%
1. No	17	8	12	10	14	56
2. Not sure	3	2	8	3	1	20
3. Yes	2	0	3	1	0	24
i) Through friends and family	2					
ii) Abraham Cowley Unit			1			
iii) Carer's support			1			
iv) CMHT			1			
v) GP			1			

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

3.5 In your opinion which of the following could help to improve access to and knowledge of mental health in your community? (Choose at least 6 options or more and rate from 1 onwards with 1 being most useful/helpful and 6 being least)

- 1 Mental Health information leaflets..... []
- 2 Mental Health information in different languages..... []
- 3 Audio information / Video information..... []

- 4 Website..... []
- 5 Trained interpreters..... []
- 6 Talks & presentations on MH..... []
- 7 Talks & presentations on MH in different languages... []
- 8 Workshops & open days on MH services..... []
- 9 MH outreach / community workers..... []
- 10 More BME trained staff in MH services..... []
- 11 Training for all staff on cultural awareness..... []
- 12 Mosques/ faith organisations..... []
- 13 Community Groups..... []
- 14 Culture Works / BME specific MH service..... []
- 15 Patient Advice & Liaison service - PALS..... []
- 16 Doctors / G.P's Surgeries..... []
- 17 Education on MH in Schools / Colleges..... []
- 18 Other..... []

Please state

Chinese community

7 Chinese respondents rated option 2 (mental health information in different languages) as most helpful and useful regarding the knowledge and access about mental health in their community whereas 5 Chinese respondents regarded option 9 (MH outreach workers) as least useful. Interestingly none rated option 6 at all which was about talks and presentation about the mental health whereas during the interviews many Chinese respondents asked for the need for more knowledge and awareness about the mental health in their community.

Indian community

Option 16 (doctors and GP) was rated as most helpful and useful by 4 Indian respondents and similar number of Indian respondents rated option 1(information leaflets) as least useful in terms of access and knowledge of the mental health in their community. Their choice of highest rated option perhaps reflects their professional background and their confidence in accessing the mental health information from the health professionals.

Pakistani community

For 11 respondents option 5 was rated as highest priority which was about the need for more interpreters and translators whereas option 17 (education on MH in schools etc) was least useful for them. Their high rated option 5 is very reflective of the literacy levels and the language issues among the Pakistani community.

Bengali community

9 respondents rated option 5(translators and interpreters) as most useful and helpful source same as the Pakistani community however option 13 (community groups) was rated

as least useful source of access and awareness about the mental health in their community. Their least popular option says something about the Bengali community as being one of the most hard to reach communities therefore engaging with this community is very challenging. It is very unlikely to find a Bengali community group in surrey area.

Nepalese community

6 respondents rated option 9 (outreach workers) as most useful and 7 respondents chose option 1 (information leaflets) as least useful. For the Nepalese community this programme about the mental health was a new experience. They learnt from the process of the interviews about the mental health issues therefore it feels maybe right for them to have option 9 rated as highest priority and option 1 as least because outreach workers could perhaps provide more support and information as compared to leaflets.

SECTION 4 – GENERAL QUESTIONS

4.1 How could your community play a role in developing services?

Table 4.1

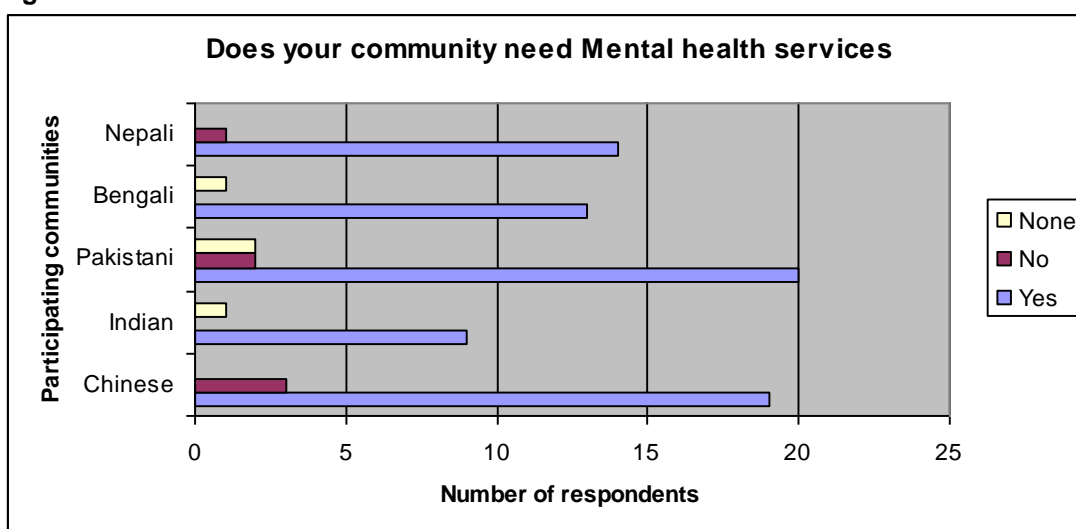
How could your community play a role in developing services?	Number / %					
	C	I	P	B	N	T/%
1. None	1	6	8	2	0	20
2. More qualified and professionally trained MH staff from BME communities	9	0	1	3	1	17
3. Referral to appropriate services	1	1	1	1	1	6
4. BME advisors and advocates to statutory organisations in developing MH services	0	1	7	5	2	18
5. Self-help	2	0	3	0	2	8
6. By participating in all mental health services education	6	2	6	4	0	21
7. Qualified interpreter in mental health issues	1	1	14	1	0	20
8. More support groups in the community to help reduce the stigma and taboo associated with MH.	10	3	2	1	3	22
9. Support from friends families	1	0	2	1	1	6
10. Community link worker with mental health service	2	0	4	3	3	14
11. Providing more outreach services	2	0	1	0	1	5
12. More volunteers available to help the BME communities in providing all aspects of health service	1	0	2	0	0	4
13. Mix with other communities and integrate	0	0	0	0	1	1
14. Community workers should become	0	1	4	3	3	13

proactive						
15. Community should be made aware about MH services	0	2	4	2	6	17
16. Fund raising to open centres	0	0	0	1	0	1
17. Religious leaders can help	0	1	0	0	0	1
18. Form a club for leisure activities and exchange ideas		1	0	0	0	1

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

4.2 Do you think your community needs services for mental well-being?

Figure 4.1



4.3 If yes, what would these services be and where would you suggest these services be located.

Table 4.2

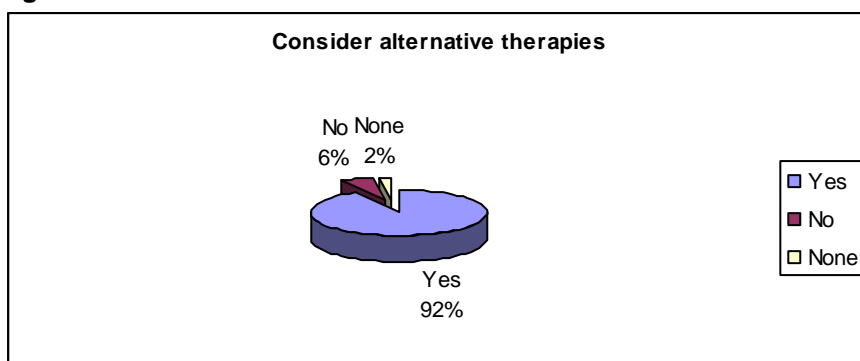
Mental Health Services and location	Number / %					
	C	I	P	B	N	T/%
1. None	0	2	8	3	3	19
2. Services	9	1	3	1	0	28
2.1 Awareness talk/promotion						
2.2) Community project offering learning and leisure programs English, social gathering, social dances cookery tai chi yoga sports	5	1	3	0	0	11
2.3 Support group	3	1	1	0	0	6
2.4 Befriending services	1	1	0	0	0	2
Language services	1	1	2	0	0	5
Transport services	0	0	2	0	0	2
Alternative therapies (Counselling)	2	0	0	0	0	2

service)						
3. Location	10	6	6	8	0	35
3.1 Community centres						
3.2 Day Centre	1	0	0	0	0	1
3.3 Within easy access or close to town	1	3	10	2	7	27
3.4 Local independent organisation	1	3	9	3	10	31
3.5 Council offices	1	0	1	1	0	4
3.6 G. P surgery	1	2	4	3	1	13
3.7 Hospitals	0	2	0	1	1	5
3.8 Faith Organisation	0	2	3	2	0	8
3.9 In areas of concentrated BME population	0	0	2	0	0	2

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

4.4 Would you consider alternative therapies?

Figure 4.2



4.4a If yes, which one/s?

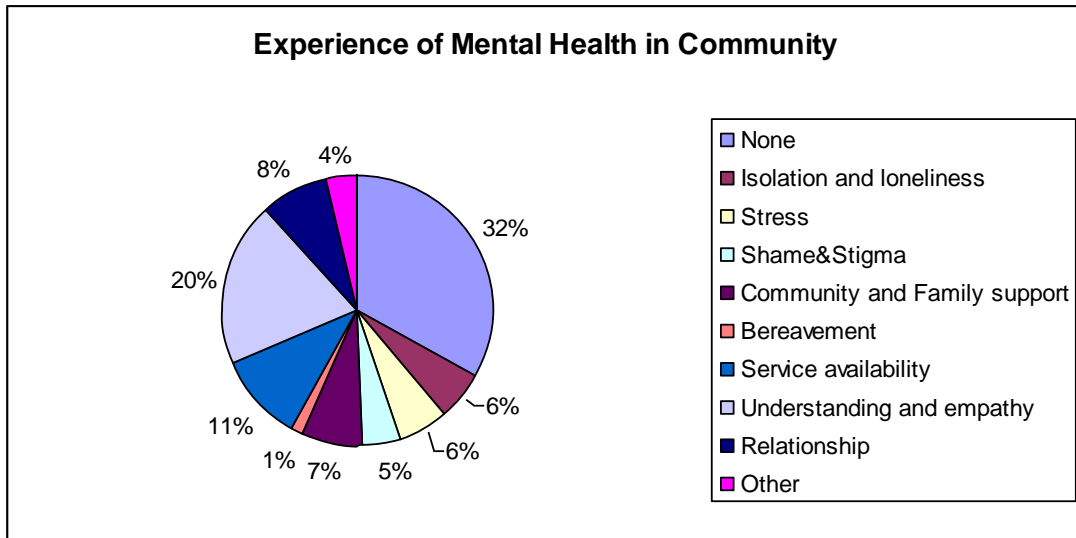
Table 4.3

Which alternative therapy?	Number / %					
	C	I	P	B	N	T/%
1. None	0	1	0	1	1	4
2.. Homeopathy	4	5	10	8	6	39
3. Spiritual healing	5	3	7	11	12	45
4. Meditation	12	7	8	5	0	38
5. Acupuncture	8	1	8	3	9	34
6. Seeking Advice from religious leader	6	5	12	8	4	41
7. Counselling	17	6	10	10	10	62
8. Other massage Chinese medicine, taichi, yoga, mahjong game, community centre, prayer, language service	5	1	2	1	0	11

C=Chinese, I=Indian, P=Pakistani, B=Bangladeshi, N=Nepalese, T=Total

4.5 Do you have any other information that you would like to share about your experience of Mental Health in your community.

Figure 4.3



Mental issues due to:

None:

Nepali-8

Pakistani – 10

Bengali – 5

Indian - 5

Isolation and loneliness

“When I was raising a young family, I needed help but there was none available” (Chinese respondent)

“Community support is important to stop loneliness and depression” (respondents)

“My sister’s severe depression is due to stress, non-stop working, isolation and has no one to talk to”

“Often muslim women are not aware when they are depressed. Isolation is the main factor that contributes to depression. It is essential that we have groups that welcome us as friends instead of seen as an individual from a different nationality, culture or religion” (Pakistani respondent)

*"I was isolated and I didn't want anyone to know, only the doctor could help me".
(Pakistani respondent)*

Stress

"My sister's severe depression is due to stress, non-stop working, isolation and has no one to talk to"

"My friend falls ill whenever he hasn't got a job. Family background and extended family responsibilities puts burden on his brain. A person with no income or secure job indulges in alcohol and it makes his condition worse". (male respondent)

"People should not take unnecessary stress, not everything is in their control. They should rely on god to ease the situation". (female respondent)

"Everyone in every house has stress, worries and issues. Sometimes the way social system works (council matters) matters are made worse and people can get more depressed and also the doctors don't seem to do their jobs properly. They are our first point of contact they should liaise with the hospitals and other agencies, but sometimes they can aggravate the situation" (female respondent)

"As a carer I felt very isolated, the stress was great. It was difficult to keep my job, look after my family and look after a partner who was clinically depressed. The effect it had on my children was also worrying. Friends and family were understanding but at the end of the day it was all on my shoulders". (female respondent)

Shame and stigma

"Individual may feel the shame and stigma so is reluctant to talk about the MH issues"

"Everything is hidden under the carpet. It is about family shame and honour. If it is a girl she will not be able to get married, if it's a boy then what about his future". (female respondent)

"The workers are local so the problem of confidentiality is at stake. People don't know how much to confide. Also of being labelled 'mad' as apposed to being physically ill, causes a problem of marrying and jobs if the fact is known that the person has had some kind of MH problem. The stress on the family is enormous to hide the facts rather than seek advice by asking the relevant organisation and workers". (female respondent)

"Mental health problem makes a person very vulnerable. There is guilt and shame involved as if some how it is the person's fault that he has a illness which cannot be seen as physical illness. All in mind because he/she cannot care/look after the family. Cannot be a good role model for children. Hide the fact so that it does not

affect the children's chance of getting "married or being pointed out by the community as 'odd one out'. (male respondent)

Community/Family support

"The affected person could join in a community group for activities, i.e. conversation, dance and exercises"

"The most help I received when I was desperate for help for my depression was through Shifa. I used to talk to other ladies in the group which helped and I felt better". (Pakistani female)

"Work with a lot of patience and love, slowly and gradually". (Bengali female)

"Family support is very important so they can recover faster and better" (Indian female)

"Should also involve family with the treatment from qualified doctors" (Indian female)

"For the patient, family must support and help along with doctors to bring good results" (Indian male)

Bereavement

"If one's close relatives passed away, should try to talk to the elderly or people with the same experiences"

Service availability

"Talk to GP in emergency, maybe referred to Abraham Cowly Unit"

"Counselling for family (not just for the individuals affected), support and education for any mental health issues"

- Befriending service is important
- Flexibility to deal with the situation
- There are no resources available for Pakistani community. Cultural and religious needs to be met, which if identified can be helped as a precautionary care before the serious MH problems. (Pakistani female)
- People in my community are afraid to take medicine in this country as they don't know what it contains. They prefer to go home and talk to their own doctors who understand their culture/religion and treat with respect. (Bengali female)

"Not only doctors but family must take part in supporting patients morally and mentally so they can recover from their illness faster and better. Also better results can be achieved if doctors also work with the patient's family to administer wholesome health treatment. Medicine alone cannot solve the mental illness if family support is not there". (Indian male)

“Doctors usually prescribe medicine without any auxiliary advice, a women’s club would be ideal to crack this problem. The activity should be secular, yoga classes to relax and heal, exercise and dancing can be performed, meditation and message classes should be held”. (Indian female)

Understanding and empathy

- I think it is individual, depends on attitude to life
- By talking and sharing the problems with people who may/ may not have the same experiences, you can help one another
- Lack of understanding about MH from others. Fear of being labelled
- judged and stigmatised
- Open days/workshops on MH in community
- Improve awareness of MH among Nepalese people
- Women should be consulted by community and health workers
- More awareness and working together to help each other
- Family members should be made aware of MH and its seriousness
- Let people tell their problem so that doctors understand and refer the patient to the right place

“Asian community stereotypes mental health” (Pakistani female)

“Mental health problems occur when people are upset and dependent and away from god. They get upset and stressed and people around them do not try to find the cause of the problem. There is no one to talk to, it scares me to talk to some one in the community because stories are spread”. (Pakistani female)

“We need people in the area who understand mental health. There should be workshops on set dates to increase awareness because sufferers can cause damage like domestic violence and house destruction. People need to be explained about how to deal with such situations. Young people should also be explained about their older community members and how to listen to them. People should be kind to each other and have good thoughts”. (Pakistani male)

People in our community think if you get married MH problems will automatically go away. I just want my daughter to get well enough to look after herself but due to the lack of availability of services for her she is getting worse. (Pakistani female)

- To explain in detail what to do to help

“Community’s attitude is not positive. They think that it is madness, they really don’t understand the difference. Majority consider anyone with MH problems as simply ‘mad’. (Bengali male)

“When there is a case the most important thing is we should not ignore it, take it seriously. We can make a lot of difference if the person is treated with friendliness and sympathy”. (Bengali male)

Relationship

- “The only thing that I am not so happy is my children married to foreigners”
- Close family relationships are important for mental health stability
- Family break up/domestic violence can lead to mental health problems
- Mental wellbeing affects the happy family atmosphere
- We want to keep ourselves happy in the family

Within the community people should help each other. There is a lot of emotional abuse especially between husband and wife. Isolation is also a major issue in our community. (Pakistani female)

“Mainly in our community women suffer from their husbands, in laws and financial problems due to dependence on husbands. These things can be the start of the mental health issues. Men suffer from mental health issues from their work/employment experience. Women also suffer from domestic issues and problems”. (Bengali female)

Other issues

“Young are indulging in smoking, drinking and drug addiction” (Pakistani male)

“Spiritual healing, praying is one of the best ways of combating MH in my community”. (Bengali female)

“What would happen once the carer is no longer there to take care? abuse at homes is a constant worry” (Bengali female)

4. DISCUSSION

The group interviewed 85 respondents and the results were analysed in the following order.

Chinese community

22 Chinese community members were interviewed to collect information and views on MH issues. All of the respondents were over the age of 50 and comprised of 26% of the whole research sample, there were 4 men and 18 women who participated and all of them were born outside of the UK. However, 18 of these respondents have been living in UK for more than 11 years, 3 have been here for 6-19 years and only 1 has been here for 1-5 years. 16 of them are British citizens and 2 with indefinite leave to remain in UK while there were also a Chinese, American and an Australian citizen. Most of the Chinese community members spoke Cantonese as their first language but Mandarin was common too, while almost all of them had Chinese as their first written language. Majority of the Chinese community was also fluent in English both for spoken and written purposes. 12 respondents had no religion, while 6 were Christians, 3 were Buddhist and 1 respondent was Muslim. All of the respondents were heterosexual with majority having no disability and 2 members had some form of physical disability.

Knowledge and awareness of Mental Health

Understanding of mental health

7 respondents thought that mental health is when mental and physical health is in balance. Whereas 4 said that when someone is unhappy or depressed or is suffering. 3 thought that mental health is when mental and physical health is unbalance. 3 more said that mental health is the psychological, emotional and mental condition. 2 regarded mental health as state of mentality and further 2 associated mental health with a mad person. 2 more felt that it's related with drugs and alcohol and additional two said that when someone is abnormal in their thinking, mind and emotions. 2 more thought that mental health is related to stress and isolation and additional 2 said that it's related to family and environmental circumstances. 10 people gave varied views on mental health there responses were, someone is born with it, ability to function and cope normally, when people don't do bad things and don't interfere with others, ability to distinguish between right and wrong, ability to interact and think for themselves, appears normal but actually dangerous, post illness but curable and finally when someone has knowledge of mental health problem.

Here are comments from some of the research participants on the issues of mental health:

"Individual may feel the shame and stigma and so is reluctant to talk about the mental health issues".

"Lack of understanding about mental health from others. Fear of being labelled, judged and stigmatised".

“Family break-ups and domestic violence can lead to mental health problem”.

Understanding mental health issues

About 11 respondents thought that mental health issues are little known to the community whereas nine people said there is a fair amount of understanding of the mental health issues in their community. Only 1 person said not at all.

How common are mental health issues

8 respondents thought the mental health issues are average and similar number thought quite common. 6 respondents replied not at all.

Experience of social issues

12 believed that they experienced language barrier as a social issue in their life. Ten thought that isolation is their experience of the social issue. 7 stated stigma and six mentioned immigration issues. 5 people experienced cultural shock and 4 experienced guilt in their social life. 3 respondents thought shame and one each thought domestic violence and resentment.

Experience of mental health issues

17 respondents have experienced stress in their life and second highest experience was anxiety among 15 Chinese respondents. 7 stated depression followed by 3 nervous breakdown and 2 for phobia and further 2 experienced Panic attacks.

Time-span of the experience

For 11 people the whole experience stayed for more than six months. Three experienced for less than three months whereas three more experienced for up to three months. Only one said between three to six months.

Seek further help

15 did not seek further help whereas 3 said yes and 4 did not reply.

Lack of access of local Mental Health services

Factors for accessing mental health services

4 respondents believed that culture, shame and services being mixed sex have been the factors affecting them to receive mental health services. For 3 respondents language is the factors and one off reasons factors are spiritual factors, physical and emotional factors, money issues, rejection from friends and family.

Accessing problems in getting support from mental health services

For 6 respondents language is the biggest hurdle in accessing support from the mental health service. 3 thought that service are not meeting needs, further 3 said self denial and stigma affects in receiving support and 3 more believed the person may dent from accessing the service. 2 thought culture and shame where as two more believed that they don't trust counsellors and psychologist. Other one off responses were where to start the search for services, self help, support from family and friends, external pressure, unable to express the problem, education issue and unavailability of the counsellors with understanding of ethnic and cultural backgrounds.

How can local mental health services improved to meet individual needs

6 thought that more cultural awareness training is required for the statutory and non statutory service providers. 5 thought more interpreters and five more believed public awareness and teaching about the mental health. 2 believed that access to psychiatrist and psychologist should be improved and other responses were counselling not helpful, confidentiality should be kept high, more flexibility in providing services, organised referrals and follow ups, referrals to alternative therapies, literature in other languages, more staff from BME background and finally doctors should not change the medicine readily.

Services for carers

17 said no, three are not sure and four said yes. (see table 3.4)

Improve access and knowledge of mental health in the community

(see table 3.7)

Chinese female respondent, *“Loneliness can lead to depression and isolation. Community support is very important to stop isolation and we get to know many friends”*.

General issues

How could community play a role in developing services

10 believe that more support groups are needed in the community to reduce the stigma and taboo. 9 believe that more qualified professional are needed from BME backgrounds. 6 consider that people should participate in mental health education. 2 believe self help would be good, further two believe more community link workers in the community and two more thought out services is required. Other responses are referrals to appropriate services, qualified interpreters, support from family and more volunteers to help BME communities.

Need for mental well being services

(see figure 4.1)

Mental health services and location

10 believe that services should be located in community centres, others said day centres, GP surgery, and council offices and within easy access to town centre. 9 consider that there should be more awareness presentations and talks five believe more leisure programmes and three would like to see more groups in the community. 2 consider more alternative therapies and others said befriending and language services.

(see table 4.2)

Consider alternative therapies

(See figure 4.2)

Choosing alternative therapies

17 respondents would like to consider counselling for treating mental health problem. 12 meditations and eight acupuncture. 6 would like to seek advice from religious leader and 5 each would consider spiritual healing and Chinese medicine. 4 consider homeopathy.

Experience of mental health in the community

(see figure 4.3 and see quotes)

. A Chinese male said, “*The affected person could join in a community group for activities, i.e. conversation, dance and exercises*”.

A Chinese female responded on family support relationship, “*The only thing that I am not so happy is my children married to foreigners*”.

It was felt that respondents from the Chinese community cooperated well in the research programme. Their understanding and awareness about mental health was better as compared to other communities especially Napalese and Pakistani community. It seemed like that the Chinese community wanted to improve their mental well being. Although acknowledging mental health issues/problems is very much a taboo matter among Chinese community like all other communities however they were more willing/accepting to make things better for their community. A large percentage of respondents would like to have more information and education about the mental health problems. They wanted more awareness and promotion of the mental health via presentation in the community or open discussions from qualified health professionals like doctors etc.

The respondents said that they would like to see more chinese representation in the mental health sector so the mental health sector could provide them with more culturally friendly service. Those representatives could liaise with the mental health department to understand the diverse needs of the Chinese community in the light of their language and culture.

Almost all Chinese would like to have alternative therapy. The respondents also said that their community needs a counsellor who could speak Chinese and relate with their background. Many respondents felt the need for self help groups in their community. They said that having support groups is a good idea in combating mental health. Interestingly Chinese association in Woking area has been up and running for many years but they don't have any as such solid meeting place where they could conduct their gatherings regularly. The results give an impression that the Chinese community are more forward and open in taking the responsibility for their mental well being. It is quite positive thing in the light of DRE objectives. I

Indian community

10 Indian community members were interviewed, all aged 50 and over and half of them were men and half were women. They comprised of 12% of the whole research sample and were all born outside UK but 9 of them have lived in UK for more than 11 years and they are British citizens while 1 respondent has been here for 6-10years and has indefinite leave to remain in UK. 4 Indian respondents spoke English as their first language, spoke Hindi and Urdu , Punjabi and Gujrati was also spoken by some members. Their first written language was again English for 3 respondents, Hindi for 2, Urdu for 2, Gujrati for 2 and Punjabi for 1 member. All the Indian respondents were fluent in English, 3 in Hindi, 3 in Gujrati, 3 in Tamil, 2 in Punjabi and French, Persian and Urdu were also spoken by some members. They were all fluent in written English as well as 2 in Hindi, 2 in written Gujrati and also some in written Urdu and Punjabi. 6 of the Indian respondents were Muslims, 2 were Hindu and 2 were Sikh. They were all heterosexual individuals and had no disabilities.

Knowledge and awareness of Mental Health

Understanding of mental health

Only few Indian respondents answered this question as they themselves did not know anyone with mental health issues. The majority said that they lived in isolation from other members of this community. Their responses were one of various views for example one said that mental health is when someone is able to function and cope normally. One more thought that mental health is the psychological, emotional and mental condition. One linked mental health with being happy and another said to have no stress in life. Further one of the responses was problems related with family issues and environmental circumstances and finally when someone is dissatisfied and thankful to God.

Understanding of mental health issues

3 respondents thought that there is a fair amount of understanding of the mental health issues in their community. 2 respondents said not at all and further two said a little. Only 1 replied a lot.

3 How common are mental health issues

7 replied that the mental health issues are quite common and 2 said not at all. Only 1 said extremely common.

Experience of social issues

6 respondents gave no thoughts. 4 believed that isolation is their social issue and three thought stigma and further 3 thought cultural shock. 2 believed shame, further 2 believed guilt and two more believed immigration issues. Only 1 mentioned resentment.

Experience of mental health issues

8 respondents have experienced stress and a little less 8 mentioned anxiety. T3 indicated panic attacks and additional three stated schizophrenia only 2 said nervous break down.

Time-span of the experience

4 said more than six months and 3 said less than three months and only one between three to six months.

Seek further help

4 said yes while 4 did not seek help. (see figure 2.2)

Lack of access of mental health services

Factors for accessing mental health

2 believed language barrier, further two believed culture and shame. Other one of the responses were religion, spiritual, translation and interpreting, transport and finally not adequate help after discharge in the community.

Accessing problems in getting support from mental health services

5 mentioned language barrier and two thought that services are not offered discreetly, two more said self denial and stigma affects in accessing the services. Other responses were services not meeting needs, difficult to start the search for services, support from friends and family is sufficient and superstition and possessed.

How can the local mental health services improved to meet individual needs

Three believe that counselling is not helpful; three more believe that services should be placed locally. Other responses are confidentiality, provide cultural help and help through community group.

Services from carers

8 said no, two are not sure while none said yes. (see table 3.4)

Improve access and knowledge of mental health in the community

(see table 3.7)

An Indian male expressed his views on the mental health issues, "*Mental health problems make the person very vulnerable. There is guilt and shame involved as if somehow it is the person's fault that he has illness which cannot be seen as physical illness. I hide the fact so that it does not affect the children's chance of getting married or being pointed out by the community*". .

General issues

How could community play a role in developing services

3 believe more support groups to reduce stigma and shame whereas two believe mental health service education and awareness of mental health in the community. Other responses are appropriate referrals, more BME advocates and advisors, qualified interpreters, pro active community workers, more involvement from the religious leaders and leisure club for social events.

Need for mental well being services

(see figure 4.1)

Mental health services and location

For services respondents consider having awareness talks, community projects for learning and leisure, support groups, befriending and language service. Six believe that these services should be located in the community centres three said within easy access of town and three more said services should be local and independent. Two believe GP surgery and further two believe hospitals and two more said faith organisations.

(see table 4.2)

Consider alternative therapies

(see figure 4.2)

Choosing alternative therapies

Seven would like to consider meditation, six counselling, five homeopathy and further five advice from religious leader and three like to consider spiritual healing. Other responses are massage exercises and acupuncture.

Experience of mental health in the community

(see figure 4.3 and quotes)

An Indian female cited, "Doctors usually prescribed medicine without any auxiliary advice, a woman's club would be ideal to crack this problem. The activity should be secular, yoga

classes to relax and heal, exercises and dancing can be performed, meditation and massage classes should be held”.

It was felt that the Indian respondents were mostly educated and they had professional backgrounds therefore engaging with them for the interview was easy. They were happy to take part in the interview as long as their identities were kept confidential. Due to their educational competence they were more aware of the issues of the mental health. It wasn't hard for them to understand the questionnaire and reply accordingly. It was felt that most of the Indians believed in "Karma" very strongly and it reflected in their answers. For example they believe that if someone has committed a sin or done wrong in the previous life then they will be punished for that in their present life and mental illness could be the result of their Karma or in other words a punishment from God. Some said that they don't live close together within their community therefore don't know much about the mental health problems of their community in the same town or city (unlike Pakistani, Bengali and Nepalese community who live in clusters). When asked about what mental health services they knew most replied CAB (citizen advice bureau). All the rest services listed in the questionnaire was unknown to them. Interestingly they knew about alcohol anonymous but it was not on the list. Only one person knew about Abrahm Cowley unit in Woking. They did ask for the advocates from their own community but not necessarily someone who speaks their own language. As a matter of fact they preferred English language because many different languages are spoken in India and therefore people speak wide range of languages and almost all Indians in this research were articulate in English they didn't require an advocate who could speak their regional language.

Pakistani community

24 respondents from the Pakistani community participated in this engagement programme, all aged 50 and over. There were 16 females and 8 male representing 28% of the research sample. All the respondents were born outside UK and 22 of them had lived here for more than 11 years while 1 had been here for 6-10 years and 1 has been in UK for 1-5 years. 21 members were British citizen and 2 had indefinite leave to remain while 1 respondent did not wish to identify their nationality. Majority of the Pakistani community population spoke Punjabi as their first language and urdu was the second prevalent language, both presenting the figures of 16 and 9 respectively. 3 members also spoke English as their first language while 2 members spoke Pushto. The first written language for 8 respondents was Urdu, 3 wrote English, 2 could write in Punjabi and 2 could write in Pushto. Most of the population was fluent in Pujabi and Urdu while 2 members were also fluent in Sinhala and Tamil. 6 members were fluent in English writing and 7 were fluent in Urdu writing, while only 3 could write in Punjabi, 2 could write in Pushto and 1 was fluent in writing Sinhala. 23 Pakistani respondents were Muslims and 1 was Sikh. 19 of the Pakistani respondents chose not to declare their sexuality while 15 were heterosexual individuals. 22 respondents declared no disabilities, 1 chose not to answer and only 1 respondent had physical disability.

Knowledge and awareness of Mental Health

Understanding of mental health:

Six respondents did not reply to this question. Four associated mental health with mental illness and four more thought that mental health is when physical and mental health is unbalance and affects the brain. Three said that mental health is when mental and physical

health is in balance. Three more felt that it means being happy and the same number said opposite and felt that mental health is when someone is unhappy, depressed and suffers. Three more said that mental health means having no stress in life. Two respondents considered mental health as having an ability to cope and function normally whereas two respondents said that their understanding of mental health is 'a mad person'. Two more said that when someone is abnormal in their thinking, mind and emotions. Another two associated mental health with problems related to stress and isolation. Others one off responses were mental health as blessing, state of mentality, ability to interact, problems related to family and environmental circumstances, curable post illness state, people who don't understand, weakness/shame and curse or black magic. It is interesting to see the mixture of responses from the Pakistani community about their understanding of the mental health. More people consider mental health as a mental state and associate it with the brain, and some regard mental health as a happy and stress free life.

Understanding mental health issues:

About thirteen people think that mental health is little understood by the community whereas nine said its not at all known to the community. Three think that a fair amount understands and only one think that a lot of people understand about mental health issues (Figure 2.1).

How common are mental health issues:

Nineteen people said that mental health issues are quite common in their community, four said average and only one said its extremely common.

Experience of social issues:

Sixteen respondents said that they have experienced language barrier in their social life experience and a little less fifteen said that they have experienced isolation in their social life experience. Eight people said that they have experienced shame and the same number said they have experienced stigma as a social issue. Seven each said guilt and cultural shock and six people experienced resentment. Four numbers of people each said domestic violence and immigration issues whereas three said witch craft and two didn't respond at all.

Experience of mental health issues:

Stress, anxiety and depression are most commonly experienced by many people in the Pakistani community. Stress amounts to have been experienced by twenty, anxiety twelve and depression ten people. Three mentioned panic attacks and four phobias. One each has experienced schizophrenia and nervous breakdown.

Time-span of the experience:

Fourteen people had above experience for more than six months. Six had suffered for less than three months whereas two experienced for up to three months. For one the experience lasted for three to six months.

Seek further help:

For the above experience only six seek further help and seventeen seek no help at all (Figure 2.2).

“We need people in the area who understand mental health. There should be workshops on set dates to increase awareness because sufferers can cause damage like domestic violence and house destruction. People need to be explained about how to deal with such situations. Young people should also be explained about their older community members and how to listen to them. People should be kind to each other and have good thoughts”. (Pakistani male)

Lack of access of local mental health services

Factors for accessing mental health services:

Nineteen felt that language is the biggest factor affecting them in accessing the mental health services. For seventeen people cultural factor that is shame and negative image of mental health affects them in accessing mental health services. Fifteen considered translation and interpreting as affecting factors and fourteen indicated transport. For six, religious factors and for three, spiritual factors affect in accessing mental health services. Among other responses were the importance to have front line BME staff to help people understand the diagnosis/problem and the rate of illiteracy among people and their inability to read therefore unable to access.

Accessing problems in getting support from mental health services :

Ten people felt that initiating the access for services is difficult. Nine people felt that the cultural factors interfere in accessing the services and they feel ashamed that people may find out. Six people said that language is the issue whereas five felt that stigma, self denial and attitude towards mental health is the cause for accessing mental health services. Three people felt that the services don't meet needs same number of people said that people may refuse to access the services and three more said that confidentiality is the problem. Two specified that the lack of the availability of the qualified counsellors with understanding of the ethnic and cultural backgrounds is the problem. One each said that services are not offered discretely, lack of transport and unable to get a job once their illness is recorded on paper.

How can the local mental health services be improved to meet individual needs: Ten people didn't reply to this question. Four felt that more people from ethnic backgrounds should be recruited in mental health services. Three felt that there should be flexibility in the provision of the mental health services and three more felt that referrals should be made to the counselling services as well as other alternatives services. Three more felt that services should be placed locally. Six expressed inter relating views on the need for providing more culturally traditionally help, through community groups and more social activities to stop the development of the mental health issues. Other responses were to provide interpreting services, public teaching/awareness, keeping confidentiality, more outreach workers, educational services to stimulate brain and for GPs to prescribe correct medication to stay physically fit.

Services for carers:

Twelve didn't know any services for carers, eight were not sure and three said yes via friends and family, Abraham cowley unit, carers support, CMHT and GP.

Improve access and knowledge of mental health in the community:

(see table 3.7)

“The most help I received when I was desperate for help for my depression was through Shifa. I used to talk to other ladies in the group which helped and I felt better”. Pakistani female

“There are no resources available for Pakistani community. Cultural and religious needs should be met, which if identified can be helped as a precautionary care before the serious mental health problems”.(Pakistani female)

General issues

How could community play a role in developing services:

Fourteen felt that more qualified interpreters in mental health issues in the community. Seven said that the presentation of BME advisors and advocates to statutory organisations in developing mental health services. Six felt that by participating in mental health education. Four considered link workers and four more felt that link workers should be pro active in what they do. Four said that community should be made aware about the mental health services. Three felt self help and two mentioned community support groups in reducing stigma linked with mental health, two more considered support from family and the other two considered having volunteers in the community to provide all inclusive health service. Other one each response were more professionally qualified mental health staff, referrals to appropriate services and providing more out reach services.

Need for mental well being services:

(Figure 4.1)

Mental health services and location:

Eight didn't suggest anything. Three said that awareness and promotion services are required, three more said that learning and leisure projects should be offered in the community. Two said language services and another two suggested transport services. Ten people suggested that services should be located within easy reach or close to town; nine felt they should be local independent organisations. Four suggested GP surgeries and three felt that they should be based within faith organisations. Two suggested that services should be located in areas of concentrated BME population.

Consider alternative services:

(Figure 4.2)

Choosing alternative therapy:

Twelve people felt that seeking advice from religious leader would be an option for them. Ten considered homeopathy and ten more considered counselling as alternative therapy. Eight each for meditation and acupuncture whereas seven would consider spiritual healing. Only two considered prayer and massage as alternative therapy.

Experience of mental health in community:

(Figure 4.3 and see quotes)

As anticipated before the field work, engagement with the Pakistani community was very difficult. Their awareness about mental health was also very limited. It could be because of the very low literacy level among the pakistani community as well the religious background

of the Pakistani community. The team felt that in order to interview respondents they had to describe the reason for the interview in detail. The interviews were using words like depression, anxiety and stress rather than mental health to get people to cooperate and get interested in giving an interview. The respondents showed reluctance and doubt for taking part in the research. It was also felt that the reason for not giving interviews was not just the issue about mental health but the lack of confidence also prevailed among many Pakistani respondents. When the team approached men to take interviews they were more reluctant than women to give interviews. Stigma about mental health is very tense among the Pakistani community. Respondents were quite defensive when approached to take part in the interview. The team had to explain to them that the questionnaire was not designed to ask direct questions about the individual's mental health state but rather about their views, perceptions and experiences of the mental health care and well-being. Men mainly associated their mental health problems with worries of employment, finances and family. They asked specifically for sports activities within their community to prevent the onset of the mental health issues whereas women asked for more social and leisure groups within the community. Some respondents indicated to link mental health facilities with the local Mosque because they believe that it's easier access for everyone and plus its less stigma to receive the mental health support in the Mosque premises.

Pakistani community also asked for a sustainable educational programme about the mental health in the community. That kind of programme should be in the community language. Some also said to get the younger generation involved in the area of the mental health because respondents felt that the young generation are educated and their understanding about the mental health issues is better. Respondents also asked for more information and support for the carers so they could deal with their situation better and become better carers. Pakistani community asked for more advocates from the community and more representation in the area of mental health from their own community.

Bengali Community

14 people were interviewed from the Bengali community comprising of 16% of the research sample, 5 of them were male and 9 were female, all aged 50 and over. 12 of the Bengali members were born outside UK and 2 were born in UK. 8 of them have been living here for more than 11 years, 1 has been here for 6-19 years, 2 have been living in UK for 1-5 years, whereas, only 1 member has been here for less than 1 year. 7 of them were British citizens 2 had the indefinite leave to remain while 3 were Bengladeshi citizens. They all had Bengali as their first language while 2 members also had English as their first language. 13 members were could also write Bengali as their first language and 2 could write in English. Majority were also fluent in English as well Hindi, and 8 members were also fluent in writing English. 13 Bengali members were Muslim and 1 Buddhist, and they were all heterosexual with no disabilities.

Knowledge and awareness of Mental Health

Understanding of mental health

2 respondents said that mental health is when people are mentally and physically healthy. Three assumed mental health with a mad person. 2 thought problems linked with the family and environmental circumstances while two more believed when mind stops working as a result of shock. Further 2 said mental health affects the brain. One off responses were

having no stress, not being on any medication, well adjusted, mental fitness, abnormal in their thinking, problems related to stress and isolation, people who don't understand, wide mental health problems not just mad.

Understanding of mental health issues

About 8 respondents thought mental health issues are little understood by the community. 5 people said fair amount and to believed a lot. (see figure 2.1)

How common are mental health issues

12 respondents said quite common one each said extremely common and average.

Experience of social issues

For 11 respondents isolation is the social experience for them. 10 respondents believed domestic violence and for 9 its immigration issues and similar number language barrier. 8 indicated resentment, 7 for each guilt and shame. 6 believed cultural shock and only 3 mentioned stigma.

Experience of the mental health issue

For 12 respondents their experience was stress followed by nine panic attacks, 6 for schizophrenia and 6 for nervous break down. 5 said phobia and one said depression.

Time-span of the experience

5 experienced it for more than six months whereas three for less than three months and further three for up to three months.

Seek further help

8 did not seek further help and four replied yes. (see figure 2.2)

“Mainly in our community women suffer from their husbands, in laws and financial problems due to dependence on husbands. These things can be the start of the mental health issues. Men suffer from mental health issues from their work/employment experience. Women also suffer from domestic issues and problems”. Bengali female

“Community’s attitude is not positive. They think that it is madness, they really don’t understand the difference. Majority consider anyone with MH problems as simply ‘mad’”. Bengali male

Lack of access of local mental health services

Factors for accessing mental health services

10 respondents believed language barrier as biggest factor. 7 respondents thought religious factors, further 7 believed translation and interpreting factor and 7 more said transport as a factor in accessing the mental health services. 5 assumed spiritual and 6 culture and shame as factors.

Accessing problems in getting support from mental health services

6 believed self denial and five said culture and shame, 3 believed language barrier and other responses were lack of transport, lack of time from family and friends, fear of taking

medication with long term side effects, unable to get job, an ill person may not know what to do.

How can the local mental health services improved to meet individual needs

4 believe that services should be located locally; 3 believe that more interpreters are required. 2 consider that confidentiality should be kept high, 2 more believe that people should be encouraged to ask, further 2 believe that agencies should be pro active. Other responses are transport facility, home tuition to learn English, more public mental health awareness, more flexible services, cultural awareness training for the service providers, staff from BME backgrounds and information in other languages.

Services for carers

10 said no, 3 are not sure while only one said yes. (see table 3.4)

Improve access and knowledge of mental health in the community

(see table 3.7)

“What would happen once the carer is no longer there to take care? Abuse at home is a constant worry”. Bengali female

“People in my community are afraid to take medicine in this country as they don’t know what it contains. They prefer to go home and talk to their own doctors who understand their culture/religion and treat with respect”. Bengali female

“Everything is hidden under the carpet. It is about family shame and honour. If it’s a girl she will not be able to get married, if it’s a boy then what about his future”. Bengali female

General issues

How could community play a role in developing services

5 believe BME advisors and advocates in the community. 4 believe by participating in the mental health education, 3 thought community link workers in the community, and further 3 believe qualified interpreters and trained staff from BME community. 2 thought more mental health awareness in the community and other responses are appropriate referrals, community groups, support from friends and family and fund raising to open more centres.

Need for mental well being services

(see figure 4.1)

Mental health services a d location

Only 1 said more talks and presentation about mental health. 8 said community centres and 3 for each preference said local independent organisation and GP surgery. 2 said within easy access of the town centre and 2 more said faith organisation. Other responses are council offices and hospitals. (see table 4.2)

Consider alternative therapies

(see figure 4.2)

Choosing alternative services

11 would seek spiritual healing, 10 counselling and eight for each homeopathy and advice from religious leader. 5 meditation and 3 acupuncture. Other responses are exercises and massage.

Experience of mental health in the community

(See figure 4.3 and quotes)

“Spiritual healing, praying is one of the best ways of combating MH in my community”.
Bengali female

It was felt for the Bengali community that they were feeling very suspicious and inquisitive as to why the need for interviewing their community. The Bengali community felt that they were being targeted and asked many details about the reason for the research. They were suspicious whether their interviews will affect their employment and immigration status in England. It was also felt that respondents didn't want to acknowledge their mental health issues. Taking interviews from the Bengali respondents was particularly hard. It took long time and several sessions to approach a Bengali respondent to gain their trust and give interview and answers to several uncomfortable questions. Bengali respondents had several very conservative views about the mental health and it was felt that some expressed those views quite clearly in their interviews. Especially those from the rural background said that Mental Health means someone who is mad, shouts, screams and throws stones to others and wears torned clothes. They also strongly believed that mental health is when someone is possessed by the evil spirits, for instance if someone suffers from schizophrenia they will interpret it as evil spirit that has taken possession of the soul of that person and controls that person and make them say and do things which are not normal. They also believed that mental health could be the punishment from god to them for their wrong doings and unjust behaviour with others. They also believed that sins of the parents are visited on their children. For some respondents the cure for the mental health problem lies in having that person married. The understanding behind is for that person to have some responsibility and thus it diverts their mind and that person gets busy with life. Many hide their mental health problems because it affects their chances of getting married and settling down. They believe that if they disclose their mental health status it would not only affect their life but it affects their siblings and especially their marriage prospects. Furthermore they believed that once someone goes in to the mental health hospital they will be stigmatised by the family and the society for the rest of their lives. Many Bengali respondents said that they don't access mental health services in this country because doctors here prescribe medicines which have adverse side effects and it make the situation even worse. It doesn't help people to get better instead it makes them look like Zombies and put on a lot of weight. They also look blank and dazed. When they ask the health professional about their concern they don't get a very satisfactory answer. Most Bengalis believed in alternative therapies regardless of their social and educational background. They asked for counselling and need for the holistic approach when treating a mental health issue. A lot of Bengali, Pakistani and Indian community members take second consultation from their spiritual and religious gurus.

Nepalese community

15 people belonging to the Nepalese community participated in this engagement programme. 13 of them were male and 2 were females making up 18% of the research sample, all aged 50 and over. All the Nepalese respondents were born outside UK and majority have lived in UK for 1-5years and only 3 have lived here for more than 11years. 13 Nepalese community members had indefinite leave to remain in UK, 1 was a British citizen while 1 members was seeking asylum. First spoken language for 14 of the Nepalese members was Nepali while 8 spoke Gurung. First written language for 13 respondents was Nepali and 1 could write Gurung. 1 members was also fluent in Hindi, 1 was fluent in English and 1 was fluent in German. 14 of the Nepalese community practiced Buddhism while 8 practiced Hinduism too. All respondents were heterosexual individuals and 10 had no form of disability while 5 reported physical disability.

Knowledge and awareness of mental health

Understanding of mental health:

6 described their understanding as state of mentality. 5 said that mental health is ability to think for oneself. 3 said when mental and physical health is in balance. 2 considered the ability to function and cope normally and 2 more felt that mental health is when one could associate between right and wrong. One off responses were the state of psychological, mental and emotional state, having insight and knowledge of mental problem, ability to interact and not being forgetful and mental and physical unbalance.

Understanding mental health issues:

14 people said there is little understanding and only 1 said fair amount. (Figure 2.1)

How common are mental health issues in the community:

9 said quite common and 6 said average.

Experience of social issues:

10 experienced shame in their social experience and nine felt shame as their social experience. 7 felt resentment and seven more felt immigration issues as their social experiences. 6 considered cultural shock and other 6 isolation. 5 felt language barrier and 3 experienced guilt as social experience. Other 2 mentioned others but didn't specify.

Experience of mental health issues:

6 respondents didn't reply whereas 6 more experienced stress and further 6 experienced depression. 5 experienced anxiety and 3 experienced nervous break down. Some other responses are dementia, anorexia and panic attacks.

Time-span of the experience:

6 experienced for more than six months whereas one off responses were less than three months, up to three months and three to six months.

Seek further help:

2 seek help and seven didn't seek help. (Figure 2.2)

Family members should be made aware of mental health and its seriousness. (Nepali male)

Improve awareness of mental health among Nepalese people. (Nepali male)

Lack of access of local mental health services

Factors for accessing mental health services:

13 respondents said cultural factors like shame and stigma, whereas 13 more said language barrier as factor and further 13 mentioned spiritual factors in accessing mental health services. 12 felt religious factor and eleven considered translation and interpreting. Only 3 mentioned transport as factor in accessing mental health service.

Accessing problems in getting support from mental health service:

12 felt language is their biggest problem and 3 didn't reply at all. 1 felt that qualified BME counsellors should be available and further 1 felt that being a female could be a difficulty.

How can the local mental health services improved to meet individual needs:

4 felt that more interpreting services should be provided and 3 felt that referrals should be made to counsellors and alternative therapies. Further 3 felt that services should be placed locally and one off responses were help through community groups, culturally traditional help, CMHT should have more out reach workers, more active agencies, information and awareness of mental health, easy access to psychiatrist and psychologist and more BME staff should be recruited.

Services for carers:

14 respondents didn't know any carers services and only 1 was not sure.

Improve access and knowledge of mental health in the community:

(table 3.9)

General issues/views

How could community play a role in developing services:

6 felt that community should be made aware about mental health services. 3 considered more support groups to reduce taboo and stigma in mental health, 3 more felt more community link workers and further 3 felt that pro active community workers are required. 2 felt BME advisors and advocates to the statutory agencies and further 2 felt self help. One off responses were integrate with other communities, out reach services, support from friends and family, referrals to appropriate services and more qualified and trained BME staff.

Need for mental well being services:

14 said yes and only 1 felt no. (figure4.1)

Mental health services and location:

3 didn't indicate anything whereas 10 felt that services should be local independent organisation, 7 felt within easy reach to town and some said GP surgery and hospitals.

Considering alternative therapy:

(figure 4.2)

Choosing alternative therapy:

12 would consider spiritual therapy, 10 counselling, 9 acupuncture, 6 homeopathy and 4 would seek advice from religious leader.

Experience of mental health in the community:

(figure 4.3 and quotes)

Nepalese community has very little understanding of the mental health. The idea of conducting a research on the mental health was quite new for them. Many terms and thought were new for the nepalese community. They used the questionnaire as their means and source of information in order to give interview. They admitted to have learnt a lot from the discussion which came up through this interview process itself. The team researcher believes that it could also be that the Nepalese respondents knew about the mental health but don't acknowledge knowing about it due to the stigma and taboo attached with the mental health. They are so new in this country that culturally they don't feel confident to talk about it openly. Most recently alcohol issues have started to come up in their community.

4.1. Reflection

Focus groups

It was felt and experienced through working with a group of Asian elders in the Pakistani community that the respondents were more willing to participate in an informal verbal discussion like perhaps a focus group instead of a structured setting of an interview. Initially focus groups were considered as one of the research tools too, however, as the research project progressed it was realised that focus groups would be difficult to organise and carry out due to several reasons. Some of the reasons which came up during the project meetings were the cultural differences among the five communities, the need for segregated groups, transport issue, the choice of the venue and the language barrier. The biggest amongst all was the fact that a co facilitator may not share the same language as the rest of the focus group. At the same time due to financial constraints, employing another person did not seem like a possibility. It also posed a danger of bias in results from the person who might help out, as well as providing a possible situation where participants might not be comfortable sharing their views in the presence of others. Kumar (1999) also recognises this '***the choice of a method depends upon the purpose of the study, the resources available and the skills of the researcher***'. (Kumar,1999, p104,109-126). As much as focus groups are ideal due to the richness of the information supplied, they were not possible in this particular research.

One to one interviews

At the same time, a researcher led interview through questionnaire was a better approach because this research project is aiming to collect data from 100 participants. A range of open-ended and closed questions have been devised (see Appendix 1). Closed questions were included to elicit factual information and open-ended questions were included for seeking opinions, attitudes and perceptions. Kumar (1999) describes another advantage of interviewing '***Interview has a wider application it can be used with any type of population***'. (Kumar, 1999, p104, 109-126), this was useful for us as we are interviewing ethnic minority member aged over 50 years. Structured interviews also provide uniform information, as this research tool was to be used with five different communities; this approach assured the comparability of data. Some members of the study population cannot read or write hence the choice of researcher led questionnaire was appropriate and if any questions were misunderstood they could be explained to the participant, as Kumar (1999) describes '***it is less likely that a question will be misunderstood as the interviewer can either repeat a question or put it in a form that is understood by the respondent***'. (Kumar,1999, p104,109-126).

The semi-structured interviews enabled us to address queries, explore complex and sensitive issues and obtain in-depth and useful information.

As this research project has a big sample size, to analyse each questionnaire effectively, this method seemed appropriate. As the research team felt that it would be unethical to interview somebody and not include their views and contributions because we were unable to analyse data due to time limitations.

Choosing questionnaires allowed us to collect a large sample which could then be considered to be representative of that community.

Choice of venue

The requirement for the interviews to take place in a public venue presented some drawbacks. The data collection and field work was scheduled during the month of December. Since December is the festive season therefore many venues were not available due to the holidays especially those venues for which participants felt comfortable to come to were closed. Alternative venues were suggested but respondents didn't feel confident and comfortable to go to those venues as a result the project fell behind the scheduled time. Moreover some participants requested home visit for the interviews to take place but researchers were not allowed to do so based on the agreed ethical proforma. The team feels that they may perhaps have missed out on the valuable insight from the respondents on some of the issues.

Possibility of recording the interviews

One community in particular (Bengali) didn't like the idea of interviews may possibly be recorded for transcribing purpose and felt suspicious of the idea therefore almost all refused to participate in the interview. Some indicated/pointed out their doubt to the current political situation and very anti Muslim media especially after 9/11 and thought that they feared that their views might be manipulated and used against them so they could be prosecuted. They gave the example of the east London incident and the police.

Working in pairs

In addition to the community engagement programme all researchers had other work commitments in their own time. It posed difficulty in coordinating with each other in the team to work together in pairs to conduct interviews. Also it was not feasible because all researchers belonged to different communities and they spoke different languages. This setting made the respondent feel very uncomfortable and uneasy during the interview because they were giving their views on a very sensitive issue in front of someone who didn't speak their language and belonged to a different culture and community. Furthermore pair work wasn't helpful in other practical ways for example in taking notes and understanding and explaining etc.

The whole team also thought that the respondents felt uncomfortable, embarrassed and intimidated during the interview and the respondents could not understand the need for having two people during the interview on such a personal, sensitive and confidential subject. The team felt that the arrangement was a total waste of time.

Religious beliefs and concepts

Religious beliefs played a very important role in the lives of the many Muslims and Hindu respondents regarding their mental health problems. Some of the members of the Muslim community believed that the mental health issue was a test from God to them. If they persevere to be patient and perform good deeds and prayed to God their problems may well get better. In relation to that the concept of the evil eye was also mentioned by many Muslim respondents. Some Hindu respondents believed that the mental health is the result of their sins or misconduct they may have carried out in their previous life i-e belief in Karma (what you sow so shall you reap). Although one Chinese respondent felt that God helped her to recover from her problem. These people also believed in divine intervention.

Among other reflections are the phrasing of some questions and its impact on the way the respondent responded (see appendix 1 Question 2.4 & 2.5). Some people felt very insecure and defensive when replying to the above mentioned questions.

As opposed to the expectations of the team members the researchers found it very hard to find their target group of 50 plus BME people in their areas who were willing to participate in the interview. All researchers sensed that many people felt very apprehensive when approached to take part in the interview.

All team members personally felt and agreed that to ask sensitive and personal questions like mental health from the same sex group as the researcher himself/herself was far more easier than from the respondent of the opposite sex group. Researchers thought that the feeling they experienced was due to many religious, cultural and personal reasons for both researchers and the respondents.

Training workshops

The team benefited hugely from all seven workshops offered to them from the Uclan University. The training delivered by Manjit Bholra (trainer) was specially appreciated by all because the team felt that she could relate well to the issues of the south Asian community. First two workshops on the mental health were very relevant and informative. They gave good background understanding about the mental health issues and proved to be very helpful for the researchers especially during their field work and data collection period.

The Nepalese community members felt that the questionnaires were very well structured and they were full of information. They found it helpful to respond to the interview in the light of the information provided within the questionnaires.

This project was an eye opener for some in terms of learning about the vastness of the mental health subject matter and for others it was the corroboration of the commonness of the mental health issues within their communities.

5. RECOMMENDATIONS

The recommendations based on these issues are:

Awareness and education

There is a need for awareness about mental health education across all communities. The awareness is mainly required to eliminate the stigma and taboo associated with mental health in these communities. The understanding of the mental health in these communities is very constricted, according to the results of the research; people link mental health only when someone is severely affected by a mental health problem for example schizophrenia. They associate more readily with depression, anxiety, stress and panic attacks but they hardly relate this to mental health.

- The education and awareness is required for both service users and the unqualified staff from the statutory or voluntary organisations. In order to deliver these programmes of education more presentations, workshops, seminars and talks etc is required on the local level where access is easier for the community.
- Literature in community languages as well as information and awareness in different formats for example videos, films or dvds is also required for increased understanding and information about the mental health.
- There is a need for an educated professional from each community to act as an interpreter as well as an advocate who understands mental health services and issues and interpret the information between the community and the statutory organisation.

Outreach BME Staff

A need for outreach workers and staff from BME background is also expressed by respondents on numerous occasions in the research.

- More BME workers in the community are required so that they can help the community in accessing the services available in the mental health organisation. Moreover these workers could also help people to gain access from generic to the mental health sector.
- Bme workers with community language skills and interpreting skills are also needed in the community to help people with translating.

Social groups

Isolation and loneliness was mentioned by many respondents as one of the causes of depression and other mental health issues.

- More support groups are required to organise social gatherings, outings, befriending service, cultural events and entertaining activities for the community. These groups could provide a place for socialising as well as help in reducing stigma and taboo linked with mental health. They eventually could benefit the community in preventing the onset of the mental health problems in people's lives.

Transport

Affordable community transport is also highlighted as a need for many people in the community.

- Community buses are required with better and local routes are necessary to improve mobility in the community. Older people mainly require transport to places like GP, hospital, town, community centres and visiting family and friends in the area.

Alternative therapies

- Trained family counsellors who are also aware of the community issues and know the community language, are needed in the community.
- Trained consultants who could provide therapy in yoga, thai chi, acupuncture, seeking advice from religious leaders and homeopathy is required in the community.

Literature in

REFERENCES

Kumar, R. (1999, p104,109-126) *Research Methodology. A step guide for beginners.* London Sage.

