

# **A light at the end of the tunnel?**



**Researching BME views on mental  
health provision in Somerset**

# A light at the end of the tunnel?

Report  
May 2007



*'When I was younger, I found it hard to make someone understand the culture difference of being a young Pakistani Muslim woman. It would have been nice to have someone to confide in, someone who understood my culture and was there to support me.'*

**S**omerset Racial Equality Council (SREC) and Somerset Primary Care Trust (SPCT) managed the research. It was supervised, funded and supported by the University of Central Lancashire (UCLAN) and commissioned by the Care Services Improvement Partnership (CSIP) for the National Institute of Mental Health in England (NIMHE).

#### PROJECT TEAM

The following people were involved with the project:

Andy Merryfield                      Assistant Director, Community Development,  
SREC

Andy manages Somerset Black Development Agency, an umbrella organisation for all the BME community groups in Somerset. Andy has a teaching background and an MPhil research degree: 'Expanding Horizons: Multicultural Education and International Links in the South West' (1996). Andy was a Co-ordinator on the project and had management responsibility for its delivery.

Loretta Ingram                      Community Development Manager,  
Somerset PCT

Loretta has a BA in Communications. She also undertook the UCLAN Community Based Research in Mental Health Course, and carried out some of research as well as being a Co-ordinator on the project. She was able to bring in experts and professionals from the Mental Health Field to augment the coursework for the researchers. Loretta is studying for an MA in Equalities and Diversity. Loretta's contribution to the entire project has been immense.

Sau man Li                              Researcher

Sau man Li is 45 years old. He is married with 2 children, age 22 & 17 and is self-employed running a take-away shop in a small market town. He is both a committee member of the Somerset Chinese Association and a deacon of Somerset Chinese Christian Church. He decided to get involved in this project because he *'wanted to find out from the people in the Chinese community how much they are aware of mental health as an issue, and to give them an opportunity to express their needs, experiences, any concerns that they have'*. Through this experience he has become aware that mental health issues are both broad and serious.

Miriam Robertson                      Researcher

Miriam Robertson is from Guatemala, and has lived in England for 29 years. She likes people and has enjoyed the work she has been doing for SREC and UCLAN. She is married with two grown up daughters and a very senior cat. She loves gardening, arts, computers, music, dancing, cooking and walking. She was particularly interested in the cultural significance of the research, especially with reference to stigma and faith. As Miriam put it *'...the journey has been amazing'*.

Rose Stephenson                      Researcher

Rose is married and is a mother of 2. She is the current Chair of the South Somerset Filipinos and Friends Association, and also a committee member of the Somerset International Women's Association, working on a voluntary basis. She learned a lot from the Mental Health Research workshops conducted by UCLAN and was involved in developing the questionnaire for the research project. She helped contact BME communities and organised venues for the interviews to take place. She was actively involved in the collation and data input of the completed questionnaires. She found the research project *'a very enriching experience'*.

Tony Powell                              Researcher

Anthony Llewellyn Powell is 46 years old, currently employed at Somerset Racial Equality Council. He volunteered his services to the project, because he was very interested in the government initiative in DRE in mental health care and services; and also the subjects being covered by UCLAN in both, community based research and mental health. *'Overall, I will remember that even though I felt that I was knowledgeable about the subject, having looked after my stepson (who is a user) for the past 8 years, I still found the content and delivery of the course was invaluable, rewarding and very educational, satisfying my initial interest.'*

Sonia Greenslade                      Researcher

Sonia was born and grew up in a mainly white society. If anyone had said to her, 15 years ago, that she would be doing the work that she does now, she would have laughed at them. Sonia came from a strict Muslim family. Her passion is to raise awareness and promote integration and diversity. She is always saying that freedom is a seven-letter word, but the meaning can be life or death, a big price to pay. *'Based on my experiences through life and work I have finally got my freedom and always help others get theirs. Your right to belong and to be free is priceless.'*

Vlademiro Rocas                      Researcher

Vlademiro Rocas is originally from Angola and is a Community leader within the Portuguese Community. He has seen civil war first hand and knows what anarchy is. He was particularly interested in *'learning what would make someone's mental health suffer in a so called civilised, democratic society; and how people can genuinely be helped without further adding to their problems'*.



## ACKNOWLEDGEMENTS

Thank you for the support given to this research by the University of Central Lancashire (UCLAN) on behalf of the National Institute for Mental Health in England (NIHME). Thank you too to Somerset Primary Care Trust (SPCT), Dorset & Somerset Strategic Health Authority (DSSHA), Somerset County Council (SCC), and Somerset Racial Equality Council (SREC).

Finally, a very big 'Thank you' to all those who generously gave their time and expertise to this project, including the participants who were interviewed, the researchers who interviewed them, and everyone else who took part in the preparation of this report.

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# Executive Summary

## 1. Introduction

Two things interested us (SREC and SPCT) about this research project: the potential to identify the needs of the BME communities in Somerset regarding available mental health services in the area and whether or not the services and their delivery are adequate including whether the communities are able to access them.

It was, of course, the icing on the cake that the communities were going to be empowered to investigate the needs themselves and suggest solutions to solve them. As the Centre for Ethnicity and Health of the University of Central Lancashire put it, the Department of Health wanted local communities '*...to be able to continue to articulate these needs to their local service providers*' (p 10).

The report is important. But perhaps as important is the satisfaction which the participation in the project has brought to the researchers and to the individuals with whom they engaged.

### 1.1 About Somerset

Somerset is a rural county. It covers an area of 3,451 sq km. and has a population of 503,400. The BME population is 4.35% or 21,898. This is small indeed but still, it is arguable that the percentage growth of all BME groups is greater in Somerset than any other area of the South West, in the main, because of the growing migrant population from the EU (pp 15-18).

### 1.2 Who did the research

13 researchers (pp.3-4) carried out the research. Although the researchers, most of whom were recruited from the 19 community groups that made up Somerset Black Development Agency, did not have a lot of expertise about this type of engagement research they, however, more than made up for it with their enthusiasm and extensive knowledge of their respective communities. In addition they undertook the training provided by UCLAN. Two co-ordinators, from Somerset PCT and SREC, supported the researchers.

### 1.3 Methodology

The first thing that the team did was to determine the scope of the research within the UCLAN project specifications. This process was further informed by discussions within the Steering Group (p 19). They then decided the questions and designed the questionnaire, and chose face-to-face interviews as a delivery tool. The ethics around how the research should be conducted was debated extensively and agreed between the researchers, the Steering Group, and UCLAN (Ethics Form, Appendix C). The Fieldwork took place between November 2006 and the first week of January 2007. The responses were then collated by the team and interpreted for the report at the end of March (Appendices K & L). The researchers interviewed 246 individuals in all. A Focus Group as a result of the emanating findings about depression also took place. This report is based on both exercises (p 31 and Appendices A & B).

### 1.4 Focus of research

The research overall aims were: 'Better engagement of BME groups in shaping mental health services, and supporting innovative community informed services'. To make this happen the research focused on 'identifying the experiences, needs and aspirations of BME individuals with regards to mental health provisions in Somerset.' This was done through exploring experiences about available treatment in general. The stigma and discrimination that is attached to mental ill health was also explored. It was also done by examining available information about mental health, the barriers to access and by interviewing BME individuals to probe into how best to promote positive mental health (p 13).

### 1.5 Management

The researchers had research responsibility for the project but with help, particularly for the day-day administration, from the two co-ordinators. The responsibility included determining the tone of the research, details, content, design of questions and questionnaires and how it was delivered. The UCLAN team also helped a great deal.

This research is a partnership project between SREC and Somerset PCT. It was hosted by SREC. The project had a Steering Group comprising 15 members and chaired by SREC (p 14). The group had the overall responsibility for ethics, quality control and integrity. It was also answerable to UCLAN and is expected to metamorphose into the BME Mental Health

Development Forum. The group was composed to include organisations with responsibility for mental health services and with the ability to take the findings of the research into consideration when designing, commissioning and delivering their services.

## 2. FINDINGS

### 2.1 The meaning of mental health

This presented the researchers with the first significant surprise as it became clear that the meaning or the perception of the meaning of mental health differs from individual to individual to a great extent. It also became clear that a majority (74%) of the people that took part in the research regard mental health in the negative with 45% relating it to meaning depression, stress or nervous breakdown' and 25% relating it to meaning an 'enduring mental illness' like schizophrenia and paranoia. Only 24% regarded mental health as positive or related it to meaning '... emotional and spiritual wellbeing' (pp 26-27).

***Recommendation: Mental health service providers must continuously market and publicise a simplified and standardised meaning of mental health (such marketing and publicity to include information about what is available, how to access what is available and ways of promoting good mental health) through the popular press, internal and partnership arrangements and the E-Quality 4 Mental Health website.***

### 2.2 Maintaining positive mental health

The finding here proved to be less of a surprise, with 44% stating that a good 'quality social interaction with family and friends' is the best way to promote positive mental health. While 19% thought that physical exercises, like dancing, walking, swimming and aerobics was the best way 10% thought that it was 'satisfaction from earning'. 8% thought that it is having 'faith' and 'helping others' (5%). However, only 33% said that they would seek professional help when they have a mental health problem (pp 27-28).

***Recommendation: Mental health service providers should explore ways of involving families and close friends as active participants in the prevention and treatment of mental illness.***

### 2.3 Accessing mental health services

The question about where people would like to access mental health services provided a myriad of preferences indeed with some preferring 'moment' houses while others said that they would rather go to advice centres like the Citizen Advice Bureaux. Health centres scored very highly with 40%. BME community association centres or venues organised by them came second with 31%. Other suggestions included alternative therapy centres and schools, for early intervention. However, a higher than expected 59% of the participants thought that the best way to disseminate information about mental health is through the media (pp 28-29). Furthermore, the fact that some people do not speak English and that available information is not adequately translated is a major problem (also see 2.4 below).

***Recommendation: Mental health service providers must make adequate provision for interpreters at the point of receipt of their services. Furthermore, if such services are to be provided at health centres they should be through designated surgeries. Otherwise they should be provided through direct arrangements with BME community groups or through representative umbrella groups.***

### 2.4 Experiences of mental health services

What some of the participants felt about their experiences of existing provisions can certainly not be mistaken for anything good or complimentary, with some rating the experience as 'bad'. As one participant put it 'they changed my medication and I felt awful'. 'I wasn't told about depression, what would help', another stated. However, a lot of these experiences are traceable to a lack of good English. As one participant put it, 'English is not my language, limit to expressing myself, made me feel useless and stupid' (pp 29-31).

***Recommendation: Staff at health and treatment centres should be trained to be more aware of the cultural differences between people and how these differences may serve, more often than not, as a barrier to fairness and equal access to services.***

## **2.5 The stigma surrounding mental health**

The question about what would stop participants from telling any one about a mental illness resulted in the finding that most BME communities regard mental illness with apprehension and, in effect, stigma or derogation about the character of any one with a mental illness. A breach of trust and confidentiality accounted for 37% while 23% would not tell because of the fear of discrimination on the ground of the condition. Shyness and embarrassment accounted for 17%, shame 12% and language 4%. 50% think that the best way to remove this stigma is by 'mounting education and awareness campaigns' through the popular media. However, others (32%) believe it can be done better if existing BME communities are 'strengthened' and encouraged to have dialogue about mental health (p 31).

***Recommendation: Service providers to work extensively with BME communities to remove the stigma that is attached to mental health, and with adequate emphasis and sensitivity for effective redress.***

## **2.6 Existing support networks within BME communities**

The question on this was specifically about the way religion or faith affects the participant's mental health. This generated a very lively and contentious debate with 49% indicating that they derive 'strength' from the central doctrines of their faith. The camaraderie at the place of worship came second with 23% while 22% said that they get strength from prayer. Others were not so sure. As one participant put it 'being told that I was with Satan...(could only make me)...think about fear and anxiety'. It is clear however, that faith does play a very important part to the mental wellbeing of most of the participants (pp 31-32).

***Recommendation: That the part religion and faith play in the mental wellbeing of the BME communities in Somerset should be fully investigated. Similarly there should be a dedicated research into depression, particularly about the extent of its effects on the mental wellbeing of the BME communities of Somerset.***

## **2.7 Culture**

The questions on how culture affected mental health or prevented people from living a life of choice provided very good data indeed. This was to prove that there is an undeniable link between mental wellbeing and confidence in cultural identity. 41 % of the participants believed that 'A strong family life and good community networks had a positive effect on mental health' on the one hand because '...families, friends meet often, discuss issues', and, on the other hand, because particular cultures have a '..tradition of resilience and cheerfulness' (pp 32-33).

***Recommendation: Service providers should ensure that they help the various community groups to grow into viable self-help groups directly, through SBDA or through the activities of Somerset PCT CDW in Mental Health project.***

## **2.8 Developing new services**

The research found that there is a real requirement for new services that meet the needs of BME individuals in Somerset; be this the needs of users of services or their carers. As one participant put it, 'it is really important that professionals are aware of cultural issues' that may impact on service provision and delivery. As another participant put it 'isolation' and the fact that '...you are away from your own country' present its own problems that need resolving if talk about equal access is not just lip service (pp 33-34).

***Recommendation: Service providers should make sure that the services that they provide and deliver also meet the needs of BME communities of Somerset. They should therefore get into the habit of carrying out consultations, to this effect, with the BME groups (such consultations to be done through SBDA or the Somerset BME Community Mental Health Development Forum).***

Recommendations are in line with the three building blocks of the DRE programme, and the Department of Health's DRE Vision 2010 (please see Delivering Race Equality in Mental Health Care (2005), pp 3-4).

## INTRODUCTION

The University of Central Lancashire, Centre for Ethnicity and Health's model of Community Engagement.

### Background

We often hear the following words or phrases:

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

Sometimes they are used interchangeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things.

The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this part is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement with a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and Minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, they wanted a number of reports to be produced that would highlight the drug related needs of a range of Black and Minority Ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and Minority Ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then go away. It wanted local Black and Minority Ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communi-

ties they are 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 six 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 & 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 the work. They would have learned about drugs, and learned about the needs of their communities, and they be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

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

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

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

- Young People
- People with Disabilities
- Service User Groups
- Victims of Domestic Violence
- Gay, Lesbian and Bi-Sexual people
- Women
- White Deprived Communities
- Rural Communities

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

### The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must

have the Community at its very heart. In order to achieve this, it is essential to work through a **host community organisation** (in this case Somerset Racial Equality Council). This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community, 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. It is important that the host organisation is able to provide a co-ordination and infrastructure (e.g. somewhere to meet, access to 'phones and computers; financial systems) for the day to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on

not more important, than the report they produce at the end of the day. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides it is important not to lose sight of the fact that it will be *the first time that these individuals have undertaken a research project*.

The final ingredient, according to the Centre for Ethnicity and Health's model is the provision of appropriate **support** and guidance. It is not expected that community groups will become involved for nothing. Typically, £15 – 20,000 approximately would be made available to the host organisation. It would be expected that the bulk of this money would be used to pay people from the target community as community researchers. A named member of staff of the Centre's Community Engagement Team

would then be allocated as a project support worker. This person will visit the project at least for half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. A package of training – typically in the form of a series of accredited workshops, is also provided. The accredited workshops give participants in the project a chance to gain a University

<b>A Host Community Organisation</b>	With good links to the target community	To Provide Basic Infrastructure for The Project. (Recruit and Co-ordinate Project Team; Provide Office Space, Phones and Computers; Look after the Finances.	To Recruit a Number of people from the target Community to do the work
<b>A Task</b>	Time Limited, Meaningful, Manageable.	A Piece of Research Into Key Needs/Gaps/issues for the Community	Learning and Development of Key Individuals; access hard to reach Groups; Raise awareness and debate; Community Ownership
<b>Support</b>	Financial (Typically Up To £20,000)	Training and Workshops; On-going Support and Guidance; Personal Tutor.	Statutory Partnerships; Steering Groups; Sustainability.

Table 1. The Key Ingredients

the project.

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that the Centre has run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes its been met with initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if*

qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but

Table 2: The Community Engagement Team.

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

Table 2. The Community Engagement Team

for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to pick up the key individuals who are developed through the project process to help them to take their 'next steps'.

### **The Centre for Ethnicity and Health Community Engagement Team.**

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework. Each group involved in the Centre for Ethnicity and Health's Community Engagement programmes is required to submit a report detailing the needs, issues or concerns of the people with whom it consulted. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

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

### **NATIONAL CONTEXT**

On 30th October 1998 David Bennett, a 38 year old African-Caribbean patient died in a medium secure psychiatric unit after being restrained by staff. The Government's response to the independent inquiry into his death resulted in the development of the 'Delivering Race Equality in Mental Healthcare Programme (DRE). DRE is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and Minority Ethnic (BME) status, including those of Irish, East European Immigrants and Romany Gypsy Travellers.

Nationally there is an over-representation of BME Mental Health patients in the acute services.

The DRE programme is based on three building blocks:

1. More appropriate and responsive services – achieved through action to develop organisations and the workforce, to improve

clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees and children;

2. Community Engagement – delivered through healthier communities and by action to engage communities in planning services supported by 500 new Community Development Workers; and

3. Better Information – from improved monitoring of ethnicity, better dissemination of information and good practice and improved knowledge about effective services. This will include a regular census of mental health patients.

The recommendations set out within this report are in line with these three building blocks which seek to motivate local services to realise the Department of Health's overall vision that by 2010 mental health services will be characterised by:

- Less fear of mental health among BME communities and Service Users
- Increased satisfaction with services
- A reduction in the rate of admission of people from BME communities to psychiatric inpatient units
- A reduction in the rate of admission of people from BME communities to psychiatric inpatient units
- Fewer violent incidents secondary to inadequate treatment of mental illness
- A reduction in the use of seclusion in BME groups
- The prevention of deaths in mental health services following physical intervention
- More BME service users reaching self-reported states of recovery
- A reduction in the disparities found in prison populations
- A more balanced range of effective therapies, such as peer support services, psychotherapeutic and counselling treatments as well as pharmacological interventions that are culturally appropriate and effective
- A more active role for BME communities and BME service users in the training of professionals in the development of health policy and the planning and provision of health services
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

It is intended that this report makes clear the urgent need for the development of mental health services which are culturally appropriate and ethnically equitable, and most importantly engages and involves local BME people in the

planning and commissioning of future mental health provision.

The report also provides a set of recommendations from which to launch the delivering the DRE programme locally and to establish a Somerset Mental Health Development Forum.

This report is funded by UCLAN and produced by Somerset PCT and Somerset Racial Equality Council and in consultation with local BME residents.

### RESEARCH FOCUS

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

Somerset Racial Equality Council, for the purposes of this project, managed and supported on behalf of Care Services Improvement Partnership (CSIP) by the University of Central Lancashire's Centre for Ethnicity and Health, was one of the host organisations which took part in the National Institute of Mental Health in England (NIMHE) Community Engagement Project 2006/7 – Delivering Race Equality (DRE) in Mental Health Care.

Our research set out to 'explore the needs of Black and Minority Ethnic individuals in Somerset with reference to: mental health service provision, access, treatment, prevention and retention'. It was designed to attempt to identify the mental health needs of BME population in Somerset and to help improve local mental health services, and to contribute to the national policy of 'Delivering Race Equality (DRE) in Mental Health Care', - a five year action plan that has been developed by the Department of Health to achieve equality and tackle discrimination in Mental Health services in England.

The objectives of the programme were to deliver improved equality of access, experience and outcomes for Black and Minority Ethnic mental health service users by:

- Building capacity in the non statutory sector
- Encourage 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 a 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.

*Sourced from UCLAN memo to all projects on report writing, updated September 2005*

Our specific overall aim was 'Better engagement of Black and Minority Ethnic groups in shaping mental health services, and supporting innovative, community informed services.'

Our research focus was 'to identify the experiences, needs and aspirations of Black and Minority Ethnic individuals with regard to mental health provision in Somerset.'

We concentrated on the following research objectives:

- Explore experiences of treatment received by BME individuals in Mental Health services.
- Explore stigma and discrimination issues.
- Examine physical access to Mental Health Services in Somerset.
- Examine access to information about Mental Health Services in Somerset.
- Explore any potential barriers to accessing services.
- Explore current practice in respect of BME individuals in maintaining or promoting positive mental health.

We then distilled the objectives further to make them achievable within the timescales and resources available. The following were agreed with our Steering Group.

- Investigate current practice of BME individuals re regarding maintaining and enhancing positive mental health.
- Explore attitudes and experiences of mental health treatment/service users (including those using self help/complementary/alternative practices) within the nationalities our

- target communities represent.
- Sample to include those with experience of being service users, carers, and those who are combined carer and service user, and those who are neither, and those who work in that service sector.
- Examine barriers to accessing Mental Health Services.
- Explore stigma and discrimination issues.

The research geographic area was to be the whole of Somerset, and in keeping with the spirit of the project guidelines, the research was to be undertaken within the community groups already known to Somerset Racial Equality Council. We defined 'adults' to mean from 18 years old upwards, and we decided to include carers and service users past and present.

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.

### **Governance and Management Structure of the Research Project**

The Department of Health through the National Institute of Mental Health in England (NIMHE) and Care Services Improvement Partnership (CSIP), awarded the contract to the Centre for Ethnicity and Health at the University of Central Lancashire, to administer and support a number of new grants initiatives including this one.

Somerset Racial Equality Council and Somerset PCT successfully bid to undertake the research for the County of Somerset, abiding by the stipulated guidelines for the project.

One of the stipulations was that a local Steering Group, (Appendix D), answerable to UCLAN, was to be established, to whom the research group would be responsible. The membership of the Steering Group would be an important element of the success of the project. Apart from overseeing the work of the research group in terms of ethics, quality, integrity, etc, by their very 'day jobs' as it were, it is hoped the findings will find their way into the decision and policy setting mechanisms for the whole area thereby maximising the opportunities for sustainability.

Membership of the Steering Group consisted of the following representatives:

David Onamade (Chair)  
Chief Executive Officer,  
Somerset Racial Equality Council

Host organisation

Andy Merryfield (Co-ordinator)  
Asst. Director (Community Development)  
Somerset Black Development Agency

Loretta Ingram (Co-ordinator)  
Community Development Manager for  
BME Communities  
Somerset PCT

Bev. Chalmers  
Manager for Adult Services, Somerset Coast  
Somerset County Council

Sharon Dyke  
Rethink – Service Development Manager  
Emily Lang  
Carer Participation Worker  
Somerset Partnership and Social Care  
(NHS) Trust

James Marriott  
Education and Training Manger  
Somerset Partnership and Social Care  
(NHS) Trust

Diana Vollans  
Head of Primary Care Mental Care Services  
Somerset PCT

Yvonne Vigar  
Commissioning Manager  
Somerset PCT

Lyn Fisher  
Community Development Officer  
Somerset PCT

Michelle Hawkes  
Head of Health Improvement  
Somerset PCT

Mark Patterson  
South West Regional DRE Lead  
Care Services Improvement Partnership

Joanna Hicks  
UCLAN Support Worker

Phil Brice  
Director of Corporate Services  
and Communications  
Somerset PCT

Community Researcher  
Rotational

The Steering group had the authority to co-opt other stakeholders or Special Advisers as and when necessary. Monthly meetings were scheduled for the Steering Group. (Appendix K, the steering group's Statement of Purpose and

## About Somerset

### *Local Geography:*

Somerset is one of the Counties of the South West Region of England.

The following is reproduced from the Somerset County Council Audit Commission Inspection Report May 2005 – Community Planning.

*Somerset is one of the most rural counties in England with a population density of 146 people per square kilometre, compared with 380 people per square kilometre nationally. There are many small and medium sized towns, villages and hamlets in Somerset and the main centres of population are Yeovil, Taunton, and Bridgwater. The road network consists of a large number of minor roads, a few major routes, and the M5 passing through the county. This affects access to services for many people living in the area.*

### *Population:*

*The population covered by Somerset County Council is 503,400 in an area of 3,451 square kilometres. The County's population grew by 7.1 per cent from 1991 to 2001 and is projected to grow by a further 4 per cent by 2010. When compared to national figures, the County has an average number of 0 to 15 year olds, a below average number of people of working age, and an above average number of pensionable age. Within the population just fewer than 5 per cent are from non – white or non-British communities, and gypsy and traveller communities occupy sites across Somerset.*

*The majority of the county's workforce is employed in small businesses or service sectors. Although 80 per cent of the land is agricultural, this only involves 5 per cent of the workforce. Average earnings within the County are below average at £353 per week; the national average is £402 per week. Average house prices in Somerset are £166,080 which is lower than the regional average of £175,940.*

*Unemployment in Somerset stands at 1.4 per cent compared with the national average of 2.5 per cent. The levels of 'poor' adult numeracy and literacy (23 per cent) are average in Somerset compared to the rest of the country. 33 per cent of the households in the County have at least one person with a serious health problem or disability (p 8, paras.15,14,16,17,18).*

*The Local Government Act 2000 gave councils a duty to prepare, with partners, a long*

*term community strategy to improve the quality of life for the area. Community strategies are the overarching strategic framework for the area and should set the overall objectives for the council's corporate strategy.*

*The Somerset Strategic Partnership (SSP) has confirmed its vision and priorities in its community strategy 'Somerset a landscape for the future'. The shared priorities of the SSP and the Council now include:*

- *Culture and leisure – creating a lifestyle. Develop a more diverse, tolerant and exciting multicultural environment for living, learning, working and visiting.*
- *Infrastructure, access and transport – creating sustainable foundations. Promote infrastructure and transport investment and development to meet the needs of Somerset's economy and communities whilst maintaining and enhancing the character, quality and diversity of the built and natural environment.*
- *Our Communities – sharing with each other a sense of belonging. Develop strategies for sustainable communities with decent, affordable and appropriate housing linked to work, with access to services and opportunities for community engagement. The Local Government Act 2000 also gave councils the power to promote the social, economic and environmental well being of their local community. In Somerset, community planning occurs at both county and district levels and this makes the process more complex than in unitary authorities. (p9 paras. 20, 21 ,22).*

*In response to the data of a high level of outward migration amongst 18 to 30 year olds and low productivity rates among businesses, the SSP has commissioned a report on the knowledge economy.*

*Pro –active steps have been taken by the Council to understand the needs of the diverse communities. The SSP commissioned a Somerset Equalities and Access Assessment which provides a comprehensive assessment of the social, environmental and economic needs and which has been used to inform the vision and community strategy. Although this ensures that the SSP has comprehensive information and data to make robust judgments about future priorities for Somerset, actions based on this*

report have not yet been taken. (p10 paras. 25, 26, 28).

**The Council does not consistently monitor take-up and service satisfaction by ethnicity and other equalities data, for example disability. While this is done by some services it is not consistent across the Council. This is a significant weakness and means, for example that the Council is unable to identify whether take-up or service satisfaction varies between BME and non BME communities or between disabled and non disabled people, and take corrective action.** (Our emphasis. p11, para.31)

**Improvements in quality of life have not been achieved for all communities. For example, the excellent comprehensive equality and access report presented to the SSP did not lead to specific actions to address the issues raised in the report. This report shows that there is continuing prejudice and discrimination against BME groups particularly gypsies and travellers, health inequalities in BME groups, reduced attainment by looked after children, and fear of crime and isolation amongst older people. The best value corporate health survey in 2003 confirms this – only 40 per cent agreed that the local area is a place where residents respect ethnic differences and nearly 20 percent disagreed. This evidence shows that the council has a lot to do to achieve improved quality of life for all residents.** (Our emphasis p 22, para.86)

Source: Audit Commission Inspection Report (May 2005), Somerset County Council – Community Planning.

**Ethnicity:**

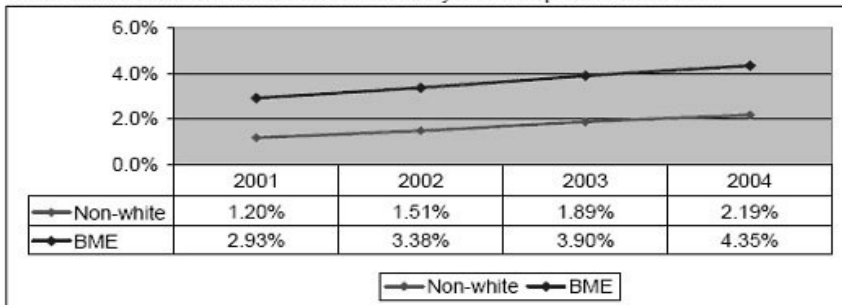
Reproduced from Office of National Statistics Report, Ethnicity Estimates 2004. Ethnicity in Somerset – Update (Hiscock, C-A., August 2006).

Throughout this report, Black and Minority

**Ethnic (BME) is defined as all those whose ethnic origin is not White British and 'Non-white refers to those whose ethnic origin is not White British, White Irish or White Other.**

The report 'Ethnicity in Somerset – June 2004' provided in-depth analysis of ethnicity data from the 2001 Census. The Census still remains the most accurate and detailed source (arguably) of information on ethnic origin, particularly at local (ward) level, but the Office for National Statistics has now produced experimental mid-year estimates of the ethnicity of the population in local authority areas. This report provides an update of the ethnic make up of Somerset and its component Districts, compared to the picture in the South West region, and identifies changes since the 2001 Census.

Chart 1: Increase in Somerset's Black or Minority Ethnic Population 2001-2004



Source: 2001 Census and Ethnicity Estimates 2002-2004, ONS

Figure 1: Chart 1: Increase in Somerset's Black and Minority Ethnic Population 2001 - 2004

	All		Male		Female	
	Non-White	BME	Non-White	BME	Non-White	BME
South West	3.46%	6.20%	3.54%	6.12%	3.38%	6.28%
Somerset	2.19%	4.35%	2.25%	4.25%	2.17%	4.52%
Mendip	2.25%	5.06%	2.69%	5.18%	2.01%	5.13%
Sedgemoor	2.11%	3.76%	2.07%	3.57%	1.79%	3.76%
South Somerset	2.13%	4.13%	1.98%	3.83%	2.15%	4.29%
Taunton Deane	2.45%	4.72%	2.54%	4.70%	2.19%	4.55%
West Somerset	1.97%	3.93%	0.59%	2.35%	0.54%	2.69%

Source: Ethnicity Estimates 2004, ONS

Figure 2, Table 1: % non-white BME Population of South West, Somerset and Districts by Gender (2004)

**Key Points**

- Somerset's BME population has increased from 2.93% in 2001 to 4.35% in 2004.
- Somerset's non-white population has increased 1.20% to 2.19% over the same period.
- Mendip has the highest BME population (5.06%) of the Somerset Districts and West Somerset has the lowest (3.93%)
- The proportion of women in Somerset from BME groups is slightly larger than the proportion of men (4.52% and 4.25% respectively). However, there is a higher proportion on non-white men (2.25%) than women (2.17%).

- Of all the ethnic groups in Somerset, the Pakistani has grown the most between 2001 and 2004, showing an increase of over 241%
- The Black African and Indian populations have also shown a substantial increase over the period, 218% and 167% respectively.
- The largest growth in the South West region was in the Black African group (143%)
- The percentage growth of all BME groups is greater in Somerset than the South West as a whole and, in many cases; it is double or even triple that of the region.

For more information and tables about ethnic composition please see Appendix D.

### **Migrant workers as a recent phenomenon in Somerset**

The following is reproduced from the report 'Migrant Workers in Somerset' – Somerset County Council, (Hiscock C-A, September 2006, please see website for the full report as referenced in Bibliography, p.66).

*Since the expansion of the European Union in May 2004, an increasing number of people from EU countries have come to work in Somerset. They have been attracted to Somerset because of local skill shortages especially in the care sector, tourism, pig farming and food preparation industries. Somerset has had relatively low unemployment rates over recent years and many local employers have been advertising in the EU for workers to fill skill gaps.*

*Within many local communities there have been increasing numbers of EU 'migrant' workers employed.*

- *In Chard, Portuguese workers have been employed by Oscar Meyer.*
- *In Frome, a large contingent of Polish workers has been evident.*
- *A growing number of migrant workers is evident in:*
  - *Burnham on Sea/Highbridge and Minehead in the tourism and care sectors.*
  - *Yeovil in the NHS*
  - *Wiveliscombe in Pig Farming*
  - *Chard in food preparation*
  - *Taunton within the care sector, including work with adults with learning difficulties*
  - *Outlying fruit farming outlets*
- *There has also been a growing use of EU workers to fill vacancies in the*

*transportation industry.*

*There is a wealth of anecdotal evidence such as this regarding the influx of migrant workers into Somerset from countries recently admitted to the EU. Despite these day to day observations, there is little information on the number, origin and characteristics of migrant workers in Somerset.*

*The report outlines what we do know, highlights trends and identifies gaps in information which need to be filled by local and national research.*

*Background information to the report on Migrant Workers.*

- *Migrant workers are a transient population and therefore difficult to count.*
- *There are several data sources on migrants entering the UK:*
  - *National Insurance Number (NINO) Registration.*
  - *Worker Registration Scheme (WRS)*
  - *Annual Population Survey (APS)*
  - *International Passenger Survey (IPS)*
  - *Immigration Control*
- *Despite this range of data sources, getting an accurate picture of the number of migrant workers is difficult.*
- *Of these sources, the only one currently available at local authority level is National Insurance Number (NINO) Registrations.*
- *There is no definitive source for the number of migrant workers in an area and all of those listed above can only provide an estimate. It must also be noted that these figures are likely to underestimate the number of migrants as they do not account for families, only individuals who register for work.*
- *The lack of data on migrant workers is nationally recognised. In May 2006 the Office of National Statistics (ONS) set up an interdepartmental Task Force on Migration Statistics. ONS is also carrying out an extensive programme of work in the form of Improving migration and Population Statistics (MPS) Project, designed to investigate improvements to the population, and migration statistics produced by the ONS. This work is on-going.*
- *Local research on migrant workers is desperately needed. South*

*Somerset has produced a valuable study of migrant workers in the district but there is currently nothing similar for the rest of Somerset. Research should focus on the experiences and characteristics of migrant workers, rather than attempting to count the population. It would be valuable preparation for future migrants from the next 'wave' of new EU member countries.*

Source: Migrant Workers in Somerset, Sept. 2006 – Carrie-Anne Hiscock, Somerset County Council.

Carrie-Anne Hiscock's report does not include the growing number of migrant workers in the Mendip area of Somerset. It is difficult to see why this is so, particularly since there is now a visible and significant number of the workers in Wells, Shepton Mallet and Street within the care sector, food preparation and tourism to name but a few.

## **Our Research**

Our overall aim has been stated earlier in this report. Our specific achievable objectives have also been mentioned.

But in line with the objectives set out in the Department of Health's Delivering Race Equality document, (which happens to be an ambition we share fully); it was anticipated that sourcing the researchers from the target community to undertake the research within the same target community, (in this case the community groups that SREC works with), there would be an added dividend, in that, individual researchers so motivated would benefit in terms of learning and development.

While the advertisement (Appendix E) for the researcher positions were designed to attract people from the community, it also made it abundantly clear that successful applicants would be expected to:

- Participate in training workshops.
- Attend team meetings.
- Contribute to written reports.
- Be involved with data collection and input.
- Contribute to an agreed research design.
- Contribute to community group sessions and workshops.
- Help establish a mental health development forum.
- Work with community groups.

It was hoped that it would be a good learning experience as well as a revealing one in terms of the subject for research. Educational support would be provided by UCLAN to give the researchers an opportunity to obtain a University Qualification as part of the programme if they wished. This was however not compulsory.

Three qualifications were on offer:

- University Certificate of achievement in Research
- University Certificate in Community Based Research
- University Certificate in Community Based Research and Mental Health

The qualification would be obtained through a collation of a portfolio of work which the researchers would be involved in locally.

The experience was also expected to serve as a spring-board to finding work in a related field. Indeed a number of our researchers are now working, or have interest in working in a related field.

UCLAN have stated that 20% of those who were formerly trained have gone on to find such work. In Somerset 5 Community Researchers have successfully obtained qualifications as a result of involvement in this project. A member of the research interpreting team was employed in March as one of the three community development workers for Mental Health in Somerset. The remaining two posts will be advertised in November 2007.

## **National Priorities**

The National Priorities from the Department of Health are:

1. The development of more appropriate and responsive services for the black and minority ethnic communities by statutory service providers.
2. The development of a health workforce capable of working with and treating different communities.
3. Better engagement of black and minority ethnic groups in shaping mental health services and supporting innovative, community informed services.
4. Better collection and more effective use of information to assess and target service developments.

## METHODOLOGY

There was a determination at SREC that it was only by including the whole of the county geographically, that we would be in a position to launch a Somerset Black and Minority Ethnic Mental Health Development Forum, using research recommendations, in order to inform the decision making and commissioning process. This admittedly made the research journey arduous and fraught with difficulties, leading to delays to our scheduled timetable. It is however generally felt that it has been well worth it as a contribution to the long term value of the research in line with NIHME aspirations.

### Who was recruited?

Recognising the enormity of the task that we had set ourselves, we were mindful, in our recruitment of researchers, to have individuals who represented a range of the BME communities (with their predominant languages) as well as being spread, geographically, across the large county of Somerset. Hence the research team consisted of individuals from a range of ethnic groups: Polish, African, Caribbean, Filipino, English, Welsh, South American, Asian and Portuguese.

### How they were recruited

Advertisements were placed in SREC's jobs vacancy mailing and local press (Appendix E), which resulted in applications from Bristol and Devon as well as Somerset. Budgetary constraints meant that not all suitable applicants could be employed but some offered to work in a voluntary capacity and were recruited as such.

### How the people recruited were trained and supported

Training of this diverse team was primarily provided by UCLAN. Additional training on 3 occasions however, dealt specifically with what currently exists in the areas of mental health provision and treatment in Somerset. This was made available by SREC and Somerset PCT so that the researchers would get additional relevant local information, and an indication of the journey that a potential patient might take towards diagnosis and treatment. It also included advice and information for researchers in the event of being with respondents to our questionnaire who became distressed or angry. Special emphasis was placed on ensuring that researchers were aware and able to conform to the agreed ethics proforma (Appendix C).

During the entire process, from recruitment

through research and report writing, researchers had access to SREC administrative and managerial resources in addition to the support available from the 2 lead co-ordinators and the UCLAN Support Worker.

### What the researchers actually did

A rather charged but healthy debate took place right at the beginning about the spread, parameters, scope, depth, tools, and target number of the sample. This healthy tension, based on the different expectations of the researchers,(pp 3&4), did cause the clashing of minds from different ethnicities (culture, background and life experiences) during the process to determine what was realistically achievable as a research, within the time scales and with the resources available. The skills employed by the UCLAN Support Worker to help the researchers navigate a way through this phase are noteworthy. With that guidance from the UCLAN Support Worker, and support from individual members of the Steering Group, the following was settled on:

- The research would cover the whole of the geographical and administrative area of Somerset.
- An achievable reduced number of objectives would be focussed on (Stated fully on page 19 of this report.)
- The tools to be used in the research would be: interviews using questionnaires for the main research and then a focus group specifically on depression to gain additional data.
- The target number of the sample was set at 250, to be sourced from as many of the larger ethnic groups that SREC and SBDA were aware of.
- A timetable was also agreed, incorporating review stages but aiming to complete by the end of March 2007.

A sub group of the research team looked at compiling a questionnaire as a research tool for collecting both quantitative and qualitative data whilst others developed leaflets, in a variety of languages, to encourage participation from community groups (Appendix A).

Based on our pilot work, the most effective encouragement to participate was, arguably, a token incentive payment in recognition of the respondents' time and willingness to share their thoughts and experience (Appendix F). A sample of 246 respondents from a range of ethnicities was garnered from across the 5 District Council areas. The

second data collection method was through a Focus Group investigating depression in BME men (Appendix B). Both the questionnaire and focus group were governed by the ethics protocol written by the group which required consent from participants (Appendix G).

The process of inputting the data into Excel and Access was long and tedious but the decision to put a place and researcher's initials on each questionnaire ensured that there was no duplication. Data analysis was made more straightforward because considerable time and effort was expended in the design of the questionnaire. In recruiting our team of multilingual researchers we had hoped to minimise the need for additional face to face interpreters but we miscalculated the high number of respondents who required language assistance. An attempt to tape responses for translation at a later date was unsuccessful as respondents were wary of the equipment and unwilling to participate.

#### **The special role of the steering group (p 14)**

The steering group had the specific task of governance of this project and by the relevance of their individual jobs and positions it was envisaged that they would be minded to incorporate the recommendations of the research into their commissioning work.

The Steering Group (appendices D and D1), consisting of a range of partners, had oversight of the research and brought in the statutory and voluntary sectors with their different perspectives and experience in the fields of mental health service provision, access, treatment, prevention and recovery.

They also offered guidance in reconciling the diverse aspirations within the research team with the terms of reference for the project.

#### **How communities were accessed**

Somerset Black Development Agency, as a member of the steering group and a SREC project were in the position to access the ethnic minority community groups in our target area. Many of the researchers were members of the SBDA, and were community leaders themselves. They were therefore in a strong position to encourage and engage with respondents.

#### **What research tools were used?**

1. Face-to-Face interviews involving the use of questionnaire. (Appendix A)
2. A focus group (Appendix B)

The Research Field work took place between November 2006 and the first week of January 2007. A risk assessment (Appendices H&J) having been undertaken, it was stipulated that

all interviews would be undertaken in public venues and not in private homes. Interviews were conducted on a one to one basis; see ethics form (Appendix C). Translators were used as necessary and respondents were given enough time to express themselves as for most, English was not their first language. A number of the respondents however could speak two or three other European languages – a noteworthy point.

The Steering Group, occasioned by Somerset PCT, strongly signalled that they would be interested in data on Depression.

Respondents were asked during the interview if they were interested in taking part in a focus group on depression and/or being on a BME Mental Health Forum. The Focus group was restricted to those with adequate English language who could understand points being raised and participate in the discussion. An aide memoiré was provided for the facilitators and 3 note takers gathered the data.

The wide scope of the research, both in terms of the geographical area and broad issues of mental health, raised frustrations, where aspects highlighted by the research could not be investigated further within the time and budget constraints of the project. More than anything else the research team was driven by the wish to promote change and 'make a difference'. Hopefully we will have opportunities to develop initiatives and create positive outcomes with the assistance and guidance of the steering group until the BME Mental Health Forum is established and able to reach an operational status.

**RESULT**

(SAMPLE GROUP)

A total of 246 people from the local BME community were interviewed.

**Core Data Analysis**

Q22) Age at last birthday:

Age Group	Total	%
18-21	26	11
22-24	16	6
25-29	42	17
30-39	84	34
40-49	50	20
50-59	21	9
50-69	3	1
60-69	2	1
70+	2	1
Total	246	100

Table 3: Participants by Age

Q23) Gender:

	Total	%
Female	135	55
Male	111	45
Total	246	100

Table 4: Participants by Gender

Q24) Ethnicity

	Total	%
Asian or Asian British: Bangladeshi	4	2
Asian or Asian British: Indian	5	2
Asian or Asian British: Other (Iranian)	4	2
Asian or Asian British: Other (South Korean)	2	1
Asian or Asian British: Pakistani	4	2
Asian or Asian British: South East Asia or The Pacific (Fijian)	2	1
Asian or Asian British: South East Asia or The Pacific (Filipino)	36	14
Asian or Asian British: South East Asia or The Pacific (Thai)	8	3
Black or Black British: African	12	5
Black or Black British: Caribbean	5	2
Black or Black British: Other (Brazilian)	3	1
Black or Black British: Other (Guatemalan)	2	1
Black or Black British: Other (Mexican)	1	1
Chinese	29	12
Dual Heritage: Other	2	1
Dual Heritage: White And Asian	2	1
Dual Heritage: White And Black African	6	2
Dual Heritage: White And Black African (Portuguese)	7	3
Dual Heritage: White And Black Caribbean	3	1
Polish	44	17
Portuguese	40	16
Portuguese (Black)	6	2
Romany Gypsy	5	2
White Other	14	6
Total:	246	100

Q25) Were you born in the UK?

	Total	%
Yes	29	12
No	217	88
Total	246	100

Table 6: Participants born in the UK

Q26) If no, how long have you lived here?

	Total	%
Less Than 1 Year	44	20
1-5 Years	120	55
6-10 Years	22	10
11 Years or More	31	15
Total	217	100

Table 7: How long have participants lived in the UK

Q27) Are you a:

	Total	%
British Citizen	82	33
Other	164	67
Total	246	100

Table 8a: Participants with British Citizenship

Q27a) Other explained:

	Total	%
EU Citizen	106	65
Work Permit	18	11
Permanent Resident of UK	17	10
Visa	9	5
Work Visa	9	5
Awaiting Citizenship	3	2
Marriage to a British Citizen	1	1
Student	1	1
Total	164	100

Table 8b: Status of participants

For the appendices please do not forget to ask SREC for a copy on 01458 274 200. Alternatively download from: [www.srec.org.uk/reports](http://www.srec.org.uk/reports)

Q28) What is your first language

1st Language Spoken	Total	%	1st Language Written	Total	%
Portuguese	56	23	Portuguese	56	22
Polish	44	18	Polish	44	17
Tagalog	36	15	Tagalog	35	14
English	35	14	English	43	17
Chinese	23	9	Chinese	23	9
Thai	8	3	Thai	8	3
Slovakian	4	2	Slovakian	4	1
Bengali	4	2	Bengali	3	1
Iranian	3	1	Iranian	3	1
Spanish	3	1	Spanish	3	1
Czech	2	1	Czech	2	1
German	2	1	German	2	1
Hungarian	2	1	Hungarian	2	1
Korean	2	1	Korean	2	1
Cantonese	2	1	Cantonese	1	1
Hindi	2	1	Hindi	1	1
Mandarin	2	1	Mandarin	1	1
Criolo	1	1	Criolo	1	1
Dutch	1	1	Dutch	1	1
Fanti	1	1	Fanti	1	1
Farsi	1	1	Farsi	1	1
Fijian	1	1	Fijian	1	1
French	1	1	French	1	1
Kurdish	1	1	Kurdish	1	1
Sotho	1	1	Sotho	1	1
Swana	1	1	Swana	1	1
Telugu	1	1	Telugu	1	1
Zuazi	1	1	Zuazi	1	1
Zulu	1	1	Zulu	1	1
Zwahili	1	1	Zwahili	1	1
Gujurati	1	1	Gujurati	0	0
Luo	1	1	Luo	0	0
Romani	1	1	Romani	0	0
Total	246		Total	246	

Table 9: Participants spoken and written 1st language

Q29) In which languages are you fluent?

Spoken	Total	%	Written	Total	%
English	131	38	English	122	39
Polish	31	9	Polish	30	10
Portuguese	24	7	Portuguese	29	9
Tagalog	20	6	Tagalog	28	9
Chinese	18	5	Chinese	19	6
French	14	4	French	12	4
German	12	3	German	8	3
Spanish	12	3	Spanish	6	2
Russian	11	3	Russian	9	3
Italian	9	2	Italian	4	1
Thai	8	2	Thai	8	2
Arabic	6	2	Arabic	2	1
Hindi	6	2	Hindi	3	1
Cantonese	4	1	Cantonese	2	1
Czech	4	1	Czech	4	1
Farsi	4	1	Farsi	4	1
Iranian	3	1	Iranian	3	1
Fijian	2	1	Fijian	2	1
Mandarin	2	1	Mandarin	0	0
Romani	2	1	Romani	1	1
Swahili	2	1	Swahili	2	1
Afrikaans	1	1	Afrikaans	1	1
Ashanti	1	1	Ashanti	1	1
Bengali	1	1	Bengali	1	1

Cebuano	1	1	Cebuano	0	0
Fanti	1	1	Fanti	1	1
Ga	1	1	Ga	1	1
Gujarat	1	1	Gujarat	0	0
Hungarian	1	1	Hungarian	1	1
Kurdish	1	1	Kurdish	1	1
Laos	1	1	Laos	1	1
Pampango (Dialect)	1	1	Pampango (Dialect)	0	0
Punjabi	1	1	Punjabi	0	0
Slovakian	1	1	Sotho	0	0
Sotho	1	1	Sotho	1	1
Swana	1	1	Swana	1	1
Swedish	1	1	Swedish	1	1
Turkish	1	1	Turkish	1	1
Urdu	1	1	Urdu	0	0
Vietnamese	1	1	Vietnamese	0	0
Zulu	1	1	Zulu	1	1
Total	345		Total	311	

Table 10: Languages which participants are fluent in

Q30) What is your religion?		
Religion	Total	%
Christian (Catholic)	89	36
Christian	79	32
None	36	14
Buddhist	13	5
Muslim	8	3
Christian (Born again)	6	2
Christian (Evangelical)	3	1
Atheist	1	1
Belief in God, (no specific religion)	1	1
Christian (7th Day)	1	1
Christian (Baptist)1	1	1
Christian (Methodist)	1	1
Christian (Pentecost)	1	1
Christian and Buddhist	1	1
Hindu	1	1
Jehovah's Witness	1	1
Mother of God	1	1
Other	1	1
Unknown	1	1
Total	246	

Table 11: Religion of participants

Q31) Do you have a disability?		
	Total	%
Yes	19	8
No	227	92
Total	246	100

Table 12a: Disability status of participants

Q32) Are you entitled to claim for state benefits for your disability?		
	Total	%
Don't Know	3	16
No	4	21
Yes	12	63
Total	19	100

Table 12b: Benefit entitlement

Q33) Sexuality:		
	Total	%
Heterosexual or straight	224	91
Do not wish to answer	19	8
Lesbian or gay woman		
Gay man	0	0
Bisexual	1	1
Total	246	100

Table 13: Participants sexuality

Q34) Are you a member of a community group or association?		
	Total	%
Yes	149	61
No	97	39
Total	246	100

Table 14a: Member of Community Group or Association

Q35) Names of community groups/associations which respondents are a member of:		
	Total	%
Somerset Portuguese Assoc.	39	25
South Somerset Filipino Assoc.	35	23
Somerset Polish Community Assoc.	25	16
SIWA	9	6
Somerset Chinese Christian Assoc.	8	5
Community Health International	6	4
Sedgemoor Polish Assoc.	5	3
Somerset Chinese Assoc.	5	3
Asian women and friends Assoc.	4	3
SW International Friends	2	1
SREC	2	1
Faith Group	2	1
Other	1	1
Fanti Union.	1	1
Glastonbury Group for Meditation and Complementary	1	1
Hidden Voices	1	1
Learning voices and SIWA - Mendip	1	1
Lions Club	1	1
MIND centre	1	1
Romany Gypsy Liaison Group	1	1

Somerset Black Development Agency	1	1
Daffodil Club	1	1
Thai Ladies Network	1	1
West Somerset International Group	1	1
Total	154	

Table 14b: Community Group / Association Membership

Q6) Have you got help for your mental health in the last 12 months?

	Total	%
Yes	30	12
No	216	88
Total	246	100

Table 18: Help for Mental Health Issues

Q35) Our main aim from the research is to develop a Somerset Mental Health Development Forum for BME residents so that we can influence how services are developed in the future. Are you interested in becoming a member?

	Total	%
Yes	144	59
No	102	41
Total	246	100

Table 15: Interest in membership of Somerset Mental Health Development Forum for BME residents

Q7) If you had a mental health problem, which of the following might you inform?

	Total	%
Doctor	166	67
Family Member	157	64
Partner	142	58
Friend	131	53
Support Group	58	24
Helpline	55	22
Other Health Professional	54	22
Spiritual Leader	43	17
Nurse	36	15
Internet Discussion Forum	29	12
Community Leader	29	12
Complementary Therapist	28	11
Solicitor	11	4
Would not tell anyone	7	3

Table 19: Where would you get information on Mental Health?

## FINDINGS

(Quantitative Analysis)

\* Please note: The numbers in some cases may add up to more, or in other cases less, than the total number of sample. This is because respondents could select more than one category, or not answer the question at all.

Q2) Do you have a doctor in Somerset?

	Total	%
Yes	212	86
No	34	14
Total	246	100

Table 16: Registered with a doctor

Q8) Do you follow a religion?

	Total	%
Yes	186	76
No	53	21
Not Answered	7	3
Total	246	100

Table 20a: Following a religion

Q8a) Are there aspects of your religious faith which affect your mental health?

	Total	%
No	134	54
Yes	69	28
No Response	37	15
Don't Know	6	2
Total	246	100

Table 20b: Does religious faith affect Mental Health

Q2b) Have you been to any of the following about your health in the last 12 months in Somerset?

	Total	%
Doctor	172	70
Pharmacy	131	53
Health Centre	104	42
Dentist	94	38
Family	89	36
Hospital	82	33
Community Group	59	24
Optician	59	24
Place of Worship	54	22
Neighbour	41	17
Mental Health Service	8	3
Healer	7	3
Voluntary Health Organisation	6	2

Table 17: Sources of health information

Q9) Are there aspects of your culture which affect your mental health?

	Total	%
No	154	63
Yes	70	28
No Response	13	5
Don't Know	9	4
Total	246	100

Table 21a: Does culture effect Mental Health

Q9b) Are there aspects of your culture which may prevent you from living the way you would like to live your life?

	Total	%
No	148	60
Yes	77	31
No Response	19	8
Don't Know	2	1
<b>Total</b>	<b>246</b>	<b>100</b>

Table 21b: Does your culture prevent living your life

Q10) What do you think are the best ways of helping someone to recover from a mental health problem?

	Total	%
Talk to someone	196	80
Go for counselling	191	78
Plan an activity or holiday	172	70
Get Medication from the doctor	143	58
Get hospital treatment	113	46
Keep knowledge of the problem in the family	71	29
Visit a healer	62	25
Return to country of origin	62	25
Stay away from members of your community	15	6
Not possible to recover from a mental health problem	9	4
Do nothing its just the way some people are	9	4

Table 22: Ways to help someone recover

Q11) 10% of the population have a mental health problem, but most do not seek help. Can you think of ways in which more people can be helped?

	Total	%
MH awareness campaigns	51	21
Outreach support to community groups, family networks, local employers and schools	48	20
anti stigma campaigns	41	17
Advertise and publicity using media/leaflets/Internet	27	11
Signposting	18	7
Organise events and activities	14	6
Support group	14	6
Don't Know	11	4
Counselling	10	4
Service Directory	10	4
Seek professional help (incl GP)	10	4
Talk to someone	9	4
Friendly Mental Health Centre	8	3
Up to the individual	7	3
Home visits	6	2
Faith	4	2
Mental health research	4	2
Training for GP about Mental Health Promotion	4	2
1:1 confidential support	4	2
Other	15	6

Table 23: Ways to help encourage people to get help

Q12) Have you ever suffered from depression?

	Total	%
Yes	93	38
No	153	62
<b>Total</b>	<b>246</b>	<b>100</b>

Table 24a: Suffered from Depression

Q12a) Have you ever been treated for your depression?

	Total	%
Yes	39	16
No	207	84
<b>Total</b>	<b>246</b>	<b>100</b>

Table 24b: Treated for Depression

Q14) Have you ever looked after someone who has a mental health problem?

	Total	%
Yes	79	32
No	167	68
<b>Total</b>	<b>246</b>	<b>100</b>

Table 25a: Caring for someone with a Mental Health problem

Q14b) Did you feel that the help you provided was appreciated by others?

	Total	%
No Response	133	54
Don't Know	2	1
No	49	20
Yes	62	25
<b>Total</b>	<b>246</b>	<b>100</b>

Table 25b: Was help appreciated

Q15) Do you know about local mental health services in your area?

	Total	%
Yes	54	22
No	192	78
<b>Total</b>	<b>246</b>	<b>100</b>

Table 26: Knowing about local Mental Health services

Q16) What information do you think should be available about mental health?

	Total	%
Advertising using media (radio/TV/Film/Newspapers) in the community	49	20
Mental Health Awareness - what to look out for and possible causes	46	19
Information about accessing services and support available	39	16
Leaflets	38	15
Signposting	35	14

Service Directory of contact numbers and addresses	17	7
Don't know	16	6
Internet	12	5
Information about depression and symptoms of	10	4
10 Key points about mental health	8	3
Anti stigma information	8	3
Confidential Advice and support centre	7	3
Books	6	2
Helpline	7	3
More accessible appointments with the GP	6	2
Self help information	5	2
Other	4	2

Table 27: Services that should be available

Community Centre	122	50
Complementary Health Centre	120	49
Citizens Advice Bureau	114	46
School	102	41
Local Council	91	37
Place of Worship	88	36
Supermarket	38	15
Library	38	15
Sports Centre	34	14
Website	2	1

Table 28c: Where would you like to access services?

## FINDINGS

(Qualitative Analysis Open Questions)

Unless otherwise stated, percentages are calculated on the frequency of the themes or issues raised by participants.

### 1. UNDERSTANDING AND AWARENESS OF MENTAL HEALTH ISSUES.

Participants conceptualised the term 'mental health' in the following ways (Q3):-

- In a negative light, as indicative of depression, stress or nervous breakdown (45%).

*'When someone has depression or is stressed they have mental health problems.'*  
(Portuguese, female)

- It was also perceived as representing a serious, enduring mental illness (schizophrenia, paranoia or a seemingly irreversible disorder requiring hospital treatment (25%)

*'Crazy, strange people – weird – could be harmful to others.'*  
(Chinese, Male)

- 4% of responses indicated loneliness or isolation as intrinsic to poor mental health.

*'Loneliness, to be away from family and frustrated and stressed because she can't speak the national language.'*  
(Black Portuguese, Female)

- 24% of responses perceived 'mental health' in a positive light representative of emotional and spiritual well-being.

*'Healthy outlook in life, not confused, alert, happy, contented, self-control, positive self-confidence.'*

There were only 2 references associating mental health with suicide.

Q17) Where do you think people should access mental health information?

	Total	%
Hospital	213	87
Health Centre	209	85
Website	178	72
Helpline	175	71
Community Association	171	70
School	170	69
Citizens Advice Bureau	160	65
Library	159	65
Complementary Health Centre	148	60
Local Council	142	58
Place of Worship	130	53
Sports Centre	116	47
Supermarket	85	35

Table 28a: Where to access services

Q18) Please indicate what you think might prevent you from accessing mental health services:

	Total	%
Breach of confidentiality	160	65
Language/communication difficulties	139	56
Don't know where to go for help	135	55
Location of service	113	46
Transport	102	42
Translation And Interpretation	102	42
Cultural reasons	54	22
Faith reasons	36	15
Being treated by a professional of the opposite sex	27	11

Table 28b: Barriers to access services

Q19) Where would you like to access mental health services, please choose from the list below:

	Total	%
Health Centre	197	80
Hospital	185	75
Community Association offering mental health services	163	66
Helpline	140	57

Participants cited a wide range of causes for mental health problems (Q.5) -

Mental Health Causes	Total	%
Family problems	72	12
Financial problems	69	12
Stress	67	12
Unemployment	56	10
Loneliness/Missing Family	65	11
Depression	32	5
Genetic or biological causes	22	4
Drugs and alcohol misuse	19	3
Bereavement	17	3
Trauma and conflict	17	3
Poor physical health	14	2
Language barrier	14	2
Homelessness	13	2
Cultural differences	12	2
Racism and discrimination	12	2
Homesickness	11	2
Media and social pressures	8	1
Poor diet	6	1
Low self esteem	5	1
Childhood problems	5	1
Unhappiness	5	1
Environment	4	1
Emotional problems	4	1
Insecurity	4	1
Don't Know	8	1
Other	16	3
<b>Total</b>	<b>577</b>	

Table 29: Mental Health causes

**Analysis points:**

1) Loneliness presents as a significant variable and is consistent with the experience of E.U. nationals working away from family.

2) This research demonstrates the importance of close relationships to our respondents, over and above social risk factors in causing mental health problems. This emphasis on friends and family is a thread running right the way through the research (eg.Q4&Q13).

**2) SELF HELP STRATEGIES AND CURRENT PRACTICE OF BME INDIVIDUALS IN MAINTAINING POSITIVE MENTAL HEALTH.**

The main lifestyle strategies participants deployed in maintaining their mental health (Q.4) fell into the following categories:-

· Quality social interaction with family or friends constituted 44% of the responses.

*'Close families. close relatives. keep well*

*balanced..... (a) set of friends. Filipino community are a united group, supporting each other.'*

(Filipino, Female)

· Physical activity accounted for 19% of responses. This included activities ranging from walking through to venue based activities such as swimming, aerobics, working out, dancing and team sports such as basketball or football.

*'Visit a gym, work out physically and I feel good about that, it exercises my brain too.'*  
(Bangladeshi, Female)

· Focusing on work and the satisfaction of earning reflected 10% of responses.

*'Everyone has a goal in life; we have to be strong to achieve it. In Portugal I was financially well, but I came here to earn more money and support my children and that gave me strength, we must never lose hope.'*  
(Portuguese, Male)

· Other strategies included: deriving support from one's faith (8%), leisure activities such as listening to music, reading and films (7%), eating well (6%) learning English or new skills (3%).

5 participants derived benefit from voluntary work or helping others. Only 1 participant used cannabis for this purpose.

When questioned about alternative courses /action participants might take if they had a mental health problem, the following responses were offered in addition to the most prevalent response, which was to seek professional help (32%).

The alternative action that participants would take if they had a mental health problem falls into the following categories:-

(However categories already cited in Q7 are consistently referred to again)

Self Help Option	Total	%
Seek the help of a professional	47	33
Talk to someone close	45	31
Reflect on one's problems to find a solution	24	17
Prayer	12	8
Research the problem	6	4
Try alternative treatments or therapy	3	2
Go on a drinking session	2	1
Return to country of origin	2	1
Keep a diary	2	1
Avoid alcohol	1	1
<b>Total</b>	<b>144</b>	

Table 30: Self Help Options

*'Study myself. Check to see whether I am on the right track.'*  
(Fijian, Female)

*'I would do research and find out for myself what kind of help I need, or try to be positive.'*  
(Dual Heritage: White and African Caribbean, Male)

**Analysis point:**

The responses here evidence trust in the expert knowledge of health professionals. This may resonate with the popular perception from outside the UK of an excellent NHS system, which endures once resident here. Access to professional services is perhaps also seen as a right, particularly if one is a tax payer. This is further evidenced in the responses to Question 20).

35 Participants who felt that they might not be able to discuss their mental health problems with anyone (Q 7c) offered the following alternatives:-

Alternatives	Total	%
Isolate oneself	10	29
Seek solace through religion	7	20
Try to address the problem oneself, through reflection or research.	6	17
Be with one's family	4	11
Socialise and keep active	3	9
Seek out distractions:		
TV, reading, sports	3	9
Discuss issues with a stranger	2	6
<b>Total</b>	<b>35</b>	<b>100</b>

Table 31: Alternative sources of help

*'I would isolate myself, so I can be crazy by myself. Somewhere very remote.'*  
(Dual Heritage: White and Black Caribbean, Male)

*'Prayer. Meditation. Have a good cry – release.'*  
(Filipino, female)

Participants also identified the following ways in which they coped with major changes in their life (Q 13):-

· Drawing on 'inner' strength and maintaining a positive frame of mind accounted for 41% of the responses.

*'When I think there is major stress, I try to be optimistic and positive. I will weigh up the advantages and disadvantages and get on with life.'*  
(Filipino, Female)

· This capacity was followed by active socialising and engagement with one's community (36%).

*'Lack of family. Community association helps him to find himself and get more confidence, in our community one person helps one another is less stress for others.'*  
(Polish, Male)

· Deriving support from one's family accounted for 30% of responses, focussing on work (5%) and deriving strength from prayer (4%).

**Analysis point:**

1) The self-sufficiency of BME individuals where they are a significant minority should not be taken for granted.

2) In much the same way as the significance of family runs throughout the research, so does the importance of the specific community association that participants may belong to.

**3. ACCESSING MENTAL HEALTH SERVICES**

30 participants provided the following reasons why they had not registered with a doctor in Somerset.

Reason why people are not registered with a GP	Total	%
In good health therefore does not feel the need	11	31
Have just arrived in the U.K	7	20
Does not know how to register	6	17
Have moved, having a G.P in another area	3	9
Does not speak English	2	6
Too busy	2	6
Waiting for paperwork or National Insurance Number	2	6
Hasn't considered it at all	2	6

Table 32: Reasons why people are not registered with a GP

83% of participants described the information they believed should be available about mental health (Q 16):-

Over and above the fact that all media should be used to disseminate information about services available (59%), participants outlined the following aspects of mental health provision they believed to be important:-

· Information that educates and informs audiences about all aspects of mental health issues particularly those social factors that stigmatise service users (30%)

*'For me, personally stigmatized. Patient, day centres. What you can do when you feel down. Pointers to help people. For Polish.....working with the Catholic Church. Bridgwater not helpful.'*  
(Polish, Female)

Information that has been translated into a range of relevant languages (17%).

*'The current information that is in Chard should be in Portuguese also.'*  
(Portuguese Female)

8 participants also stressed the importance of accessing information – and services – through specially designated venues.

*'Special house that deals with specific problems done confidentially. Make accessible. In Sweden they call it the 'moment house'. Like a one stop shop.'*  
(Turkish, Male)

However when asked to give reasons why particular venues for accessing mental health services held certain advantages (Q. 20), the following was supplied:-

Health Centres accounted for 40% of the responses, for accessing expert knowledge and the confidentiality and trust it inspired.

*'First Health Centre. Trust the professionals.'*  
(Slovakian, Male)

Community Association venues were also highly rated (31%) on the grounds of securing cultural and language support. (3 participants cited their church as an appropriate venue and this might be included in this category as churches are generally deemed to be a community resource).

*'Community association offering mental health services is the access I like the most and is more adequate to me. It is the easiest to access.'*  
(Portuguese, Female)

Further suggestions were: telephone helplines (for anonymity and confidentiality) 13%, Hospitals (for accessibility and rapid response) 4%, Schools (for early intervention) 3%, alternative therapy centres (for the relaxed ambience) 3% and finally Citizens Advice Bureaux (for convenience) 3%.

#### **Analysis point:**

There is a clear attachment to both 'spaces' – the Health Centre and whatever venue hosts Community Associations, both providing particular forms of re-assurance. This could be very specific to the sensitive nature of mental health issues (rather than physical problems).

#### **4) EXPERIENCES AND ATTITUDES TOWARDS MENTAL HEALTH SERVICES**

25 participants described their experience of treatment they had received for mental health problems in this area (Q 6a) The following distinguishes the types of treatment they received and their subsequent response: -

15 participants were prescribed medication only. 1 participant described a good outcome with this treatment; however 3 detailed a bad reaction.

*'Help from Dr. - . Psychologist. Dropped my medication because I thought I was getting better. They changed my medication and I felt awful.'*  
(Caribbean, Male)

10 participants received counselling or psychiatric support ('talking therapies'). 4 of these described the quality of their treatment, 3 in positive terms, and one negatively.

*'I had counselling, offered by my G.P., it is really good. I was in denial about my illness and it made me see things in a more positive way. I go to a counsellor at my local GP surgery.'*  
(Pakistani, Female)

*'Psychiatrist in hospital help her from family (sons/daughters) – bad not helpful at all – particularly wasn't told what she could do about depression, what would help.'*  
(Portuguese, Female)

This negative experience (described with the help of a translator) accords with the response of another participant who highlighted language barriers.

*'Communication, English is not my language, limit to expressing myself, made me feel useless and stupid. General public think you re not clever enough, you are measured by your English. I try to talk issues through with my husband. I could have done better.'*  
(South Korean, Female)

Not surprisingly 1 participant, with good English, benefited from treatment.

*'Good. Helpful. I can speak the language, easy to express my feelings.'*  
(Portuguese, Male)

· Further to the above, 7 participants confirmed receiving a combination of treatments – medication and counselling or psychiatric support and 1 participant sought private psychotherapy which he/she found helpful. Only 1 participant had attended a support group.

· One crisis situation was described (with the help of translation) by a participant.

*'After epileptic fit, I got help from the hospital, it was helpful. One day he wanted to be seen by G.P. at the hospital and they sent him away, so he drank. Then he had a fit and the hospital treated with medication to help him with vices etc.....'*  
(Polish, Male)

· 3 participants claimed positive help from their GP's.

*'The doctor felt he could do nothing for me because it was because of racial harassment. He offered to arrange a break for me at a special centre but I could not do this. In general the doctor was good to me.'*  
(Portuguese, Female)

· 12 participants indicated ways in which they would like additional help:-

Increased counselling support (6), quicker access to counselling (2), more information about medication (2), help with childcare (1), home visits (1) and finally one participant would have preferred referral to a psychiatrist.

#### **Analysis point:**

The above suggests that successful treatment is very much contingent on language competency. Language may also be a barrier to attending a self-help group; there was only one attendee recorded. The significance of setting up the BME Mental Health Forum cannot be underestimated.

#### **Carers**

52 participants described their experiences of caring for someone with a mental health illness in Somerset (Q. 14a). However a number of responses were invalidated; they referred to past experience overseas or confused this role with their professional roles as social care workers.

· 41 participants described the emotional

support they gave through talking, listening and generally supporting that person.

*'My friend was depressed. I talked to her, spent time with her, talking. Talking was very important.'*  
(Slovakian, Male)

· 11 participants described experiences of looking after someone with enduring mental health problems.

*'Hell on earth from aged 7. Attempts on life, removed freedom, emotionally draining.'*  
(Romany Gypsy, Female)

· 30 of these carers indicated that the care they provided was appreciated by the person they cared for or that person's family. Only 2 carers felt that their support had been acknowledged by service providers (Q. 14c). Nevertheless 9 carers claimed they had received some advice from service providers and in the case of 1 carer, access to a sitting service (Q. 14e).

*'Sitting as a carer. So I can go shopping.'*  
(Romany Gypsy, Female)

· 5 carers had received help from other family members and 2 had received help from their church.

- 21 carers supplied reasons why they did not get any help and/or what help they would have liked.

- 5 carers lacked awareness of what help might be available.

- 4 carers did not particularly want help

- 3 carers simply did not ask.

Further individual reasons supplied were that:-

- The person cared for would not acknowledge the extent of their illness.

- The carer felt they could not break the confidentiality of the person they cared for by seeking support.

- It would have involved too much bureaucracy.

4 participants clarified what help they would have liked. Others would like access to a Sitting Service, and advice and guidance from someone with whom they could discuss their problems.

#### **Analysis points:**

The support networks that exist within BME communities should not go unacknowledged or taken for granted just because 'communities stick together'. Immense responsibility rests on the shoulder of those who play a supportive role whether it is catering for the material or

emotional needs of an individual or both. It would be hoped that carers organisations will review their existing literature to reflect the valuing and acknowledgement of this.

## **5. STIGMA AND DISCRIMINATION SURROUNDING MENTAL HEALTH ISSUES**

When asked what would stop them telling someone about a mental health issue (Q. 7b), 58 participants responded as follows:-

- A lack of trust that confidentiality would be maintained accounted for 37% of responses.

*'Privacy, break of confidence, distortion and amplification.'*  
(Filipino, Female)

- Stigma due to ignorance of or discrimination against the condition accounted for 23% of responses.

*'Afraid of being labelled and discriminated against.'*  
(African, Male)

These reasons were followed by shyness and embarrassment (17%), shame or loss of self-esteem 12%, not wanting to worry anyone (3%). 4 participants gave further reasons; Language problems. They do not like the doctors. A previous bad experience of mental health within the family and a fear of being locked away.

To dispel the stigma attached to mental health issues and encourage more people to seek help for their problems (Q. 11), participants offered suggestions that fell into the following categories:-

- By mounting education and awareness campaigns, in appropriate languages (leafleting, advertising, print and broadcast media, internet and schools) 50%.

*'Remove the stigma of mental health, articles in the newspaper, magazine, leaflets in common places.'*  
(Filipino, Female)

*'All media – local venues in our language'*  
(Portuguese, Male)

- By strengthening and developing existing BME community association networks, opening up dialogue on mental health issues and thus support (32%).

*'More help from community organisations*

*which unfortunately don't have enough funding to help at all. It would be nice to have a positive relationship and someone who is not judgemental.'*

(Dual Heritage: White and Black Caribbean, Male)

*'Organize Polish community meetings for people to feel better especially when they first arrive. People feel isolated and lonely when they first arrive and need help.'*

(Polish, Female)

- By establishing designated, user-friendly venues for informal advice and self-help groups (8%).

*'(We need) a place where someone could have support, relax, express feelings with confidentiality. A person who is friendly, not necessarily to talk to someone with a degree in mental health.'*

(Portuguese, Female)

- Other suggestions included knowing that greater awareness of BME users' needs had been raised within the NHS and Social Services (4%)

*'Just try to be friendly to people. Services should be nicer. For example, I went to the hospital and the lady made me feel like ughhhh!'*

(Thai, Female)

Lastly, 5 participants felt that information should be available in the workplace and 3 would appreciate home visits.

The seriousness of stigma attached to mental health issues by different communities must not be underestimated.

## **6. EXISTING SUPPORT NETWORKS WITHIN BME COMMUNITIES**

Just over a third of participants (34%) described the ways in which religious faith affected their mental health (Q. 8b). All except for 6 participants described their engagement with their faith in a positive light. The following aspects of faith commitment and its relevance emerged from the interviews:-

- Strength deriving from the central tenets or doctrine of a particular faith accounted for 49% of the responses.

*'Religion has helped me. Moral and ethical standards I had embedded in life, faith was stopping me doing anything silly, although I felt suicidal, depressed. Religion stops me*

*from feeling alone. I had a faith intervention in my life which helped me.'*

(Polish, Female)

· The communitarian dimension of faith, that is the shared traditions amongst family and friends, combined with attendance at a place of worship, also proved significant, accounting for 23% of responses.

*'(It is) a bond between friends and relatives. And the Polish Mass.'*

(Polish, Male)

*'Another time I had depression from my work...and so I decided to leave everything and I went to the funeral of .....and it helped me recover.'*

(Polish, Male)

· Strength derived from personal prayer was reflected in 22% of responses.

*'If I have any worries, I will start praying. I will ask Allah. This is what my religion says. Allah is the greatest. He decides everything. As a Muslim you are given guidance.'*

(Filipino, Female)

*'Yes for good. Talk to God in my own time on my own terms. Having no family around has been stressful.'*

(Portuguese, Male)

· Negative associations with religion were described by 6 participants of which the following two accounts are particularly significant. In the first, the participant had not lost her faith but did not feel part of her particular faith community.

*'It is important but I have lost time to practice my faith. It is very difficult in Shepton Mallet. I don't feel we are seen as belonging.'*

(Portuguese, Female)

This participant had clearly had an unpleasant encounter with an unidentified sect.

*'Being forced to read the bible whilst in.....House and being told that I was with Satan and that I could come to Jesus and that was the only way my mental health problems would go away. I was afraid all the time. I could only think about fear and anxiety.'*

(Caribbean, Male)

Lastly, 1 participant identified themselves as a provider of pastoral care (denomination unspecified).

*'God changes things. As a pastor other's problems could affect me if I let it. (I am) called*

*out to others.'*

(Romany Gypsy, Male)

### **Analysis points**

The faith centres are good venues for dissemination of information, providing emotional support and accessing services.

The data raises the importance of not making assumptions about faith and ethnicity.

## **7. CULTURAL DIFFERENCE**

Questions on culture (Qs. 9a and 9c), probably elicited some of the most affective and illuminating data of all that was gathered during the course of the research, demonstrating unequivocally the relationship between mental well being and confidence in one's cultural identity. 76 participants identified ways in which their culture affected their mental health. For some, their particular culture was a positive source of strength, whilst for others, cultural difference and an 'outsider' status was a source of stress. Their responses can be broken down as follows:-

· A strong family life and good community networks had a positive effect on mental health 41%

*'Family, friends meet often, discuss issues. Discuss how to bring up kids in society, teaching them about culture.'*

(Indian, Male)

Further positive endorsements of cultural attachment included the fact that participants' particular culture had a tradition of resilience and cheerfulness. That religion was significant to participants' culture accounted for 7% of responses.

· Conversely, awareness of cultural difference, 'outsider' status in Somerset, isolation and the experience of racism accounted for 24% of responses.

*'I don't like the way they (British) treat people without education, sort of racist – they could be very rude and look down on the less fortunate people.'*

(Mexican, Female)

*'Through being adopted into a white family (I am Jamaican) a white orientated community, I was forced to hide my roots, not to think like a black person, must be a white person.'*

(Jamaican, Male)

The acknowledgement that a culture had stigmatised mental health issues accounted for 12% of responses.

*'There is a stigma in Chinese culture about talking about mental health.'*

(SM 1)

· 6% of responses confirmed that a high family expectation of success, traditional to many cultures, was a cause of stress.

*'In African culture it's always tough at the top. Your success has to be shared by the extended family and not just yourself or your immediate family. Unremitting demands will be made by the extended family and they can drive you mental.'*

(African, Male)

· Finally, 2 participants encapsulated very well the ambiguities of their culture.

*'Blind faith – drummed into you at an early age (Islam). You are brainwashed about Muslim / Asian culture. The faith side is good; it makes me feel good but the dos and don'ts of culture can be quite sick.'*

(Pakistani, Female)

*'I was brought up in a traditional way. Church – corporal punishment. I can remember the old ways. Very strict, therefore contradictions – love / hate.'*

(Portuguese, Male)

19 respondents fully understood the question of whether their culture prevented them from living their life as they wished. As might be expected across the wide range of ethnic groups who participated in the research their responses were highly subjective making categorisation difficult. The following is a representative sample.

*'I need to be a model for my daughter, sometimes I would like to get dressed up and go out like in western culture but it's not appropriate because of my Muslim culture.'*

(Black Portuguese, Female)

*'Early marriage. Matchmaking for money. Makes feel angry and distressed.'*

(Fijian, Female)

*'Pressure on the Romany people, to live in bricks and mortar, against their culture.'*

(Romany Gypsy, Female)

#### **Analysis point.**

This cultural research alerts us to elements which are an incubus in a range of cultures. Sensitivity to cultural difference must be taken very seriously.

## **8. DEVELOPING NEW SERVICES**

The need for the development of new services is implicit in much of the above research or explicit in terms of improving accessibility and de-stigmatising mental health services. The research also evidences the needs of carers (Q. 14f). The final question of the study, calling for further opinions from respondents (Q. 21) elicited a limited number of responses (49 overall) but they strongly affirmed current needs. Categorising these responses under our main research topics, they break down as follows.

14 participants called for, in various ways, the development of greater cultural awareness.

*'It is really important that professionals are aware of cultural issues and professionals need to train in cultural awareness.'*

(German, Female)

13 participants highlighted issues surrounding cultural difference.

*'Everything that I've said so far can be multiplied by 10 because I am not native here.'*

(African, Male)

11 suggested the types of new support, or services, they required.

*'...How to deal with problems being away from your own country. People quite isolated how to make people feel part of this community.'*

(Indian, Male)

8 stressed the need for support networks.

*'Having a local Portuguese community centre/venue/ place which you can come to and talk. Regular visits from community workers.'*

(Portuguese, Male)

7 outlined discrimination issues.

*'An unforeseen illness and the fear of not being heard if you don't get support with a language problem as well; people can be very cruel.'*

(Dual Heritage: White and Black African, Female)

4 identified issues of accessing services.

*'We need more information and where to find it.'* (Polish, Male)

## Analysis point

The wide range of expectations about new services, add to the relevance and significance of the BME Mental Health Forum; which could assess some of the feedback and enable the process of change.

## FOCUS GROUP ON DEPRESSION IN BME MEN

(15 FEBRUARY 2007)

Research has indicated that men are particularly unlikely to access existing mental health services or indeed to recognise or admit any mental health problems (*'Delivering Race Equality in Mental Health Care; Department of Health 2005 London*). It was therefore decided by the research team, and commended by the steering group, that there should be a focus group investigating depression in BME men.

Focus group members were recruited from those who had indicated that they were willing to participate in further research during their individual interviews. A decision was made to invite only those whose command of the English language would enable them to understand the discussion and be able to participate in it.

The lead co-ordinators selected a group of men between the ages of 19-50:

3 African  
1 Caribbean  
2 Portuguese  
2 Romany Gypsy  
2 Filipino  
1 Pakistani

Although the identity and ethnicity of each contributor was noted (and is retained) it was decided that for the sake of anonymity, it would not be stated in this report. In view of the small sample size we were aware that there was a danger of individuals being identified if we attributed comments in the write up.

The venue was chosen to be accessible, although with a bias to the south of the county, where the majority of participants resided. The room used had a display promoting 'Fairtrade' and international links and helped to promote a positive but relaxed ambience. Travel expenses were paid in addition to an attendance allowance and 'miles to travel' was not seen as deterrent to attend with 2 travelling nearly 60 miles. There were 2 facilitators, both of whom were BME with one of them being a Counselling Psychologist. In addition there were 3 note takers (members of the research team). The focus group notes are a summary of the responses recorded by the 3 note takers. The additional

recording equipment was tested before the meeting began and found to be unsuitable for the acoustics of the room and the size of the group. The format of the focus group was discussed with the facilitators before hand and they had the notes to guide them. (Appendix B)

## Pre-amble:

Participants were reminded about the purpose of the research, to *'explore the needs of BME individuals in Somerset with reference to: mental health service provision, access, treatment, prevention and recovery.'*

Specifically the focus group were encouraged to share experiences as it was recognised that men in general were unable or unwilling to identify themselves as having a mental health problem, are reluctant to seek help and find services inappropriate or unappealing. These problems are even more evident amongst BME men who additionally feel that there is a specific stigma attached to developing a mental health problem and perceive that the mental health system will discriminate against them.

Initial discussion was about the understanding of the term 'mental health' which we considered was vital in order to establish the current terminology amongst our communities and whether there was predominance of positive or negative aspects of mental health.

## Understanding Mental Health

*'difficult to cope with everyday life'*

*'mental health is on a scale of good to bad'*

*'the effects of stress make you vulnerable'*

*'shock of any sort can cause mental health problems'*

*'mental health problems are about "keeping up with the Jones's" creating peer pressure around health wealth and happiness, not necessarily in that order'*

*'mental health problems can be caused by your social surroundings'*

*'problems off psyche'*

*'difficulties with coping, you might need help with resolving problems'*

*'always hearing voices'*

*'the stress vulnerability model is a key factor, if stress levels are high then one feels worse'*

*'a shock of any kind may lead to depression even if it's just moving home'*

Clearly the majority of participants understood the term 'mental health' in negative terms, with only one suggesting mental health could be presented on a scale from good to bad.

*'different mental health problems may reflect different coping strategies some that may be more rational'*

*'good mental health is when someone is joyful or happy and someone can laugh and is able to socialise.'*

*'you're happy with yourself and others'*

*'good mental health is feeling OK, dealing with challenges, being able to talk to others, enjoying day-to-day activities and adjusting; bad mental health is feeling overwhelmed and being unable to adjust and having emotional problems'*

*'good mental health is to be patient when dealing with things'*

This set of responses gives a wide range of opinions as to what mental health means to this group of people

*Understanding Depression and its causes*

*'Feeling low, unable to do anything and feeling lethargic'*

*'Stuck in a rut with no light at the end of the tunnel'*

*'Not confident with self, being stopped from doing a good job, feeling down and thinking everything is wrong''*

*'Not talking responsibly neglecting self'*

*'Mind has to be soothed so you need to do things you find pleasurable but when you're depressed you're unable to do these things.'*

*'Inability to do things that one enjoys (a loss of creativity)'*

*'Failure to meet objectives'*

*'Other people not believing in you, your qualifications not recognised so being in low-skilled employment'*

*'frustration and lack of control'*

*'racism contributes'*

Here we see the specific issues relevant to a migrant worker/BME man where the pernicious effects of racism are a constant and for the well qualified migrant worker there is the additional trauma when their qualifications are not recognised, so demeaning their status and sense of self worth.

### **Social Distracters or Crises Situations**

*'Social surroundings like housing, if you are living somewhere that is not nice then it will effect you; comparisons are made with others highlighting inequalities'*

*'Starts with stress especially about financial problems'*

*'The social climate with an egotistical society where people think only of themselves' society; not just western culture, you are seeing the news which is bad with visions of war and then high taxes, you get a different view of the world and how it really is; that brings anxiety'*

*'although there are conflicts between religion and terrorism there is more accepting of different cultures and it is up to people like us to be more accepting'*

*'sympathy is a thing of the past; society is getting us to think about ourselves but not as a community'*

The responses to this question indicate the complex nature of our lives, society and relationships between people, events and cultures.

Knowing the differences between cultural, biologic and social causes of depression

*'Manic'*

*'Post-natal'*

*'There is a problem of people not recognising it'*

*'There is a fear of being hospitalised, fear of being sectioned, made me feel apprehensive about seeking help. I did seek help but wondered what would happen. This made me feel frightened.'*

*'You need to admit to it'*

People were generally reluctant to respond, unless they were an existing mental health service user, which underlines the likely need

to develop trust which requires time, along with other resources.

### Issues of Stigma

*'In Nigerian culture you might not tell anyone'*

*'I would go first to the family, which is big; it is clear which members of that family you would go to because of the sort of people they were. They might offer physical help like £50 to give a boost and/or spiritual help'.*

*'If you get sent to someone (counsellor) they spend ages building trust then as the time runs out and you are leaving they get to the point'.*

*'The family barber/hairdresser use to be the psychologist!'*

*'I had trouble admitting it to myself (mental health problems...).. the counsellor is not any help'.*

*'You need to find the root cause with help from a trusted member of our own community and emphasis on the spiritual'.*

Clearly it is of considerable interest to commissioners of services to understand cultural needs and perceptions and this is an area which requires wider and further investigation.

Most of the group believed that: (there are) 'feelings of shame, as it is said that, "depression only happens to women".'

*'how honest can you be with people? You walk down the street. Do you say you feel like rubbish or do you say you're fine? The problems get brushed under the carpet. "I'm not working I'm unwell." They expect you to put on a brave face; people don't want to know. It makes it worse when you are told to "pull your socks up or snap out of it". There is too little compassion in society'.*

*'people do not believe you as there is little information about it. Some people smile and say, "you just don't want to work" '.*

*'Other people don't want to think about it, they don't care'.*

*'I talked about suicide attempts and the reaction was "you're crazy" It is hard for my wife who does not understand; only my mother is supportive, which makes it worse so you just want to disappear, kill self and finish with problems'.*

Linking to the need for more information this plea also indicates a need for a more holistic

approach where

'wellbeing' is a priority across all services.

Access to and culturally appropriate treatment and the role of faith

*'talk to GP- it feels like there are 2 people inside one telling me to stay and one to go. I filled in a questionnaire was sent to hospital and there sometimes I want to speak and sometimes I want to listen but my doctor wants me to talk'.*

*I don't know; doctors give medicine'.*

*'GP's don't have time for depression, you need someone to listen'.*

*'information at work would be useful and someone to listen not just medicine'.*

People to listen and an increase in information about mental health in far more places (like at work) came through clearly with these responses.

*Socialising is a problem worsened by depression so meeting in groups of people with similar experiences who listen and share helps BUT not a fan of psychiatric units as they miss the human touch; you don't need to make friends with people but sharing the experience is part of the healing process as part of therapy is being understood'.*

*'having always worked in an office coming here and working in a factory was a nightmare. At the moment I feel much better as I help my association in the office and will get a qualification in computers'.*

*'a family member who suffered from depression thinks he is an expert'.*

Here experiences were shared rather than the question investigated and more time was required but was not available.

*'we come from different cultures and backgrounds and need to consider faiths not religions'.*

*'demonisation of religion is incorporated into mental health practise yet maybe spirituality should be incorporated but christianity is not for everyone'.*

*'I am a gypsy; the lowest of the low; religion or spirituality is a delicate thing'.*

Clearly, as can be seen from these contributions, this is an extremely important area for

mental health across our strands of prevention, access, treatment and recovery yet recognising that 'religion or spirituality is a delicate thing'

The time restrictions which we set and abided to nevertheless were very frustrating as some people were keen to continue the discussion. Although it was understood that the topic was serious people were relaxed enough in each other's company that there was an air of jollity and laughter. Everybody felt that the experience (of attending the focus group) was very positive and therapeutic in itself. There was considerable enthusiasm to investigate the potential to repeat and or expand the event and also interest in the proposed BME Mental Health Forum.

## DISCUSSION

### Access

Most people have a doctor and, by the evidence supplied, have great expectations of the health services to meet their mental health needs. However language barriers present real problems.

Theoretically professional expertise holds out much promise, but on the basis of participants experience this is not always fulfilled in reality. A strong attachment of feelings has built up around the various community associations in Somerset and their meeting places. Many participants view these venues and avenues as preferred sources, not only for practical information, but also for practical & emotional support. Therefore this backs up the argument for the development of self-help groups or one-to-one counselling.

What has hitherto functioned voluntarily must now be acknowledged and vigorously promoted.

### Awareness

*Depression* is the dominant understanding of mental health. Loneliness presents as a contributory factor. Not surprisingly, family and friends provide principal emotional support (Responses to Q3).

The opportunity to access enjoyable leisure and sports facilities rated highly amongst participants, alongside the opportunity to socialise and derive support from fellow members of their community. (Responses to Q4).

### Experiences, culture, and Religion

Language barriers and thus poor communication lead to lack of awareness and then mistrust of the treatments available to service users. This issue ought to be at the heart of the DRE in Mental Health Initiative.

Significantly, participants showed greater interest in the value of talking therapies as opposed to medication (Responses to Qs 6a, 9 and 10)

Underlying these concerns is the need to be understood at two levels of engagement; at the cultural level, in terms of understanding someone's specific problems and sensitivities, and at a second level, in terms of understanding their particular clinical mental health problem.

Consequently many participants feared breaches in confidentiality, and apprehension that they simply would not be understood. (Responses to Qs 9.10 and 18)

There are powerful arguments to suggest that sensitivity towards cultural differences must be developed across services, including those services who aim to support carers.

Popular conceptions that certain ethnic groups are more family orientated and thus can be relied on to care instinctively for vulnerable family members are challenged. Society cannot take this for granted, in the context of today's tempo and stresses of life.

Faith plays a key role in the participants' understanding of mental health issues, proving not only as central to the family and community life of many of our participants, but also central to their own sense of self identity and self worth. The role of faith as a contributory factor, positively or negatively, in the lives and mental health of BME individuals and groups is a good topic for further research.

### Stigma

Interview and Focus group research highlighted Stigma as an issue. It is seen as a form of oppression which so many participants actively wished to eliminate through media, education, awareness training, etc.

## REFLECTION

We started out on this project not without our individual and collective preconceptions of 'Mental Health'. They were typically based on

first hand/ third party experiences within our own distinct communities. These conceptions have been challenged by our own journey through the research project. For example we have found out:

1. that different communities react very differently to the expression 'Mental Health'
2. that the support from families & community cannot be taken for granted and is in any case not universal or uniform
3. that stigma is an oppressive phenomenon equally powerful among BME as it is in the wider population if not more.

This research highlighted the need in Wells and Mendip generally, of greater support for E.U. employees resident in the area. A pleasant, designated venue is needed where they can access information at times suitable for the many who work night shifts. Cafes and take-away outlets are strongly felt to be useful points at which information can be displayed.

Participants in both Wells and Shepton Mallet stressed the importance of exercise, swimming, jogging and walking, in counteracting depression. (This raises the issue of the accessibility and affordability of sports facilities).

## Experiences

The following quotes from some of the researchers typify the variety of individual experiences from this project.

'The issues that I had identified from my part of the research are that majority of people:

1. Have no experience.
2. They did not realise that mental health can be affected by change.
3. They do not know about any mental health services in their areas.
4. Isolation can only make things worst not better.
5. Language or communication problem is a major barrier.'

*'Education, education, education very important, but not just for the young. People need to be educated, they need to know how to gain information about the mental health issues, and they also need to know where services are, and how they can be accessed. Those who are unfortunate to have a mental health problem need to get more involved in community activities, so that they feel that they are being part of the community, that they are wanted and not rejected'.*

*'A minority of people in my research think that religious faith can help to recovering from mental illness. As a Christian I strongly agreed with them, because as I am writing these paragraphs about my involvement in the project, my dear father have just had a major operation and is still recovering in hospital, it is God's mercy and comfort that is helping me and my family'.*

Just by participation in the research, without prompting, expectations have been raised within the communities who took part in it. There is a hope that "for once, for BMEs, changes will actually happen from such a report".

Also the role of faith in BME circles even in today's world, or possibly because of it, was rather sobering.

It is our collective view that the Community Engagement Model leaves an impact, or at least a marker, in the Community and for that alone the project has been worthwhile and worthy of perseverance through all the stages and processes.

## RECOMMENDATIONS

1. Mental health service providers must continuously market and publicise a simplified and standardised meaning of mental health (such marketing and publicity to include information about what is available, how to access what is available and ways of promoting good mental health) through the popular press, internal and partnership arrangements and the E-Quality 4 Mental Health website.

2. Mental health service providers should explore ways of involving families and close friends as active participants in the prevention and treatment of mental illness.

3. Mental health service providers must make adequate provision for interpreters at the point of delivery of those services. Furthermore, if such services are to be provided at health centres they should be through designated surgeries. Otherwise they should be provided through direct arrangements with BME community groups or through representative umbrella groups.

4. Staff at health and treatment centres should be trained to be more aware of the cultural differences between people and how these differences may serve, more often than not, as a barrier to fairness and equal access to services.

5. Service providers to work extensively with BME communities to remove the stigma that is attached to mental health.

6. That the part religion and faith play in the mental wellbeing of the BME communities in Somerset should be fully investigated. Similarly there should be a dedicated research into depression, particularly about how it affects the mental wellbeing of the BME communities of Somerset.

7. Service providers should ensure that they help the various community groups to grow into viable self-help groups either directly, through SBDA or through the activities of Somerset PCT CDW in Mental Health project.

8. Service providers should make sure that the services that they provide and deliver also meet the needs of BME communities of Somerset. They should therefore get into the habit of carrying out consultations, to this effect, with the BME groups, even if the consultations are only done through SBDA or

the Community Mental Health Development Forum.

*For relevance and emphasis the DRE Building Blocks and Vision 2010 is re-quoted below:*

*The DRE programme is based on three building blocks:*

*1 More appropriate and responsive services – achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees and children;*

*2 Community Engagement – delivered through healthier communities and by action to engage communities in planning services supported by 500 new Community Development Workers; and*

*3 Better Information – from improved monitoring of ethnicity, better dissemination of information and good practice and improved knowledge about effective services. This will include a regular census of mental health patients.*

- *Less fear of mental health among BME communities and Service Users*
- *Increased satisfaction with services*
- *A reduction in the rate of admission of people from BME communities to psychiatric inpatient units*
- *A reduction in the rate of admission of people from BME communities to psychiatric inpatient units*
- *Fewer violent incidents secondary to inadequate treatment of mental illness*
- *A reduction in the use of seclusion in BME groups*
- *The prevention of deaths in mental health services following physical intervention*
- *More BME service users reaching self-reported states of recovery*
- *A reduction in the disparities found in prison populations*
- *A more balanced range of effective therapies, such as peer support services, psychotherapeutic and counselling treatments as well as pharmacological interventions that are culturally appropriate and effective*
- *A more active role for BME communities and BME service users in the training of professionals in the development of health policy and*

*the planning and provision of health services*

*A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities*

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## **APPENDICES**

For the appendices please ask SREC for a copy on 01458 274 200. Alternatively, you can download a copy from [www.srec.org.uk/reports](http://www.srec.org.uk/reports).

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