

National Institute for Mental Health in England-NIMHE
BLACK AND MINORITY ETHNIC MENTAL HEALTH PROGRAMME

Bedfordshire African Community Centre
Known as “BACC”

AFRICAN REFUGEES, ASYLUM SEEKERS AND NEW MIGRANTS
MENTAL HEALTH PROJECT IN LUTON

COMMUNITY ENGAGEMENT PILOT PROJECT

FINAL REPORT

Supported and sponsored by



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Project Team

Mr. Bony N. Shamalo (Project-Coordinator)

I am Bony Ndjov-a-Shamalo; I am 46 years old and I work as the Centre Co-ordinator and the Project Manager. I have experience of working with African refugees, asylum seekers and new migrant families both in the UK and other European countries for over 14 years. I have been with Bedfordshire African Community Centre since inception. I saw the need to take up a project on mental health based on my work experiences and findings with Africans living in Luton and Bedfordshire areas. Little did I know the seriousness and gravity of the mental health issue in the African community when the project started. After the research I am now convinced and aware what the large public knows about the mental health issue within the African community is just the tip of the iceberg. I am fluent in many languages included: Kikusu, Swahili, Lingala, French, Swedish and English.

Joshua Muhindo (Researcher)

I am Joshua Bendelitsa Muhindo. I am 35 years old and I was employed in this project as the Assistant Co-ordinator. I am currently studying at London Professional Studies for a MBA degree. I came into this project with skills and knowledge acquired from my previous experiences in research and recruitment in the Mayisha II project (an African Sexual Life study and the Adventist Development Relief Agency). I am fluent in three languages: Swahili, Luganda and English.

This research has helped me understand fully the need of an impending action to address the mental health issues within the Black African community as rapidly as possible.

Charlton T. Mandayaya (Researcher)

My name is Charlton Takunda Mandayaya and I am 26 years. I have a wide background in research and information management systems. I found myself in this project because I am fluent in Shona and English. But later on, I became strongly involved as I started to learn a lot from the course on mental health then on the research ground as I was employed as a researcher. I did not know that racial inequality could affect people's mental health. But I was good at meeting people in their milieu. My understanding of mental health has changed ever since I completed the research.

Horace Nyirenda (Researcher)

I am Horace Nyirenda and 38 years old and worked in the project as a Lead Researcher. My experience is mainly working with the youth in church and help teaching them. For this project, I was responsible for organising meetings, rehearsing with other support workers and surveys. I also wrote the methodology section of this report.

One of my major strengths is listening to people. I have extensive years of experience in teaching youths at schools and in church level. I have been involved in voluntary sectors

for many years. My experience as a pastor and a teacher has helped me to deal with mental health issues. But I must confess that this project has left me speechless in front of the threat that mental health constitutes. Moreover, I am astonished by the percentage of people who did not know that they are suffering from mental health problems.

Violet Mutambirwa (Researcher)

I, Violet Mutambirwa 26 years old started to work as a volunteer for the Bedfordshire African Community Centre. I have just been in to United Kingdom to join my family, I did not know much about the mental health problems facing the African community in the UK. The fact that I was a woman and that I was fluent in both English and Shona has helped me reached a greater percentage of people.

My knowledge of mental health issue has increased a lot. I put aside my wrong definition of mental health and was able to help people to really understand what mental health is all about. I think this is very important for a researcher to understand mental health and in order to carry out successful research.

Iffrah Hirsi (Researcher)

My name is Iffrah Hirsi and 43 years old. I worked on this project as a researcher and currently working in Somali Women Centre located in Luton. I had previously worked for the Somali refugees and asylum seekers in Holland. Even though I came to this project with a wide experience working with women who were suffering from the aftermath of the horrible war in Somali, I must confess that the project was a grand opportunity for me to understand the whole issue on mental health. It is wider and larger than what I anticipated when I started the project.

Archer Moyo (Researcher)

I am Archer Moyo and 34 years old. I was employed in the project as a researcher. I approached the project with a background in town and country planning. However from

this project I have gained a lot of experience in social and physical research. As far as the mental health issue is concerned, the project has given me an opportunity to gain insight concerning the mental health problems with the BME groups. Besides I have gained new skills in community research.

In addition from taking part in the survey for the project, I have done the introduction of the report.

Chinyere Uche (Researcher)

I, Chinyere Uche 29 years old started as a volunteer in BACC. I have worked as a community worker before joining this project. So I was interested in this particular project because of my prior experience in research and community, which I acquired from Youth service placement in my country (Nigeria).

I have realised that the problem of mental health on the African community is more serious than it appears. Therefore there is a need for serious steps to be taken for Africans to integrate them in the wider community.

Johnson Nyirenda (Researcher)

I am Johnson Nyirenda and 32 years old, I am a pastor and employed as a researcher for the project. My researching skills were very instrumental to the findings of this report. I am fluent in a number of languages including Swahili, Chewa, Nyanja, Tumbuka and English.

Before the research I was in an opinion that mental health was associated with mental sickness or dementia. As a Pastor, this project has helped me broaden my knowledge on mental health of the people. I have realized that mental health is a larger issue than what I

thought previously. Now this can be helpful in my future career to better understand the mental health of the people.

Acknowledgements

In a project that works with and for the community there are often many agencies, groups, community organisations, statutory agencies and individuals that contribute to making it a success. The Black and Minority Ethnic Mental Health Programme – Community Engagement Pilot Project is not different from others.

Without the continued support of many individuals such as:

- Dean Pinnock, National Institute for Mental Health in England (NIMHE) – Race Equality Lead, Eastern Region
- Valma James, Director of the Key 2 Diversity Access (Consultant)
- Paul Asquith, former Support Worker – University of Central Lancashire (UCLAN)
- Alia Syed, Senior Support Worker – University of Central Lancashire
- Imran Mirza, Support Worker - University of Central Lancashire
- Jacqui Burnett, former Equality and Diversity Lead, Bedfordshire and Hertfordshire Strategic Health Authority.

We would not have such a successful project.

This Project was funded by National Institute for Mental Health in England (NIMHE), sponsored and managed by the University Of Central Lancashire (UCLAN). We would like to formally thank them for having made tremendous contributions to the realisation of this project.

A big thank you to everyone who has contributed to this project and a special thank you to all the researchers listed below who have given up their time to make this project possible, not forgetting you for your support.

Mr Horace Nyirenda -Lead Researcher

Mr Joshua Muhindo -Assistant Project Coordinator

Mr Charlton T. Mandayaya-Researcher

Mrs. Violet Mutambirwa-Researcher

Mrs. Iffrah Hirsi-Researcher

Mr Archer Moyo-Researcher

Mr Chinyere Uche- Researcher

Mr Johnson Nyirenda- Researcher

Executive Summary

Bedfordshire African Community Centre (BACC) is a community organisation based in Luton, acting as a resource body and aimed at providing advice and support for African communities living in Luton and the Bedfordshire areas.

BACC was one of 11 BME community groups across England that were selected as part of a National Pilot Project to gain better understanding of the needs of ethnic minorities.

The Delivering Race Equality in Mental Health Care (DRE) is a national action plan to promote mental health services in Black and Minority Ethnic (BME) communities designed to deliver on three key building blocks,

- More appropriate and responsive services
- Community engagement
- Better information

The overall aim of the action plan is to achieve:

- Equality of access
- Equality of experience
- Equality of outcomes

for BME mental health service-users. (DRE, 2005)

Bedfordshire African Community Centre was focusing on identifying the mental health needs of African asylum seekers, refugees and new immigrants of ages starting from 18 years to 65 years old. The respondents must be living in Luton and Dunstable areas of Bedfordshire with a focus on those who had experienced wars or /and conflicts in Africa..

At the time the project proposal was written (February 2006), Luton Borough Council records were showing that 1.74% of Luton's population was Black Africans (estimated total population of Luton is 185,200; Luton Borough Council Census 2003), 4.15% were Caribbean and 0.45% was other Blacks. This Black African population is increasing at a rate of 5.6% annually.

It is commonly assumed that Blacks and Asians people do not access mainstreams provision, because they do not need them, and that they seek and receive help in their own 'close-knit' communities. Indeed, several studies appear to support this notion. Moyenda (1997), for example, interviewed individuals and groups (230 people in total in London and Luton.). It was then identified that there was lack of recognition of psychological, physical, and mental trauma experienced by African communities. There was perceived inability to access support or mainstream services which had impact on their employability, health, social well-being, family relationships, and stability causing stress related health problems.

Researchers went through external trainings and support that was provided by the Centre for Ethnicity and Health, UCLan. The questionnaire was designed to elicit experiences and needs of Black African Communities. As part of the project, the researchers were given the opportunity to achieve level one certificates in 'Community-Based Research' and 'Mental Health Policies and Practice'. 6 of the 8 researchers achieved one or both of these.

The Focused Implementation Site (FIS) acted as the Steering Group for the project and bi-monthly meetings were attended by BACC. The FIS membership consists of representatives from a wide range of relevant agencies including the Community Mental Health Trust, Luton PCT, the Bedfordshire and Luton Strategic Health Authority as well as Luton City Council.

We hope that the findings may help in developing appropriate services in partnership with statutory, public and voluntary organisations. We also hope that we will develop support for groups that will have been identified that require support.

The interview conducted resulted in getting 90 respondents: 57% males and 43% females. This covered an age range of (18) constituting 1.5% of respondents; (19 – 21) 3% of respondents; (22 – 24) 6.3% of respondents; (25 – 29) 27% of respondents; (30 – 39) 36.4% of respondents; (40 – 49) 19.7% of respondents and (50+) 6.1% of respondents.

40% of the respondents had lived in other European countries while 60% came straight from African countries.

Most of the respondents were married followed by small proportion that was single.

The respondents had different reasons why they came to settle in Luton. This includes but not limited to studies, marriage, family accommodation, friends, refugee/immigration, work, etc.

About 72.2% of the respondents have settled in Luton for 1 – 5 years while 13.3% had lived in Luton for less than a year.

Majority of the respondents experience financial problems both in their country of origin and the UK. Other problems encountered include: war, separation from family, violence and loss of loved ones. When respondents arrived in the UK, some of the problems they were repeatedly subjected to are unemployment, language difficulties, racial discrimination, homelessness, racial abuse, uncertainty of legal status and social isolation.

Interestingly, 54% of the respondents had considered themselves to have had/knew someone who had mental health problem. Most mental health problems were however

handled within families, discussions and with help from pastors or Imams. A good number indicated they had to carry the burden alone, as they get no support of any kind. Some however obtained support from General Practices (GPs).

With regards to availability of services, the report indicates that although services are available, there is not enough information about them 42.2% of 90 respondents found it hard to access these health services.

Suggested areas of improvement include translating information necessary into different languages so that people are given the right information at the right time. Another suggestion in this regard was the need to tailor services to suit different users.

This will no doubt enable and indeed help ethnic minorities access easily services, which are directly made for them.

Introduction

Background

We often use the following words or phrases

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

Sometimes they are used interchangeably to mean the same thing. Sometimes, the same word or phrase is used by different people in the same meeting to mean different things. The Center for Ethnicity and Health has a very specific notion of Community Engagement and this section is an attempt to describe it. The Center's model of community engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone came in November 2000,

when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLAN) to administer and support a new grants initiative. The initiative aimed to get local Black and Minority Ethnic groups across England to conduct their own needs assessments, in relation to drugs, education, preventive and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health 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, to an extent even more important, was the process by which this was to be done. If all the Department of Health wanted was a need assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and Minority Ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have long term impact.

This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then go away. It wanted local Black and Minority Ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a need assessment at the start of the project; what they would have is proven access to the community 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 months process to learn about drug related issues and about 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 the communities, they would be able to continue to articulate those needs to their local

service providers, and the local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health model of Community Engagement was born.

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

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

New communities have also been brought into the programme although Black and Minority Ethnic communities remain the focus of the work. The Centre has also worked with

- Young people
- People with disabilities
- Service use groups
- Victims of domestic violence
- Gay, lesbian and bisexual people
- Women
- White deprived communities
- Rural communities

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

Bedfordshire African Community Centre (BACC)

Bedfordshire African Community Centre is a voluntary sector organization established in 2002 to provide support and advocacy to the African population in Luton. We aim to meet the needs of the African Community members by developing and promoting the interest of Black Africans and disadvantaged groups in the wider community. We target Black African ethnic groups who are predominantly refugees, asylum seekers and new migrants.

BACC was one of eleven Black and Minority Ethnic community groups across England that were selected as part of a national project to gain better understanding of the needs of ethnic minorities. The project was funded by NIHME Eastern and managed and supported by UCLAN.

According to the 2003 census the population of Luton was estimated at 185,200 of which Black Africans are 3,223 (making them 1.74%) of the total population. Other researchers (e.g. Needs of Asylum Seekers and Refugees settled in Bedford) that were conducted on this increasing group, it was identified that there was lack of recognition of psychological, physical, and mental trauma experienced by African communities. There was perceived inability to access support or mainstream services which had impact on their employability, health, social well-being, family relationships, and stability causing stress related health problems. Put differently there is no relevance and equality in mental healthy provision in our society.

According to the paper 'Delivering Race Equality in mental health care', page 14; equality in mental healthy services is not a new requirement. Many of the actions described in DRE have their roots in existing legislation, guidance or initiatives. Delivering Race Equality in Mental health Care (DRE) is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority (BME) status.

The objectives of this project are:

- To identify the mental health needs of African Asylum Seekers, refugees and New Migrants who arrive in Luton.
- To propose measures to reduce the number of Asylum seekers and refugees entering mental health institutions under section 3 of mental health Act (being institutionalised).
- To recommend a system for identifying a service that is appropriate to the experience of the African community e.g. community support mechanism and to improve access to more mainstream services.
- To help reduce or prevent the African Communities experiencing the same as the earlier black ethnic minority communities in regards to diagnosis and treatment of mental ill health.

It is hoped that any information emerging from this report will be key to commissioning and planning services for diverse and 'hard to reach' communities. We also hope that new partnerships between statutory bodies and these communities will be formed. Capacity building of individuals and groups involved in the project will also be a key outcome.

Methodology

Recruitment, Roles and Responsibilities

Bedfordshire African Community Centre (BACC) advertised through Herald and Post (Luton Newspapers) for seven researchers to work and help to research in the Mental Health Project to be conducted in Luton and Dunstable areas. The people and abilities, which BACC were looking for included among others:

- A. Someone with good communication skills
- B. Someone with ability to collect data and analyse
- C. Someone who could grasp the concept of research methodology after training
- D. A person who could work effectively in the area of Luton and Dunstable because of its diversity
- E. Someone who belonged to an African community

Seven researchers were recruited through an interview, which was conducted at BACC offices. The recruited researchers had very good communication skills. UCLAN engaged all seven (7) researchers in training programme with an aim of preparing them for research work.

The training, which was conducted by UCLAN, was divided into two areas and these were:

1. Community research and
2. Mental health policies and practices.

Amongst of the seven researchers who attended trainings, five of them gained qualification in university certificate in community research and mental health policies and practices.

Research Description, Target group and Access to the Community

All data collected was done by using a questionnaire. All the researchers were involved in compiling the questionnaire by using the knowledge acquired during the training sessions. A positive aspect, which surfaced as the questionnaire was being compiled, was that the cultural backgrounds of researcher was fitting very well into the project as they were Africans themselves who at one point or the other have experienced mental health problems.

A pilot survey was done with 10 questionnaires. The pilot survey helped BACC and researchers to address areas and questions, which were not logical, clear and lacked of psychological impact.

Ninety people from African Communities were interviewed successfully. The interviewees were consulted individually to go through the interview, however, there were some people who refused to be interviewed due to reasons like time consuming, they claimed to be busy, some did not want to be involved and that the questionnaire is too long.

People targeted were the youth; old men and women with ages ranging from 18 to 65. During the interviews it was clear that each researcher was able to know a language or two from African communities. The knowledge of languages of African communities helped to link researchers to many people who have come from the same part of the world. Linking helped researchers to be more effective.

Task Delegations

The project had various tasks, which were accomplished by researchers effectively. Some tasks delegated include:

- Filling
- Attending meetings to represent researchers
- Writing reports
- Typing
- Searching the web for information
- Attending Mental Health Forums
- Distributing and designing flyers for the projects and
- Designing the questionnaire

Teamwork was central in accomplishing all of these aforementioned tasks.

Steering Committee

A steering committee, which was represented by Focused Implementation Site (FIS) Programme Board, was implemented. The Focused Implementation Site is a Multi-Agency committee whose sole purpose for this research was to help monitor and make recommendations to researchers. Meetings were held once a month to this effect; in addition, the steering committee played a crucial problem-solving role for researchers in areas where they encountered any problem while carrying out the research. The committee was also there to critically analyse data, monitor the report writing process and ensure it represented the needs of the African Community.

Data Analysis

Two approaches were used to analyse data after research was completed. These are:

- A. Qualitative Data Approach dealt with themes, subjects and topics found in the questionnaire. Some of the researchers analysed this data manually by going through each questionnaire and critically analyzing each question.

B. Quantitative Data approach dealt with figures and numbers. Inputs were word processed and translated into graphs and charts of different types.

RESULTS

N.B. All Percentages rounded to 1 decimal point

Below is the data collated from the 90 questionnaires that were completed by the target group. The data is produced below in two categories, core data and primary data:

SECTION 1: Core data

Table 1: Age Group

Age	Count	%
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16 – 18	1	1.5%
19 – 21	2	3%
22 – 24	6	6.3%
25 – 29	20	27%
30 – 39	39	36.4%
40 – 49	18	19.7%
50 ⁺	4	6.1%
Total	90	100%

Table 2: Gender

Gender	No of Respondents	Percentage
Male	51	56.7
Female	39	43.3
Total	90	100

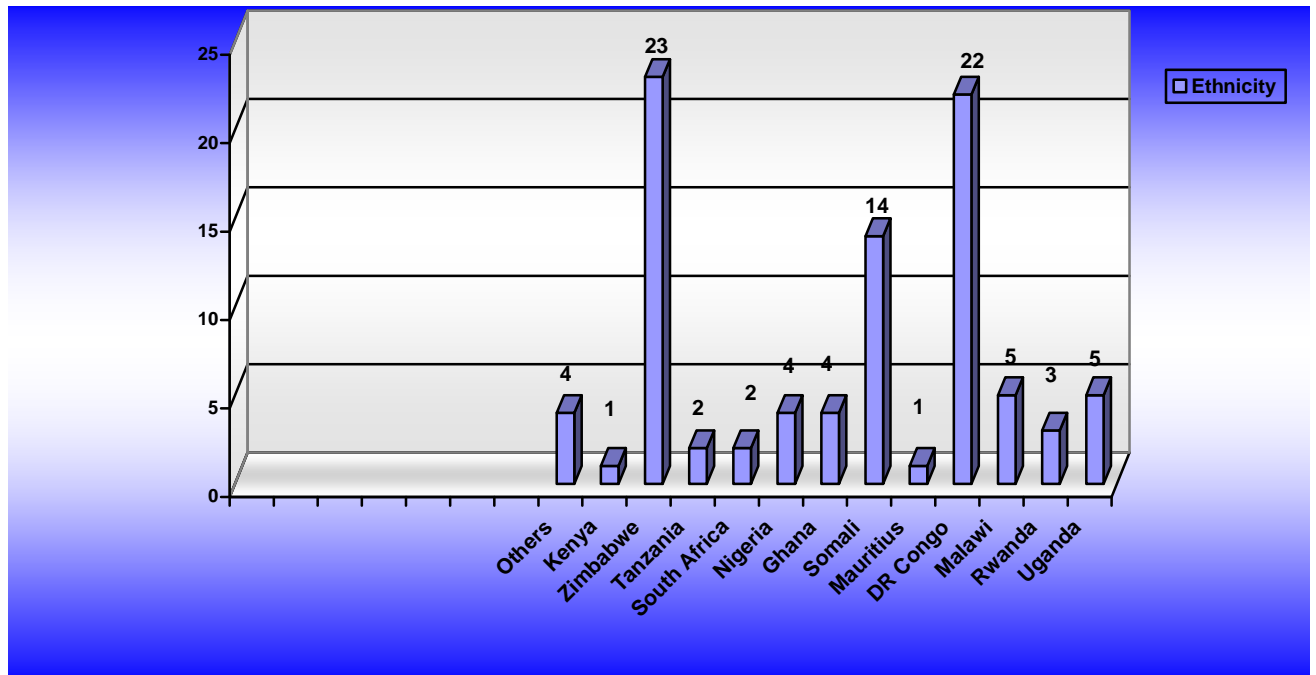
Table 3: Ethnicity

Ethnicity	Number of Respondents	Percentage
Black British	1	1.2
Black African	85	94.4
Other African	4	4.4
Total	90	100

Table 4: Country of Origin

Country of Origin	Number of Respondents	Percentage
Uganda	5	5.6
Rwanda	3	3.3
Malawi	5	5.6
Democratic Republic of Congo	22	24.4
Mauritius	1	1.1
Somalia	14	15.6
Ghana	4	4.4
Nigeria	4	4.4
South Africa	2	2.2
Tanzania	2	2.2
Zimbabwe	23	25.6
Kenya	1	1.1
Others	4	4.4

Total	90	100
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Graph 1: Country of origin

Table 5a: Length of Residency in UK

Years	Number of Respondents	Percentage
Less than 1 year	7	7.8
1 - 5	59	65.6
6 – 10	13	14.4
11 +	11	12.2
Total	90	100

Table 5B: Length of residency in Luton

Years	Number of Residents	Percentages
Less than 1	12	13.3
1 - 5	65	72.2
6 - 10	9	10.0
11 - 15	3	3.3
16 - 25	1	1.1
Total	90	100.0

Table: Marital Status

Status	Number
Married	60
Widowed	3
Single	20
Divorced	2
Enforced Separation	1
Separated by choice	2
With partner	2
Total	90

Table 6: Language written and spoken

Language	Written	Spoken	Percentage Written	Percentage Spoken
English	51	58	39.8	37.2
Italian	3	3	2.3	1.9
Swahili	12	14	9.4	9
French	24	26	18.8	16.7
Dutch	3	4	2.3	2.6
Chichewa	1	3	0.8	1.9
Somali	9	10	7	6.4
Kinya-rwanda	2	3	1.6	1.9
Afrikaans	0	0	0	0
Lingala	5	9	3.9	5.8
Luganda	2	1	1.6	0.6
Arabic	1	1	0.8	0.6
Yoruba	1	1	0.8	0.6
Ndebele	3	5	2.3	3.2
Shona	9	14	7	9
Nyanza	0	1	0	0.6
Twi	1	1	0.8	0.6
Swedish	1	2	0.8	1.3

Total	128	156	100	00
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Table 7: Status

Status	Number of Respondents	Percentage
Refugees/ Indefinite leave to remain	27	30
Humanitarian protection	1	1.1
Asylum Seeker	6	6.7
Extended Leave to Remain	15	16.7
Discretionary Leave	1	1.1
Naturalised – Other EU Country	9	10
Awaiting Appeal	0	0
No status Granted	3	3.3
Other	11	12.2
Total	90	100

Table 8: Sexuality

Sexuality	Number of respondents	Percentage
Lesbian	0	0
Homosexual	1	1.1
Heterosexual	68	75
Bisexual	1	6
Trans gendered	0	1.1
No answer	20	27.2
Total	90	100.0

Table 9: Disability

Disability	Number of Respondents	%
Yes	3	3.3
No	87	96.7
Total	90	100

SECTION 2: Primary Data

Which area do you live in?

Table 9a: Areas

Area	Number of Respondents	Percentage
Luton	87	96.7
Dunstable	3	3.3
Total	90	100

Luton and neighboring areas

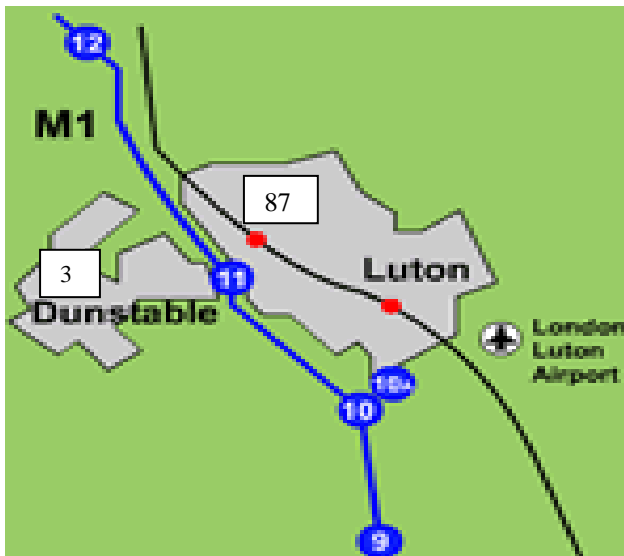
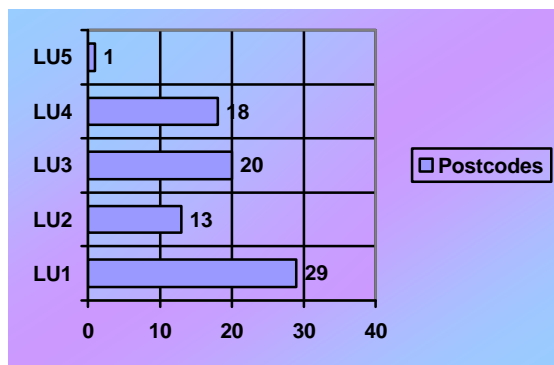


Table 9 B: Postcodes around Luton and Dunstable

87 respondents live in Luton

3 respondents live in Dunstable



1 respondent live in area with postcode LU5
18 respondents live in area with postcode LU4
20 respondents live in area with postcode LU3
13 respondents live in area with postcode LU2
29 respondents live in area with postcode LU1

Table 10: Employment Status

Employment Status	No of Respondents	Percentages
Employed	36	40.0
Part time employed	18	20.0
Voluntary work	9	10.0
On emergency support	1	1.1
Student	18	20.0
NASS	2	2.1
Not permitted to work	6	6.7
Total	90	100.0

SECTION 3

The aim of this section is to explore the background/experience to the interviewee and to find out what the interviewee understand by the term ‘Mental Health’ and accessing and receiving of mental health services.

Table 11: What events have you experienced in your home country or during your journey to UK?

Event	No of Responses	Percentage of 90 respondents
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War	19	21
Torture	14	15
Violence	19	21
Destruction of your home	5	5.5
Sexual assault	0	0
Rape	2	2.2
Domestic Violence	5	5.5
Persecution	12	13.3
Bereavement and loss of loved ones	13	14.4
Separation from family and friends	22	24.4
Lived in Refugee Camp	3	3.3
Detention and Imprisonment	1	1.1
Family problems	9	10
Serious illness	0	0
Financial Problems	34	37.8
Local Displacement	5	5.5
Other	2	2.2
Total of answers	165	

Note: More than one answer was required.

Table 12: What events have you experienced since your arrival in the UK?

Event	No of Respondents	Percentage of 90 respondents
Detention	5	5.6
Homelessness	12	13.3
Family Problems	14	15.6
Poverty	7	7.8
Separation from Family/ Friends	29	32.2

Violence	2	2.2
Racial abuse	19	21.1
Unemployment	38	42.2
Uncertainty about your legal status	14	15.6
Social Isolation	13	14.4
Racial Discrimination	27	30
Language difficulties	25	36.1
Sexual assault	0	0
Domestic violence	2	2.2
Serious illness	2	2.2
Financial Problems	32	35.6
Rape	0	0
Other	2	2.2
Total	245	

Note: More than one answer was required.

Table 13: Have you experienced any of the following mental health problems before you left home and/or since you arrived in the UK?

Event	No of Respondents	Percentage of 90 respondents
Depression	33	36.7
Guilt	7	7.8
Anxiety	14	15.6
Mood Swing	17	18.9

Suicidal Thought	3	3.3
Headaches/Migraine	23	25.6
Intrusive thoughts	2	2.2
Flash backs/Nightmares	1	1.1
Difficult sleeping	25	27.8
Emotional numbness	1	1.1
Loss of appetite	10	11.1
Drinking too much alcohol	5	5.6
Poor Concentration	8	8.9
Memory loss	1	1.1
Aches	8	8.9
Pain	11	12.2
Others	1	1.1
Total	196	

Table 14: Have you ever had or known someone who has got mental health problems?

Event	No of Respondents	Percentage
Yes	49	54
No	41	46
Total	90	100

Most respondents indicated that the main causes of mental health were stress, depression and rejection. Other wise problems started include drugs and alcohol abuse, depression, speech problem and persecution

Table 15: What support did you or the person receive?

Source of Support	No of responses	Percentage of 90 respondents
GP/ Family doctor	17	18.9
Pastoral /Imam	31	34.4
In/Out patient services	8	8.9

Any Community mental health team	5	5.6
Any psychological/taking therapy	6	6.7
Days service for the people with mental health	8	8.9
No support	22	24.4
Other	12	13.3
Total	142	

Table 16: In your opinion, which service is the most effective?

Service	No of respondents	Percentage of 90 respondents
Family	10	11.1
GP Service	15	16.7
Spiritual Support	7	7.8
Ashanti	2	2.2
Hospital	5	5.6
Communication Between detainees and family	1	1.1
Community mental health	7	7.8
Talking therapy mental health unit	9	10
Day service	3	3.3
Housing	2	2.2
In/out-patient services	2	2.2
Voluntary services	1	1.1
Don't know	2	2.2
Total	66	

Why the respondents think that the following services are most effective:

- **Family:** they feel confident, getting permanent support and understanding of the cause as to when the problem started. They also feel a sense of connection and relation that would help them to come out and talk about the problem; the Patient feel good and confident to be loved by friends and family.
- **Mental Health Units:** try to stop the patient from committing suicide and the related problems. There is permanent support and familiar to patient environment.
- **Pastoral Support:** brings hope especially when the problem is shared with the church people. The experience makes me feel confident, praying and counselling, believe in God.

- **General Practitioner (GP):** caring for the patient, familiarizing the patient with the services, help with medication, getting more counselling, family feel comfortable and confident to talk, knowledge to deal with the problem and information.
- **Out/In-patient Service:** Service adjusted to the patient's environment.
- **Talking therapy:** meeting other people in the same situation, listen skills, empathizing, can meet people from same ethnic background.
- **Hospital:** psychological reason, full recovering /improvement, medication.
- **Social Services/Ashanti:** Meeting friends in the same situation, which he can trust.
- **Day Service:** opportunity to have some training, understanding of illness, this is a place where more time is spent with patient, befriending and social activities, and finally it a place where needs are assessed.

Table 17: How easy has been to access the service?

Accessibility of Health Services	No of participants	Percentage of 90 respondents
Very easy to access Health Services	4	4.4
Easy to access Health Services	20	22.2
Hard to access Health Services	23	25.6
Very Hard to access Health Services	15	16.7
Total	62	

Why they think it has been easy to access services:

-**Very easy** to access health services because: it is within the local town where the patient resides. They feel it was easy because they were British National. And finally it is because of institutions that cater for such services.

-**Easy** to access health services because: it is open to every one, information is available, data records are available, there are referrals from GP's, There is time convenient to the patient, Staff attitudes have changed in that they understand patients needs.

- **Hard** to access health services because: there is lack of exposure, no facilities at all in the community, waiting time to meet the GP, misunderstanding with the staff, they (services providers) do not listen to patient, it takes several visits before getting referrals to the specialists, too much paper work (bureaucracy).

-**Very hard** to access health services because of bureaucracy (have to book appointment through a GP) service providers do not listen to patients, patients have to live in the country long.

Most respondents avoided this aspect

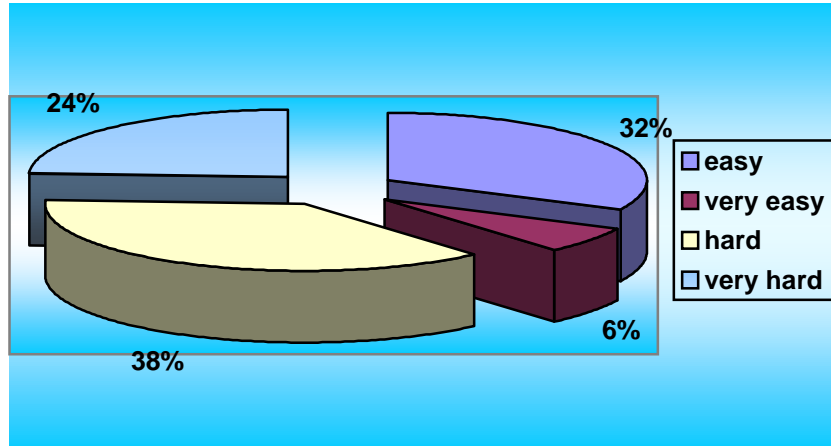


Figure 1: Accessibility of health services

Table 18: Q.25 How do you rate the services you received?

Very Poor	Poor	Good	Very Good	Excellent	Don't know
6	10	17	12	3	9

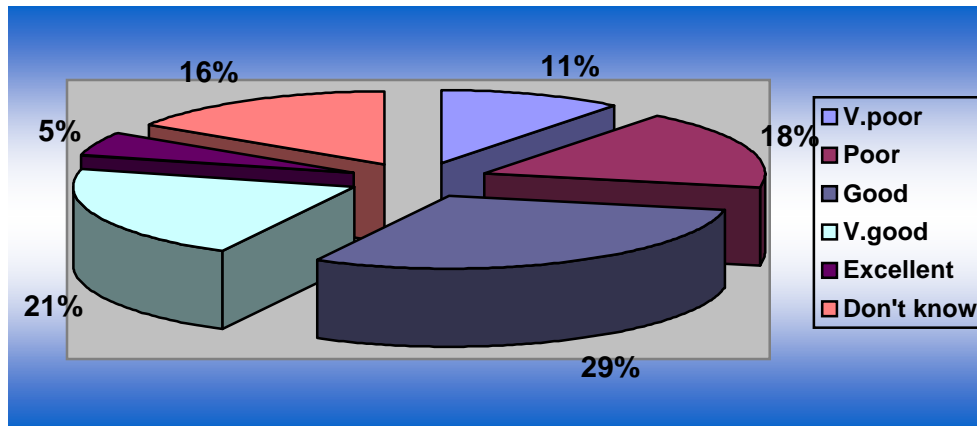


Figure 2: Service ratings

Table 19: Q.26 Have you/or the person using the services improved?

Service user benefit	No of participants	Percentage
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Yes definitely	24	26.7
Yes to some extent	30	33.3
No	12	13.3
No answer	14	15.6
Total	90	100

Q.27 Were you or the person using the service given sufficient information about your or their condition and treatment? n=58

Table 20: Information provided by services

Too much	The right amount	Not enough
6	25	27

Q.28 Were you or the person involved as much as you wanted to be in decisions about care and treatment? n=64

Table 21: Involvement in decisions

Yes, definitely	Yes, to some extent	No
18	21	25

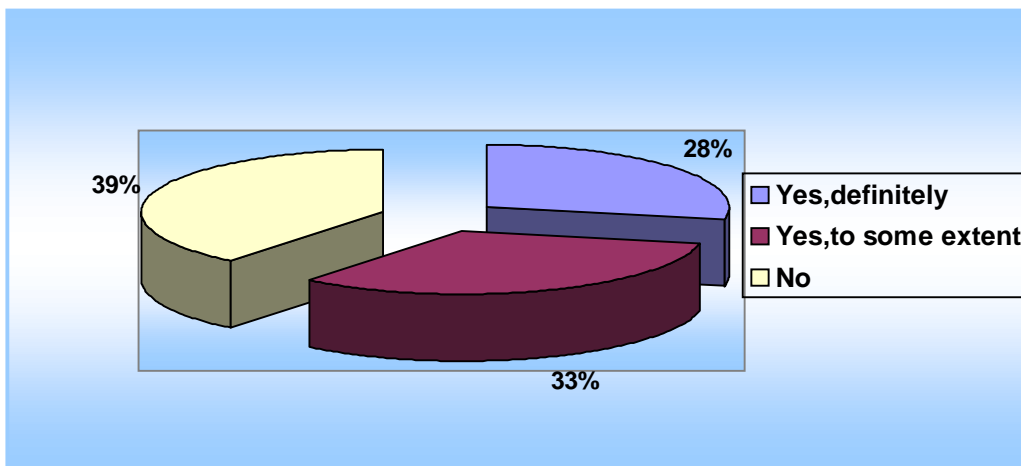


Figure 5: People involvement

SECTION 4

The aim of this section is to find the interviewee's opinion on how mental health services can be improved

Table 22: Q29. Which local services would you recommend to users?

Services	Number of respondents	Percentage of 90 respondents
Support of relatives & friends	52	57.8
Medication	40	44.4
Counselling	56	62.2
Therapy	32	35.6
Information	41	45.6
Spiritual support	42	46.7
Drop-in services	25	27.8
Help from others in the same position	30	33.3
General	8	8.9
General Practitioner	20	22.2
Befriending	21	23.3
Hospital	23	25.6
Support worker	40	44.4
Interpreter	1	1.1
Sending them back home	1	1.1
More support from the Government	1	1.1
Total	433	

Table 23: Q.31 What kind of help do you think Refugees and Asylum seekers with mental health problems need?

Help	No. of responses	Percentage of 90 respondents
Support of relative and fiends	47	52.2
Medication	37	41.1
Counselling	54	60
Therapy	24	26.7
Information	38	42.2
Spiritual Support	44	48.9
Drop ins	22	24.4
Help from others in the same position	29	32.2
General	4	4.4
General practitioners	20	22.2
Befriending	14	15.6
Hospital	23	24.6
Support worker	39	42.2
Other	3	3.3
Total	378	

Q32. What can be done to improve current services in the area?

The following written answers were given to the above question

1. One –to – one service
2. Translation of information
3. Home visit
4. Question time reduced
5. Emergency services
6. Visitations
7. Reduce the length of appointments
8. User involvement
9. More support workers
10. Respect for Black people
11. Tailor services for different groups
12. Hiring standards
13. Communication
14. Staff visits
15. Reduce waiting list
16. More facilities

Most respondents indicated that their living standards are very poor, hence if this were not addressed, people would experience more stress. One respondent said:

“We don’t have proper accommodation”. Respondent

Q.33 Is there anything positive or negative about the local mental health services?

Positive:

1. Services fairly good
2. Accessible information

Negative

1. Lack of information in African languages
2. A lot of bureaucracy
3. Negative about the system

DISCUSSION

The focus of the research was to identify those that are at risk of mental ill health such as depression and anxiety associated with experience from war zones in Africa or discrimination particularly amongst refugees, asylum seekers and new immigrants. The report is also intended to identify the mental health needs of the target group to prevent deterioration and reduce the admission rate. This is in line with the five-year vision of the document *“Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services”*, in particular section 1.32.

The sample was chosen randomly from the Luton population with emphasis on refugees, asylum seekers and new immigrants. The respondents’ origins include 25.6% from

Zimbabwe, 24.4% from Democratic Republic of Congo, 15.6% from Somali and the rest from other countries; see distribution as shown in Table 4.

The findings of the research showed that mental health problem was common amongst Black Ethnic Minority in Luton, Bedfordshire. In the survey, 54% of the respondents knew someone or had experienced mental health problem, this is more than half of the sample size which confirms that mental health exist amongst this target group.

The background of the respondents was highlighted to gain a clearer picture of how they perceive and access services. 16.8% had suffered from depression before and on arrival to the United Kingdom. Based on the findings, this could be linked predominantly to financial difficulties, separation from families/friends, experience of war in their home country and on arrival in United Kingdom, unemployment, financial problems and separation from family/friends.

On arrival in UK, 42% respondents faced unemployment, 36% encountered financial problems, 21% experienced racial discrimination and 36% of the respondents considered themselves to have language barriers. This shows the challenges faced by the respondents during the transition period and the communication gap, which could serve as a stepping-stone for misunderstanding or having difficulty in accessing services.

In analyzing the services received by those who had or knew someone who had mental health problem, 34% received support from the Pastor/Imam, 24% did not receive any support and the General Practitioner (GP) supported 19%. This shows where the level of trust and the service with the most outreach to the target group.

This implies that church services and mosques in the community have been complementing the work of the GP by providing support and counseling services such as peer support at the centres. Centres such as drop-in-centres, day services should be made easily accessible, both in target groups to be reached and the sign posting. They provide a good opportunity for befriending services and participate in social activities.

The General Practitioner (GP) was identified as the most effective service by 17% of the respondents although those who had or knew someone who had mental health problem felt it was hard to access the service. Family support was nominated as the second most effective by 11% of the respondents. In their comments, the respondents raised concern on the issue of medication. One respondent said:

“Though it aided recovery, made the patient calmer... but in some cases it seemed to be only effective for a short period because either the client stopped taking the medication and relapsed into his or her former state or they relied heavily on medication. In some cases, dosages had to be increased as a result of the body of the patient becoming immune to the amount of dosage prescribed at that time”.

Out of the 64 respondents who answered, 39% were of the opinion that they or the person they knew was not allowed to be involved as much as they wanted to be in their care and treatment. Most of the respondents commented, “They or the users were not involved in the decision making”. They felt that they were not considered capable of knowing the best treatment and in some cases the service providers did not bother to find out if they had any substantial contribution based on their experience. However, 61% out of the 64 that answered felt to some extent they or the person they knew was allowed to contribute to decisions involving their care and treatment.

The respondents were asked to recommend a local service to users. 62% recommended counselling. Interestingly, it may be recalled that 22% recommended the GP. This low figure may be linked to the problems associated with accessing the GP’s services.

In order to provide better services for refugees, asylum seekers and new immigrants with mental health problems, there was a need to evaluate which option is best suited for the target group and could be a strong influence in ensuring that there are improved local

services in the treatment of mental health issues. 60% recommended counselling, 52% support of friends/relatives and 49% suggested spiritual support. The

Suggestions for improvement of the current services included, more attention should be given to clients by adopting a user involvement approach.

Individuals who have suffered mental health problems as well as those in certain minority ethnicity should be encouraged to work with those in similar situation by creating jobs for them. This will facilitate the recovery of patients as they feel understood and this removes communication gap barrier.

Also, they believed that patients should be involved in their treatment process and be listened to by the GP or psychiatrist. Also, the length of appointment should be increased to provide value while there should be a conscious effort to reduce the amount of time users are on the waiting list. Concerning interpretation services, important information on mental health should be translated to major foreign languages especially African languages. Cultural sensitive methods such as matching patients with psychiatrist who are familiar with their culture and background could help the patient's recovery.

Furthermore, there should be a social worker specifically for people that have mental health problems. The duty of the social worker would entail regular visits to those affected with mental ill health. Charities should be used as access points to reach out to BME communities with support from the government towards capacity building in this respect.

Finally, poor living standard was identified as one of the factors affecting mental health. Therefore, the respondents felt a conscious effort needs to be made by the authorities to improve accommodation for refugees and asylum seekers with work permit. Delicate issues such as the immigration's operational processes should be properly sorted out speedily and in a friendly manner while making communication more accessible between

detainees and friends or relatives. This can contribute to the reduction of stress and depression.

The respondents were asked to give their opinion on the services in their locality. The following are examples of this:

“They try to help”

“It is a good step forward and they must be encouraged”

“They try to be very supportive”

“There are a lot of people with mental health problems roaming the streets and most of them are Blacks”

“At least this research is a positive initiative”

“It [the mental health services] is not known, not advertised”

“They don’t involve patients in their treatment”

Recommendations

- There is a need to be more information disseminated through the local media on local mental health services and how it can be accessed and be available in the community especially amongst BME groups.
- Important information on mental health should be translated to major foreign languages especially African languages
- There is a need to have proper education on mental health issues through community groups such as charities, religious groups etc to minimize the stigma and fear of mental health services. The services need to be made more culturally sensitive and work as an integrated system to ensure effectiveness.
- Patients should be much more involved in decision making regarding their treatment process.
- The General Practitioner (GP) needs to be made more accessible. The authorities need to reduce the length of time it takes to get an appointment; interpreters should be easily accessible. GPs are encouraged to provide more information to the affected person. This is expected to facilitate speedy recovery.
- Long-term recovery should be addressed by a combination of the services such as counseling, support from family/friends, day centres etc depending on the individual case, their background and need.
- Service users should be allowed to contribute to their treatment and adequate provision should be made for capacity building amongst BME community to ensure maximum participation.
- Greater effort should be put into tackling discrimination and the provision of equal opportunities in gaining a job and accessing services like education.

- There should be an outreach social worker specifically for people that have mental health problems. The duty of the social worker would entail regular visits to those affected with mental problem
- Church services and mosques should be involved in providing spiritual support and counseling services such as peer support at the centres
- Centres such as drop-in-centres and day services should be easily accessible, both in target groups to be reached and the sign posting. They provide a good opportunity for befriending services and participate in social activities. Day services was preferred by some people compared to a GP because they felt the day services give more time to the target group, listening to them and trying to solve their problem while the GP is always constrained for time
- The operational processes of the immigration system should be improved as this can contribute to reducing stress and depression. Make the opportunity for communication more available between detainees and friends or relatives
- Improve accommodation for refugees and asylum seekers
- Qualified staff with a similar background in terms of ethnicity helps in making the patient and the family feel more comfortable.

References

[1] Department of Health (11 Jan 2005) "Delivering race equality in mental health care; An action plan for reform inside and outside services and the government response to the independent inquiry into the death of David Bennett" Point 3.77,p.51

[2] Jo Neale B (Hons) Psychology, Msc, senior research fellow, Marcia Worrell PhD, senior lecturer, Institute for health research, University of Luton & Gurch Randhawa PhD, Msc Research and Evaluation, Bsc (Hons), principal research fellow (Oct 2005) "Mental Health Practice" Vol 9,No.2

[3] 2003 Mid year Population estimates for Luton "Luton Children & Young Peoples Plan (2006-2009)"Draft for Consultation August 2005 to January 2006.

Appendix

National Institute for Mental Health in England-NIMHE
BLACK AND MINORITY ETHNIC MENTAL HEALTH PROGRAMME

Bedfordshire African Community Centre
Known as “BACC”

AFRICAN REFUGEES, ASYLUM SEEKERS AND NEW MIGRANTS

MENTAL HEALTH PROJECT IN LUTON

COMMUNITY ENGAGEMENT PILOT PROJECT

Questionnaire –Interview

CONSENT

Bedfordshire African Community Centre is conducting this study and is about identifying the Health services provided, the ease of access and how efficiently they have been able to meet the needs of African between ages of 18 to 65 in Luton, Bedfordshire area as regard their mental health. We will be asking you question about your experience and knowledge of Mental Health services in the area.

The aim of the survey is to identify Mental Health needs among Asylum seekers/refugees and new immigrants of Africa origin. Between the age of 18 to 65 both male and female, living in Luton and Bedfordshire. A report on the findings will be used to inform policy and also to lobby for the services that you tell us you need.

Please read the declaration below and **sign**, or **mark** in the space provided. Please ask the researcher to read the declaration and explain it to you if you so wish.

I have been invited to participate in this study and voluntarily accept. I confirm that:

- The aims of this research have been explained and made clear to me
- That this form has been read out to me and that I have been free to ask questions.

I understand that:

- My participation in this study is entirely voluntary
- I can withdraw form this study at any time by informing the researcher of my intention to withdraw
- I don't have to answer any questions if I don't want to, but I am encouraged to answer where I can
- I have been offered to have all the materials verbalised
- Any comments that I make, will not be attributed to me unless I expressly give my consent
- All the information I provide will be in confidence and that it will only be shared amongst those working on the research. (I understand that the researchers may

disclose information that I give which reveals harm to others or child abuse this will be dealt with in accordance with BACCs disclosure procedure)

- Any report form this study will be written in such a way that contributors and contributions are anonymous. The researchers will endeavor to present all the information in a manner that does not lead to the easy identification of participants.

I have been provided with a copy of this consent form.

Signed or Marked: _____ Date: _____

For further information or clarification on any aspect of the research, please contact Bony N Shamalo at BACC on 01582484807.

Sponsored by:

SECTION 1:

Core Question

1. How old are you?

- 16-18
- 19-21
- 22-24
- 25-29
- 30-39
- 40-49
- 50+

2. Gender?

- Male
- Female
- Trans gendered or Transsexual

3. What is your ethnic group and country of origin?

- Black British, please specify.....
- Black African, please specify.....
- Other Black, please specify.....
- Other African

4. Your country of origin

a. Other countries you have lived in

.....

.....

5. Marital status:

- Married
- Widowed
- Single
- Divorced
- Enforced separation
- Separated by choice
- With partner

6. What area do you live in?

- Luton
- Dunstable
- Others (please specify).....

a. Postcode (first three letter and number only)

Please note: you do not have to give your postcode, and all information will remain confidential.

7. How did you come to live in Luton?

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

8. How long have you lived in Luton?

- Less than a year
- 1- 5 years
- 6 – 10 years
- 11 – 15 years
- 16 – 65 years

9. Which languages do you speak?

- a. Spoken.....
- b. Written.....

a. Which languages are you fluent in?

- a. Spoken.....
- b. Written.....

10. Were you born in the UK?

- Yes
- No

If No, how long have you lived in the UK?

- Less than a year
- 1- 5 years
- 6 -10 years
- 11 years or more

11. Status:

- Naturalised British
- Refugee/Indefinite leave to remain
- Humanitarian protection
- Asylum seeker
- Extended leave to remain
- Discretionary leave
- Naturalised – other European country (please specify.....)
- Awaiting appeal
- No status granted
- Other (please specify).....

12. Do you have any disability?

- Yes
- No

If yes, please state.....

Employment status

- Full time employment
- Part time employment
- On emergency support
- Voluntary work
- Student
- NASS
- Disabled – working

- Disabled not working
- Retired
- Not permitted to work
- Other (please specify).....

13. Are you satisfied or dissatisfied with your existing locality?

- Satisfied
- Neither/Nor
- Dissatisfied

Why?.....

14. Sexuality

- Lesbian
- Homosexual
- Heterosexual
- Bisexual
- Trans gendered or trans sexual
- I don't want to answer

SECTION 3:

The aim of this section is to explore the background/experience to the interviewee and to find out what the interviewee understands by the term “mental Health” and accessing and receiving of mental health services.

16. What events have you experienced in your home country or during your journey to UK?

- War
- Torture
- Violence
- Destruction of your home
- Sexual assault
- Rape
- Domestic violence
- Persecution
- Bereavement and loss of loved ones
- Separation from family and friends
- Lived in a refugee camp
- Detention/*imprisonment*

- Family problems
- Serious illness
- Financial problems
- Local displacement
- Other (please specify).....

17. What events have you experienced since your arrived in the UK?

- Detention
- Homelessness
- Family problems
- Poverty
- Separation from family and friends
- Violence
- Racial abuse
- Unemployment
- Uncertainty about your legal status
- Social Isolation
- Racial discrimination
- Language difficulties
- Sexual assault
- Rape
- Domestic Violence
- Serious illness
- Financial Problems
- Other (please specify).....

18. Have you experienced any of the following either before you left home and/or since

You arrived in the UK?

- Depression
- Guilt
- Anxiety
- Mood Swings
- Suicidal thought
- Suicidal attempts
- Headaches/ Migraine
- Intrusive thoughts
- Flash backs Night mares
- Difficult sleeping
- Emotional numbness
- Loss of appetite
- Drinking too much alcohol
- Poor concentration

- Memory loss
- Aches
- Pain
- Other (please specify).....

19. Have you ever had or known someone who has got mental health problems?

- Yes
- No

If yes when did the problem start?

.....

How did the experience impact on your life or the person you know?

.....

20. What support did you/the person receive?

- GP/Family doctor
- Family
- Pastoral/Imam
- In/out-patient services
- Any community mental health team, please specify.....
- Any psychological/talking therapy
- Day services for people with mental health problems
- No support
- Others (please specify).....

21. In your opinion, which service is the most effective?.....

22. How easy has it been to access service?

- Easy
- Very easy
- Hard
- Very hard

Why?.....

23. Why do you think it was the most effective?.....

24. Were you satisfied with the service received?.....

25. Have you/or the person using the service improved?

- Yes, definitely
- Yes, to some extent
- No

Feel free to explain.....

26. Were you/or the person using the service given sufficient information about Your or their condition and treatment?

- Too much
- The right amount
- Not enough

27. Were you or the person involved as much as you wanted to be in decisions about Care and treatment?

- Yes, definitely
- Yes, to some extent
- No

28. How do you rate the services you received?

- Very poor
- Poor
- Good
- Very good
- Excellent
- Don't know

SECTION 4

The aim of this section is to find out the interviewee's opinion on how mental health services can be improved.

29. Which local service would you recommend to users?

30. Do you know any mental health services that could be helpful but not made available.....

31. What kind of help do you think Refugees and Asylum seekers with mental health Problems need?

- Support of relative and friends
- Medication
- Counselling
- Therapy
- Information
- Spiritual support
- Drop ins
- Help from others in the same position
- General
- General practitioner
- Befriending
- Hospital
- Support worker
- Other (please specify).....

32. What can be done to improve current services in the area?.....

33. Is there anything positive or negative about the local mental health services?

Positive.

Negative

THANK YOU FOR YOUR TIME

