



Herefordshire &
Worcestershire

Community Engagement Programme

NIMHE Mental Health Programme

REPORT OF THE COMMUNITY RESEARCH PROJECT FOCUSING ON
THE LEVEL OF INTERACTION BETWEEN BLACK AND MINORITY
ETHNIC INDIVIDUALS AGED 50 AND OVER AND SERVICE PROVIDERS
IN RELATION TO MENTAL WELL BEING IN WORCESTERSHIRE

**“Are Black and Minority Ethnic communities in Worcestershire
appropriately supported by, and well-informed about, the health
system in relation to mental health services? “**

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West Midlands
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Executive Summary

This Community Engagement Project (CEP) was successfully awarded to Age Concern Herefordshire & Worcestershire, intending to conduct community research focusing on the level of interaction between black and minority ethnic individuals aged 50 and over and service providers in relation to mental well being in Worcestershire. The title of this investigation is “Are Black and Minority Ethnic communities in Worcestershire appropriately supported by, and well-informed about, the health system in relation to mental health services? “

The project had two main foci – to collect data and to provide opportunities for learning, development and capacity building in the community. The research team consisted of members who spoke and represented main language groups within the BME community. The research team represented the following community languages between them: English, Cantonese, Mandarin, Urdu, Sylheti, Bengali, Hindi, Punjabi, Farsi and Spanish.

The research sample consisted of 40 members of the Worcestershire BME communities – and was representative of Chinese, Pakistani, Indian, Bangladeshi and one other background. The researchers recognised that it is more important to consider the individuals in the community rather than see the community as an homogenous group.

Due to the sensitive nature of the research topic – mental health – the researchers decided to use a *one to one semi-structured interview* approach as this would ensure anonymity, privacy and confidentiality that could otherwise not be assured with focus groups or other larger data collection methods. The method chosen would provide a rich data set consisting of both quantitative and qualitative responses.

During these one-to-one semi-structured interviews, the respondents were asked a number of yes/no answers and given prompts (quantitative) as well as given opportunities for personal comments (qualitative) throughout. The researchers believed that providing this opportunity would allow collection of rich and informative data in pursuit of the research aims.

The findings highlight a wide range of issues which impact on the daily interactions of members of the Worcestershire BME community and health professionals. Furthermore, personal attitudes to, and perceptions of, general health and mental health were collected.

The quantitative data is reported in the findings section as a percentage of respondents’ views, and the richer more complex data from the comments is reported as qualitative quotes.

Problems with communication were flagged up very early on by the respondents – these problems ranged from simple language problems to more complex interaction difficulties possibly due to cultural differences. Misunderstandings, incorrect assumptions and simple lack of

communication on both the service providers' and at times the services users' sides are central to the research findings. Trust between providers and clients emerged as a central theme – however, establishing these positive relationships needs time and community engagement, and a commitment from the National Health Service to continue improving access to services.

Positive comments in the research focus on the importance of family, friends and communities to the respondents' sense of general health and mental well-being. Respondents identified a range of personal attributes and activities which they believe help them to maintain mental health. For the most part, service users are quite satisfied with health services in general, and given the fact that many of the difficulties faced by service users are not directly related to the scope of the service providers' work, yet have an impact on their quality of life, some statutory or voluntary agencies could take this issue on board as part of an holistic well-being process.

The recommendations focus on providing interpreter services and multilingual information, together with the awareness that often the printed media is not always the best way to get information across as many older people may have trouble processing some print. The use of existing and new technologies which do not depend on the printed word could be a useful option. Informational support would help GPs meet the clients' needs and promote the link between physical health and mental health. Anxiety, loneliness, physical pain associated with the ageing process and financial difficulties are also mentioned as key issues throughout the respondents' comments, and raises issues of the increased need for talking therapies.

Recommendations

1. Designate various local agencies to be information centres for certain communities/language groups. This research shows a need for a professional translator/interpreter service in Worcestershire to assist clients' access services, such as booking appointments and communicating with service providers, especially in cases of a serious nature where good command of the language is required. These agencies may need to expand their role to advocate for, support or signpost clients in specifically addressing some causes of social problems, such as personal and financial difficulties, housing and employment. Positive action schemes may offer support to clients in recovery to gradually compete in the marketplace for work and other community involvement, as financial hardship and rejection at the job application stage have been mentioned in this research as a possible causes of anxiety and stress. Perhaps there is a case for the use of automated telephony in various languages. In addition, webspace can be made available to disseminate essential information, given the flexibility, scope and relative low cost of this medium; this can then be accessed by clients with computer skills, or helped by their families or agency staff.
2. Encourage health authorities to explore the **expectations** that service user and provider have about each other's behaviour. It is likely that cultural

misunderstandings are the main cause of communication problems as people *expect* certain behaviours from one another – with language problems being a compounding factor. The attitudinal areas of respect, dignity and self-esteem of service providers as well as BME clients, their issues and concerns, need to be openly addressed. The researchers suggest relevant agencies might use or commission multilingual DVDs, radio or TV programmes, such as popular dramas, which would have the dual role of informing and demonstrating mainstream health and mental health issues that all people have in common. This initiative could also promote the latest medical news and developments so that communities have access to up-to-date information about the health system. Such projects can be part of Diversity and Equality /Cultural Awareness Training programmes.

3. For the PCT/AT/MHT to **monitor** the language difficulties of certain service users and link this to further support, perhaps from Community Development Workers, with consent from client and service providers. This would encourage GP surgeries, as well as other areas of the health system to continue exploring **language options** for clients, employing culturally aware medical and administrative staff, and/or new technologies, and assist clients with booking appointments and consultations; perhaps through options to choose own language in an automated booking system, or involving the use of technologies with graphics/other languages, according to the clients' level of literacy. Where possible, look into possibilities of offering talking therapies.

4. Encourage NHS/PCT/MHT facilities and staff to display, or make available, **multimedia resources** that highlight *specific* physical or mental health conditions – such as depression, dementia and Alzheimer's, hopefully avoiding the use of the general term "mental health", which has a stigma attached - in a range of community languages. Perhaps the term psychological health, or others, could be adopted. Staff can also assist in the preparation and dissemination of resources relevant to the BME communities.

5. Encourage **GP's to ask clients** about their mental/emotional state, as part of the general consultation routine, and recommend alternative therapies, including talking therapies, if relevant to the clients' life experience and present situation.

6. Community liaison workers and/or interpreters could be a useful means of providing a personal interface between service providers and service users, and where relevant offer cultural awareness training. The function of these workers could be to encourage more active participation by the BME groups to provide timely information to service providers, as well as request *appropriate* information from service providers/health system.

1. Introduction

1.1 The Centre for Ethnicity and Health's model of community engagement

Background to the community engagement model

We often hear the following words or phrases:

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

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

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

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

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

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

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

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

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

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

The key ingredients of the model

There are four essential ingredients or building blocks to the UCLan Community Engagement model.

1. An issue about which communities and other key stakeholders such as commissioners and policy makers share some concern

The issue can be almost anything, but frequently involves a concern about inequitable access to, experience of or outcome from services. The community and other stakeholders may not agree about the causes of inequity or what to do about it – the key however is that they share a concern. Usually the concern will be framed within some kind of local, regional or national policy context (e.g. teenage pregnancy reduction).

2. The Community

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to

achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

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

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

3. The Tasks

The third key ingredient is the task or tasks that the community undertakes. According to the Centre for Ethnicity and Health model, this must be action-orientated. It should be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn; awareness will be raised; stigma will be reduced; people will find opportunities to volunteer and gain qualifications; new partnerships will be formed; and new workers will enter the workforce. 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.

4. Support and Guidance

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers².

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

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

A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

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

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

The UCLan community engagement team

The Centre for Ethnicity and Health has a large and experienced community engagement team to support the work. The team comprises of two programme directors, senior support workers, support workers, teaching and learning staff, an administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

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

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

Programme outcomes

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

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

- the Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.
- the Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- all DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

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

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

1.2 The Age Concern Herefordshire and Worcestershire Project

Age Concern Herefordshire & Worcestershire is a charity whose brief is to assist the over 50s in leading a healthy, active and well-informed life. An important aspect of their work is the provision of information about services available.

Herefordshire and Worcestershire are two large counties in the West Midlands, traditionally focused on rural industries and populations, and have until recently not attracted the large migrant numbers which might have been attracted by the larger industrial cities of the West Midlands such as Birmingham and Coventry. Therefore, the Ethnic Minority Communities are diverse and concentrated in areas across the counties.

The majority of the ethnic minorities represented in this research have lived in Worcestershire since the 1960's and 1970's. They are mostly retired and have lived generally in extended family settings, now with children and grandchildren. They tend to own their own homes and support their families as much as possible. Many of our respondents have been factory workers who did not manage to learn English during their working life, as their work colleagues were also from the same or other ethnic minorities, and leisure time was limited. Some of the respondents are formally educated, and literate in a number of languages, but they all have adapted to life in Britain while simultaneously maintaining a number of traditions that they value highly, in the same way as anyone who travels abroad still enjoys taking part in activities that remind them of happy times in the home country. Some of the respondents are quite devoted to their religion, in the sense of observing prayer times, foods, dress code and general behaviour.

The ethnic groups represented in this study can also be described in terms of language spoken or nationality. It must be said that those people who have lived in Britain for decades are more than likely quite British in attitude, although this might be difficult to see through the physical appearance, due to the traditional clothes they wear; further contact and communication needs to be made before assessing that person's circumstance and background. The Chinese - mostly Cantonese speaking – Pakistani, Bangladeshi and Indian groups represented in this research are from a range of geographical areas and cultural groups and living in quite different circumstances, meaning that it would be misleading to call this group uniform or homogeneous. Some respondents live alone, some with partners and others with families; some were retired, some of working age and looking for work, and some were involved in the task of caring for others, as would have been traditionally done. These days, some people are being encouraged by health and social care authorities to receive some payment

for the carers' work they do, although this is a fairly new concept to most of them.

The 1991 census showed the ethnic population of Worcestershire to be 1.5% of the total; the 2001 census showed this population to have increased to 2.5%, with the largest group represented to be Pakistani at 0.5%. Many of these people arrived in the two counties in the 1960s for the purpose of providing manual labour in the light manufacturing industry.

According to the 2001 census, there were 2,917 Pakistanis, 1,640 Indians and 970 Bangladeshis in Worcestershire (Census 2001). Recent unofficial figures from respective community organisations show, the number for Pakistanis and Bangladeshis has increased by 20%. Currently available evidence from various ethnic sources now indicates that Pakistanis and Bangladeshis are the largest Minority Ethnic group in Worcestershire. (source: Jalalabad Association and WMWA)

Religion is believed to be a very powerful force, and for most of Pakistani and Bangladeshi Muslims, it is a motivating factor in their personal existence. **Sunni Islam** is the main religion practiced by 98% of the Muslims locally, meaning that 2% follow other sub sects from within the mainstream Islamic faith.

Cultures/Languages

The majority of Pakistanis and Bengalis tend to adhere strictly to their Muslim culture, which is generally dictated by Islamic faith. Due to the geographical backgrounds of the people, there are some minor yet noticeable variations in life style, family traditions and practices within respective communities. Most Pakistanis living in Worcestershire come from the "Pakistani controlled Kashmir" Mirpur area, usually speaking Urdu, Mirpuri and Punjabi. The older Worcester Bangladeshi population is mostly from the Sylhet region of the country, and speak Bengali and/or Sylheti- and due to recent history, the older people have a working knowledge of spoken Urdu. Extended family life style is found to be the norm in both communities.

Worcester, Redditch, Hereford, Kidderminster and areas close to South Birmingham are the main centres where the Ethnic Minority Communities represented in this report live. This project was based around the languages represented by these local communities, and knowledge of some of their sensitivities. The selection process for researchers reflected this and thus the choice for Urdu (male and female researchers), Bengali, Cantonese and English, reflecting the languages of fairly established ethnic populations, as new arrivals from Eastern Europe tend to be aged under fifty, therefore not part of this research target group.

Due to the varied nature of each ethnic minority community, it is important to think more of them as individual members of the wider community rather than the community group as one entity.

The focus of this report

Since 2000, over 250 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Programmes.

National Institute for Mental Health in England Community Engagement Programme:

Age Concern Herefordshire & Worcestershire were one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007. The objectives of the programme were to deliver improved equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

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

Aims of the ACHW Project

Collecting data

- To determine the views on mental health held by the community by investigating the perceptions and experience of the general health service providers and mental health service providers.
- To develop an interview methodology that acknowledges the perceived sensitive nature of the topic of mental health. Individual interviews seemed the most appropriate, as it best assures confidentiality and anonymity, in case some of the findings become controversial.
- To record some stated and alluded needs of the general community by the respondents.

Learning, development and capacity building

- To put together a **steering group** of local community members and agency commissioners as well as individuals active in the area of mental health in the two counties in order to ensure on-going local sustainability of interest in the issues raised by the research.
- To investigate the possibility of better information flow between service providers and service users.
- To document perceived obstacles to access to health services leading to mental health services and thus more satisfaction with services.
- For researchers, agencies and community individuals to take advantage of this opportunity to engage with current mental health issues, help develop more responsive services and build individual and group capacity for greater involvement.

The initial aim of this project was to gauge the level of knowledge and experience of local ethnic minorities about the general health and mental health services available in the county. Seeing human health as holistic, the researchers felt comfortable in asking questions about general interaction at GP, hospital and other services accessed, in the hope that some incidences of direct interaction with mental health services might be described. The preconception that mental health is a taboo, or at least controversial, subject for some of these individuals was one concept to be explored with caution; this was the main reason for selecting the one-to-one interview, rather than the focus group approach where a large group of people speak openly and the range of views is recorded.

Exploring client and GP interaction was another focus of the research, as the GP practice is the usual – though not the only – way of accessing mental health services: this does not mean waiting until issues disrupt the everyday life of individuals and families, but approaching the health system much earlier.

This included learning about the level and type of knowledge of the respondents about existing services, options and how to access them. Existing research shows that BME communities have not accessed mental health services through GPs, often becoming involved at the hospitalisation or detention stage under the Mental Health Act, when problems may have reached a critical stage. In this case, prevention is better and cheaper than cure, and both client and health system would benefit.

This research has explored the **informational needs** of the communities, in terms of health as well as of systems in place to access services. The expectations of both service user and provider are an area that may need further exploration, as it is this interplay/interaction that determines when and where a service may be accessed; for this reason, some of the

questions deal with impressions and comments about client and GP practice communication.

Other objectives of this project include the **learning, development and capacity building** of the individuals and communities involved. At the personal level, the researchers have taken part in university study, working towards a Certificate in Community Research and Mental Health, which will hopefully build confidence for further study and knowledge; the respondents have given some of their knowledge for the purpose of increasing understanding about the communities and providing more relevant services. In addition, the Steering Group members may continue to liaise in future research and activities, meaning better inter-agency communication and all the benefits that this may bring.

2. Methods

2.1 Recruitment of the researchers and steering committee

The selection process for researchers was based around the languages represented by the local communities, and knowledge about some of their sensitivities, therefore the choice for Urdu (male and female researchers), Bengali, Cantonese and English. The background of those recruited was: three part-time workers, one student about to hand in a Master's dissertation in Clinical Psychology, and a full time mother hoping to progressively get back into the workforce. The Lead Researcher, an existing Development Officer, recruited community members representing various community languages.

With the aim of building community research skills, various agencies and community contacts were asked to refer suitable people. Attending workshops and activities as part of a short university course would benefit that individual and the community in terms of employment and representation. In addition, existing contacts were approached and informed of the potential for study and professional development scope of this project, notwithstanding the fact that the time requirement would be about one day a week, resulting in only those able to commit to such a schedule (perhaps those unemployed but not looking for full time employment, or in existing part-time employment).

The steering group was made up of 18 people from the vast range of stakeholders in the community. From: NHS personnel; voluntary organisations (e.g. Worcestershire Association of Carers); West Mercia Constabulary; Community First; Citizen's Advice Bureau; Worcestershire Race Equality Council and others. The diverse range of backgrounds in the Steering Group was useful in eliciting a variety of views at the planning and interview stages of the research. Some of the Steering Group members, being high ranking officers in their organisations, were able to share important knowledge and concerns which would be incorporated in the questions. This was initially demonstrated at the development stage of the interview questions, at a sub-meeting represented by the Worcestershire Mental Health Partnership, the Worcestershire Carers' Unit and the Lead Researcher to outline the first draft of the clients' questions. Subsequent drafts were emailed to the Steering Group for feedback and discussed at Steering Group meetings; it was at this point that each steering group member made comments, often highlighting the interests of their client base.

The inclusion of a number of key managers in voluntary and statutory agencies in the Steering Group would ensure communication with strategic planners and commissioners through internal reporting systems, in tandem with promoting the Department of Health's DRE agenda

A large number of steering group meetings were held over the length of the project:

Table 1: Meeting dates

Meeting no.	Date	Place
1	7 th June 2007	NHS offices
2	28 th June 2007	NHS offices
3	9 th August 2007	Community meeting hall
4	11 th October 2007	NHS offices
5	7 th December 2007	NHS offices
6	25 th January 2008	NHS offices

See Steering Group membership: Appendix 2

2.2 Selecting the Research Sample

A number of agencies and other community contacts, including the steering group (see below) were asked to refer or recommend organisations or individuals who may wish to participate. Every researcher was asked to contact their community links and promote the existence of the project. Due to not every researcher having the same range of contacts, some networking support was arranged to increase the possibility of finding respondents.

Presentations were made by ACHW staff at various events and locations: at local mosques, asking the gentlemen to take part in the project, as well as inform their wives and relatives; at Eid Milan and other lunch clubs, at language and exercise classes and at Information and Advice sessions. Contact was also made by mail and phone with the various community organisations in the county- see appendix of local organisations.

The existing networks were extremely useful in approaching potential respondents to promote the research project. Issues of logistics and existing trust with the individuals, some having known the researchers for a number of years, made the whole process less cumbersome. The relevant researchers attended the various community activities and venues, such as lunch clubs, exercise classes, English classes, places of worship and other venues and asked clients to participate or pass this information on to family and friends, in an attempt to ensure anonymity. One such event was the Eid Milan celebrations where the relevant researchers were introduced to the community members whom were asked to come forward and help this project.

There were a number of obstacles to overcome due to the actual number of people available in the target age group prepared to participate, who would not feel intimidated by the nature of the research, by not perceiving the subject matter as taboo. This process was ongoing, and a number of potential respondents were targeted in various ways: by phone, letter, notice at a lunch club or gathering, or a request at the mosque for individuals to find out more about the research if interested.

Issues of literacy, language and dialect had to be considered, especially so in relation to Cantonese/Mandarin and Bengali/Sylheti. Other issues included the level of previous involvement of the particular researcher with the community members and whether enough trust could be developed for the purpose of the interviews. Additionally, the time of year in relation to holidays and other religious celebrations were issues to be considered.

2.3 Research Approach/Collecting data

Due to the perceived sensitive nature of the interviews' subject matter, the research team decided to adopt a *semi-structured interview* approach to gather a broad range of quantitative and qualitative data. The semi-structured interview would allow respondents broad scope to add any information that they felt was important or relevant. It was also felt that other approaches, such as focus groups might inhibit participation, or in a worse-case scenario an unintended disclosure by a participant might result in ostracism or alienation depending on the other participants' views of mental health and illness.

In order to secure anonymity and privacy, a number of venues were assessed for suitability, such as, community centres; mosque meeting rooms; Worcestershire Mental Health Network (WMHN) meeting rooms; restaurants etc. The researchers considered that other approaches, such as questionnaires, would be too difficult to implement due to the range of the respondents' levels of literacy in their various languages, including English.

Each researcher ensured that the respondents signed a **consent form** outlining the ethical responsibilities and rights, and their option to not participate partly or wholly. Digital voice recorders were purchased for these interviews, as it was thought that recording the interviews would allow the researcher to check understanding and meaning at a later time.

The questions were designed to gather a combination of **quantitative** and **qualitative** data; this was done by asking simple yes /no questions followed by prompts to elicit further insights or reasoning by the respondent. Each interview was coded using the initials of the researcher followed by the number of the interview, and it was this code that was used throughout the analysis so that the origin of the response could be tracked. It was agreed by the research team that the interview was to last about one hour, relatively a long time, but it was possible to skip non-applicable sections, which would leave time for further expansion of some questions.

The final sample consisted of 40 individuals.

Table 2: The Research Sample

Ethnic Group	Language	Number
Pakistani	Urdu, Punjabi	22
Bangladeshi	Bengali, Sylheti	5
Chinese	Cantonese, Mandarin	10
Indian/other	Hindi/English	3

2.4 Ethics

As originally planned, the direction of the research project called for two ethics requirements: UCLan (for the BME respondents) and NRES (for the NHS respondents) to ensure due ethical consideration to each group of intended interviewees-BME community members and service providers. After some drafts, the UCLan form was successfully completed and accepted and the research was given the go ahead. More troublesome was the completion of the NHS ethics form: this NRES Form was specific to the interaction between Black and Minority Ethnic clients and NHS staff. It was quite lengthy and required specific knowledge of the terminology; a thorough understanding of the research process; and the rigorous requirements for those conducting research within the NHS. The team struggled to complete this form so requested assistance from the UCLan support workers and some members of the steering group who were people more knowledgeable of the process.

The process of considering as many eventualities of the research interview situations was time consuming, often calling on the researchers' knowledge of health and safety and legal requirements, as well as common sense and imagination. Issues of privacy, anonymity, cultural and religious knowledge were considered, without trying to be prejudiced about the clients' beliefs and the general experience of each ethnic community, therefore avoiding stereotyping them into one homogeneous group. In this sense it is better to see them as individuals who are *representative of a community*, with diverse interests and personal backgrounds.

Learning, development and capacity building

The University of Central Lancashire provided a set of seven mental health awareness and community research workshops, attended by every researcher in order to: build capacity and knowledge; gain research skills; to feel part of the larger research process; to make links with experts in the field; to understand the wider context of mental health nationally; and to improve one's personal and professional development.

Furthermore, successful attendance and completion of the tasks would enable the researchers to gain the qualification of either attendance, or certificate after completing the set assignments. Whenever possible, transport was shared to reduce costs, which also provided opportunities for discussion and group building. Some timetable flexibility was needed due to school starting and finishing times, as it was impracticable at times to find childcare for the parents in the group.

The researchers attended seven workshops and four quarterly meetings in Birmingham, a number of steering group meetings, weekly research team meetings and fortnightly Support Worker meetings in Worcester. At the weekly research meetings, the group discussed their knowledge of the community, their expectations of the research, ways of using the appropriate vocabulary in the various languages, and any other concerns

3. RESULTS

3.1 CORE DATA- as requested by UCLan.

Table 3: Age last birthday.

Age last birthday	Number of Respondents	%
25-29	0	
30-39	0	
40-49	1	2
50+	39	98
TOTAL	40	100

Table 4: Gender

Gender	Number of Respondents	%
Male	12	30
Female	28	70
Total	40	100

Table 5: Ethnicity (using the 2001 census categories)

Ethnicity	Number of Respondents	%	
Asian or Asian British	Indian	2	5
	Pakistani	22	55
	Bangladeshi	5	13
	Other	1	2
Black or Black British	Caribbean	0	0
	African	0	0
	Other	0	0
Chinese or other ethnic group	Chinese	10	25
Other	Other	0	0
	TOTAL	40	100

Table 6: Were you born in the UK?

	Number of Respondents	%
Yes	1	2
No	39	98
TOTAL	40	100

Table 7: If no, how long have you lived here?

	1-5 years	6-10 years	11 or more years	Did not answer	TOTAL
Number of Respondents	1	0	38	1	40
%	2	0	96	2	100

Table 8: Citizenship

Are you a British Citizen	Yes	No	Did not answer	TOTAL
Number of Respondents	39	0	1	40
%	98	0	2	100

Table 9: Languages

First Spoken Language	Number of Respondents	%
Chinese	10	25
Hindi and English	2	5
English	2	5
Urdu	6	15
Punjabi and some Urdu	14	35
Arabic	1	2
Bengali/Sylheti	5	13
	40	100

First Written Language	Number of Respondents	%
Chinese	8	28
Hindi and English	1	3
English	3	10
Urdu	7	23
Punjabi and some Urdu	7	23
Arabic	1	3
Bengali/Sylheti	3	10
TOTAL	30	100

NB: Not all respondents write in first language.

Table 10: All languages

All language fluent in (spoken)	Number of Respondents	%
Chinese (Cantonese)	10	23
Hindi and English	2	4
English	6	13
Urdu	6	13
Punjabi	14	30
Benghali/Sylheti	6	13
Arabic	1	2
French	1	2
TOTAL	46	100

NB: Some respondents stated they were fluent in more than one language, therefore some totals are greater than 40.

All language fluent in (written)	Number of Respondents	%
Chinese (Cantonese)	8	31
Hindi and English	0	0
English	6	23
Urdu	8	31
Punjabi	0	0
Benghali/Sylheti	2	7
Arabic	1	4
French	1	4
TOTAL	26	100

NB: Some respondents do not write in their known languages.

Table 11: Religion

Religion	Number of Respondents	%
None	6	15
Christian	2	5
Islam	27	69
Buddhism	2	5
Hinduism	1	2
Sikhism	1	2
Other	1	2
TOTAL	40	100

Table 12: Sexuality

Sexuality	Number of Respondents	%
Heterosexual	34	85
Did not wish to answer	6	15
TOTAL	40	100

Table 13: Disability

Disability	Number of Respondents	Nature of Disability	%
Yes	10	Parkinson's disease (1) Arthritic Joint Deformities (1) Diabetic complications (1) back pain (1) knee joint pain (1) Heart condition (1) Did not state (4)	25
No	30		75
TOTAL	40		100

3.2 Results – Quantitative analysis

What is your understanding of health and well being?(Qn 1A)

Agree with Statement that mental health involves...	Number of Respondents	(%)
general feelings of happiness, positive, feeling satisfied and able to do things	21/40	53%
being able to handle everyday stress and routines	23/40	58%
feeling in control of life and one's emotions	21/40	53%
enjoying or coping with family life	10/40	25%

Are you aware of symptoms or problems associated with mental well-being? (Qn 1B)

RESPONSE	Number of Respondents	%
YES	27	68
NO	3	8
NO ANSWER	10	25%
TOTAL	40	100

**Are you aware of any symptoms of problems with mental well-being?
(Some respondents gave more than one response)
(Qn 1B. Comments)**

RESPONSE	Number of Respondents	% OF TOTAL
felt not sleeping well was a symptom of mental health problems	27/40	(68%)
said that anxiety was a symptom of mental health problems	20/40	50 %
agreed that anger was a symptom of mental health problems	19/40	48 %
poor memory was a symptom of mental health problems	26/40	66 %
Unsure	5/40	13%

**How would you treat yourself if you are not feeling mentally well?
(Qn. 2)**

Respondents talked about personal action, social action and a number of activities both inside and outside the house. Respondents report an awareness of activities that:

Response	No. of Responses	Percent of given responses	PERCENT (%) of TOTAL SAMPLE of 40
distract their thoughts from themselves and their present problems	6/27	22%	15%
keep up and develop social networks	11/27	41%	23%
keep their spirits up or help them keep calm and relaxed	2/27	7%	5%
just manage or cope with their condition/present situation	4/27	15%	10%
involve seeing a GP	2/17	7%	5%
Not sure	3/27	11%	8%
Did not respond	13	n/a	33%

Have you ever talked to anyone about your mental well-being? (Qn.3)

RESPONSE	Number of Respondents	%
had talked to someone else about their mental well-being.	19	47%
cope alone rather than talk to others	12	30%
had spoken to a family member	9	23%
TOTAL	40	100

Have the actions above been successful in resolving your mental health issues?" (Qn.3Aii)

Response	No. of respondents	%
Yes	5	38
No	3	23
Not sure	1	8
occasionally	1	8
Only for a short while	2	15
It doesn't really matter	1	8
TOTAL	13	100

Who would you speak to about your mental well being?"

(Qn. 3Aiii)

RESPONSE	NUMBER	%
would speak to a family member	10/40	25
would speak to a friend	9/40	23
Would talk to a faith leader	4/40	10
would talk to an alternative therapist	3/40	8
Did not answer	14/40	34

Reasons for speaking or not speaking to someone else about mental health problems (Qn. 3A iv):*"no reason, I like to keep things to myself"**"Only when I trust the person. This person must live a good life, and be willing to help other people."**"She is my sister and I trust her."**"Best friend is always trustworthy. Best friend would not tell others"*

“They are the closest people to me.”

“Because she is my wife.”

“Feel good.”

“Doctor can provide most beneficial help and support.”

Would you ever seek support from your GP in relation to your mental well-being?

Responses to 3A(v)

RESPONSE	NUMBER	%
Yes	9/40	23
No	9/40	23
No answer	22/40	54
TOTAL	40	100

Those that answered No said this because of problems with language

“No, because it requires language support.”

“I can’t communicate with them. If I am in Hong Kong, I might.”

Other points raised were:

- **Positive and negative attitudes to effectiveness of treatment, and to different types of treatment, such as pills**

“No, because I think GP cannot help me with it. It’s things that are going on in my life and nothing can change it. GP cannot help me on my mental well being. GP can only give me tablets. Just like giving me tablets for insomnia. Old people must be unhappy, that’s the way of life. I can’t help it, and other people can’t help me as well. The only good thing is that we have pension, or else I will die. I will only feel better if there is absolutely no pain and I can walk around. I don’t think talking to anyone will help at all.”

- **Attitude to skills and purpose of GP only for physical ailments, although some would find their advice quite reassuring.**

“GP will check my normal blood pressure or my urine sample, or to check if I am ok. Just like there was once when I told the GP about my heart beating very fast, and I don’t know if it’s heart problem or not. GP about my bad husband, I feel unhappy, and I won’t tell GP, because I don’t think GP deals with that. I will only tell my neighbour and share with them because they understand me.”

- **Choice of alternative- in this case Chung Yi (Chinese doctor) over Western medicine. Also choosing friends to talk to instead of GP.**

“No, it is a waste of time. It won’t help much. They won’t even know what unhappy means to me. I trust Chung Yi more.”

Responses to 3B(i)

“Who did you speak to about your mental well-being?”

RESPONSE	NUMBER	%
Alternative therapist	10/40	25
Family member	9/40	23
Friend	9/40	23
Faith leader	3/40	8
Did not answer	9/40	23
TOTAL	40	100

Responses to 3B(ii)

Would you ever seek support from your GP about your mental well-being?

RESPONSE	No. of RESPONSES	Percent of those who responded (18)	PERCENT (%) of TOTAL SAMPLE (40)
Yes	11	61%	28%
No	5	28%	13%
Unsure/mixed	2	11%	5%
Did not answer	22	n/a	55%

Responses to 3B(iii)

“What form of support do you think is important about mental well-being?”

RESPONSE	TOTAL	%
Listening	14/40	35
Advice	13/40	33
Encouragement	12/40	30
Taweez	3/40	8

(NB:Some gave more than one response)

NB: Taweez/Taweez are holy words from the Quran used for healing and well-being.

What do you think are some causes of mental ill-health? (Qn.3B iv)

The responses to their perception of causes for mental health show a number of concerns for this age group, and gives further research possibilities to find out more about their needs and concerns in order to provide *more appropriate and responsive services*

PERCEIVED CAUSE	TOTAL	%
Bereavement	12/40	30
Anxiety	12/40	30
Anger	11/40	28
Physical ill-health	11/40	28
Community issues	8/40	20
Financial issues	8/40	20
Being a carer	7/40	18

NB: Some respondents agreed to more than one option

Did you manage to resolve your mental health issues through seeking support? (Qn. 3B v)

RESPONSE	No. of RESPONSES	PERCENT (%)
Yes	13	33%
No	2	5%
Unsure/mixed	4	10
Did not answer/ n-a	21	53%

SECTION B:

About Primary and Secondary Health Care

Have you had any communication difficulties in dealing with the NHS? (Combined Qn. 4 and 5)

RESPONSE	NUMBER	PERCENT
had communication difficulties when dealing with the NHS	29/40	73%
had language problems when dealing with the NHS	17/40	43%
experienced cultural difficulties when dealing with the NHS	12/40	30%
communication problems when making general enquires with the NHS	5/40	13%
communication problems related to people's names and titles, acronyms and contact numbers	No one	No one

**Did the GP seem helpful and genuinely interested in your problem?
(Qn. 6 Prompt 1)**

RESPONSE	NUMBER	PERCENT
Yes	28	70%
Did not answer/were unsure	12	30%

**Did the GP demonstrate this to you by listening to you?
(Qn. 6 Prompt 2)**

RESPONSE	NUMBER	PERCENT
GP demonstrated genuine interest by listening to client	14	35%
Unsure/did not answer	25	63%
Thought it depends on quality of interpreter	1	3%

Did the GP give you advice or reassurance? (Qn. 6 Prompt 3)

20% responded that GPs gave advice and reassurance

Did the GP diagnose your situation or condition? (Qn. 6 Prompt 4)

RESPONSE	No. RESPONSES	PERCENT (%)
Yes	25	63%
No	1	3%
Unsure	5	13%
Did not answer	9	22%

Responses to Question 6 Prompt 5:

Did the GP offer any counselling?

RESPONSE	No. RESPONSES	PERCENT (%)
Yes	17	43%
No	15	38%
Unsure/ Did not answer	8	20%

Responses to Question 6 Prompt 6:

Did the GP offer any medication?

RESPONSE	No. of RESPONSES	PERCENT (%)
Yes	24	60%
No	7	18%
Did not answer	9	22%

Responses to Question 6 Prompt 7:

Were you supported for sufficient time (days/weeks/etc) until your mood improved?

RESPONSE	No. of RESPONSES	PERCENT (%)
Yes	13	33%
No	10	25%
Unsure/Did not answer	17	42%

**Did the GP ask you whether your physical condition is affecting your emotional (*low mood, anxiety, stress, other*) well-being?
(Qn. 6 Prompt 8)**

35% were asked by the GP about the link between the physical and emotional well-being.

Were you referred to other specialists? (Qn. 6 Prompt 9)

18% responded that they were referred to secondary care

**Did the GP inform you about future action and what to expect next?"
(Qn. 6 Prompt 10)**

40% responded that they were told about what future action to take next

**Did the GP inform you of any alternative therapies available?
(Qn. 6 Prompt 11)**

5% responded that the GP had told them about alternative therapies available

Were you satisfied with the service or treatment provided?" (Qn. 7)

RESPONSE	No. of RESPONSES	PERCENT(%)
Yes	16	40%
No	4	10%
Unsure/mixed	3	8%
Did not answer	17	42%
TOTAL	40	100

Was the first appointment with the referral satisfactory? (Qn. 10)

13% responded that the experience was satisfactory

Questions were designed to replicate the areas above in relation to secondary care; however, as only 7 of the respondents had any experience of secondary care it was decided not to report these results numerically. However, qualitative data from these questions will be reported.

Section C: About Alternative Therapies (questions 14-18)

Question 14a: "Have you tried alternative therapies?"

23% responded that they had

ALTERNATIVE THERAPY	No. HAVE TRIED	PERCENT (%) of TOTAL SAMPLE
Hakeem	5	13%
Herbal	2	5%
Homeopathic	1	3%

Acupuncture	2	5%
Chung Yi	1	3%
None	2	5%
Did not answer	27	66%

One respondent had been referred to an acupuncturist by the Substance Abuse Team, meaning that some attempt is being made at combining therapies. It also seems that the Chinese respondents may not define Chung Yi as an alternative, as it often is the first point of contact, especially for older and more traditional people. The seven people who went on to give some detail about this experience said that in general they seem to listen to them, give them some good advice, and although not all their problems had been solved, they felt the better for going. Some respondents reported using these alternative therapies while abroad.

Question 14b. How did you find out about this [alternative treatment to standard medicine]?

Response	No. of Respondents	%
Family	6	15
Friends	4	10
Faith Leader	1	3
Media	4	10
Other	1 (GP referral)	3
Did not answer	24	59
Total	40	100

Most answered that family, followed by friends and media were the main source of advice to see an alternative therapist. GP and faith leader informed one client each.

Question 15: Describe experience of visiting alternative practitioner.

Response	No. of Respondents	%
Positive	5	13
Negative	1	3
Neutral	3	8
Did not answer	32	80

Question 16: Were there any communication problems?

Response	No. of Respondents	%
Yes	1	3
No	9	23
Other	0	0
Did not answer	30	74

Question 17 Prompt 1: Did the alternative therapist seem helpful and genuinely interested in your problem?

Response	No. of Respondents	%
Yes	3	8
No	0	0
Neutral	4	10
Did not answer	33	82

NB: Only a small number of respondents had visited an alternative therapist.

Question 17 Prompt 2: Did the alternative therapist diagnose your situation/condition?

Response	No. of Respondents	%
Yes	4	10
No	4	10
Neutral/Unsure	2	5
Did not answer	30	75

NB: Please note only 10 responses in total.

Question 17 Prompt 3: Did the alternative therapist offer any treatment and explain its effects?

Response	No. of Respondents	%
Yes -total	13	33
Counselling	1	3
Medication/tablets	5	13
Acupuncture	1	3
Food therapy/diet advice	3	8
Prayers	1	3
Herbal Medicine	1	3
Special Waters and powder	1	3
No-total	2	5
Did not answer	25	63

Question 17 Prompt 4: Did the alternative therapist ask you how your physical condition is affecting how you feel emotionally?

Response	No. of Respondents	%
Yes (low mood and stress)	2	5
No	6	15
Neutral/unsure	0	0
Did not answer	32	80

Question 17 Prompt 5: "Did the alternative therapist refer you to other specialists?"

Only one therapist referred client to another specialist/practitioner.

Did the alternative therapist inform you about your condition and possible future effects? (Qn. 17 Prompt 6)

Response	No. of Respondents	%
Yes (verbally)	4	10
No	0	0
Neutral/unsure	0	0
Did not answer	36	90

NB: The total range of respondents re alternative therapists ranges between 9 and 13, so these responses can be seen in terms of that. .

Section D. My situation at the moment (from questions 19-28)

Do you have someone to care for you if you are unwell?

RESPONSE	No. of RESPONSES	PERCENT
have a carer to care for them when unwell	6	15%
Did not have a carer to care for them when unwell	18	45%
have a family member to look after them if unwell	21	53%
Did not have a family member to look after them if unwell	13	28%
Had a friend to care for them if unwell	2	5%

Question 20: Do you have someone to accompany you to visits to GP or to alternative practitioners?

Response	No. of Respondents	%
Yes	13	33
No	21	53
Did not answer	6	14
Total	40	100

Question 21: Would your carer, family or friend know who to contact if you were unwell?

Response	No. of Respondents	%
Yes	24	60
No/ unsure	8	20
Did not answer	8	20
Total	40	100

Are you aware of the following support and information contacts?**(Qn 22)**

Agency Known by Respondents	No. of Respondents	Percent (%)
NHS/ information leaflets	10	25%
Worcestershire Hub	1	3%
Worcestershire Access Centre	2	5%
Age Concern	15	38%
Advocacy Services	1	3%
Worcestershire Mental Health Network	1	3%
NHS Websites	1	3%

Do mental ill-health issues affect your life in any way these days?**(Qn 23)**

Response	Number of respondents	%
YES	16	40
NO	10	25
NO RESPONSE	14	35
TOTAL	40	100

Have you used any mental health services lately? (Qn 24)

Response	No. of Respondents	%
Yes	2	5
No	22	55
Did not answer/	16	35
Total	40	100

What is your attitude to mental ill-health in our society? (Qn 25)

55% did not answer or were unsure of this question

	Number of respondents	%
Positive attitude	7	18
Negative attitude	11	28
Unsure/ neutral	12	30
Did not answer	10	25
TOTAL	40	101

Are you aware of the effect of caring for people who are not feeling mentally well? (Qn. 26)

Response	Number of respondents	%
Yes	17	43
No	7	18
Unsure	4	10
Did not answer	12	30
TOTAL	40	101

Do you feel that you need to know more about mental ill-health and mental well-being?" (QN. 27)

Response	Number of respondents	%
Yes	15	38
No	7	18
Did not answer	18	45
TOTAL	40	101

Do you know where to find out information about mental health and mental well-being? (Qn. 28)

Response	Number of respondents	%
Yes	4	10
No	18	45
No response	18	45
TOTAL	40	100

3.3 Qualitative Data Results and Analysis

Section A: General Questions (questions 1 -3)

Question 1.A

What is your understanding of health and well being?

Basically, this first question asks for the respondents' understanding of good health and how people feel when they are well. Comments given include a range of physical and mental states, often related to actual feeling, mood or behaviour. Many see *physical health* very much affecting *mental well being*. Being the first question, it was more of an "ice-beaker" and an introduction to health in general, as this might flag up issues, especially if their mental health has affected their physical health. Most of the comments were general thoughts about how they view health in general.

Question 1A Prompt 5:

List some activities you do to stay in a positive frame of mind

The following are quite important responses, as they reveal the respondents' personal meta-awareness of their own psychological well-being. Some of the comments can be grouped as follows:

a) consciousness of family and social networks:

- 1. I think maintaining a good relationship with other people, such as my husband, is very crucial in staying positive, but I feel that I am not in this kind of state at the moment.
- 28. love to see my grand children, feed them and play with them.
- 17. talk to family .go out and sometimes shop around. Eat healthy.

b) personal activities:

- 3. Doing Exercise, water my plants, talk to my neighbours, and going out to the city.
- 15.try to keep myself involved in different activities. Do some voluntary work .go out meet people.
- 22. talk to family, do some gardening (she grows a few vegetables) and go out.
- 27. watch my favourite tv channel and cook my favourite dish and eat well and sleep well.
- 13. Housework, cooking, walking daughter to school, watching television, praying.

c) limitations and difficulties:

- 2. Don't just sit still, try to do whatever I want. But I know I am limited. I can't do many things because I have difficulties moving around.
- 6. I will compare myself with other people in a positive way, in a sense that I feel I have a better life than other people. Also, many people have worse life than me. Though many people live better lives than me, it doesn't bother me at all. I will also try to know more friends who we can share our lives with. I will listen to other people, because it provides room for me to think. I will find more hobbies, doing art and crafts, writing calligraphy, going out, and study English.

d) being socially and physically active:

- 7. Communicate well with others, can be humorous, play ma jong, do exercise.
- 8. Read books and talk with other people.
- 9. Talk with other people
- 10. Keeping in touch with family, keeping fit by daily exercise
- 29. Join other activities clubs and voluntary organizations. Try to help others who are having some mental health problems.
- 30. Read, pray, walk, visit family and friends and look after grandchildren.
- 23. talk to family, visit friends and family.

e) religion:

- 4. Praying to God, positive thinking; e.g. when I feel that my daughters are not with me, I will feel a bit down, but when I feel that there are people who care about me and they're still around, I will feel better.
- 25. Try not to worry. Keep my faith strong that any could happen and I am just a woman.
- 11. offering prayers, attend social function
- 12. Exercise, walking, reading, learning about different religions and praying.

f) the importance of healthy eating:

- 20. healthy eating, walking , voluntary work.
- 5. Maintaining a good diet, and keeping myself in a good and clean living condition. Sleep well, be quiet and calm. Don't go to places where there are a lot of germs.

Question 1B Prompt 5: These additional comments about symptoms of mental health problems have been put in the following categories:**a) Personal feelings**

- 1. Feeling unhappy, being very quiet and depressed, look miserable and withdrawn.
- 2. Feeling unhappy all the time, lost interest in things.
- 3. They will feel that there is something wrong with their mind. Feeling no direction, no motivation, unable to carry out daily activities.
- 4. Always not happy, memory problem, feeling depressed
- 5. Forgetfulness, panic attack, etc.
- 6. A constant low feeling; insecure, sad; at times the word enjoyment is meaningless.
- 7. strange behaviour Not happy but moody.
- 8. because she is dependent on her children, she feels embarrassed and thinks she is a burden to the family.

b) Physical Effects:

9. I would say that people who are mentally unwell will have physical symptoms such as not walking straight and they cannot walk fast.
10. Not sleeping well, not feeling happy, feeling dizzy and agitated
11. sleepless nights, loss of interest, worried about children and financial worries.
12. very talkative, occasional mood swings, mostly depressed.

c) Social Effects:

13. A heart that always want to seek attention from family, a feeling of getting blamed.
14. The body will feel uncomfortable, and have bad relationships with other people
15. The person will get angry easily, because he/she will feel like nobody seems to care and ask about them. We all need people attending to us.
16. Family problem and unemployment
17. Unable to explain to others within and outside family sometimes not being taken seriously.
18. The ability to talk to someone what they think.
19. People and life is looked at with suspicion.
20. Loss of control of their behaviour
21. Especially when persons lose a family member (bereavement). Other family issues.
22. unable to explain to others even to GP. Sometimes not being taken seriously.
23. Feeling unhappy, being very quiet and depressed, look miserable and withdrawn.
24. very stressed, does not want to share her illness [thinks people will make fun of her]

Question 2 Prompt: "Do you have any other comments?"[about what people can do to treat themselves if they are not feeling mentally well] .

The free responses about self treatment are quite varied and include:

a) Personal action and activities such as taking, or not taking, tablets and alcohol.

1. I don't do exercise and I won't take tablets to make myself feel better.
2. I will feel better if people come and talk to me. TV is helpful. I can't do exercise because I have Parkinson's disease. I feel that I have the worst illness. I don't drink alcohol, or use tablets.
3. No alcohol, no tablets
6. No alcohol, it will only make things worse, because I tried it before.
10. The days I feel depressed, I take two tablets which put me to sleep.
16. Alcohol was a problem but not any more.

b) Religion.

- 4. Sing praise songs, read the Bible
- 14. Quran.
- 16. Say prayers

c) Watching television.

- 2. TV is helpful. I can't do exercise because I have Parkinson's disease.

d) Thinking out loud (talking to oneself) to clarify their own ideas.

- 9. I personally feel that talking to oneself at times creates ideas, thoughts and at times answers. Please do not get me wrong, I am sane however going through bereavement, change in life and coping to the best of my ability.

e) Self control and staying positive.

- 12. I try to control myself and be positive.

f) Seeing a GP.

only see GP

g) Social activities such as talking to others, seeking mentoring, going to clubs and social functions.

- 5. Talk with other people
- 7. taking part in social activities event
- 8. seek mentoring
- 11. Socialise regularly, attend clubs, forums.
- 13. only recreation she knows is meeting people and chatting.
- 17. See friends.

It would be useful to know whether those who choose to take no tablets do so for any particular reason, whether they are in pain or seeking alternative treatment.

Responses to 3B(i) Prompt 5:**Reasons for speaking to others about your mental well-being"**

These responses demonstrate the value of a supportive community, of people with common values and who have known each other for some time, and have developed a sense of trust.

a) Neighbours:

- 1. I share with my neighbours when they approach me and asking how I am. I feel that they care for me so I share with them. But once they left, I feel down again.

b) Alternative/traditional medicine:

- 2. Chung Yi can help me and give me medication which will make me better. Discuss with neighbour will make me more happy, because sometimes they give me good advice as well.
- 8. Tried modern medicine and they are not always a cure.

c) People one can trust:

- 3. I trust the person that they won't tell others. I feel better when I can have dialogue with other people.

4. They must be people who know me, who shares the same topic, and who matches my personality.
5. I get friendly with other people very easily. Part of it is due to my personality. So as long as they match with my personality, I am fine.
6. Friends will know my attitude and know my situation. Their advice can be very supportive.
11. A trusted family member.

d) Religion:

10. My faith and prayer is who I speak to and cope.

Question 3A(i): “Please describe, in your own words, what you do to cope when you are feeling mentally unwell.”

WITHDRAWAL

Respondents felt they were not understood and that they withdraw socially, they were quite negative in whether this was a successful action and felt it did not matter whether it worked for them or not...

- *“I choose to keep it to myself and not tell anyone because I feel that the more I speak, the more mistakes I will make and that will create argument.”*
- *“Whether it works for me or not, it doesn’t really matter”*
- *“No one can understand me. I use self motivation technique. Back in the old days, I must help my mother and bring up my daughters. People will look down on me, there’s no use talking with them, I must rely on myself and turn stress to strength - but it’s very difficult. I had a lot of tears and sadness”*
- *“stay at home, do not speak. Take food and tea. watch tv”*
“when really depressed just stay at home. Keep quiet, “Try to sleep”
- *“Sometimes start crying.” “occasionally crying is helpful”*

Despite the fact that participants reflected on withdrawal as a coping mechanism, there were mixed feelings as to whether this was successful

- *“Whether it works for me or not, it doesn’t really matter”*

For some it has been positive but not without difficulty

- *“Yes, but it’s very difficult. I had a lot of tears and sadness”*

MEDICATION

Some respondents indicated how they turned to medication in order to cope

- *“. take two tablets - works only for a short period of time”*
- *“Take medicine and rest”*

In the main respondents felt that this relieves them for a short period. “It relieves me of that low feeling”

Taking medication was a successful measure for most of the participants but something which lasted a short time.....

- *“It relieves me of that low feeling”*
- *“occasionally it is helpful”*
- *“works only for a short period of time”*

FAMILY

A number of respondents highlighted how the family was used in order to cope with

- *“Get involved with family”*
- *“talk to my husband, discuss family and financial issues – it works for a few days”*
- *“always try to speak to my children but no one is ready to listen.”*

RELIGION

A number of respondents reflected on how they turn to praying in order to cope...

- *“say prayers”*
- *“ask family to pray for me”*
- *“Say prayer”*

OTHER

Other things indicated were:

- *“See Doctor if needed”*
- *“Try to go to social gatherings and visit friends”*

Section B:

About Primary and Secondary Health Care (questions 4 to 8)

Questions 4:

**“What is your experience of visiting gp (doctors’) surgeries?
(How do you feel about visiting your GP?)**

Responses to Question 4:

Both positive and negative aspects were highlighted. Again the **problems with language and communication** are very clear, either not being able to understand information about the appointments, or the interpreters which have been arranged for them.

At times, respondents wonder about the GP services, as their past knowledge of doctors is so different to the present, and one wonders what kind of relationship is built between doctor and patient these days due to time and cost restraints, amongst other reasons. Often it is the administrative element that seems to be a problem, such as long waits, appointment cancellations and dealing with medical practice staff.

On the **positive** side, many people are very happy with the service, the interpreters, the support workers who drive them and translate for them, and the caring atmosphere that is offered.

Question 5 Prompt 9: Do you have any other difficulties in contacting and dealing with the NHS?

Various topics are raised by the respondents of their own accord. Language and culture are the main difficulties faced here, although sometimes the interpreting available is very well received.

Responses to Question 5 Prompt 9 have been put under the following categories:

a) Misunderstandings due to untrained interpreters being used for consultations

1. *Language barrier is a big issue, but don't really need a Chinese doctor, having an interpreter is enough. Most of the time the interpreter is very helpful.*
2. *I won't express my feeling to GP because they will not understand and I know my own feeling well.*
3. *Language, but if the interpreter is good, then it's fine.*
4. *Language; if the interpreter is not working well, then there's a big problem, There was an incident when my son accompany me to the hospital. I was told by my son that a scan will cure my illness immediately. I was quite surprised. But it's when I went to the hospital that I realized my son had got the wrong message. My treatment is actually going to use electricity to cure my disease.*
5. *Language is a big barrier, usually the interpreter is very helpful. Culture can be a problem, but I haven't come across that yet. But I have come across an experience where my wife took some medication and felt really ill. I noticed that the medicine is very "hot" (Chinese medicine term), so I made some ginseng for my wife and she got better. I know the GP will not understand this.*

b) Folk medicine knowledge:

6. *I don't think there are a lot of difficulties, because my daughters are very supportive. As for cultural difference, this is what I can recall: there was one year when the GP ask me to take a flu jab, I remember a friend once told me that I don't need to take it because we're born in Hong Kong and we already have that antibodies to fight the flu. So that's a cultural difference.*

c) Behaviour of staff:

7. *many NHS staff misbehave with Asian*

d) Poor communication styles:

8. *Some GP just refuse to communicate. I feel better when the GP explain to me clearly what my condition is. But if GP find it frustrate to communicate with me, I feel bad. If there's no interpreter, there's a big problem. Some interpreters are not too competent and that could be a problem as well. Especially when they need to tell us what the GP said.*

e) Distance from home to hospital for some treatments:

9. *Hospitals are usually too far for older people to travel.*

Question 6 Prompt 1: Did the GP seem helpful or genuinely interested in your problem?

Respondents feel that there are complex problems related to GP and patient interaction and some of the statements below highlight these problems. There are some concerns about lack of information about medicines and their condition, and how to improve their condition.

Some responses to Question 6 Prompt 1:

Answering Yes; that the GP did seem helpful and interested:

“good advice and very reassuring. He told me that everything is fine. They will check on me if they don’t see me for a long time. Reassure me that things will get better.”

“Yes, bilingual GPs are very helpful”

Answering No; that the GP did not seem helpful or interested:

“The GP...] Just tell me that I have certain condition, like high blood pressure. And tell me what to do. Didn’t give me any advice or try to understand me. He threaten me that I will go blind if my blood pressure is high, but who wouldn’t have high blood pressure unless they loss all their blood? I don’t feel good at all.”

Unsure/mixed response

Some of these responses highlight the poor level of communication, for which trained interpreters or other support staff can help to explain medical matters to the clients in the appropriate level of language.

2. I don’t know what the GP is thinking. Whatever GP said, or ask I will just respond.

4. I can’t tell because it’s all up to the interpreter.

17. GP tries to reassure but it is of no benefit for me as I do not know what he/she is saying. Medication is repeatedly going on and problem is unchanged.

Responses to Question 6 Prompt 8: “Did the GP ask you whether your physical condition is affecting your emotional (*low mood, anxiety, stress, other*) well-being?”

These comments/suggestions focus around the following characteristics:

a) **Poor interpersonal communication between doctor and patient.**

1. *No, the GP won't explore how my physical condition is causing me low mood, anxiety or stress*
2. *No, but I think there are many factors to it. Sometimes it depends on the interpreter, sometimes it depends on GP initiative, and it depends on the expressiveness of the client as well. GP usually just tell me what causes the problem, and ask me how the medication affects me. But my personal view is that if this is all that the GPs do, it won't help a lot, but if the GP can bring **me and my family more together**, that will definitely help.*

What can I do? Even if I am not satisfied I can't do anything. I have no choice in my illness. They will only give me tablets, and won't look at my psychological side

b) **The role of the interpreter or advocate.**

Some comments bring up a dilemma regarding whether the interpreter/advocate should be a total stranger to the client or not. Issues of confidentiality and anonymity are raised, as it is generally believed that some distance is preferred.

3. *I think the interpreter might not be too appropriate sometimes because I might have missed something what I want to say. **It's better to have an advocate who knows me.***

c) **Expectations of patient according to their own past experience.**

Due to the short length of a normal consultation, it seems to be more difficult for any long term rapport to be developed between doctor and client. Language difficulties make this even more difficult, especially with the older clients, or the new arrivals to this country.

3. *Better if someone can talk to me and let me know more about my condition (mental and physical)*

4. *No, but I guess it's because I can't communicate with the GP. I don't want to waste other people's time. But even if there's communication, it's between GP and the interpreter. But if the GP spend some quality time and explain to what causes the problem, how it can be recovered, and how I am feeling, I will definitely feel more reassured.*

2. *I feel that it's enough. I can't think of anything else the GP can do.*

4. *More helpful if they are more aware of my psychological needs.*

d) **Choice of talking therapy not made available to client.**

5. *No, it will be good if I am offered a counsellor or psychologist. I think it's necessary. No doctor will ask me whether my cough will affect my daily life, or whether it will make my mood low. I want to have a GP who will look at my feeling, to give me extra advice on daily living, and to find a suitable medication for me after an assessment.*

6. *No. Sometimes when I feel unhappy I want to talk to someone. But GP did not offer anything.*

7. *No. When I'm ill, I won't think about my own psychological well being, and most of the time I don't have the knowledge to express it. It might not*

have come to my mind at that very moment, but if GP initiate this topic, then it will make me more aware, and I will speak more. So GP should initiate this. It will be helpful if GP can refer people to counseling. The more people involve the better. And this definitely will make a positive difference. GP should ask more questions and investigate why the problem occurred, and see if there is a psychological cause to it.

Question 13: Were you satisfied with the service or treatment provided by the secondary care?

These responses may highlight a limited experience with secondary care, thereby the low response rate, although the higher incidence of unsure or negative answers might suggest a need for better communication and client interaction.

a) Comments from satisfied clients (Qn. 13)

1. *'Yes, kind of satisfied.'*
2. *'Yes, it was wonderful at that time because my muscles and nerves were very relaxed after massage.'*

b) Comments from 'not satisfied' clients

3. *'feel anxious as I don't know what the first appointment is all about. I don't know whether I will have cataract operation in my first appointment and no one has ever explain that to me'*
4. *'No. It's again communication problem.'*
5. *'No, the surgeon refused to speak to me.'*
6. *'No. They can't even meet my simple need such as requesting a cup of hot water, they said only cold water are available. I feel that language is a big problem.'*
7. *'I tried secondary care before, but it's has no effect for me. No real success to the treatment to my issue.'*
'No, they did not realise how severe my case was and because of this misjudgement [misdiagnosis]I went through all unpleasant experiences. But my problem has never been addressed.'

c) Unsure/mixed responses

8. *'I was in such a critical state that I could not realise how it was. At that time I was suicidal and self harming.'*
9. *'I feel more satisfied when it's a Chinese professional.'*
10. *'I felt lonely during the process, but I was treated. So I am ok now.'*
11. *'I don't know, but I have a good interpreter. I feel that they're very responsible and arrive on time.'*
12. *'yes but for how long I have to go through this.'*

Question 23: “Do mental ill health issues affect your life in any way these days?”

The following responses highlight the older person’s concerns about their own health and the people around them, at times trying to help friends or other carers with limited knowledge about services. Dementia is mentioned as an issue as friends might become ill, and how stigma affect people’s chances of finding steady work, even those in recovery who are trying to build their lives up again.

Responses to Question 23:

a) Coping with Dementia

1. *‘I know some of my neighbours acted strange sometimes, like shouting in the middle of the night, but I don’t know whether it’s due to mental health or not. I feel that when people gets old, they lose their brain and start feeling afraid of dying, become like a child, cannot make the right decision, become dull, which is why they feel unhappy and depressed. GP cannot help too much, people with this condition must need 24 hours care.’*
3. *‘I have a friend who just kept on speaking and non stop, making no sense, and she even knock on my door sometimes. I don’t know how it will affect me though.’*
6. *‘My neighbour has dementia and always forgets to turn off the cooker and leave it on. And always accuse others of stealing her stuff.’*

b) Lack of Knowledge about mental health

2. *‘I know nothing about mental health’*
4. *‘No, but I have met these people before, and I am willing to do what I can to help them.’*

c) Clients’ experience of mental health within their own communities

5. *‘I have a friend who injured his hand because he has a tendency to self-injure. I feel that it’s due to psychology, but the GP has only look at the physical side of the problem. I have another friend’s son who seems to have depression. I advise her to see a counsellor and doctor, but I think my friend is reluctant to do it and finds it hard to communicate with her son.’*
7. *‘I have heard about these sort of problems. If these people are my friends, it will make me worry because I care for them. I have a nephew, who wander around, walk naked, and felt that walls were around him. He was not making sense. I was very worry about him.’*
10. *‘They get distracted and upset.’*
11. *‘Yes my sister gets very upset.’*
12. *‘Yes, my children and their families mostly suffer.’*

d) Clients’ Own Situation

8. *‘My physical condition.’*
9. *‘Yes I think sometimes I am a nuisance to my family and friends.’*
13. *‘Yes, I am healthy and fully recovered now but I am facing discrimination. I am involved in many voluntary jobs but none of them is ready to take me into regular employment because of my mental health record. All my benefits have been withdrawn as I am declared healthy. I am in a very confused state. I need a job. I have to pay my bills and feed myself.’*

4. DISCUSSION

Keeping in mind the age group of this research, it is not surprising to have a good representation of traditional views regarding some subjects, as people's experience leads them to a certain set of expectations and perhaps comfort zone regarding treatment and relationship between doctor and patient.

Many of the answers reflect issues of language, culture, isolation and personal knowledge and skills. Section A dealt with respondents' personal knowledge views and attitudes to mental health

The aims of the project were presented under the two main headings of: collecting data and; learning, development and capacity building. This discussion will be presented in the same way.

4.1 Discussion of the data collected

Due to the varied nature of the ethnic minority communities in the two counties it is important to think more of the individual member of the wider community rather than the community group.

As a starting point, it can be clearly stated that BME clients are a diverse group of individuals with a diverse backgrounds and life experiences, and this is reflected in the wide range of responses throughout this report. Their views on health and mental health may differ due to their individual contexts, which may include factors such as gender, nationality, age, length of time in Britain, and of course the community and family in which they live: what information is available, what is and is not, generally acceptable, as well as their present personal situation.

Very few respondents said they were totally unaware of mental well-being problems, and there was general agreement on some causes and symptoms of mental health and ill-health. Although these were not expert definitions, by any means, some reflected a certain life experience that offered a knowledge and awareness of problems and of some strategies that can be employed to overcome some mental health problems.

The issue of communication, invoking both language and culture, was one aspect that appears throughout the document as a steady barrier to proper interaction between service user and provider. Whether linguistic or cultural knowledge- by all parties involved- needs energy invested, or whether technology can be used to fill the gap, is an area for further discussion. Preconceptions on the part of both service user and provider may need to be explored, to gauge how well people keep up with change. As researchers, we have made some comments in the recommendations section, in the hope that our level of knowledge about the various BME communities/individuals has been of some value.

It is important to note the important role of the English language and level of literacy in both, or more, languages of the clients, often contrasted by how

long they have been British residents or citizens. It must be stated that decades ago, many of these clients we now see as older clients, were once busy working long shifts in shops and factories, with limited opportunities for English language learning. The reason for this statement is an attitudinal one: if we see these individuals as a product of our own society and we understand their role in the economic development of this country, their actions and existence can be perceived from a new and richer perspective.

Generally speaking, mental health sufferers in the communities in question are treated less favourably. In some areas of education and family life, family members are considered the best to care for affected relatives. Mention of the female individual with a mental health condition in most families is a taboo. Other concerns raised in discussions with the community include the decrease in social activities, common interests and communication, and the cultural differences between older and younger generations within families is generally perceived to be a serious concern, and a potential source of mental health difficulties.

It was peculiar to find that many interviewees - well known to the researcher - did not wish to participate in research without reassurances of data safety and confidentiality. No one agreed to have their voice recorded, and most respondents were approached at least 3 times before agreeing to an interview. The fact that the word "mental" was being used was the reason, as the respondents do not want their community stigmatized, due to the subject matter and the target audience.

One respondent had been referred to an acupuncturist by the Substance Abuse Team, meaning that some attempt is being made at combining therapies. It also seems that the Chinese respondents may not define Chung Yi as an alternative, as it often is the first point of contact, especially for older and more traditional people. The seven people who went on to give some detail about this experience said that in general they seem to listen to them, give them some good advice, and although not all their problems had been solved, they felt the better for going. Some respondents reported using these alternative therapies while abroad.

The responses to their perception of causes for mental ill-health show a number of concerns for this age group, and gives further research possibilities to find out more about their needs and concerns in order to provide *more appropriate and responsive services* (Qn.3B iv)

It seems that there is little time during a visit to the GP to find out what expectations exist on the part of the client. Clearly, some clients want access to talking therapies, but there doesn't seem to be the mechanism to make this request; perhaps the fact that there are waiting lists for some services might mean that GPs and other service providers downplay the existence of these services to reduce disappointment and even longer waits for appointments (Qn 6 Prompt 8)

4.2 Conclusion

More Appropriate and responsive services

Language and culture seem to be the two main stumbling blocks to communication. The recurring themes of knowledge of English and other community languages-spoken and written- appear at every interaction with health services. This report did not set out to research communication options and preferences for the purpose of better service delivery, but the researchers feel that this is an area of need. We are aware that the NHS already produces literature and is conscious of BME language demands, as there is a wide spectrum of education and experience in the target communities. I am aware of the local PCT's present efforts at improving communication in various languages, as in the course of my position as Ethnic Minorities Development Officer, I have assisted the Patients Advice and Liaison Scheme (PALS) proof-read and "road-test" pamphlets translated for the Worcestershire population.

Cultural knowledge is another demanding area, as NHS staff may feel the amount of essential knowledge about BME groups and individuals is overwhelming- and it probably is. Two of the researchers have previously been involved in providing Cultural Awareness Training for NHS staff, and often the information requested and conveyed was religious and general cultural practices; often about "do's and don'ts" with certain "ethnic groups/cultures/nationalities", but in hindsight, the message is that what service users usually want is to be able to communicate a point clearly at a time of need- perhaps a time of fear, if the medical problem is serious. The researchers believe that it is the **expectations** of each individual that need to be addressed, combined with access to the right information about the health system, in appropriate formats, and that in general it is the attitudinal areas of perceived *respect and dignity* that stand out the most. It is likely that cultural misunderstandings are the main cause for some communication problems, compounded by language problems, as service providers and service users assume or expect certain behaviours from each other: it is this area of knowledge that may need to be addressed by the NHS, either through internal training or general information.

Perhaps this research may serve to highlight the seriousness and depth of the language and cultural problems faced by some of the clients, and encourage the NHS to continue to improve its communication services, which is likely to benefit all service users.

Community Engagement

Although obvious, it must be stated that the BME communities and individuals also have a responsibility to make use of existing NHS services and initiatives, as well as find ways of giving feedback to the right people in the service provider field - NHS and others - especially with sensitive or specific information. This report has tried to highlight the personal difficulties of the older BME clients due to the lack of good command of the English

language - and often their own community languages, either written or spoken, due to educational, social and economic circumstances - as the prime time to learn the host community language was probably many years ago when they were working and starting life over again in a new country, when there may have been little time to attend English lessons. In a nutshell, the majority of these people were too busy working to study or even interact with the English speaking communities in the 1960s and 1970s when they probably arrived. It's likely that new arrivals in 2008 have higher levels of literacy in their own language and probably English, and better systems in place to support them learn English; therefore more able to make use of existing services in the general community.

Better Information

We hope this report has demonstrated that it is the quality and not the quantity of information available; that information has to be made available in the right format at the right time in the right place - not an easy task. If the clients' level of literacy is limited, by whatever reasons - personal, social, economic and educational - the NHS may offer information resources either in various formats, or in formats specifically researched and designed for each local target group. The researchers feel that the DVD format has the potential to include written and spoken in a number of languages, including the lingua franca, English; this suggestion may need to be investigated further by the NHS as this topic was not specific to this research project.

4.3 Recommendations

Better Information/More Appropriate and responsive services

1. Designate various local agencies to be information centres for certain communities/language groups. This research shows a need for a professional translator/interpreter service in Worcestershire to assist clients' access services, such as booking appointments and communicating with service providers, especially in cases of a serious nature where good command of the language is required. These agencies may need to expand their role to advocate for, support or signpost clients in specifically addressing some **causes of social problems**, such as personal and financial difficulties, housing and employment. Positive action schemes may offer support to clients in recovery to gradually compete in the marketplace for work and other community involvement, as **financial hardship** and rejection at the job application stage have been mentioned in this research as a possible causes of anxiety and stress. Perhaps there is a case for the use of automated telephony in various languages. In addition, webspace can be made available to disseminate essential information, given the flexibility, scope and relative low cost of this medium; this can be accessed by clients with computer skills, or helped by their families or agency staff.

More Appropriate and responsive services

2. Encourage health authorities to explore the expectations that service user and provider have about each other's behaviour. It is likely that cultural misunderstandings are the main cause of communication problems as people *expect* certain behaviours from one another – with language

problems being a compounding factor. The attitudinal areas of respect, dignity and self-esteem of service providers as well as BME clients, their issues and concerns, need to be openly addressed. The researchers suggest relevant agencies might use or commission multilingual DVDs, radio or TV programmes, such as popular dramas, which would have the dual role of informing and demonstrating mainstream health and mental health issues that all people have in common. This initiative could also promote the latest medical news and developments so that communities have access to up-to-date information about the health system. Such projects can be part of Diversity and Equality /Cultural Awareness Training programmes.

More Appropriate and responsive services

3. For the PCT/AT/MHT to **monitor** the language difficulties of certain service users and link this to further support, perhaps from Community Development Workers, with consent from client and service providers. This would encourage GP surgeries, as well as other areas of the health system to continue exploring **language options** for clients, employing culturally aware medical and administrative staff, and/or new technologies, and assist clients with booking appointments and consultations; perhaps through options to choose own language in an automated booking system, or involving the use of technologies with graphics/other languages, according to the clients' level of literacy.

4. Encourage **GP's to ask clients** about their mental/emotional state, as part of the general consultation routine, and recommend alternative therapies if relevant to the clients' life experience and present situation.

Better Information

5. Encourage NHS/PCT/MHT facilities and staff to display, or make available, **multimedia resources** that highlight *specific* physical or mental health conditions – such as depression, dementia and Alzheimer's, hopefully avoiding the use of the general term "mental health", which has a stigma attached - in a range of community languages. Perhaps the term psychological health, or others, can be adopted. Staff can also assist in the preparation and dissemination of resources relevant to the BME communities.

Community Engagement/ Better Information

6. Community liaison workers and/or interpreters could be a useful means of providing a personal interface between service providers and service users, where relevant offering cultural awareness training. The function of these workers could be to encourage more active participation by the BME groups to provide timely information to service providers, as well as request *appropriate* information from service providers/health system.

4.4 Discussion of the learning, development and capacity building

In order to reflect on the learning and development of the research team each of the researchers has written a final reflection on their experience in the project.

REFLECTIONS

In essence, this project has been a springboard into community research, where the research group found out the large amount of knowledge and experience that goes into a research project. One major mistake of this particular piece of research was the large number of questions making the interview quite long and tiring for the respondents. This led to a lot of data to process at the analysis stage which, in turn, created other problems in terms of time, pressure, and basic management. Many of the questions have sub-sections included in order to find out in more detail the respondents' thinking, but this made recording the answers showing the thought process that took place during the interview quite difficult. In terms of learning, this project really has been a great experience for the researchers, three of whom are now employed in mental health, and the remaining two looking forward to further involvement in either general or mental health. In relation to the community members, this project has introduced the topic of mental health and provided them with some contacts to link up with in future if the need for mental health information arises. Another success of this project has been bringing a number of agencies to work together as part of the steering group thereby making connections for future mental health initiatives.

4.4.1 Researchers' Individual Reflections

Abel Leung, regarding Chinese Background Respondents

"By carrying out the research, I have had a chance to speak with older people openly about mental health. Although initially I was surprised by their understanding of what good mental health is, as I asked more participants, a pattern began to emerge. Usually the views of mental health are linked with physical health. It seems that good mental health is always related to the absence of pain and illness. Pains and illnesses are the main causes of their distresses. Older people - the Chinese respondents - often view good mental health as the absence of illnesses, and neglect the view that it can also be an active and on-going sense of well-being with positive feeling. I don't think it means that older people disagree with, or are not aware of the active side of good mental health, but it might be that physical illness can often de-motivate a person and it can become a big barrier which limits the older people's enthusiasm of living an improved quality life.

In thinking about the solution to this problem, I am glad that the interview itself has other questions that encourage people to think positively. One question asked 'List some activities you do to stay in a positive frame of mind/healthy', and the answers that I got were really surprising, and in a sense refreshing as well, because I suddenly realised that there are actually numerous ways of maintaining good mental health. These are the activities that they suggested

- maintain good relationship with others
- do things one desires
- Exercise

- Talk to others
- Water a plant
- Going for a walk
- Praying to God
- Treasuring other people's love
- Maintaining a good diet
- Keep the environment clean
- Learn to be calm
- Compare with others in a positive way
- Developing a hobby
- Life long learning
- Try to be humorous
- Read books
- Keep in touch with families
- Looking after others
- Watching TV

The one thing that impressed me most is that as each person shared about these activities, I could see a smile on their faces, indicating that they really enjoy doing these activities. By asking these positive questions, the interview had actually become a therapeutic tool and allowed each person to reflect on the positive side of life. This has definitely become one of the valuable lessons I have learned while carrying out the research.

4.4.2 Researcher Reflections

Erina Molla, regarding research with the Bangladeshi Community.

“In the beginning it was difficult to reach the community. We tried to reach them by contacting different organisations, Mosques and community leaders. Finding time for interviews was a problem, with many excuses presented.

As a last resort, the interview questions were posted to some families with a covering note in my own language – Bengali - and only got responses from those respondents quite well known to the researcher. They felt they could not complete the questionnaire because it was too long and complicated for them. I went on a Sunday and helped them. I realized we needed to find other ways to reach this community.

I managed to interview some ladies by going to their own homes in the evenings, as they were happy to do this and they preferred less formal situations. I have managed to interview six people, although in reality some of the questions were not fully completed due to time and other more personal constraints.

The findings show that they have far more basic concerns even before they begin to worry about mental health. For example: not being able to communicate with their doctor. They complained about not having any community interpreters. It will be hard to make them understand mental health as they can't even explain things about their general health. They find going to the doctor is very difficult so they often don't bother; they talk with their family and friends instead of visiting a GP.

I am glad these interviews gave me a chance to help them with their every day English. Once a week I go to a Bangladeshi ladies house where a few other ladies gather to learn English. We together made a list of where they wanted to improve their English. They are now finding it easier as I explain in their own language. More ladies want to join as I don't charge them anything, but ladies with young children are unable to join this class at present due to childcare issues.

To access the Bangladeshi community to gauge their understanding of mental health and services available is a difficult task. Resources that demonstrate the importance of mental health and what the health system offers at present would be useful, as they need to see what mental health really means and what we can do about it. We need to show them the seriousness of this problem and the help that is available.

Better communication seems to be one option. One possible way to do that is share with Mosques and other Bangladeshi organisations the effects of mental health, in a clear message that they can relate to. At present the community doesn't seem to have a clear idea about the state of mental health in Britain: about various conditions, options, effects and treatment available. Due to fairly high levels of illiteracy, pamphlets and booklets in Bengali or English are not passing on the information, as the older members depend mostly on other family members to interpret these to them. Perhaps, the spoken/ DVD/TV/radio media might be more effective, such as adverts, popular drama or similar format on Bengali TV and radio programmes that the respondents can identify with."

4.4.3

Malik Fayaz, regarding research with the Pakistani community.

Until 1971, when East Pakistan became Bangladesh, members of both communities, i.e. Bangladeshis and Pakistanis were considered Pakistanis. In the 1981 census, for the first time, there was a separate figure for Bangladeshis living in Worcestershire. These issues are important in regard to national and cultural identity, and ethnic monitoring for health service providers.

Religion

Religion is believed to be a very powerful force, and for most of Pakistani and Bangladeshi Muslims, it is a motivating factor in their personal existence. **Sunni Islam** is the main religion practiced by 98% of the Muslims locally, meaning that 2% follow other sub sects from within the mainstream Islamic faith.

Cultures/Languages

The majority of Pakistanis and Bengalis tend to adhere strictly to their Muslim culture, which is generally dictated by Islamic faith. Due to the geographical backgrounds of the people, there are some minor yet noticeable variations in life style, family traditions and practices within respective communities. Most Pakistanis living in Worcestershire come from

the “Pakistani controlled Kashmir” Mirpur area, usually speaking Urdu, Mirpuri and Punjabi. The older Worcester Bangladeshi population is mostly from the Sylhet region of the country, and speak Bengali and/or Sylheti- and due to recent history, the older people have a working knowledge of spoken Urdu. Extended family life style is found to be the norm in both communities.

Mental Health Research and Cultural Sensitivities

Due to people’s religious beliefs and diverse cultural elements, mental health issues in such communities are not openly discussed. (WMWA, 2008)]

Generally speaking, mental health sufferers in the communities in question are treated less favourably. In some areas of education and family life, family members are considered the best to care for affected relatives. Mention of the female individual with a mental health condition in most families is a taboo. Other concerns raised in discussions with the community include the decrease in social activities, common interests and communication, and the cultural differences between older and younger generations within families is generally perceived to be a serious concern, and a potential source of mental health difficulties.

4.4.4 Lead Researcher’s Reflections

Sergio Gonzalez

The main focus for the research taking place was finding out whether the respondent community, hopefully representative of the general ethnic/national/language communities, was aware of mental health issues and services available. In addition, identifying any barriers to the communication of this information and suggesting ways of overcoming this problem - or other ways of ensuring good communication between service providers and ethnic communities - seemed a useful direction for the research.

Allocating one day a week to the project meant that at times the whole team was unable to meet due to emergencies, although it allowed thinking and preparation time for research and Support Worker meetings - some of which were also cancelled due to ill health. In hindsight, regular written tasks with strict deadlines could have been asked of the researchers, with the aim of increasing skills and confidence in the written medium. Perhaps workshops and support for more members of the research team to contribute more actively to the report writing might in future projects encourage capacity building in the community.

Finally, the analysis stage of the research would have benefited from more discrete allocation of tasks, as once the raw data had been collected, there were further complications and the team could not meet for a number of sessions. In contrast, this allowed extra time for reflection and individual analysis.

References

Age Concern Herefordshire & Worcestershire (ACHW) (www.achw.org.uk)

Department of Health (2005) Delivering Race Equality
(www.actondre.org.uk)

Worcestershire County Council Hub
<http://worcestershire.whub.org.uk/home/wccindex.htm>

Worcestershire Mental Health Network (info@wmhn.org.uk.)
(<http://www.wmhn.org.uk>)

Worcestershire Mental Health Partnership NHS Trust
<http://worcestershire.whub.org.uk/home/wcc-social-aop-mh-partnershiptrust.html>

Worcestershire Muslim Welfare Association (WMWA)

Additional Information

<http://www.nhs.uk/ServiceDirectories/Pages/Trust.aspx?id=RWQ&v=6>

http://www.worcestershirehealth.nhs.uk/WMHPT/Local_Support_Groups.asp

http://www.worcestershirehealth.nhs.uk/WorcestershirePCT/Compliments_and_Complaints/

Appendices

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Appendix 1: Statement of purpose and terms of reference

Community Engagement Project UCLAN ACHW STEERING GROUP

STATEMENT OF PURPOSE AND TERMS OF REFERENCE

STATEMENT OF PURPOSE

The **CEP UCLAN ACHW Research Project Steering Group** is a partnership of organisations which aims to ensure effective partnership responses are developed and delivered to the mental health needs of Black and Minority Ethnic residents within the local region, via the UCLan/NIMHE Community Engagement Programme.

The steering group follows certain key principles which ensure that at all levels there is an approach which fully involves and includes users/ carers and professionals working together in a spirit of openness and collaboration.

The purpose of the **CEP UCLAN ACHW Research Project** Steering group is:

- To support the development and delivery of the community engagement programme in (name of town/city/region)
- To ensure that the group's work complements local priorities and strategies, and that there is a mechanism for evaluating the findings and recommendations that the group may make;
- To ensure that the community engagement team have genuine opportunities to influence mental health policy and provision locally and to promote mental health and recovery;
- To help and support key individuals who develop extra capacity through the project process continue their involvement in the related field;
- To contribute to the Delivering Race Equality Strategy in Mental Healthcare and its 12 recommendations;
- To work collaboratively with local community engagement team and partners to ensure sustainability after the 9 month period;

TERMS OF REFERENCE

Role and Purpose

1. To ensure that good practice is adhered to in relation to ethical issues such as: informed consent, confidentiality, anonymity, data storage, risks to researchers, risks to participants, incentives and payments, vulnerable groups and diversity issues
2. To ensure that the research fits with local priorities, ensuring that findings and recommendations of the work are taken forward and that opportunities for sustainability are maximized
3. To ensure that the steering group meets its specific duties during the project life, these include:

Timescale (As appropriate, e.g.)	Objective
June/July	Develop defined focus for the research and input to ethical issues. Approve ethics form for submission to UCLan Ethics Committee
August	Give Input and final approval to draft research tool (e.g. questionnaire, topic guide.)
Sept/Oct	Offer appropriate assistance to help access respondents as required by the research team.
Nov/Dec	Offer review/feedback of analysed data
January	Offer review/input to report (especially recommendations and commissioning ideas).
	Approve final draft report.
From March	Give input and support to launch of findings

Membership and Accountability

4. All work of the CEP UCLAN ACHW Steering Group will adhere to those principles stated in the action plan "Delivering Race Equality in Mental Healthcare"
5. The Steering Group also has the authority to co-opt other stakeholders/special advisers as and when necessary.
6. The Chair of the Steering Group, Mrs Meryl Johnson-Mair, has been drawn from the membership.

Structure

7. The Steering Group will meet on a six to eight - weekly basis for the duration of the community engagement programme and quarterly thereafter; with the option of agreeing additional meetings should it be required.

8. ACHW will service the Steering Group. Agendas and any associated papers will be sent out in advance of the meetings, affording members the opportunity to consider the issues beforehand. Minutes will be sent out as soon as possible after the meeting.

Reference: These terms of reference have been adapted from the work produced by Somerset Racial Equality Council. Thanks and acknowledgement to those who worked on compiling the original.

Appendix 2: Steering Group Membership

The membership of the **CEP UCLAN ACHW Steering Group** will consist of the following representatives:

- Magda Prail,
- Chief Executive, Age Concern Herefordshire & Worcestershire
- Meryl Johnson-Mair,
- Lead for Corporate Diversity and Equality, Worcestershire PCT.
- Sue Reynolds, Manager, Older Adults, Worcestershire Mental Health Partnership Trust NHS
- Logan Mailvaganam, Race & Diversity Officer, Worcestershire Mental Health Partnership Trust NHS.
- Sofia Jabeen, Corporate Diversity and Equality, Older People's Services Worcestershire County Council,
- Elizabeth Lloyd, Chief Officer, Worcestershire Association of Carers
- PC805 Jim Harris, Diversity Liaison Officer, West Mercia Constabulary
- Jackie Threshie, Practice Facilitator for Older People, Worcestershire Acute Trust
- Sergio Gonzalez, CEP UCLAN ACHW project
- Peter Oteng, Manager, (WREC) Worcestershire Racial Equality Council
- Sarah Edwards - Locality Manager, Worcestershire Mental Health Partnership NHS Trust
- Rachel Porter- Network Development Officer, Worcestershire Mental Health Network
- Superna Makwana- Worcestershire Carers Unit
- Kate Glenholmes, Clinical Manager, Primary Care Mental Health Services, Worcestershire.
- Ms Sam Whitby, WMHT Research Governance Group.
- Kate MacCormac, Worcestershire Mental Health Network (WMHN)

NAME OF MEMBER	JOB TITLE/ORGANISATION
Race Equality Lead (Name)	Mrs Ranjit Senghera
UCLAN Support Worker (Name)	Mrs Nasreen Akhktar/ Mrs Samena Akram
FIS Manager (Name)	Loretta Fuller
Project Lead/Co-ordinator	Magda Prail
Community Researchers (NB can be rotational) (Name/s)	Mr Sergio Gonzalez- Lead Mr Malik Fayaz, Mrs Arifa Nadeem, Mrs Erina Molla Mr Abel Leung

Appendix 4: Original questionnaire – BME interviews and Service provider interviews



“Are Black and Minority Ethnic communities in Worcestershire appropriately supported by, and well-informed about, the health system in relation to mental health services. “

Semi-structured Interview administered by Age Concern Herefordshire & Worcestershire to Black and Minority Ethnic communities’ individuals aged 50 and over. This research is part of the Delivering Race Equality program - NIMHE/ CSIP in conjunction with the University of Central Lancashire (UCLAN).



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INSTRUCTIONS TO RESEARCHER CARRYING OUT THIS INTERVIEW

Establish an agreed meaning of mental health and well-being.

Allow respondent thinking time, then use prompts, and tick wherever appropriate.

Add any additional questions asked must be written on the page (although voice will be recorded)

If respondent attended more than one type of secondary referral or alternative treatment, use a second questionnaire to record this information.

CEP UCLAN bme questions DRAFT 17 (04/01/08).

1A) What is your understanding of health and well being?

(Discuss general health, mental health, mental ill-health.)

.....
 ...

Prompts:

- generally feeling happy/ positive/satisfied/able**
- feeling able to handle everyday stress and routines**
- feeling in control of life/emotions**
- enjoying or coping with family life**

List some activities you do to stay in a positive frame of mind/healthy

.....

1B) Are you aware of any symptoms of problems with mental well-being?

- Yes No

For example:

- not sleeping well,**
- anxiety (constantly worried)**
- anger**
- memory problems**
- other**

If you said yes, we would find it useful if you could describe, in your own words, what types of difficulties you think people generally experience regarding their mental well-being:

.....
 ...

 ...

 ...

2.How would you treat yourself if you are not feeling mentally well?

.....

- rest/sleep
- exercise
- tablets
- recreational activities
- alcohol
- other (please state:)

Comments

.....

3. Have you ever talked to anyone about your mental well-being?

- Yes (please answer section 3B)
- No (please answer section 3A)

3A (for those who answered No)

(i) Please describe, in your own words, what you do to cope when you are feeling mentally unwell.

.....

3A (ii) Have these actions above been successful in resolving your mental health issues?

- Yes
- No

Has this worked for you?

Comment:

.....

3A (iii) If ever you need to speak to someone about your mental well-being, which person are you most likely to choose? (just imagine who you would choose)

- family member/s
- friend/s
- faith leader – details please
- alternative therapist (Chung Yi (Chinese doctor), Hakeem, etc.)
- other (please state):

.....

3A (iv) Please describe, in your own words, the reasons for your selection:

Can you give me some reasons why you would choose that person?)

.....

3A (v) Would you ever seek support from your GP in relation to your mental well-being?

(Would you ever go and see your GP about your mental health?)

- Yes No

Please explain, in your own words, the reasons for your answer:

.....

 ...

3B. (if you answered Yes to Qn 3)

3B (i) Who did you speak to about your mental well-being?

- family member/s
- friend/s
- faith leader – please specify
- alternative therapist (Chung Yi [Chinese doctor] , Hakeem, etc)
- other (please state):

Please explain, in your own words, the reason for selecting this person:

.....

 ...

3B (ii) Would you ever seek support from your GP about your mental well-being? Yes No

Please explain, in your own words, the reasons for your answer:

.....
.....
.....
.....

3B (iii) What kinds of help or support are most important to you in relation to your mental well-being?

Prompts:

- listening
- giving advice,
- Taveez
- Encouragement
- other

Comments

.....
.....
.....
.....
.....

3B (iv) Could you describe some causes or reasons for not feeling mentally well?

Prompt/ask for further comments, but not in detail:

- not sleeping well,
- anxiety
- anger
- bereavement/ loss
- physical health, etc,)

being a carer (for family/friend)

community issues

financial issues

others

.....
.....

3B (v) Did you manage to resolve your mental health issues through seeking support?

Yes No

Comment:

.....
.....
.....
.....
.....

QUESTIONS ABOUT SERVICE PROVIDERS (PRIMARY CARE)

If you visit/visited a GP surgery:

4.What is your experience of visiting gp (doctors) surgeries?

(How do you feel about visiting your GP?)

Prompts:

the appointment booking system

the location (parking,traffic,etc.)

the atmosphere

the office staff

the medical staff

other comments:

.....
.....
.....

5. Have you had any communication difficulties in contacting and dealing with the NHS? (do respondents understand the term NHS can also include primary, secondary, acute and GP surgeries?)

Yes No

Comments:

Prompts:

language (access to an interpreter, communicating with people, etc.)

culture,

general enquiries,

names,

acronyms,

contact numbers,

work titles,

location,

others. Please state.....

Comments:

.....

6. Did the GP...

<p>seem helpful and genuinely interested in your problem?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/></p>
	<p>By listening to you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>Comments</p>
	<p>Giving advice or reassurance?</p>
	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p>

	<p>.....</p> <p>.....</p>
<p>diagnose your situation/condition?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diagnosis (optional)</p>
<p>offer any treatment ?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Prompts:</p> <p><input type="checkbox"/> Counselling</p> <p><input type="checkbox"/> Medication</p> <p><input type="checkbox"/> were you supported for sufficient time (days/weeks/etc) until your mood improved?</p> <p>Other comments/suggestions:</p>
<p>ask you about how your physical condition is affecting the way you feel emotionally?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Prompts:</p> <p><input type="checkbox"/> Low mood</p> <p><input type="checkbox"/> anxious</p> <p><input type="checkbox"/> stress</p> <p><input type="checkbox"/> other (please state:)</p> <p>Other comments/suggestions:</p>

<p>refer you to other specialists/to someone else?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prompts:</p> <p><input type="checkbox"/> Gateway Worker</p> <p><input type="checkbox"/> Qualified nurse, etc</p> <p><input type="checkbox"/> Psychologist</p> <p><input type="checkbox"/> Psychiatrist</p> <p><input type="checkbox"/> Other – medical/ non medical</p> <p>.....</p>
<p>..inform you about any future action (what to expect next) ?</p>	<p>Verbally <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pamphlets or leaflets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other ways <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>...inform you about any alternative therapies available?</p>	<p>Verbally <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pamphlets or leaflets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other ways <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type of alternative?</p> <p>.....</p> <p>.....</p>

7. Were you satisfied with the service/ treatment?

Yes No

Comments:

.....
.....
.....
.....
.....

8. Please select one of the following ...

A. **If you received any** alternative treatment, **go to** question 14 (on page 15)

.....

B. **If you received** no treatment **at all...**

Can you give me some reasons for this? What stopped you?

Prompts:

Missed appointment/ referral?

Other reasons.

What has been happening since?

Now go to questions 19-28.

.....

C. If you followed up the GP's referral to secondary care (may need to explain this), Please continue with questions.

SECONDARY CARE SERVICES (Please state whether MH referrals or not)

9. Who referred you to this service?

gp

other professional . Please state

.....

10. Was the first appointment/process to your satisfaction?

Yes No

Comment:

.....
.....
.....

Prompts: reception staff, time taken.

11. Have you had any communication difficulties in contacting and dealing with the NHS? (do respondents understand the term NHS and that it includes primary, secondary, acute and GP surgeries?)

Yes No

Prompts:

language (access to an interpreter, communicating with people, etc.)

culture,

general enquiries,

names,

acronyms,

contact numbers,

work titles,

location,

others. Please state.....

Comments:

.....
.....
.....
.....
.....
.....

12. Did the [secondary practitioner- please state which] ...

<p>seem helpful and genuinely interested in your problem?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure</p> <p>By listening to you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p> <p>Giving advice or reassurance?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Comments</p> <p>.....</p> <p>.....</p>
<p>diagnose your situation / condition?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diagnosis (optional)</p>
<p>offer any treatment?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prompts:</p> <p><input type="checkbox"/> Counselling</p> <p><input type="checkbox"/> Medication</p> <p><input type="checkbox"/> were you supported sufficient time (days/weeks/etc) until your mood improved?</p> <p>Other comments/suggestions:</p>
<p>ask you about whether your physical condition is affecting the way you feel emotionally?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prompts:</p> <p><input type="checkbox"/> Low mood</p> <p><input type="checkbox"/> anxious</p> <p><input type="checkbox"/> stress</p> <p><input type="checkbox"/> other (please state:)</p> <p>Other comments/suggestions:</p>

<p>refer you to other specialists/to someone else?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prompts:</p> <p><input type="checkbox"/> Gateway Worker</p> <p><input type="checkbox"/> Qualified nurse, etc</p> <p><input type="checkbox"/> Psychologist</p> <p><input type="checkbox"/> Psychiatrist</p> <p><input type="checkbox"/> Other – medical</p>
<p>inform you about any future action (and future effects of the treatment)?</p>	<p>Verbally <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pamphlets or leaflets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other ways <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>inform you about any alternative therapies available?</p>	<p>Verbally <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pamphlets or leaflets <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other ways <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Type of alternative?</p> <p>.....</p>

13. Were you satisfied with the service/ treatment?

Yes No

Comments:

.....

ALTERNATIVE THERAPIES- HAKEEM/ ACUPUNCTURE/etc.

(Please state which)

.....

14. How did you find out about this [alternative treatment to standard medicine]?

Prompts:

- family,
- friend,
- faith leader (Imam, priest, etc.) Please specify.
- media
- other. Please state

.....

15 . Please describe your experience of visiting this
[alternative medicine] practitioner?

Prompts:

- the booking system
- the location (parking,traffic,etc.)
- the atmosphere
- the office staff
- the practitioner
- other comments:

.....

.....

6. Were there any communication problems, such as language, etc.?

Yes No

Comment:

.....

17. Did the [alternative practitioner] ...?

<p>seem helpful and genuinely interested in your problem?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure By listening to you? Yes <input type="checkbox"/> No <input type="checkbox"/> Comments... Giving advice or encouragement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Comments</p>
<p>diagnose your situation / condition?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Diagnosis (optional) </p>
<p>offer any treatment and explain its effects?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Prompts: <input type="checkbox"/> Counselling <input type="checkbox"/> medication Other comments</p>

<p>ask you about whether your physical condition is affecting the way you feel emotionally?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Prompts:</p> <p><input type="checkbox"/> Low mood</p> <p><input type="checkbox"/> anxious</p> <p><input type="checkbox"/> stress</p> <p><input type="checkbox"/> other (please state:)</p> <p>Other comments/suggestions:</p>
<p>refer you to other specialists?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/></p> <p>Prompts:</p> <p><input type="checkbox"/> GP (General Practitioner)</p> <p><input type="checkbox"/> Other</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>inform you about what your condition means and possible future effects?</p>	<p>Verbally <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</p> <p>Pamphlets or leaflets <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</p> <p>Other ways <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</p>
<p>inform you of any alternative therapies available?</p>	<p>Verbally <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/></p> <p>Pamphlets or leaflets <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</p> <p>Other ways <input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No</p> <p>Type of alternative mentioned?</p> <p>.....</p> <p>.....</p>

18. Were you satisfied with the treatment/ medication/ service /etc?

(Was it effective?)

Yes No

Comments:

.....
.....
.....

My Situation at the Moment

19. Do you have anyone who can look after you if you are unwell?

Yes. **Please continue.** No.

If yes, please state

Prompt; carer, family, friend, other.....]

Comments:

.....
.....
.....
.....

20. Do you have a carer/someone to accompany you to GP visits, referrals, or alternative practitioners?

Yes No

Comments:

.....
.....
.....

21. [if applicable] Would your carer/ family/friend know who to contact if you are unwell?

Yes No

Comments:

Prompt:

Has this happened before?

What was the outcome?

Comments:

.....
.....
.....
.....

22. Are you aware of any of the following support and information contacts:

- NHS information (leaflets, etc.)**
- Worcestershire Hub number**
- Access Centre number (Adult and Community Services)**
- Age Concern (various offices/centres)**
- Advocacy services (various)**
- WMHN office**
- Support groups**
- Websites (NHS, WMHN, etc.)**
- other community groups and associations**

Other:

.....
.....
.....
.....

23. Do mental ill health issues affect your life in any way these days?

- Yes
- No

Comments:

family

friends

neighbourhood

workplace

other

.....
.....
.....

24. Have you used any mental health services lately?

Yes No

Comments:

.....
.....
.....

25. What is your attitude to mental ill health in our society?

Positive Negative Neutral Unsure

Comments:

.....
.....
.....

26. Are you aware of the effect of caring for people who are not feeling mentally well?

Yes No

Comments:

.....

27. Do you feel you need to know more about mental ill health and mental well being?

Yes No

Comments:

.....

28. Do you know where to find out information about mental health/well being?

Yes No

Comments:

.....
.....
.....
.....
.....
.....

NOW PLEASE ANSWER UCLAN’S MONITORING CORE QUESTIONS.

UCLAN Core Questions:

1.1 Age last birthday:

1.2 Gender: Male
Female
Tran gendered

1.3 Ethnicity: White British
Irish
Other (please explain)

Mixed White and Black Caribbean
White and Black African
White and Asian
Other (please explain)

Asian or Asian British Indian

- Pakistani
- Bangladeshi
- Other (please explain)

- Black or Black British Caribbean
- African
- Other (please explain)
- Chinese or Other Group Chinese
- Other (please explain)

- 1.4 Were you born in the UK:
- Yes
 - No

- If no, how long have you lived here:
- Less than 1 year
 - 1 – 5 years
 - 6 – 10 years
 - 11 years or more

- 1.5 Are you a:
- British Citizen
 - Refugee
 - Asylum Seeker
 - Other (please explain)

1.6 What is your first language?

Spoken or signed:
.....

Written:
.....

1.7 Which languages are you fluent in?

Spoken or signed:
.....

Written:
.....

- 1.8 What is your religion: None
- Christianity
 - Buddhism
 - Hinduism
 - Judaism
 - Islam
 - Sikhism

Other (please explain)

1.9 Sexuality:

Lesbian or gay woman

Homosexual or gay man

Heterosexual or straight

Bisexual

Do not wish to answer

Other (please explain)

1.10 Do you have a disability:

Yes (please explain)

No

Appendix 5: Some Interview Responses

Responses to Question 1A. What is your understanding of mental well being?

1. Can move around, feeling happy, no illness, feeling bright
2. Physically feeling comfortable. Feeling no pain at all. I feel healthy when I can eat and walk. And I feel mentally well when I can sleep properly.
3. No pain, no sickness. Feeling calm, no worries, being able to talk to each other in a relax way
4. Feeling happy, sleeping well, being able to move around
5. I'm aware of the differences between mental and physical health. To be physically healthy, there must be no illness, no dizziness, and no pain in the body. As for being psychological healthy, one should have good memory, feeling bright, being able to control emotion, not easily angered, always happy, don't worry about things.
6. No illness
7. Feeling bright, no illness, each part of body working properly. Feeling positive, don't "think ourselves into a dead end". I can see a distinction between health and enjoyment. A person on a wheel chair can also enjoy, but it doesn't mean that they are physically healthy.
8. Being able to sleep well, eat well and feeling bright. No illness, loving, and communicate well.
9. No illness, no pain, can read books, feeling excited, can talk other people.
10. Healthy means no illness, no pain. Usually people over 65 will start to have some sort of illness such as high blood pressure. Good mental health would mean that a person need to be feeling bright, sociable, out going, and caring for each other.
11. Being physically fit to do things is a real mental health
12. Being in good health and in control of life and emotions; a happy and secure family environment; having a sound job.
13. Someone who is healthy. The best pastime and path to mental peace is prayer.
14. Can cope with daily routine of life. Enjoy a quality life.
15. Generally feel ok. Able to handle everyday stresses.
16. Coping well with routine work.
17. When I am behaving well, eating and sleeping well.
18. When I am mentally and physically in control. Dealing with others and satisfied.
19. No illness
20. Feeling positive, want to go out, meet people.
21. No medication, being independent, being satisfied.
22. Very hard to get answer from this client. She says she is unwell since very long and she is unable to understand well being. According to her mental health and well being are related to each other. If we are physically ill we can never feel well mentally]
23. Feeling fit physically and mentally.
24. Able to cope physically and emotionally.
25. Feeling physically fit to go out, to read books and enjoy life.
26. Being satisfied with your self and have no physical or financial issues.
27. If we do not need to visit doctor's frequently.
28. When we are able to cope and feel satisfied.
29. Feeling happy and positive.

Responses to 1A Prompt 5:

I think maintaining a good relationship with other people, such as my husband, is very crucial in staying positive, but I feel that I am not in this kind of state at the moment.

Don't just sit still, try to do whatever I want. But I know I am limited. I can't do many things because I have difficulties moving around.

Doing Exercise, water my plants, talk to my neighbours, and going out to the city.

Praying to God, positive thinking: e.g. when I feel that my daughters are not with me, I will feel a bit down, but when I feel that there are people who care about me and they're still around, I will feel better.

Maintaining a good diet, and keeping myself in a good and clean living condition. Sleep well, be quiet and calm. Don't go to places where there are a lot of germs

I will compare myself with other people in a positive way, in a sense that I feel I have a better life than other people. Also, many people have worse life than me. Though many people live better lives than me, it doesn't bother me at all. I will also try to know more friends who we can share our lives with. I will listen to other people, because it provides room for me to think. I will find more hobbies, doing art and crafts, writing calligraphy, going out, and study English.

Communicate well with others, can be humorous, play ma jong, do exercise.

Read books and talk with other people.

Talk with other people

Keeping in touch with family, keeping fit by daily exercise.

Offering prayers, attend social function.

Exercise, walking, reading, learning about different religions and praying.

Housework, cooking, walking daughter to school, watching television, praying.

Hard work. Enjoying family life.

Try to keep myself involved in different activities. Do some voluntary work go out meet people.

Older lady hard to understand. She has never been out of her place on her own .she is totally dependent on her sons.

Talk to family .go out and sometimes shop around. Eat healthy.

Doing Exercise, water my plants, talk to my neighbors, and going out to the city.

Older lady , talks a lot .has dementia, diabetes, arthritis, depression and many other problems.

Healthy eating, walking , voluntary work.

Take bath, dress up, meet friends, do shopping and say my prayers.

Talk to family. do some gardening (she grows a few vegetables) and go out.
Talk to family, visit friends and family.

Go out, come to lunch club. talk with other people.

Try not to worry. Keep my faith strong that anything could happen and I am just a woman.

Offering prayers, attend social function

Watch my favourite tv channel and cook my favourite dish and eat well and sleep well.

Love to see my grand children, feed them and play with them.

Join other activities clubs and voluntary organizations. Try to help others who are having some mental health problems.

Read, pray, walk, visit family and friends and look after grandchildren.

Question 2: “How would you treat yourself if you are not feeling mentally well?”

Response Categories

- a) distract their thoughts from themselves and their present problems.
See responses 2, 5, 15, 20, 21, 24,
- b) keep up and develop social networks
See responses 1, 6, 7, 8, 11, 13, 16, 18, 19, 22, 27,
- c) help them keep a physically and mentally active schedule.
See responses 4,8, 10, 11, 19, 27,
- d) keep their spirits up or help them keep calm and relaxed
See responses 9, 26,
- e) just manage or cope with their condition/present situation
See responses 12, 14, 17, 26,
- f) involve seeing a GP:
See responses 14, 17,
- f) not sure:

See responses 3, 23, 25,

Responses to Question 2.

1. Talk to others
2. I would have lot of sleep. I will keep myself very busy and mainly go out to the market and buy stuff. If I stay at home, I will do housework and not to think about the problem that make me sad.
3. I don't know, I can't sleep well, can't do what I want. It will be a difficult time for me.
4. Water plants, go out to city, speak to other people, do exercise, don't rely on medication, boil soup
5. Physical problems can affect mental well being. When I had to have an operation, I had many thoughts. I don't know when I am going to die and I felt a bit worry, but when I start giving it back to God, I got over it.
6. Go and see other people, talk with others, watch TV
7. Talk to friends
8. Want other people to talk with me more, especially my husband, and take me out and walk around.
9. Sleep 8 hours, exercise, get support from children, talk to friends and deal with the problem.
10. Exercise, visit friends, walk, talk to myself, pray.
11. Recreational activities, socialise, attend clubs and forums.
12. [Tablets only listed.]
13. Go out, talk to others , shop around.
14. See GP, take medication.
15. Go shopping , talk to my husband, do crosswords.
16. Talk to family and friends, although they are tired of this whole issue.
17. Take tablets ,see GP and go out for a change.
18. Go and see other people, talk with others, watch TV
19. Talk to friends, do knitting.
20. I try to change the place ,go to some other house to stay with my other children.
21. Sleep , go out , watch tv.
22. Go out talk to friends, invite friends at home.
23. Confused, mixed up with other domestic issues].
24. Go out, watch tv, occasionally take some sleep.
25. Does not explain, crying shouting ,self pity]
26. Try to sleep ,take medication.
27. Taking interest. Self push to get active and go out.

Responses to **Question 3A(i): "Please describe, in your own words, what you do to cope when you are feeling mentally unwell."** fall under the following categories:

1. I choose to keep it to myself and not tell anyone, because I feel that the more I speak, the more mistakes I will make and that will create argument.
2. N/A
3. N/A
4. pray

5. No one can understand me. I use self motivation technique. Back in the old days, I must help my mother and bring up my daughters. People will look down on me, there's no use talking with them, I must rely on myself and turn stress to strength.
6. : N/A
7. : N/A
8. : N/A
9. : N/A
10. : N/A
11. : N/A
12. : Watch TV, etc
13. : N/A
14. : n/a.
15. Take two tablets.
16. Try to go to social gatherings and visit friends.
17. n/a
18. dna.
19. dna.
20. Take medicine, try to sleep. Get involved with family.
21. Say prayers, ask family to pray for me and take medicine.
22. Talk to my husband, discuss family and financial issues. See doctor if needed.
23. Stay at home, do not speak. Take food and tea. Watch tv.
24. Always try to speak to my children but no one is ready to listen. Some times start crying. Take medicine and rest.
25. When really depressed just stay at home. Keep quiet, occasionally crying is helpful.
26. dna.
27. dna.
28. Say prayer, meet family or friends.
29. dna
30. dna
31. dna.

Responses to Qn 3B iv: comments re reasons for ill mental health.

'For me, causes of bad mental health are being anxious of falling, and loneliness'

'Thinking too much negative things. Eg. no family around, too much sickness. Comparing with other people more healthy and wealthy people.'

'Lack of communication with others'

'The problem does not happen overnight. It's due to lack of communication.'

'A sound job.'

'Social issues, work tension also count.'

Responses to Question 4:

Negative

1. I feel worried whenever I receive letter from GP, their letters are indication that I have a problem and I need to see them. I know nothing about the surgery system so I can't describe my experience with staff,

- because I know nothing about what other people are saying.
2. There good and bad GPs. The good ones check me thoroughly, and ask me about details. The bad ones just test my blood pressure and off I go. There was one time when I hurt my back. All that the GP did was just to check my reflex, ask me a few question and that's it. I didn't receive any tablets.
 3. Sometimes I worry about the arrangement, whether interpreter will come or not.
 4. Generally it's ok, but sometimes I have long waits in the surgery.
 5. Sometimes appointments are cancelled without client's knowledge
 6. Location and office staff can be a problem sometimes
 7. Booking and language
 8. Booking, time and language.
 9. Miserable, never get satisfaction. always wanted to communicate and express about my stresses and illness. shortage of time is another issue.
 - 10.Booking system is very unreasonable. do not feel comfortable
 - 11.Language is a problem. I can't communicate in English
 - 12.Only problems with appointment booking system.
 - 13.Cannot see GP without appointment.
 - 14.Appointments not easy. Waiting at surgery is annoying. staff usually not cooperative.
 - 15.Communication is an issue
 - 16.Appointment booking system is a problem. Still waiting for long periods of time is unsatisfactory
 - 17.OK but do not understand what kind of help will be useful for me.

Positive

1. All is fine but with interpretation GP are generally nice and has solved my problems. GP can find interpreter who can drive me home. The surgery's atmosphere is good. Not too far. Staff are very courteous.
2. From my experience, they're quite good. My GP who is also a friend of mine, and we have kept a very good relationship.
3. No problem
4. Very satisfied with the service. The GP is concern with me and I feel being cared for.
5. Yes, very helpful. Everything is very near and convenient, and staff are helpful.
6. My GP is excellent, caring, a good listener and shows empathy. I am happy.
7. I have no problems with my GP.
8. Found GP service always very satisfactory.
9. Do not have any problem. No complaint at all.
- 10.Need to visit my GP regularly. I do not have any problem with the services so far.
- 11.Good but language is a problem.
- 12.Language
- 13.Very happy the surgery is open and we can go anytime.
- 14.It's fine.

Responses to Question 6 Prompt 1:

RESPONSE	LINK TO 17 RESPONSES BELOW	PERCENT (%) of No. RESPONDED	PERCENT (%) of TOTAL SAMPLE
YES	3, 5, 11, 12,	24%	10%
NO	1,7, 10, 13, 16, 17.	35%	13%
UNSURE/MIXED	2,4, 6, 8, 9, 14, 15,	41%	18%
DID NOT ANSWER	23 people	N/A	58%

1. [The GP]Just tell me that I have certain condition, like high blood pressure. And tell me what to do. Didn't give me any advice or try to understand me. He threaten me that I will go blind if my blood pressure is high, but who wouldn't have high blood pressure unless they loss all their blood? I don't feel good at all.
2. I don't know what the GP is thinking. Whatever GP said, or ask I will just respond.
3. Yes, the GP told me that the treatment should be fine. Only take the medication when required. GP also told me about the treatment process.
4. I can't tell because it's all up to the interpreter.
5. Yes, good advice and very reassuring. He told me that everything is fine. They will check on me if they don't see me for a long time. Reassure me that things will get better.
6. Yes, but they do not have the initiative to ask about my psychological well being. They just enquire about my physical side. I think GP's word is very reassuring in itself. Let's say if a person see something strange in his/her body, they will feel worry. But if the GP say the person is ok, then the person will feel better right away. GPs' words have authority, which is why if they take an extra step to look at psychological well being, it really will make a difference.
7. Not very reassuring. I feel that more can be done. GP should not just see me for a while and give me medication.
8. I can't be 100% sure, because of the language barrier
9. Some GP are very good. They will do a complete check on me, such as checking my body temperature and heartbeat, but some bad GP here will just ask me or just look at my tongue. I find that very disrespectful and they are not interested in me. When I say I am unwell, the GP should detect the problem through different equipment; that would be reassuring.
10. Sometimes GP are not helpful to our satisfaction.
11. Yes, they are reassuring
- 12. Yes, bilingual GPs are very helpful**
13. Always have communication issue.
14. Language problems.
15. Someone else needs to speak on my behalf, not sure.
16. GP tries to reassure but it is of no benefit for me as I do not know what he/she is saying. Medication is repeatedly going on and problem is unchanged.
17. Long time medication is going on and no change.

Responses to Qn 6 Prompt 8:

8. No, the GP won't explore how my physical condition is causing me low mood, anxiety or stress

9. No, see above

10. No. Sometimes when I feel unhappy I want to talk to someone. But GP did not offer anything.

11. No, it will be good if I am offered a counsellor or psychologist. I think it's necessary. No doctor will ask me whether my cough will affect my daily life, or whether it will make my mood low. I want to have a GP who will look at my feeling, to give me extra advice on daily living, and to find a suitable medication for me after an assessment.

12. No

13. No, but I think there are many factors to it. Sometimes it depends on the interpreter, sometimes it depends on GP initiative, and it depends on the expressiveness of the client as well. GP usually just tell me what causes the problem, and ask me how the medication affects me. But my personal view is that if this is all that the GPs do, it won't help a lot, but if the GP can bring **me and my family more together**, that will definitely help.

14. No, but I guess it's because I can't communicate with the GP. I don't want to waste other people's time. But even if there's communication, it's between GP and the interpreter. But if the GP spend some quality time and explain to what causes the problem, how it can be recovered, and how I am feeling, I will definitely feel more reassured.

15. I think the interpreter might not be too appropriate sometimes because I might have missed something what I want to say. **It's better to have an advocate who knows me.**

16. No. It will help if GP look into my feeling, because GP's word is very reassuring.

17. No. When I'm ill, I won't think about my own psychological well being, and most of the time I don't have the knowledge to express it. It might not have come to my mind at that very moment, but if GP initiate this topic, then it will make me more aware, and I will speak more. So GP should initiate this. It will be helpful if GP can refer people to counseling. The more people involve the better. And this definitely will make a positive difference. GP should ask more questions and investigate why the problem occurs, and see if there is a psychological cause to it.

QUESTION 13 RESPONSES:

RESPONSE	LINK to RESPONSES (14 in total)	PERCENT of THOSE RESPONDED	PERCENT(%) of TOTAL SAMPLE
Yes	4, 13,	2/14= 14%	5%
No	1, 2, 8, 9, 10, 14,	6/14= 43%	15%
Unsure/Mixed	3, 5, 6, 7, 11, 12,	6/14= 43%	15%
Did not answer	26 people	n/a	65%

1. I feel anxious as I don't know what the first appointment is all about. I don't know whether I will have cataract operation in my first appointment and no one has ever explain that to me

2. No. It's again communication problem.
3. I was in such a critical state that I could not realise how it was. At that time I was suicidal and self harming.
4. Yes, kind of satisfied.
5. I feel more satisfied when it's a Chinese professional.
6. I felt lonely during the process, but I was treated. So I am ok now.
7. I don't know, but I have a good interpreter. I feel that they're very responsible and arrive on time.
8. No, the surgeon refused to speak to me.
9. No. They can't even meet my simple need such as requesting a cup of hot water, they said only cold water are available. I feel that language is a big problem.
10. I tried secondary care before, but it's has no effect for me. No real success to the treatment to my issue.
11. I am taking medicine. I do not know what satisfaction is.
12. yes but for how long I have to go through this.
13. yes ,it was wonderful at that time because my muscles and nerves were very relaxed after massage.
14. ; No, they did not realise how severe my case was and because of this misjudgement [misdiagnosis] I went through all unpleasant experiences. But my problem has never been addressed.

Question 20: "Do you have a carer/someone to accompany you to GP visits, referrals, or alternative practitioners?"

Responses to Question 20:

1. Yes, usually neighbours.
2. People from Chinese community centre take me to GP.
3. Support workers help me to book the interpreter.
4. Support workers help me to arrange and my daughter will accompany me.
5. Yes, my husband will accompany me.
6. Yes, my wife will accompany me
7. Yes, family and friends
8. Yes, always family members
9. no, there are no bilingual carers available to accompany people to GP
10. No. I live on my own. Son studying, however, visits to GP are no problem - just take a taxi or walk.
11. Don't need it.
12. A family member. .
13. Do not need a carer.
14. Only family
15. Have family but they do not have enough time.
16. Have to make arrangements in advance if situation arises.
17. Grand children feel embarrassment if they have to accompany me to the doctor
18. No family- no carer. Living alone
19. No comment [actually this is a problem, as family are too busy to help]